





Improving Quality VMMC


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

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# Timeline

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

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- 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 Chobebele resettlement area)

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- 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

- Chobebelele 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