health

Department:
Health
REPUBLIC OF SOUTH AFRICA

National VMMC programme | **Consolidated documents**

(July 2020)

INTRODUCTION AND PURPOSE

This pack outlines the key pieces of information that you need to provide excellent VMMC services. You can navigate the pack using the contents page below. At the end of this pack is a short summary and checklist for you to keep track of all of this information.

1. INTRODUCTION AND PURPOSE

2. HOW TO MANAGE CONTRACTS

2.1. INTRODUCTION

2.2. CONTRACT MANAGEMENT BEST PRACTICE

2.3. RT35 CONTRACT OVERVIEW

2.4. ROLES AND RESPONSIBILITIES

2.5. PAYMENT FOR THE SERVICE

2.6. PERFORMANCE MANAGEMENT

2.7. REPORTING

2.8. RISK MANAGEMENT

2.9. DISPUTE RESOLUTION

2.10. BREACH AND TERMINATION

2.11. FRAUD AND CORRUPTION

2.12. AUDITS AND INSPECTIONS

2.13. SLA DURATION AND CLOSE OUT

2.14. ANNEXURES

2.14.1. ANNEXURE 1: VMMC OPERATIONAL READINESS CHECKLIST

2.14.2. ANNEXURE 2: VMMC districts and targets; implementing partners' reporting obligations; implementing partners' key personnel and their key competencies in accordance with the RT35

2.14.3. ANNEXURE 3: Contract risk management process, risk form, risk register; anticipated risks register

3. GUIDANCE NOTE FOR RT35 SLA

3.1. CONTRACTING

3.2. THE SUPPLIER AND THE PURCHASER

3.3. SLA CLAUSES TO COMPLETE

4. HOW TO CONTRACT GENERAL PRACTITIONERS (GPS)

4.1. PURPOSE/OBJECTIVES OF THESE GUIDELINES

4.2. CONSIDERATIONS FOR SELECTING GPS

4.3. OBLIGATIONS OF THE GP

4.4. NATIONAL VMMC PROGRAM POLICY VIOLATIONS

4.5. CONSEQUENCES FOR POLICY VIOLATIONS

4.6. OPERATIONAL READINESS REQUIREMENTS

4.6.1. ADMIN REQUIREMENTS

4.6.2. PROCESS REQUIREMENTS

4.6.3. APPROVALS AND STRUCTURAL REQUIREMENTS

4.6.4. SOPS, GUIDELINES, POLICIES AND JOB AIDS

4.6.5. INFRASTRUCTURE

4.6.6. SUPPLIES, EQUIPMENT AND CONSUMABLES

4.7. EMERGENCY SUPPLIES

4.7.1. EQUIPMENT AND INSTRUMENTS

4.7.2. INTRAVENOUS INFUSION

4.7.3. EMERGENCY DRUGS

4.7.4. DISPOSABLE COMMODITIES

4.8. CONTACT PERSON

4.9. REFERENCES

5. YOUR COORDINATION TOOLKIT

5.1. INTRODUCTION

5.2. PROGRAMME COORDINATION

5.3. PROCESS OF COORDINATING THE VMMC PROGRAMME

5.4. CONCLUSION

6. YOUR DATA MANAGEMENT TRAINING MANUAL

6.1. DATA TOOL TRAINING MANUAL

6.2. VMMC DATA REQUIREMENTS

6.3. TOOLS USED

6.3.1. DHMIS POLICY

6.3.2. CLIENT INTAKE FORM

6.3.3. VMMC REGISTER

6.3.4. MONTHLY SUMMARY SHEET

6.3.5. DATA RECEIPT FORM

6.3.6. DHIS INPUT

6.3.7. TRAINING CURRICULUM & APPROACH

6.3.8. PROPOSED ATTENDEES

6.3.9. ANNEXURES

6.3.9.1. ANNEXURE 1: PROPOSED AGENDA

6.3.9.2. ANNEXURE 2: EVALUATION OF TRAINING

6.3.9.3. ANNEXURE 3: JOB AIDS

7. YOUR DATA VERIFICATION MANUAL

7.1. DISTRICT DATA VERIFICATION MEETING MANUAL

7.2. MEETING STRUCTURE

7.3. PROPOSED ATTENDEES

7.4. ROLES & RESPONSIBILITIES

7.5. APPENDIX

7.5.1. MEETING AGENDA

7.5.2. MEETING PRESENTATION

7.5.3. MEETING MINUTES

7.5.4. DISTRICT DATA MEETING QUARTERLY QUESTIONNAIRE

7.5.5. QUARTERLY DATA VERIFICATION MEETING REPORT

8. SUMMARY

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

1. INTRODUCTION AND PURPOSE

Dear colleague

Your guide to managing and monitoring the RT35 contracts with ease is here!

Voluntary Male Medical Circumcision is one of the most effective HIV prevention interventions, as part of a combination prevention approach.

To achieve financial sustainability of the VMMC programme, the National Department of Health (NDoH), in partnership with National Treasury, awards transversal contracts to fund VMMC service delivery in 26 districts. These RT35 transversal contracts present an opportunity for increased domestic funding, financial ownership at the sub-national level, and improved allocative efficiencies.

To ensure high-quality service delivery and timely payments of service providers and sub-contractors, NDoH has compiled a manual to assist the Provincial and District Department of Health officials to effectively manage and monitor the implementation of the RT35 contracts.

In this manual you will find resources and guidance on how to:

1. Complete your **contract administration activities** in a standardised and high-quality manner
2. Customize **Service Level Agreements (SLA)** between districts and service providers
3. Contract and manage **General Practitioners (GP)**
4. Establish and maintain **stakeholder coordination structures** at the district level
5. Ensure VMMC **data is submitted** to capturing sites accurately and timeously
6. Verify the **accuracy of service provider data** at the district level

I trust that you find these resources will equip you with the knowledge, tools, and templates to strengthen local VMMC contract management mechanisms. I wish you a successful working relationship with your new RT35 partner.

Thank you in advance for your continued cooperation and commitment to the VMMC programme.

Sincerely,
Collen Bonecwe

National VMMC programme director

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

National Treasury Transversal VMMC Contract |

2. CONTRACT MANAGEMENT FRAMEWORK

Version 1 (June 2020)

Contact person

Mr Collen Bonnecwe

Medical Male Circumcision Programme Director, National Department of Health

Email	collen.bonnecwe@health.gov.za
Telephone	+2712 3958021
Mobile	+27 82 4405118

Mr Dayanund Loykissonlal

Medical Male Circumcision Programme Manager, National Department of Health

Email	dayanund.loykissoonlal@health.gov.za
Telephone	+27 12 3959186
Mobile	+27 71 6033144

TABLE OF CONTENTS

ACRONYMS ..... **iv**
1. Introduction **6**
2. Contract management best practice **8**
3. RT35 contract overview **10**
4. Roles and responsibilities **16**
5. Payment for the service **22**
6. Performance management **25**
7. Reporting **26**
8. Risk management **29**
9. Dispute resolution **36**
10. Breach and termination **37**
11. Fraud and corruption **38**
12. Audits and inspections **39**
13. SLA duration and close-out **40**
ANNEXURE 1: **42**
ANNEXURE 2: **43**
ANNEXURE 3: **46**

List of tables

Table 1: Bid evaluation process 12
Table 2: B-BBEE status level 13
Table 3: Description of clauses under section C of the RT35 contract 14
Table 4: Roles and responsibilities of provinces 17
Table 5: Roles and responsibilities of the contract manager based on the RT35 SLA 19
Table 6: VMMC DOH official or implementing partner responsibility assignment matrix 21
Table 7: Summary of payment of the service chapter templates and relevant documents 24
Table 8: Risk identification matrix 32
Table 9: District contract manager's QA and reporting obligations 33
Table 10: Province's QA and reporting obligations 34
Table 11: Implementing partners' QA and reporting obligations 34
Table 12: Summary of service level management chapter templates and relevant documents 35
Table 13: Summary of duration chapter templates and relevant documents 41
Table 14: VMMC districts and targets 43
Table 15: Implementing partners' reporting obligations 44
Table 16: Implementing partners' key personnel and their key competencies in accordance with the RT35 45
Table 17: Risk Form 48
Table 18: Contract risk management risk register 49
Table 19: Contingency planning – anticipated risks plan 50

List of figures

Figure 1: Contract management basics: plan, execute, check, evaluate 8
Figure 2: Principles of good contract governance 9
Figure 3: VMMC core technical team 17
Figure 4: Province's work breakdown structure for contract administration based on the RT35 SLA 18
Figure 5: Contract manager responsibilities 19
Figure 6: Contract manager's work breakdown structure for contract administration 20
Figure 7: VMMC step-by-step payment process 22
Figure 8: Payment verification steps 23
Figure 9: VMMC data flow timeframe 27
Figure 10: Data Quality Assessment process in accordance with NDOH DQA strategy 28
Figure 11: VMMC CQI process in accordance with the SA VMMC guidelines 29
Figure 12: Contract risk management process (see Annexure 3) 31
Figure 13: Contract risk management process 47

Acronyms

AE	Adverse Event
B-BBEE	Broad-Based Black Economic Empowerment
BEC	Bid Evaluation Committee
CEO	Chief Executive Officer
CQI	Continuous Quality Improvement
CSD	Central Supplier Database
DDOH	District Department of Health
DHIS	District Health Information System
DHMIS	District Health Management Information System
DQA	Data Quality Assessment
EQA	External Quality Assurance
GCC	General Conditions of Contract
GP	General Practitioner
HAST	HIV and AIDS/STI/TB
HPCSA	Health Professions Council of South Africa
IE	Independent Expert
NDOH	National Department of Health
NGO	Non-Governmental Organisation
NT	National Treasury
OCPO	Office of Chief Procurement Officer
PDOH	Provincial Department of Health
PEPFAR	United States President's Emergency Plan for AIDS Relief
PFMA	Public Finance Management Act
PMU	Programme Management Unit
PPPFA	Preferential Procurement Policy Framework Act
QA	Quality Assurance
QI	Quality Improvement
RACI	Responsible, Accountable, Consulted and Informed
RT35	National Treasury Transversal Contract
SANC	South African Nursing Council
SBD	Standard Bidding Documents
SLA	Service Level Agreement
SOP	Standard Operating Procedures
SOW	Scope of Work
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBD	To Be Determined
TCBD	Transversal Contract Bidding Documents
TWG	Technical Work Group

VAT	Value-Added Tax
VMMC	Voluntary Medical Male Circumcision
WBS	Work Breakdown Structure
WHO	World Health Organization
WPG	Working Practice Guidelines

2.1. INTRODUCTION

South Africa's Voluntary Medical Male Circumcision (VMMC) programme is being executed through a set of contractual relationships between implementing partners and the respective Provincial Departments of Health (PDOH). To effectively execute this contract, the National Treasury (NT) of South Africa embarked on a National Treasury Transversal Contract (RT35) contracting process for 26 districts that are not supported by the United States President's Emergency Plan for AIDS Relief (PEPFAR) supported. Following the appointment of implementing partners in each of these districts, the management of the Service Level Agreements (SLAs) remains the responsibility of the province and District Department of Health (DDOH).

This contract management toolkit has been developed to support the effective management of these SLAs in ensuring that the required service is received from the relevant implementing partners and that all obligations to the implementing partners are met. Contract management is a complex process and the efficient management and oversight of any contract requires a clearly laid out process, allocation of responsibilities, and remedial actions, where required.

The purpose of this manual is to provide a comprehensive and practical guide for the successful implementation of the VMMC programme. This toolkit provides a set of tools and techniques for PDOH district contract managers (henceforth, referred to as contract managers) on the elements required for successfully administering the VMMC contracts. The toolkit consists of this manual and the accompanying templates.

