VMMC Services in a Rural Community: An AE Cluster in a Resettlement Area in Zimbabwe

Amy Herman-Roloff
U.S. Centers for Disease Control and Prevention
Timeline

• Non-VMMC-dedicated clinical Team at Masase Hospital trained in March, 2014 and started performing ~ 30 MMCs/week

• During an outreach from June 2-8 the team provided 315 MMCs – 23 at Masase Hospital and 292 at Gaha Rural Health Clinic (the Masase outreach clinic for the Chobelele resettlement area)

• The IP reported a cluster of 13 AEs on June 12 – this number increased to 17 by the time of the quality improvement visit on June 24. In the end, 19 AEs were identified – all 19 had infection, three of whom had wound dehiscence.
Chobelele Area
Quality Improvement Team
Methods

• Clinical observations (hospital-ward and the clinic)
• Review of clinical records
• Inventory of medical consumables
• Face-face interviews with:
  – Providers
  – Clients
  – Parents of clients and from the community
  – Community leaders (e.g., school headmaster)
AE Case Summary

• Initial report – 17 clients admitted for AEs
  – Two had severe wound infection and dehiscence requiring cleaning and re-suturing
  – 15 were admitted with moderate infections primarily for logistic purposes (i.e., social admission).

• The QI team identified two more AE cases in the community

• Total of 19 incident AEs (19/315 = 6.0%)
Assessment Findings – Clinical System

• Masase custodian cleaned rooms at Gaha, but mattresses were not cleaned after each operation – no hygienist was part of the team

• The severity of the AEs may have been overstated due to inexperienced/untrained outreach facility staff and/or the need for social admissions

• In some instances the national AE guide was vague – e.g. wound dehiscence which requires re-exploration (including re-suturing) is defined as severe

• Record keeping incomplete
Recommendations – Clinical System

• Adequate staffing during procedure, 2-days and 7-days after the procedure (hygiene, record keeping, and clinical services)
• Procure swab sticks for sepsis which is not responding to first line regiment of antibiotics.
• All VMMC team members who provide procedures or follow-up services should complete VMMC training.
• Rectify discordance in PEPFAR and national AE definitions
• “Hotline” for on-demand technical assistance
Assessment Findings - Community

- Chobelele is a traditional circumcising community (in July at ~ $20/circumcision)
- Parents reported unanimous support for the MMC program – but none accompanied their children for the MMC
- Parents reported using more salt in saline water than was recommended on the national post-operative care hand-out
- Two clients observed with traditional treatment
Recommendations - Community

• Strengthen community education about post-operative management (traditional medicine and strength of salt solution)
  – Stakeholders (e.g., teachers at school)
  – A parent who attends the procedures who can serve as a “peer educator”
  – Train drivers on post-op instructions and handouts

• Community mapping (traditional MC, water, traditional medicine, etc.)

• IPs may provide support items (underwear)
Resulting Programmatic Improvements

• Align demand creation and service delivery
  – Hybrid model where roving teams may augment local capacity to assure adequate service delivery
  – Trained clinical teams provide follow-up care

• Training coverage has improved

• No single “hotline” established but select providers are on call for consultation

• Underwear is provided as needed
Resulting Programmatic Improvements

• Increase in monitoring visits (QI – quarterly for each site, DQAs, EQA and SIMS)
  – Observe post-op counseling and provides refresher
  – Schedule QI and DQA visit after high-volume campaigns

• Engagement of community leaders during demand creation (for community entry and traditional medicine practices)
Resulting Programmatic Improvements

• Engagement with teachers to promote post-op care, as a link to parents, and as key community stakeholders