This manual is intended to establish, and maintain, a uniform system of managing VMMC contracts so that they comply with the various Standard Operating Procedures (SOPs) of the National Department of Health (NDOH). This manual should ideally be used as the primary referencing document for the management of the VMMC contracts, as well as a checklist for actionable tasks.

The principles of the SLA contract are incorporated in this document that remains the primary guide for the implementation of the VMMC programme. The Specific Conditions of Contract (RT35-2019) and General Conditions of Contract (GCC) are an integral part of the SLA contract and are incorporated as an Annexure of the SLA and are discussed in this manual. In the event of a conflict between the provisions of any of these three contract documents, the provisions of the SLA contract will take precedence over the provisions of the RT35 and GCC contracts.

Application of this manual

This manual provides the contract manager with a guide for administering VMMC contracts at the district level and site level. The manual provides all the detailed plans, activities, reporting structures, and background information for the process of administering VMMC contracts.

As mentioned above, it can be used by all district officials and implementing partners involved in the programme to enable them to understand the different aspects of the programme and the various district

official and implementing partner responsibilities. However, the district contract manager remains the primary target audience for the toolkit. The following conditions and assumptions apply with respect to the application of this manual:

- The contract manager role is synonymous with the district HIV and AIDS, sexually transmitted infections (STI)/tuberculosis (TB) (HAST) manager and district VMMC coordinator roles.
- The overarching responsibility of the contract manager is to manage the efficient implementation of the VMMC RT35 and SLA contracts at district level. This manual provides the structures and procedures which must be adhered to by the contract manager to ensure that the objectives of the SLA contract are accomplished, and that the implementing partners meet their deliverables.

How to use this manual for each section and what to look out for:		
References to applicable sections in the RT35 or SLA	It is important to consult more detailed guidelines or annexures for each section – look out for references to these.	
Roles and responsibilities	The responsibilities of the province, the contract manager, and the implementing partners are provided respectively.	
Templates and relevant documents	Where templates are available for the completion or submission of reports, reference is provided.	

2.2. CONTRACT MANAGEMENT BEST PRACTICE

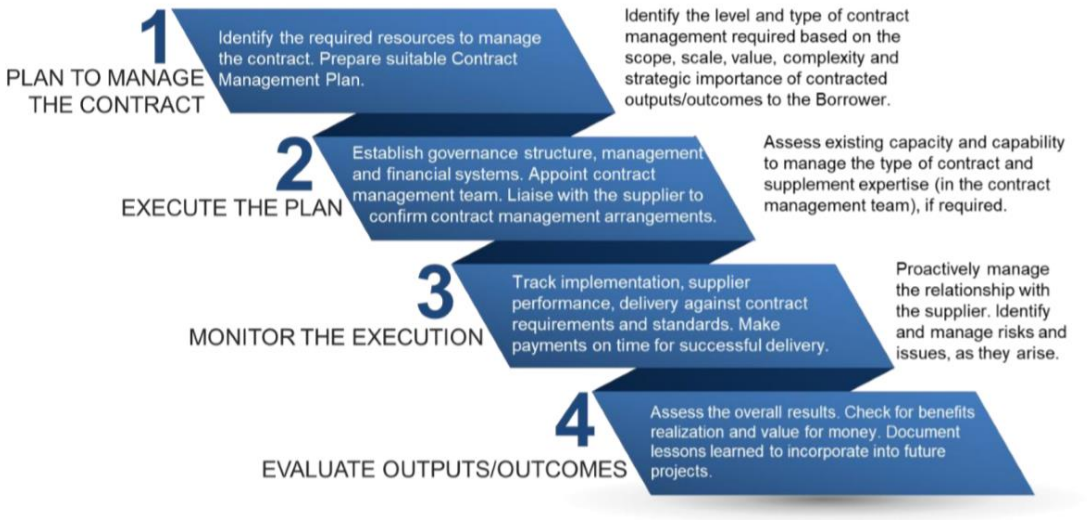
The key objectives of contract management are to ensure that the contract is[1]:

1. Delivered on time, at the right place and in the right quantity;
2. Completed to the required specifications, standards and/or quality;
3. Completed within the agreed price.

Contract management continues throughout the life of the contract. This means that the accountable officer (the contract manager) needs to plan for, and undertake:

1. Effective and efficient management of performance, delivery and payment;
2. Methodical and measured change control;
3. Active risk mitigation and management;
4. Agile resolution of issues and disputes.

Contract management best practice involves planning how to manage the project, implementing this plan and then evaluating the results. These key processes are shown in the figure below.



Source: Procurement Guide - Contract Management Practice, World Bank (2018)

Figure 1: Contract management basics: plan, execute, check, evaluate

To achieve good contract performance, the client must ensure that the terms of the contract are adhered to, and that both parties to the contract understand their respective obligations. Contract management also involves a level of flexibility by both parties and a willingness to adapt the contract terms to reflect

[1] *'Procurement Guide - Contract Management Practice', World Bank (2018)*

any changing circumstances, as appropriate. Good contract management is strengthened by systematic and efficient planning, execution, monitoring and evaluation.

Contract management also goes beyond the daily management responsibilities to include the overall governance of contract management - governance is a critical element of contract management that can make all the difference to its sustainability and success. The governance structure is expected to reflect the province's circumstances and the needs of the contract. It should be based on an assessment (as part of the project preparation) of the province's contract management capacity, with measures to bridge any identified gaps. A governance structure allows the delegations, accountabilities, responsibilities, decision making, lines of reporting, district official and implementing partner engagement et al. to be mapped and agreed in advance. This approach ensures accountability and probity.

The figure below highlights the principles of good contract governance:

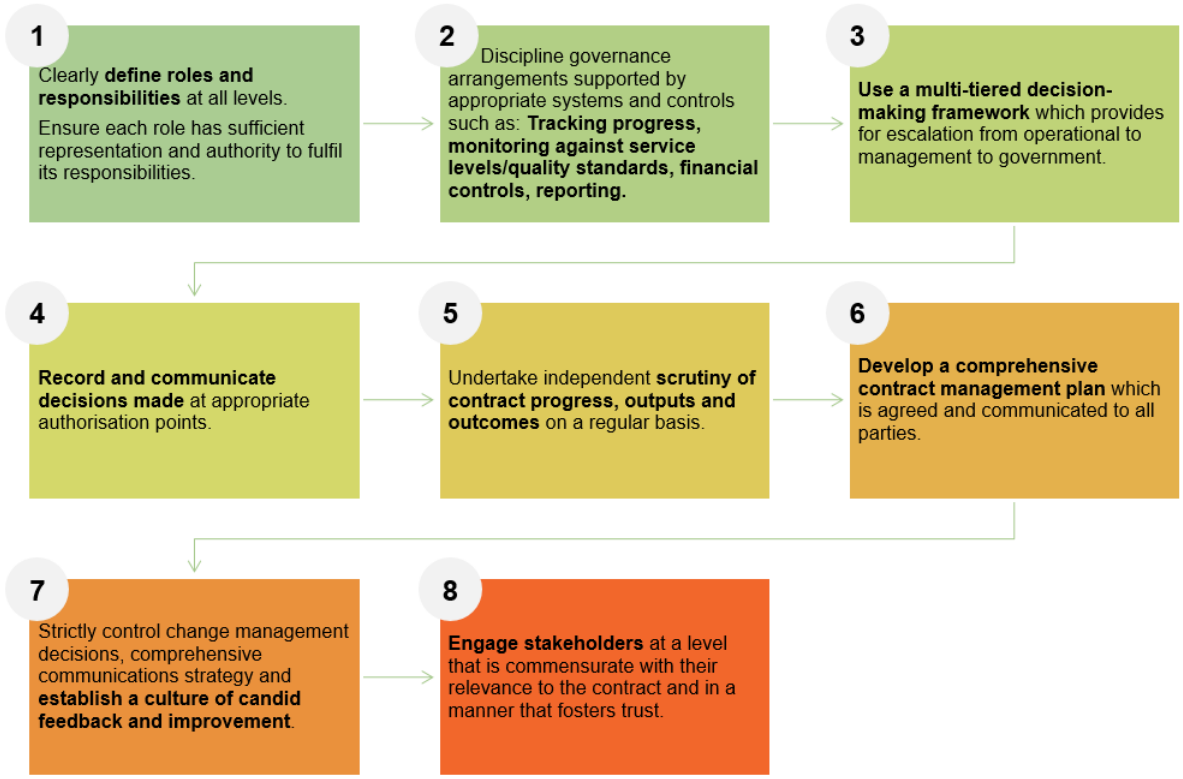


Figure 2: Principles of good contract governance

2.3. RT35 CONTRACT OVERVIEW

This section summarises the RT35 procurement process and contracting requirements and it contains the following sections:

a) RT35 Section A – Scope of Work (SOW)

- RT35 contract Terms of Reference.

b) RT35 Section B – Procurement Process

- Legislative framework;
- Bid evaluation criteria (phases 1-3).

c) RT35 Section C – Post-Award Requirements

RT35 SECTION A – SCOPE OF WORK

→ SLA contract: Section 9 (Obligations of the implementing partners)
→ Annexure 2: (VMMC districts and targets)
→ Annexure 2: (Implementing partners' reporting obligations)
→ Annexure 2: (Implementing partners' key personnel and their key competencies in accordance with the RT35)

The following items are provided in the RT35 contract Terms of Reference (Section 3):

- **A comprehensive list of key deliverables required of the service provider**. These are also listed in Section 9 (Obligations of the Service Provider) of the SLA contract. A contract manager needs to familiarise themselves with these obligations to ensure efficient monitoring of the service provider's deliverables.

- The geographical area covered by the VMMC programme, along with **annual targets per district** and the target age groups (see Annexure 2). The target group for VMMC is males between the ages 10-49 years. However, clients who present for VMMC outside of this age range (above the age of 49, but not below the age of 10) are still to be circumcised. The priority age group for demand generation is men between the ages of 20-34 years. Modelling has shown that VMMCs conducted within this age group have the most impact in reducing HIV/AIDS infections in South Africa and are the most cost-effective in terms of infections averted. As a result, to incentivise the circumcision of clients in this priority age group, the DOH reserves the right to reimburse the appointed implementing partners by a factor more for males who are circumcised in the target age group 20-34.

- **The implementing partners' reporting requirements**. These are the responsibility of the provincial contract manager to ensure the delivery of all the reports. Annexure 2 provides a list of these required reports.

- **A detailed list of six key personnel for the implementing partners**, along with a description of their roles and the required competencies for each one. Annexure 2 provides a summary of the responsibilities and required competencies for each of the six individuals. It is worth noting that the implementing partners' team is not limited to the key personnel highlighted in Section

3.1.5 of the RT35 contract, additional personnel may be added at the discretion of the province and/or the implementing partners, and upon agreement with the implementing partners.

- **Details on the location where services will be provided.** The **district will provide the implementing partners with the facility** where VMMC services will be rendered, with adequate space. Should the implementing partners opt to use their own facility, the cost will be at the account of the implementing partners and the implementing partners must obtain approval from the province.

- Information on the implementing partners' responsibility to **ensure that all medical consumables and VMMC kits utilised comply with minimum medical device SANS requirements and/or international standards**. The NDOH must approve all new surgical/devices for VMMC. NDOH must approve all new content specifications for VMMC kits.

RT35 SECTION B – PROCUREMENT PROCESS

→ RT35 Section 4 (Legislative framework)
→ RT35 Section 6 (Evaluation criteria)
→ RT35 Section 6.1.1; Submit Standard Bidding Documents (SBD) and Transversal Contract Bidding Documents (TCBD) documents
→ TCBD 1 Authorisation declaration form
→ RT35 Section 6.3.1.2 (Formula to calculate points during Phase 3)

LEGISLATIVE FRAMEWORK (RT35 Section 4):

- The bid and all contracts emanating from it are subject to the GCC issued in accordance with Treasury Regulation 16A published in terms of the Public Finance Management Act (PFMA), 1999 (Act 1 of 1999). This Act regulates financial management in the national and provincial governments. The Special Conditions of Contract (RT35) are supplementary to that of the GCC. Section 3(3) of the PFMA notes that in the event of any inconsistency between the PFMA and any other legislation, the PFMA takes precedence.

- Bid requirements are in line with the NDOH guidelines and World Health Organization (WHO) guidelines, although the NDOH takes precedence where the two conflict.

- This is an open bid, limited to organisations with the structures stipulated in the SOW in Section 3 of the RT35.

The SOW for the appointed implementing partners includes recruiting, contracting, managing and reimbursing the contracted service delivery partners. The service delivery partners need to provide the minimum package of VMMC services to males (as per NDOH VMMC guidelines) in PEPFAR and non-PEPFAR supported districts with the goal of contributing towards the respective district's VMMC targets. The total number of service delivery providers recruited in each district is left to the discretion of the appointed implementing partners. The number of implementing partners recruited and deployed will depend on the size of the catchment area as well as what might be considered optimal coverage.

EVALUATION CRITERIA (RT35 Section 6):

The evaluation process is conducted according to the phases in the table below.

Table 1: Bid evaluation process

PHASE I	PHASE II	PHASE III
Mandatory and other bid requirements	Technical Compliance	Price and Broad-Based Black Economic Empowerment (B-BBEE)
Compliance with mandatory and other bid requirements	Compliance to the item specification	Bid evaluated in terms of the 90/10 preference system

PHASE 1 – Mandatory requirements

These are compulsory items that bidders are required to submit in order for them to be considered in the evaluation for award. Bidders who fail to comply with the mandatory requirements are disqualified. These requirements are as follows:

- Submit Standard Bidding Documents (SBD) and Transversal Contract Bidding Documents (TCBD) listed in Section 6.1.1 of the RT35 contract
- Pricing structure and schedule – bidders are required to submit an all-inclusive price per procedure per geographical district, but only for districts in which they wish to provide the service. The price includes VMMC services, as indicated in the terms of reference, all relevant consumables necessary to render the service, including VMMC kits and Value-Added Tax (VAT).
- Bidders are required to also complete the Authorisation Declaration form (TCBD 1) and List of Goods and Services Offered form (TCBD 1.1) for all relevant goods or services. The TCBD 1 form is a declaration by the bidder on whether they are sourcing goods or services from a third party, and provisions of the third-party sourcing details where applicable.
- Submissions of tax compliance status and Central Supplier Database (CSD) registration

PHASE 2 – Technical specification compliance:

This is an evaluation of the bidder's technical capability to provide a service in accordance with the scope of the programme, which also includes the listed obligations of the implementing partners and the required personnel. The evaluation is based on the following:

- Submitted proof of registration with professional bodies such as the Health Professions Council of South Africa (HPCSA) and South African Nursing Council (SANC).
- Submitted proof of professional indemnity/insurance, which covers liability claims against the bidder, staff employed by the bidder, or subcontractors.
- Submitted team qualifications and experience, as well as a summary list of all the staff that will be involved in the medical procedures.

- Submission of at least two reference letters from previous clients in the last three years, with a preference for letters from province/district.
- Submitted work methodology/approach through a concise capability statement/project proposal, proving the ability to perform the scoped activities.
- Other submissions include: a declaration of funding, shareholding portfolio, and a company profile.

PHASE 3 – Preference point system evaluation:

In terms of regulation six of the Preferential Procurement Regulations pertaining to the Preferential Procurement Policy Framework Act (PPPFA), 2000 (Act 5 of 2000), responsive bids will be adjudicated by the government on the 90/10-preference point system in terms of which points are awarded to bidders on the basis of:

- The bid prices (maximum 90 points);
- B-BBEE status level of contributor (maximum 10 points).

A formula used to calculate the points for price is provided in Section 6.3.1.2 of the RT35 contract. Also provided, is the score card for B-BBEE status. The formula is as follows:

$Ps = (1 - \frac{Pt-Pmin}{Pmin})$, where:

- Ps = Points scored for comparative price of bid under consideration;
- Pt = Comparative price of bid under consideration;
- Pmin = Comparative price of lowest acceptable bid.

In addition to the bid prices, a maximum of 10 points may be allocated to a bidder for attaining their B-BBEE status level of contributor in accordance with the table below:

Table 2: B-BBEE status level

B-BBEE Status Level of Contributor	Number of Points
1	10
2	9
3	8
4	5
5	4
6	3
7	2
8	1
Non-compliant contributor	0

OTHER AWARD CONDITIONS (RT35 Section 7):

- The government reserves the right to award contracts to more than one contractor for the same districts.
- The maximum number of suppliers per district to be awarded will be at the discretion of the Bid Evaluation Committee (BEC).

RT35 SECTION C – POST-AWARD REQUIREMENTS

→ RT35 Section C (Post-award conditions)
→ SLA contract Section 6 (Contract duration)
→ Annexure 1 (Operational readiness checklist)
→ Annexure 2: (Implementing partners' reporting obligations)

This section of the RT35 contract provides post-award conditions for the implementing partners and the administration of the contract, some of which are also incorporated in the SLA contract. The table below provides a summary of the sections and the key items under each section.

Table 3: Description of clauses under section C of the RT35 contract

Name	Descriptions
Duration of Contract	• The duration of the contract will be for a period of 42 months commencing from 01 April 2020 to 31 March 2023 (also see Section 6 of the SLA contract).
Participating Government Departments / Institutions	• All nine PDOH. • Departments that had existing RT35 contracts in place for VMMC services can only participate in this bidding process once their contracts have expired. • On behalf of the department, an accounting officer or accounting authority can participate in the bidding process, subject to approval by NT and the relevant contractors.
Roles and Responsibilities	• Contract administration – the administration and facilitation of the RT35 contract will be the responsibility of NT. Transversal contracting and all correspondence in this regard is to be directed to The Chief Directorate (Transversal Contracting, National Treasury). • Contractors are required to advise the Chief Directorate when unforeseeable circumstances will adversely affect the execution of the contract. Full particulars of such circumstances, as well as the period of delay, must be furnished. • Supplier performance management – this is the responsibility of the province. Where supplier performance disputes relating to the contract cannot be resolved between the contractor and the relevant purchasing institution, NDOH and NT must be informed accordingly.

Service Level Agreement (SLA)	• An agreement between the provincial department and the appointed implementing partners that governs the contractual relationship and terms of reference of the specific services to be rendered. • Additions or amendment to the SLA shall not be in contradiction to the Special Conditions and General Conditions of Contract.
Contract Price Adjustments	• Provides formulae and procedures for the calculation of the annual contract price adjustment of the RT35 contract.
Post-Award Reporting	• Provides reporting requirements for the successful bidders, which are incorporated in in Annexure 2.
Contract Administration	• The administration and facilitation of the RT35 contract will be the responsibility of NT. • Transversal contracting and all correspondence in this regard must be directed to the Chief Directorate: Office of Chief Procurement Officer (OCPO): Transversal Contracting, NT. • Contractors are required to advise the Chief Directorate when unforeseeable circumstances will adversely affect the execution of the contract. Full particulars of such circumstances, as well as the period of delay, must be furnished.
Breach of Contract	• The government reserves the right to terminate the contract(s) for not honouring contract obligations, including submission of information required by NT, as well as NDOH and PDOH and end-user institutions.

Section 6 of the SLA states that, notwithstanding the date of signature, the SLA contract becomes effective on the date of commencement for a period of three years.

The province has the authority to extend the SLA with the implementing partners post-31 March 2023 on rates and terms agreed on by both parties. Province's also reserve the right to terminate the contract on any other date as agreed upon for non-performance of the required services, as detailed in the GCC of the SLA.

2.4. ROLES AND RESPONSIBILITIES

The oversight of the VMMC programme is based on quite an extensive structure between NDOH, PDOH) and the district offices. For an effective management of the contract, it is important to firstly clearly outline the organisational structure governing the broader programme.

In preparation for the execution of contract tasks, the province and contract managers must acquaint themselves with the implementing partners' team. This will enable them to align programme responsibilities to the relevant stakeholders within the implementing partners' team, as well as manage accountability. Annexure 2 provides a summary of the key personnel in the implementing partners' team, as stipulated in Section 3.1.5 of the RT35 contract, along with the responsibilities of each of the six key personnel.

At the national level, the VMMC programme falls under the HIV cluster[2]. The Deputy Director-General is responsible for the VMMC programme nationally and sets the strategic direction and leads coordination efforts for the different partners involved in the programme.

The national VMMC Programme Management Unit (PMU) oversees the NDOH's ongoing work in this area and includes both national and non-national staff. The PMU, which is led by the national VMMC programme director consists of six sub-committees:

1. Service Delivery, Quality Assurance and Training
2. Communication and Demand Generation
3. Monitoring, Evaluation and Operations Research
4. Leadership and Advocacy
5. Governance and Coordination
6. Resource Mobilisation

The VMMC Technical Work Group (TWG) and sub-committees consist of multiple DOH officials and implementing partners that play a critical role in VMMC implementation and meet on a quarterly basis to review programmatic updates, sub-committee updates and discussion of emerging issues that require consultation. The sub-committee may meet more frequently depending on the task that requires attention.

The figure below presents the national VMMC Core Technical Team, which also comprises the PMU.

[2] VMMC Operational Plan 2016

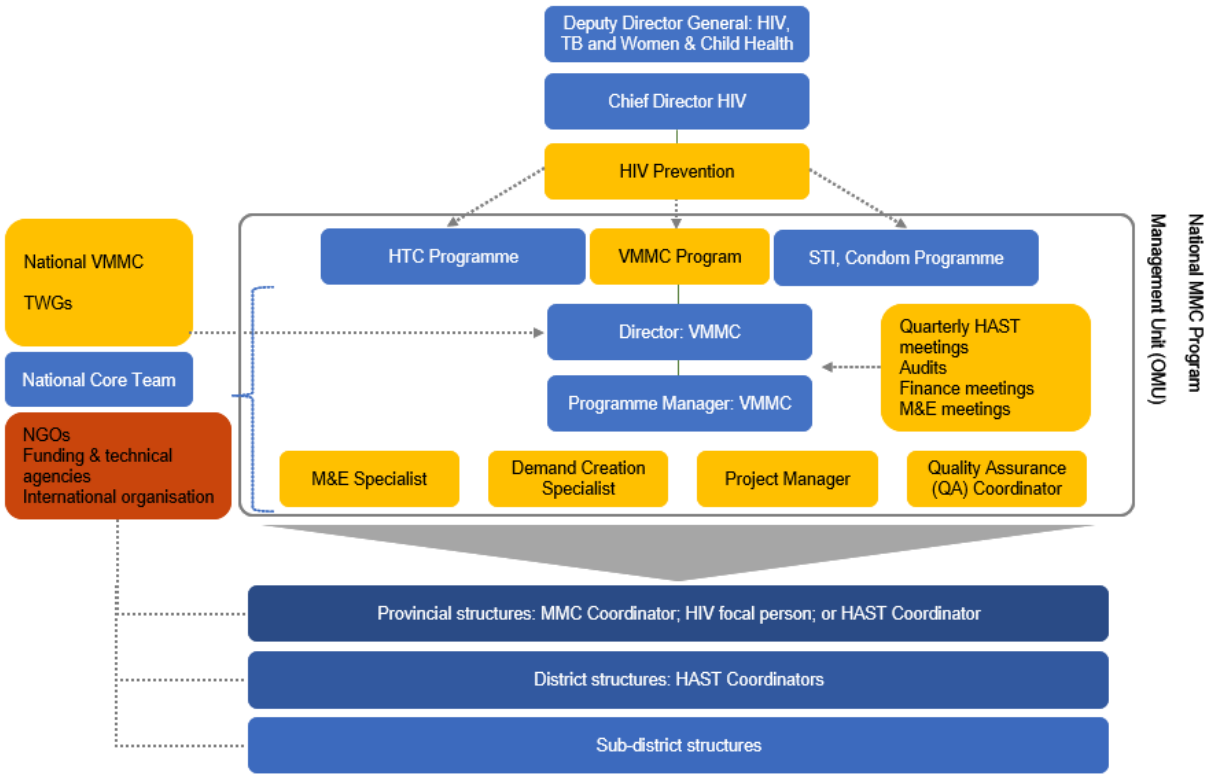


Figure 3: VMMC core technical team

At the Provincial level, each of the nine provinces has a technical team with responsibilities that are similar to the National VMMC Core Technical Team but tailored to address their unique needs. The Provincial technical teams consist of three to five members and are tasked with the responsibility of communicating and monitoring implementation. The provinces also convene Steering Committee meetings and/or TWGs with various DOH officials and implementing partners involved in VMMC, as the need arises.

The principal responsibility of the province is to provide oversight on how the Districts' implement the SLA contract. The table below provides a detailed breakdown of this responsibility, as defined in section 10 of the SLA contract.

Table 4: Roles and responsibilities of provinces

Relevant SLA Section	
"Manage the interface between the end-user/structures in province and the service delivery partner."	Chapters 6-11
"Authorise relevant scope and specification changes and all increases in budget requirements."	N/A
"To provide the format of documents and outline processes required to expedite payment of invoices."	Chapter 3

The figure below provides an overview of the province's work breakdown structure, from planning to implementation, and to post-contract phase.

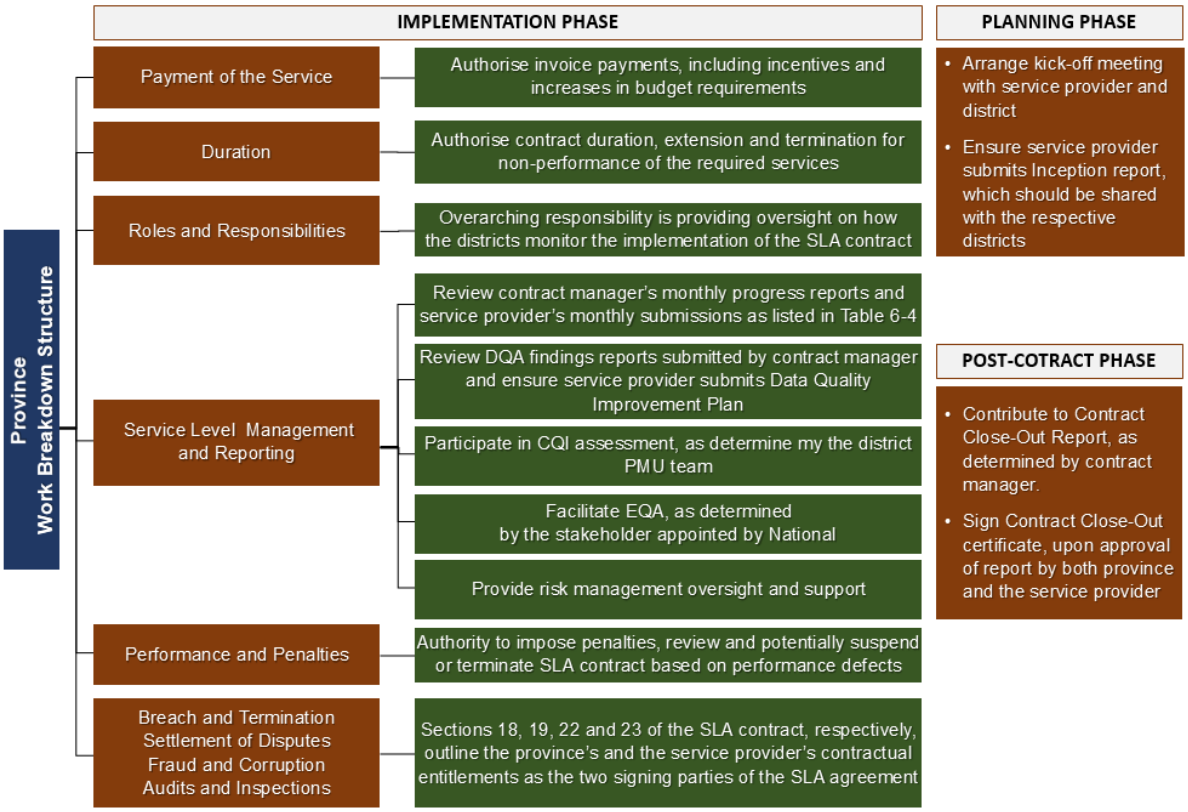


Figure 4: Province's work breakdown structure for contract administration based on the RT35 SLA

See Annexure 2 for the implementing partners' responsibilities and Section 9 of the SLA contract for a more detailed list. It is worth noting that the list of personnel in the implementing partners' team is not limited to these six that are listed in the RT35 contract. The final arrangement with the province, including the SLA contract, will determine the final list of personnel in the implementing partners' team.

CONTRACT MANAGER'S RESPONSIBILITIES

Good practice requires that a contract manager is appointed for every contract. The contract manager needs to have the appropriate range of qualifications, skill mix and experience. The figure below presents an overview of the typical responsibilities of a contract manager.

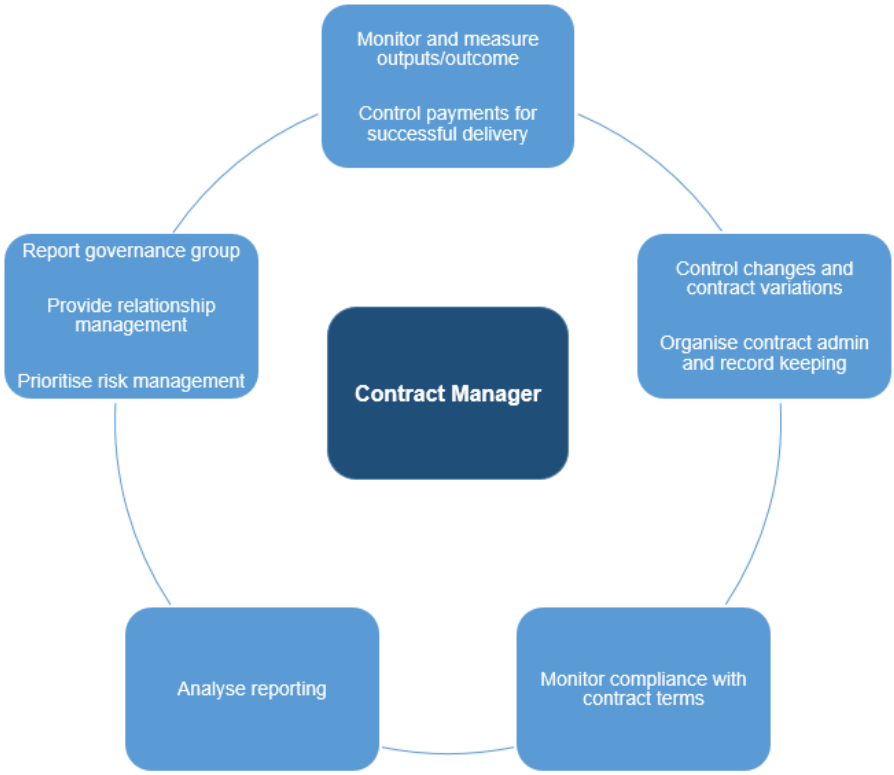


Figure 5: Contract manager responsibilities

For the VMMC contract, the principal responsibility of the contract manager at the district is to monitor the implementation of the SLA contract by the implementing partners. The table below provides a detailed breakdown of this responsibility, as defined in section 10 of the SLA contract, and the relevant sections in the manual where each of the responsibilities is further expanded upon.

Table 5: Roles and responsibilities of the contract manager based on the RT35 SLA

	Relevant Manual Section
"Monitor service deliverables and outputs against the overall VMMC programme objectives."	Chapter 6, all sections
"Monitor progress of service delivery partner in the district, identify issues and support corrective action to facilitate delivery."	Chapter 6, section 6.1.3
"Verify the number of VMMCs performed every month by service delivery partner in the district."	Chapter 6, section 6.1.1
"Interrogate and reconcile the verified number of reported circumcisions in the age-appropriate male population with the invoiced amount provided by service delivery partner in the district."	Chapter 3
"Manage interaction and coordinate activities with the provincial, district and facility managers to enable the service delivery partner to carry out service delivery."	Chapter 6

The figure below provides an overview of the contract manager's work breakdown structure (WBS), from planning, to implementation, and to post-contract phase.

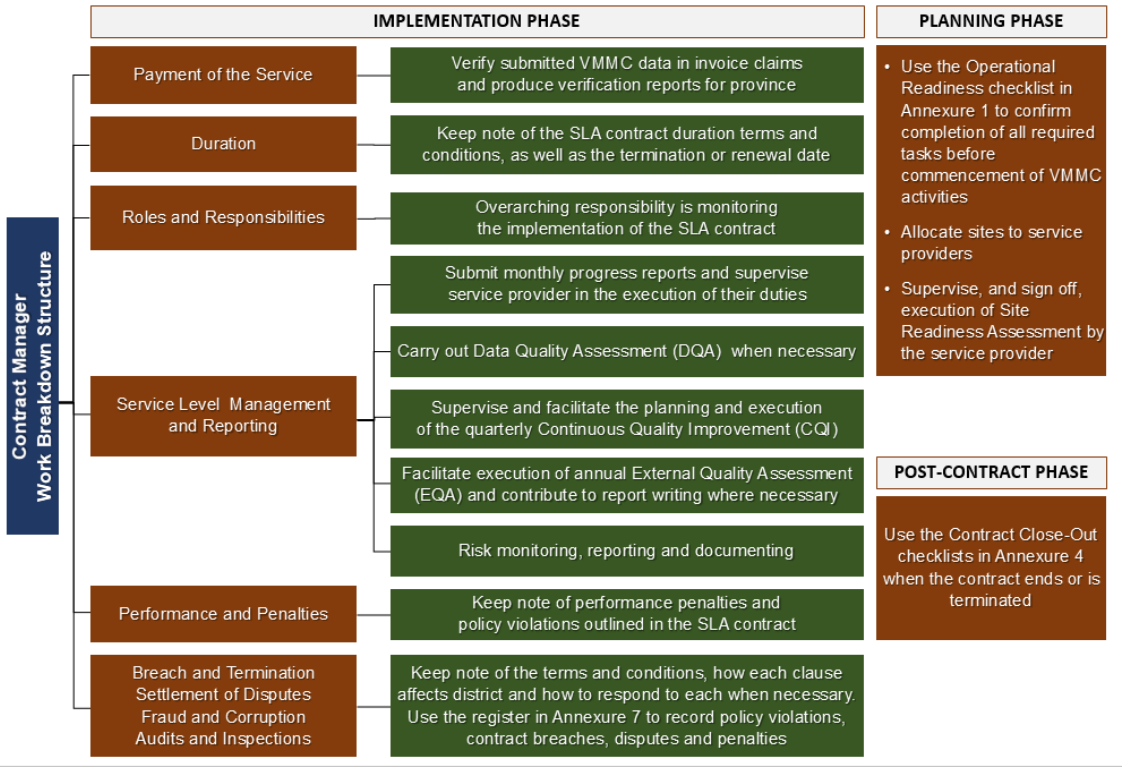


Figure 6: Contract manager's work breakdown structure for contract administration

RESPONSIBILITY MATRIX

A responsible, accountable, consulted and informed (RACI) matrix is the simplest and most effective means for assigning roles and responsibilities for each task, milestone, or decision on a programme. Knowing exactly who is responsible, who is accountable, who needs to be consulted and who must be kept informed at every step will significantly improve a contract manager's chances of programme success, and it eliminates confusion. The table below provides a list of the key processes and outputs involved in the implementation of a VMMC contract, and proposes allocation of responsibility for each deliverable/responsibility to the relevant party based on the RACI matrix codes.

The following is a brief description of the RACI codes[3]:

- **Responsible:** people or DOH officials or implementing partners who do the work. They must complete the task or objective or make the decision. Several people can be jointly responsible.

[3] https://www.cio.com/article/2395825/project-management-how-to-design-a-successful-raci-project-plan.html

- **Accountable:** person or DOH official or implementing partner who is the owner of the work. They must sign off or approve when the task, objective or decision is complete. Success requires that there is only one person *Accountable*, which means that "the buck stops here".
- **Consulted:** people or DOH official or implementing partners who need to give input before the work can be done and signed-off. These are active participants.
- **Informed:** people or DOH official or implementing partners who need to be kept in the picture. They need updates on progress or decisions, but they do not need to be formally consulted, nor do they contribute directly to the task or decision.

Table 6: VMMC DOH official or implementing partner responsibility assignment matrix

LEGEND:

R	**Responsible** for performing the task.
A	**Accountable** for the task such as the supervisor - the owner of the work.
C	Provides **Consulting** expertise or input to the person responsible for the task and others.
I	**Informed** of task progress or results, usually by the person responsible.

	TASKS	National	Province	Contract Manager	Implementing partners
1	**PRE-CONTRACT PERIOD**				
1.1	Signing of RT35 contract	R	I	-	-
1.2	Compilation of SLA contract	-	R	C	C
1.3	Signing of SLA contract with implementing partners	-	R	C	R
1.4	Province kick-off meeting	-	R	C	I
1.5	Implementing partners' inception report	-	A	C	R
1.6	District kick-off meeting	-	I	R	C
1.7	Site allocation to implementing partners	-	I	R	C
1.8	Site Readiness Assessment	-	I	A	R
1.9	Sign off on Site Readiness Assessment	-	C	A	R
2	**CONTRACT PERIOD (Implementation)**				
2.1	Monthly progress reports	I	A	R	R
2.2	Monthly VMMC statistics	I	A	R	R
2.3	Ad-Hoc Data Quality Assessment	I	A	R	C
2.4	Quarterly Continuous Quality Improvement (CQI)	I	A	A	R
2.5	External Qualify Assessment (EQA)	R	A	C	C
2.6	Risk identification	R	R	R	R
2.7	Risk assessment, mitigation and reporting	I	A	R	R
3	**POST-CONTRACT PERIOD**				
3.1	Contract close-out report	I	A	R	C
3.2	Contract close-out checklist	I	C	R	A
3.3	Contract close-out certificate	I	A	R	C

2.5. PAYMENT FOR THE SERVICE

→ SLA Sections 4, 5, 11 (payment of the VMMC service)
→ VMMC Statistics Verification Form and Report)

Sections 4, 5 and 11 of the SLA contract provides vital information about the payment of the VMMC service, terms of payment, price adjustments, and invoicing terms. There are a number of payment provisions which must ideally be adhered to:

- All payments should be made once a month;
- The implementing partners should submit an invoice in addition to their monthly statistics by the 7th of each new month to enable the verification process;
- The province will pay out invoices on the last day of the month.

The figure below outlines the process that must be followed by the implementing partners, contract manager and PDOH to ensure the right payment is made, timeously.

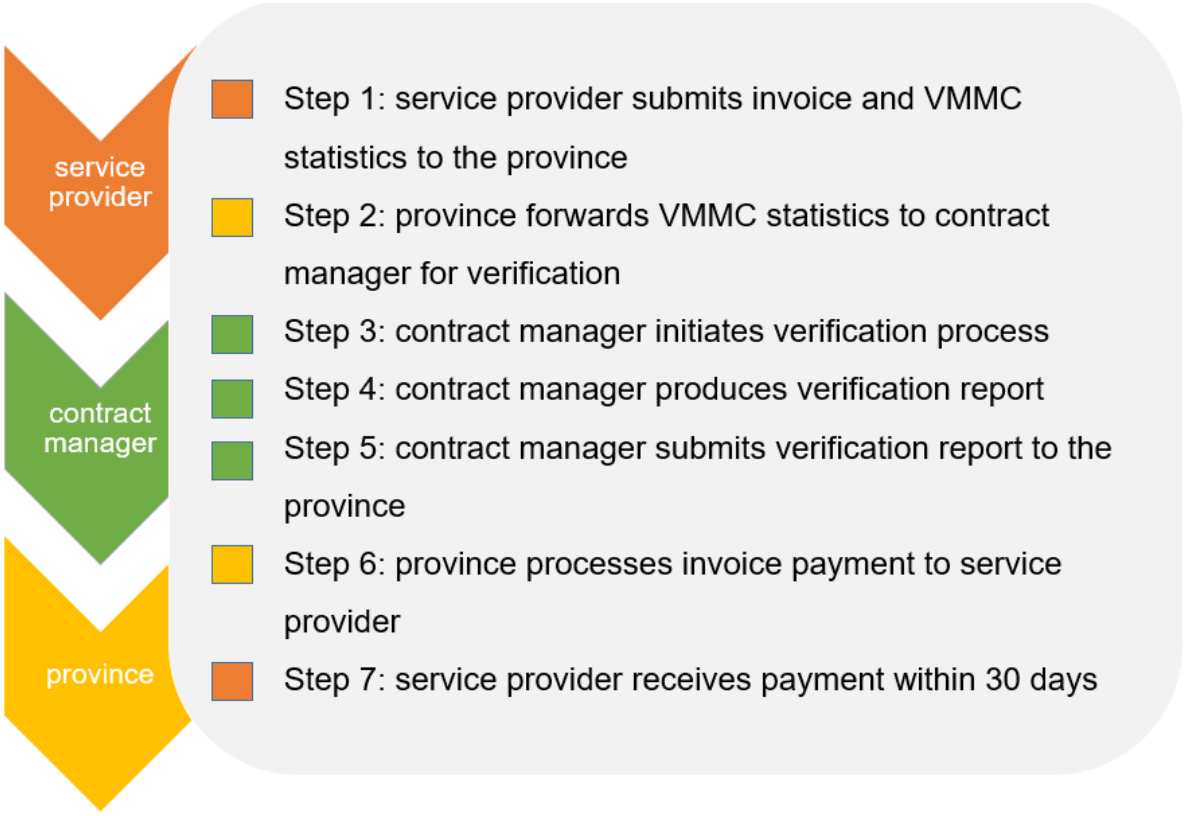


Figure 7: VMMC step-by-step payment process

The DDOH and PDOH reserve the right to amend or adjust the implementing partners' contract amount, time and conditions of payment where consistent and significant failure to meet programme targets are observed such as poor programme quality assurance (QA) standards and the minimum package of

services for VMMC or incurring a high number of moderate and severe adverse events (AEs) exceeding 2% per site per quarter– meaning 2% of the statistics for every three months in the year.

CONTRACT MANAGER RESPONSIBILITIES

Once the contract manager has received all the required data and information linked to the implementing partners' activities for a given month, and for which an invoice is being submitted, they will take the following steps to complete the verification process within three days of receipt.

There are two levels of verification required prior to the payment of an invoice submitted by a implementing partners:

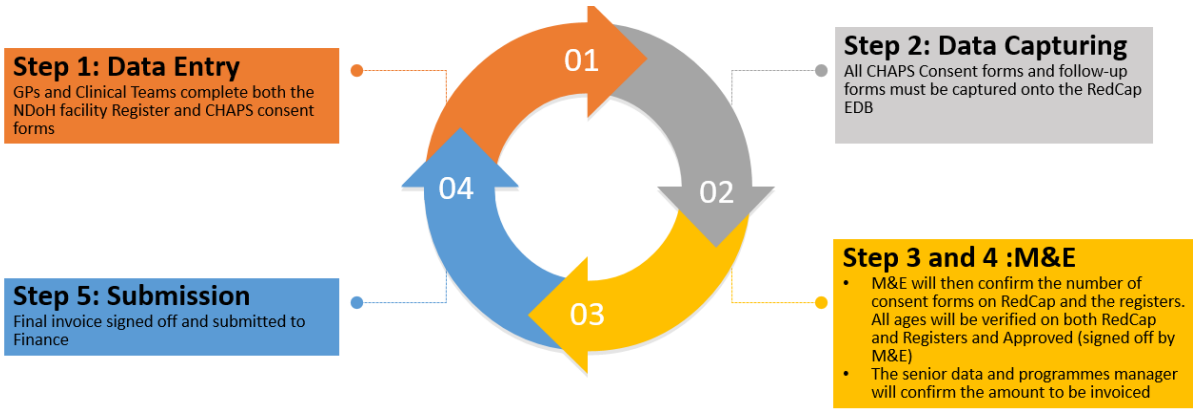


Figure 8: Payment verification steps

a) First level verification (day 1):

- Extract a copy of the District Health Information System (DHIS) data corresponding to the data period in the implementing partners' invoice claim. For example, if the implementing partners submitted an invoice claim for the period between 1st to the 30th of April, the extracted DHIS data should be for the same period.
- Compare the DHIS data with the data in the Monthly Summary Data Form to determine whether there are any irregularities between the two data sets. For example, is the number of clients circumcised the same in both data sources? The managers can develop and use the VMMC Statistics Verification Form to do this assessment.
- If there is variation in the data, the site level verification should provide clarity on the variance or the source of variance. In the event that the two data set are aligned, the site level verification should still be carried out to ensure that there are no data duplications in the implementing partners' claim. Meaning that, an implementing partner is not claiming for circumcisions that have previously been claimed.

b) Second level (site) verification (day 2):

- Make an appointment with the facility, at least 24-hours beforehand, for the verification using site-level information.
- Notify the facility manager to ensure that the documents required for the verification are ready. These are the VMMC facility register, AE register and VMMC client files.
- Through developing and using the VMMC Statistics Verification Form and/or Report, the manager can compare the list of VMMC clients submitted by the implementing partners with the records in the VMMC facility register and client files.

c) Verification sign-off (day 3):

- Submit verification report (VMMC Statistics Verification Report) to the province via email.

PDOH RESPONSIBILITIES

- Determining and communicating the list of documents that an implementing partner is required to submit along with their monthly invoice submission.
- Actioning the contract manager's recommendations in the verification report.
- Processing invoice payments.

IMPLEMENTING PARTNER RESPONSIBILITES

- Submit an invoice with VMMC monthly statistics (including a list of VMMC clients and the Monthly Summary Data Form) by the 7th of each month.
- Submit the facility signed and stamped yellow forms from the VMMC Surgical Register to the district.
- Account for data variances and any other anomalies identified during the data verification process.

TEMPLATES AND RELEVANT DOCUMENTS

The table below provides a summary of the templates to be used by the contract manager in the execution of their claim data verification tasks.

Table 7: Summary of payment of the service chapter templates and relevant documents

Activity	Template	Relevant Documents
First level verification	N/A	• DHIS data • Submitted Monthly Summary Form • Stamped yellow register forms

Second level (site) verification	Verification Form	• Submitted VMMC list • VMMC register • VMMC client records
Verification Sign-off	Verification Report	N/A

2.6. PERFORMANCE MANAGEMENT

→ SLA Section 13 (Performance and penalties)
→ SLA: National VMMC programme policy violations)
→ (Policy violation, contract breach, disputes and penalties register)

The following sections of the SLA are crucial for understanding how penalties are applied in the programme.

- SLA 13.3 - "*The PDOH is entitled to impose penalties for late or defective performance and policy violations (Annexure C) by the implementing partners. In this regard, the PDOH shall deduct 5% from the amount due and payable to the service delivery partner for a VMMC deliverable. This can be in the form of AEs incurred by the patient upon having the VMMC procedure or policy violations. Each AE or policy violation shall be treated individually and can be aggregated. For the avoidance of doubt and for example, three policy violations can attract a 15% penalty deduction and, coupled with one AE, this amounts to a 20% penalty deduction."*

- SLA 13.4 - *"If it is found that the rate of AEs continues to exceed 2% over a quarter, the PDOH reserves the right to review and potentially suspend/terminate the service delivery contract with service delivery partner in the district."*

Section 13 of the SLA provides an extended description of performance and penalties, and Annexure C of the SLA provides a list of national VMMC programme policy violations.

CONTRACT MANAGER RESPONSIBILITIES

The contract manager is not responsible for the implementation of these penalty clauses. However, it is crucial for them to understand what constitutes contract violations (also termed policy violations) and what would be required of them in the process of responding to these policy violations, which are handled by the provincial contract manager. Similarly, to the invoice payment process, the contract manager may be required to do a data verification to contribute to this process.

PDOH RESPONSIBILITIES

The following is a summary of the key performance defects that the province is entitled to action, as stipulated in section 13 of the SLA contract. The rest of the violations can be found in Section 13 and Annexure C of the SLA contract;

- Impose penalties for late or defective performance and policy violations (see SLA Annexure C) by the implementing partners. The SLA extracts in section 7.1 above provide a detailed description of this.
- If it is found that the rate of AEs continues to exceed 4% over a quarter, the province reserves the right to review and potentially suspend/terminate the service delivery contract with the implementing partners in the district.
- If it is found that there are more than two policy violations per month, the province reserves the right to review and potentially suspend/terminate the service delivery contract with the implementing partners in the district.
- For any repeat non-performances after remedial action has been taken by the implementing partners, the province is entitled to cancel the SLA agreement by giving the implementing partners 30-day's written notice.

TEMPLATES AND RELEVANT DOCUMENTS

Policy violations, contract breaches, disputes and penalties registers are required to help the contract manager keep track of contract breaches and plan for potential impact on the district.

2.7. REPORTING

Regular monitoring and programmatic reports are an effective method for the PDOH and DDOH to determine whether an implementing partner is adequately providing the contracted services. The following is a list of quality systems employed in the VMMC programme, which are discussed in the following sub-sections:

- 6.1.1 Monthly data monitoring;
- 6.1.2 Ad-Hoc Data Quality Assessment (DQA);
- 6.1.3 Quarterly Continuous Quality Improvement (CQI);
- 6.1.4 Annual EQA;
- 6.1.5 Risk management.

MONTHLY DATA MONITORING

The District Health Management Information Systems (DHMIS) Policy (2016) provides standard operating procedures for the management of VMMC data. It defines the requirements and expectations to provide comprehensive, timely, reliable, and good quality routine evidence for tracking and improving health service delivery. The Working Practice Guidelines (WPG) prescribe the data reporting processes and data flows, as shown in the figure below, that all VMMC DOH officials and implementing partners are required to abide by. The timeline for submission of routine data and feedback on data quality and performance in the figure below provides date-linked data activities from facility to national level.

The RT35 (3.1.1.11) and SLA (9.1.7) contracts both stress that the implementing partner is required to ensure that VMMC data is uploaded on to the DHIS as per the WPG.

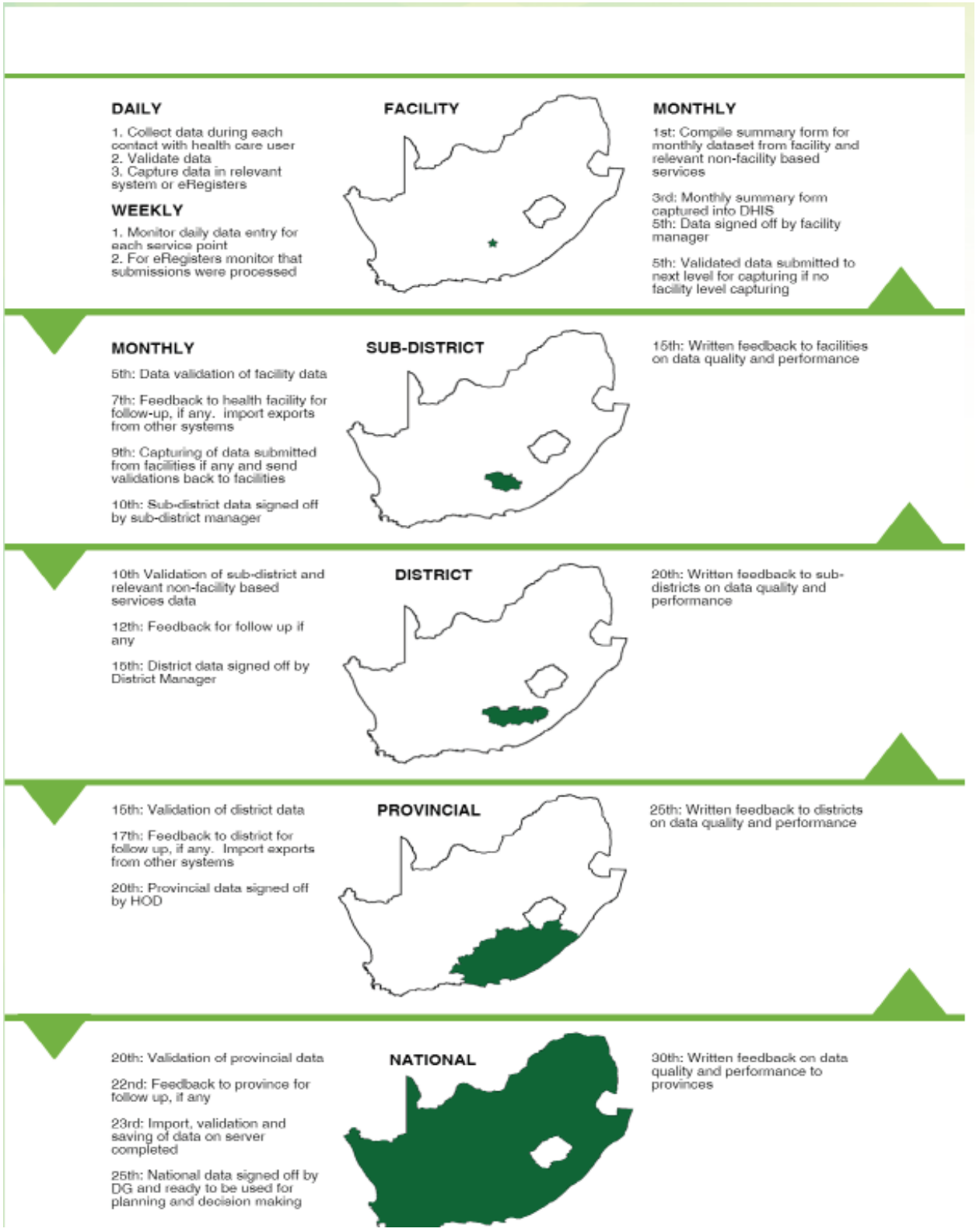


Figure 9: VMMC data flow timeframe

AD-HOC DATA QUALITY ASSESSMENT

DQA is one of the interventions that national uses to measure the effectiveness of the VMMC programme, as outlined in the National DQA Strategy (Version 1, October 2019). The DQA is used to review how data is collected, maintained, and managed within the programme. The figure below provides a step-by-step outline of the DQA process that the contract manager is required to follow. The frequency of DQAs is at the discretion of the district. DQAs typically happen when the district identifies irregularities with a facility's data set, which is why the site selection criteria are based on DHIS discrepancies and the high rate of AEs. Facilities displaying quality issues are selected for further investigation through the DQA process. The National DQA Strategy document expands each of the steps involved in the DQA process.

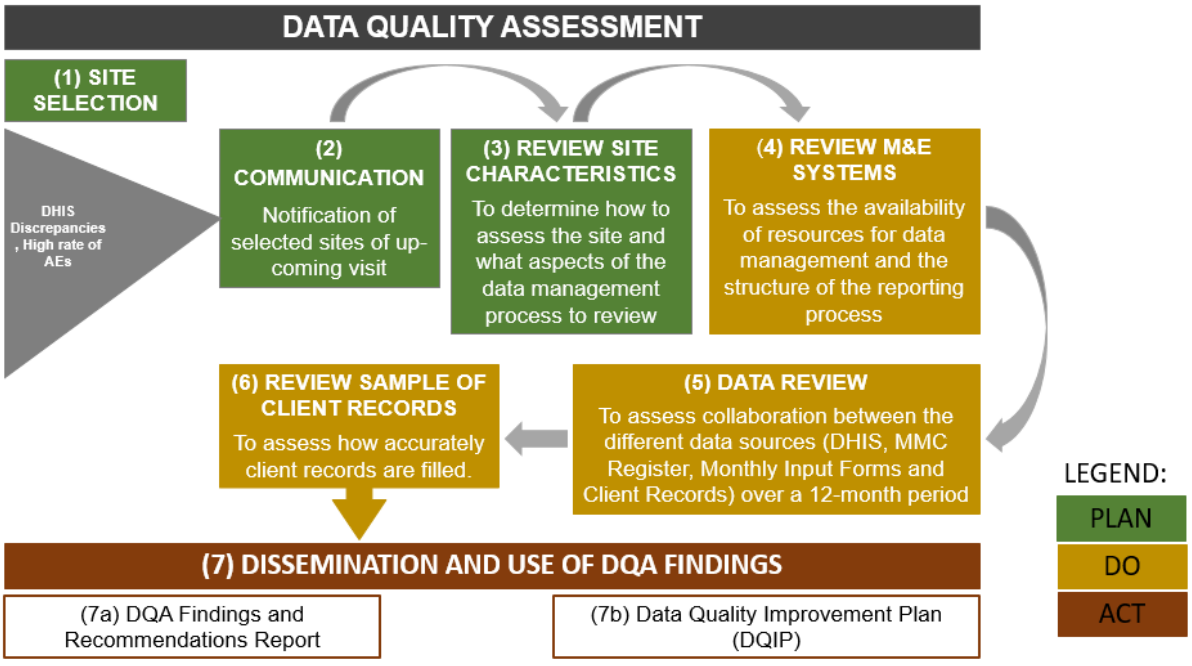


Figure 10: Data Quality Assessment process in accordance with NDOH DQA strategy

QUARTERLY CONTINUOUS QUALITY IMPROVEMENT

CQI is a formal approach to analysing performance and systematically improving it through ongoing efforts. The figure below illustrates the constructive CQI process whereby selected sites are assessed to gauge the extent of service delivery performance. The assessment considers: compliance to quality standards; performance against quality indicators and guidelines; identified gaps; on-site monitoring of remedial plans and actions put in place; as well as regular re-assessment of the impact of remedial plans on the identified gaps. The process in the figure below is in line with the guide in chapter 10 of the National Guidelines for VMMC (2016), which provides extensive information on each of the CQI steps.

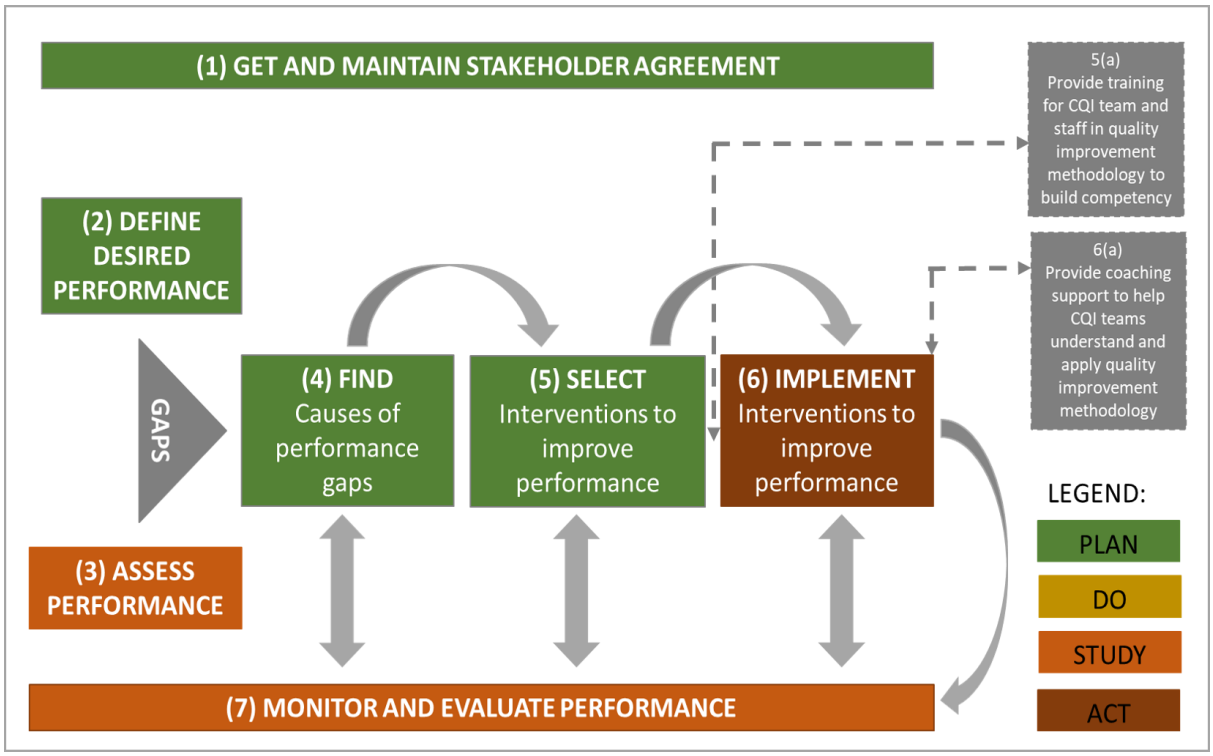


Figure 11: VMMC CQI process in accordance with the SA VMMC guidelines

ANNUAL EXTERNAL QUALITY ASSESSMENTS

To further enhance the safety and quality of services and to ensure that VMMC services meet global standards, it is recommended that national conduct annual EQAs. The objective of an EQA is to monitor VMMC service delivery programmes by conducting assessments of implementing partners and their sites; to assure that all VMMC service provisions meet appropriate standards and clinical practices. National developed an EQA findings report template that can be used by the EQA implementing partners to present results from the process.

2.8. RISK MANAGEMENT

- → Annexure 2: (Implementing partner QA manager obligations)
- → Annexure 3 (Contract risk management process, risk form, risk register, anticipated risks register)
- → Monthly progress reporting
- → SLA Section 11.5 (Implementing partner information on access to information)
- → RT35 Section 3.1.4.5 (Implementing partner information on access to information)
- → SLA Section 9 (Implementing partner QA obligations)
- → RT35 Sections 3.1.1, 3.1.5.2.6 (Implementing partner QA obligations)

A risk is any event that could hinder the implementation of the SLA contract and prevent the VMMC programme from progressing as planned, or from achieving successful completion and subsequently

its defined objectives. One of the most important duties of contract managers regarding commercial contracts, such as the SLA and RT35, is the accurate identification and proper treatment of commercial contract-related risk issues. There are two broad categories of commercial contractual risks[4]:

- **Liability risk:** e.g. breach of contract issues, claims, warranty problems, terminations, intellectual property infringement charges, alleged confidentiality disclosures, disputes, and litigation; and;
- **Business risks**: e.g. poor relationships, failure to obtain objectives, bad public relations, declining morale, instability, weakening of brand integrity, loss of goodwill, and reduced revenue or profits.

Commercial contractual risk management involves the calculated actions to reduce the severity, frequency and unpredictability of damages, losses, and claims. Although, to some extent, it also involves managing the occurrence of negative events that threaten the VMMC programme operations. The figure below provides a sequential contract risk management process to be followed by the contract manager and any VMMC DOH officials and implementing partners who bring a risk to the attention of the contract manager.

[4] read.nxtbook.com/ncma/contractmanagement/january2014/managingcontractualriskissues.html

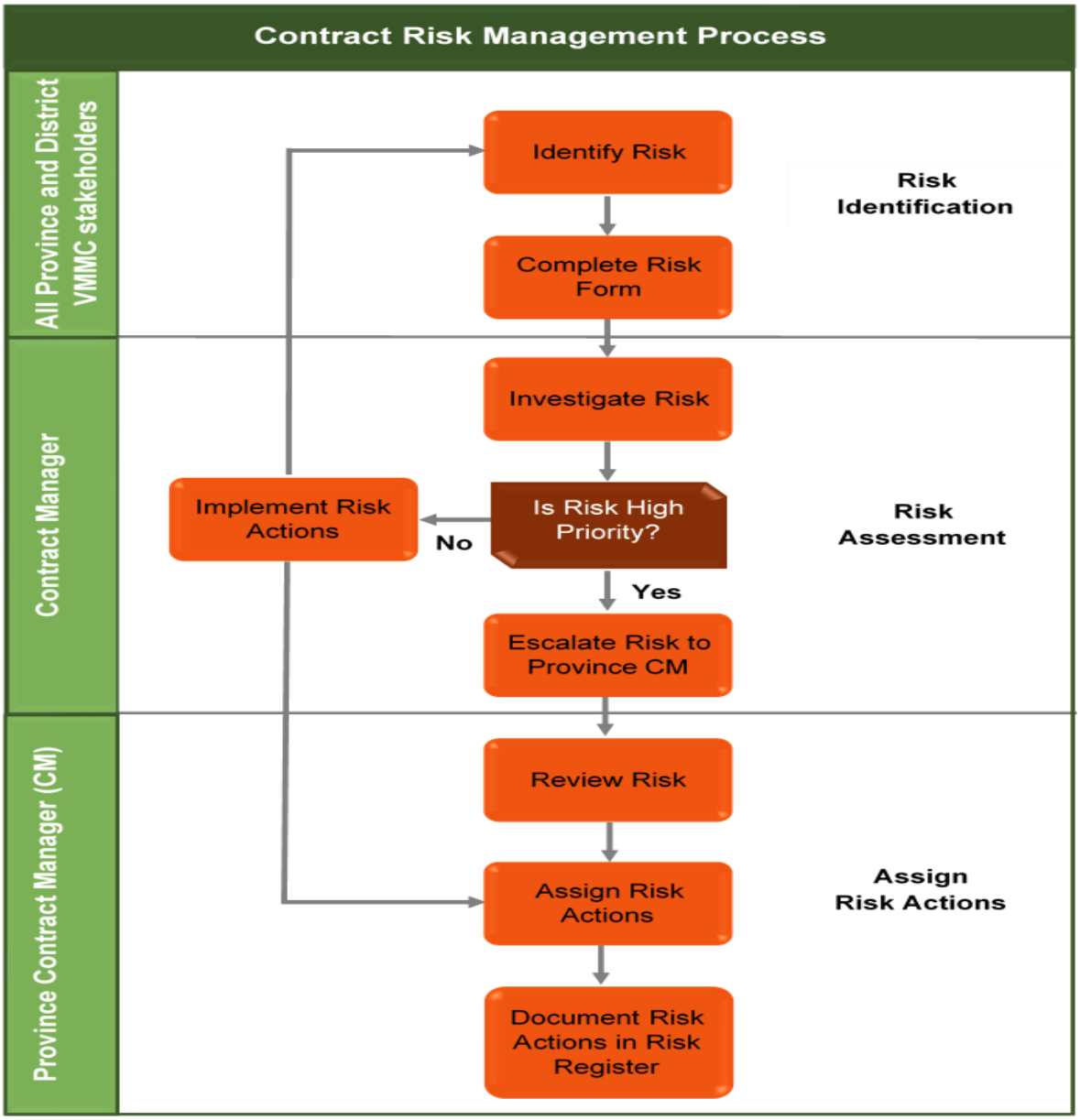


Figure 12: Contract risk management process (see Annexure 3)

Annexure 3 provides detailed descriptions of the risk management steps. The contract manager also relies on the rest of the district and province PMU teams in the identification of risks. Risk awareness requires that every programme team member be aware of what constitutes a risk to the programme and being sensitive to specific events or factors that could potentially impact the programme in a negative, or even positive way.

Any new risks identified will have to be classified using the risk identification matrix in the table below. The matrix determines:

1. The risk consequences (minor, moderate or severe);
2. The likelihood of the risk occurring (rare, likely, almost certain) – if it's a contingency risk;
3. The severity of the risk consequences (low risk, medium risk, high risk).

In determining the risk priority, the contract manager must consider whether the risk is likely to affect the five key aspects of the programme performance: deliverables, quality, timeframes/scheduled targets, resources and budget.

Table 8: Risk identification matrix

Risk Identification Matrix		What are the risk consequences?		
		A. Minor	**B. Moderate**	**C. Severe**
What is the likelihood of the event?	**3. Almost certain**	Medium	High	High
	2. Likely	Low	Medium	High
	1. Rare	Low	Low	Medium

The risk form in Annexure 3 can be used by anyone who identifies a risk. This will be submitted to the contract manager who will follow the process previously stipulated, and who will use the risk register in Annexure 3 to document said risk.

Unexpected risks will occur during the programme lifecycle. However, some risks may be obvious and can be identified and planned for prior to the programme kick-off as part of risk contingency planning. Contingency planning is the development of responses in advance for various possible future situations that might impact the programme. Although negative events probably come to mind first, a good contingency plan should also address positive events that might disrupt programme operations - such as a very large number of clients (demand) for circumcision.

Contingency planning explains the steps to be taken when a risk identified occurs, in order to reduce its impact. The Anticipated Risks Register in Annexure 3 can be used to plan for obvious risks. in Annexure 3 also provides an illustration of risk contingency planning.

CONTRACT MANAGER RESPONSIBILITIES

The contract manager is responsible for monitoring the quality of the contract and progress towards VMMC deliverables by the appointed implementing partners. As stipulated in Section 11.5 of the SLA contract and Section 3.1.4.5 of the RT35 contract, the implementing partner is required to give the province and district full access to all information, books, and records relating to VMMC work. The contract manager's responsibilities in the quality systems listed in the preceding section are outlined in the table below.

Table 9: District contract manager's QA and reporting obligations

Activity	Contract Manager's Responsibilities
Monthly Monitoring	• Submit monthly progress reports on the last working day of the month to province, via email. • Validate monthly data submissions from the implementing partners • Ensure that the implementing partner has confirmed a schedule for the required monthly CQI meetings, which are the responsibility of the implementing partners' QA manager to conduct. • Take part in monthly CQI meetings and produce minutes to accompany the monthly progress report.
Ad-Hoc DQA	• Monitor monthly VMMC data for DHIS discrepancies and a high rate of adverse events, which are the primary criteria that determine the necessity for a site DQA. • Compile a Data Quality Assessment (DQA) findings report. The report is to be submitted within five days of the DQA completion, to the province, via email. The province will share the report with the implementing partners to develop an actional plan for the recommended mitigation measures.

Quarterly CQI	• Overall, the contract manager's responsibility is supervising planning and execution, which entails the following:
	  ○ Schedule CQI assessments.
	• During the Site Readiness Assessment, which is executed by the implementing partners, ensure that the district VMMC PMU appoints individuals to form the Quality Improvement (QI) team. The team should be made up of about four people, which includes representation from the province and the district, as well as the implementing partners' QA manager (Annexure 2).
	• The implementing partners' QA manager is responsible for overseeing and coordinating the CQI assessment. The contract manager must, therefore, ensure that the QI team, led by the QA manager, is equipped to carry out the CQI assessment, which includes the following:
	  ○ Securing copies of the CQI tool and report;
	  ○ Booking appointments with the selected sites, via the facility manager;
	  ○ Finalising the CQI timeline per site;
	  ○ Reviewing the implementing partners' CQI report and validating the content before it is sent off to national;
	  ○ Supervising the implementation of the implementing partners' CQI action plan, which is submitted to the district and province along with the CQI report.

Annual EQA	• Participate in the EQA assessment, either as an observer or an assessor. The actual role will be determined during the planning for the EQA. • Not responsible for the final report, but will participate in the report writing.
Risk Management	• Collect risk forms form the respective district officials/implementing partners whenever a risk is identified. • Develop and implement effective risk management strategies for identified risks. • Document all reported risks in the risk register in Annexure 3. • Keep the anticipated risk register in Annexure 3 updated and record any new potential risks. • Request a risk management analysis report from implementing partners, where necessary. • Execute contract close-out to handle risks and ensure that the contract close-out process in section 4.2.1 of this manual factors in risk management. • Capacitate district PMU and relevant district officials and implementing partners in risk awareness, so they are equipped to identify risks and raise them with the contract manager. This can be done through regular workshops and lesson learned sessions.

PDOH RESPONSIBILITIES

The table below provides an overview of the province's obligations in ensuring quality assurance, as well as reporting.

Table 10: Province's QA and reporting obligations

Activity	Provincial Department of Health Responsibilities
Once-Off	• Arranging kick-off meeting with implementing partners, which should include the contract manager. • Ensuring that the implementing partner submits an Inception Report before they commence with VMMC activities or carry out the Site Readiness Assessment. This report details the work plan, key activities and timelines for the work (to be agreed upon with the province). The report should also be shared with the respective districts, to help them with planning for implementing partners and site allocation.
Monthly Monitoring	• Review contract manager's progress reports. • Authorise invoice payments for the implementing partners, after reviewing the contract manager's verification report.
Ad-Hoc DQA	• Review contract manager's DQA findings report. • Ensure that the implementing partner submits a Data Quality Improvement Plan based on the DQA findings, within seven days of receiving the DQA findings report.
Quarterly CQI	• Participate in the CQI assessment, in the manner determined by the district PMU team.
Annual EQA	• Facilitate and participate in the EQA, in the manner determined by the DOH officials and implementing partners appointed by national.
Risk Management	• Provide oversight and support the contract manager in managing risks, especially where the necessary risk mitigation action can only be authorised by the province.

IMPLEMENTING PARTNER RESPONSIBILITIES

Section 9 of the SLA contract, and Sections 3.1.1 and 3.1.5.2.6 of the RT35 contract, provide a comprehensive list of the implementing partners' obligations with respect to quality assurance, within the context of the defined quality systems in section 7.1 above. The table below offers a summary of the implementing partners' key quality assurance responsibilities, although this is not limited to these specifications. The implementing partners' QA manager is accountable for the execution of these tasks.

Table 11: Implementing partners' QA and reporting obligations

Activity	Implementing partners' Responsibilities
Once-Off	• Inception Report. • Site Readiness Assessment. • Conduct baseline quality assessments on performance of all sites against standards in the national VMMC guidelines. • Establish quality improvement teams.
Monthly Monitoring	• Conduct monthly CQI meetings and develop a CQI action plan to close gaps identified in all CQI and EQA activities.

	• Submit the following reports to the contract manager for distribution to the province and national: CQI Action Plan, AE Report, and follow-up rates using DOH reporting tools.
Ad-Hoc DQA	• Address DQA findings.
Quarterly CQI	• Oversee and coordinate their internal QA, DQA and CQI and compile reports for submission to district, provincial and national DOH VMMC programme and HAST teams. • Develop and implement a CQI action plan to address and close any gaps identified; compile comprehensive reports on CQI evaluations and submit to NDOH; • Conduct quality re-assessments to determine whether a particular site is improving after CQI support visits. • Provide mentorship and support to enable staff to address gaps identified in CQI assessments. • Conduct CQI training workshops (at least two per annum).
Annual EQA	• Oversee and coordinate EQA, DQA and CQI and compile reports for submission to district, provincial and national DOH VMMC programme and HAST teams. • Submit the following reports to the contract manager for distribution to the province and national: CQI Action Plan, AE Report, and follow-up rates using DOH reporting tools.
Risk Management	• Implement the SOP protocol for VMMC AEs to monitor and address adverse events in all VMMC sites of operation. • Develop and submit an AE action plan to resolve AE incidents.

TEMPLATES AND RELEVANT DOCUMENTS

The table below provides a summary of all the templates and relevant documents necessary for the contract manager to execute the duties listed in this chapter.

Table 12: Summary of service level management chapter templates and relevant documents

Activity	Template	Relevant Documents
Monthly Data Monitoring	Monthly progress reports Programme management and reporting calendar	DHMIS Policy (2016) WPGs
Ad-Hoc DQA	DQA findings report	National DQA Strategy (Version 1, October 2019).
Quarterly CQI	Programme management and reporting calendar	National Guidelines for VMMC (2016) – Chapter 10
Annual EQA	N/A	National Guidelines for VMMC (2016) – Chapter 10
Risk Management	Risk Form Risk Register	N/A

2.9. DISPUTE RESOLUTION

→ SLA Section 19 (Dispute resolution)
→ Annexure 7 (Policy violation, contract breach, disputes and penalties register)

Section 19 of the SLA stipulates what happens when any dispute arises from the interpretation, application, or implementation of the SLA.

CONTRACT MANAGER RESPONSIBILITIES

According to Section 19, an Independent Expert (IE) is responsible for resolving disputes, which also includes disputes involving the province, district, and respective contract managers.

OTHER DOH AND IMPLEMENTING PARTNER RESPONSIBILITIES

Section 19 of the SLA contract provides detailed steps on fast-tracking disputes, should the disputing parties fail to reach a resolution, independent of third-party interference.

TEMPLATES AND RELEVANT DOCUMENTs

Policy violation, contract breach, disputes and penalties registers are provided in Annexure 7 to help the contract manager keep track of contract breaches and plan for potential impact on the district.

2.10. BREACH AND TERMINATION

→ SLA Section 18 (Breach and termination)
→ Annexure 7 (Policy violation, contract breach, disputes and penalties register)

A breach of contract occurs when the terms and conditions of a contract/agreement are violated, when one party fails to fulfil its promises according to the provisions of the agreement. In the context of the VMMC SLA and RT35 contracts, a contract breach will occur when the implementing partners do not honour the stipulated contract obligations, as listed in Section 9 of the SLA contract. This also applies to the province honouring their obligations, as the second signing party in the SLA agreement.

Section 18 of the SLA stipulates what happens in the event of a breach of the agreement by either party or their entitlement to terminate the contract, meaning it will end prior to it being fully performed by the signing parties. An example of such breaches that may result in termination include:

- Failure to take remedial action on policy violations by the service provider and the service provider's subcontractors;
- Non-reporting of severe AEs by either the service provider or the service provider's subcontractors.

CONTRACT MANAGER RESPONSIBILITIES

The contract manager is not responsible for resolving, or making decisions on contract breaches. However, they should be aware of what action is required of them in the event of possible contract termination.

OTHER DISTRICT DOH AND IMPLEMENTING PARTNER RESPONSIBILITIES

The aggrieved contract breach party (province or implementing partners) is entitled to the actions listed in Section 18 of the SLA contract.

TEMPLATES AND RELEVANT DOCUMENTS

Policy violation, contract breach, disputes and penalties registers help the contract manager keep track of contract breaches and plan for potential impact on the district.

2.11. FRAUD AND CORRUPTION

→ SLA Section 22 (Fraud and corruption)
→ Close-out documents (report, checklist, and certificate) in case of contract termination

Section 22 of the SLA stipulates what happens if acts of fraud or corruption are performed by any of the parties in the SLA Agreement, or any third-party involved directly or indirectly in the SLA. According to this clause, should it be found that at any stage of the SLA prior (including negotiations) or subsequent to the effective date, as well as upon and after termination of the contract, any of the parties and third parties involved directly and indirectly in the SLA, has committed or contemplated acts of fraud or corruption the SLA contract will be terminated immediately.

CONTRACT MANAGER RESPONSIBILITIES

The contract manager is not responsible for resolving fraud or corruption cases. However, they should be aware of what is required of them to respond in the event of possible contract termination or remedial action that affects the implementation of the VMMC programme in the district.

OTHER DOH OR IMPLEMENTING PARTNER RESPONSIBILITIES

Provinces have the authority to action termination based on fraud or corruption.

TEMPLATES AND RELEVANT DOCUMENTS

In the event that the contract is terminated, the contract manager should use a checklist to complete the contract close-out process.

2.12. AUDITS AND INSPECTIONS

→ SLA contract Section 23 (Audits and inspection procedures)
→ VMMC Statistics Verification form and report

Section 23 of the SLA contract binds the implementing partners to the following audit- and inspection-related procedures that the province may conduct through their internal or external auditors:

- **Financial records:** Undertake a complete audit of the implementing partners' financial records pertaining to the VMMC programme to confirm the accuracy of transactions, and the inflow of payments to or from various sources and calculation of reserves; and;
- **Statistics verification:** On a monthly basis, carry out verification of VMMC statistics reported by implementing partners by means of electronic systems and manual processes.

CONTRACT MANAGER RESPONSIBILITIES

Chapter 6 of this manual has made provisions for the audit and inspection responsibilities of the contract manager. This also includes the monthly VMMC statistics verification.

OTHER DISTRICT DOH AND IMPLEMENTING PARTNER RESPONSIBILITIES

Chapter 6 of this manual has also made provisions for the audit and inspection responsibilities of the implementing partners and the province.

TEMPLATES AND RELEVANT DOCUMENTS

Chapter 6 of this manual has also made provisions for the audit and inspection templates and relevant documents.

2.13. SLA DURATION AND CLOSE-OUT

→ Contract Close-out report template, checklist, and certificate

CONTRACT MANAGER RESPONSIBILITIES

Once the contract is in effect from the signing date, the contract manager's responsibility is simply to be aware of the contract duration, and begin a contract close-out process once the period of the contract is due to lapse. This is irrespective of whether a new contract may be signed with the same implementing partners - the existing contract needs to be properly closed out.

Closing-out of a contract inherently means bringing the contract to an orderly end and verifying that all the deliverables are complete. As a result, project close-out is usually the last task in contract administration. Each activity in the contract must be finalised and all work that has been completed, or cancelled work, must be documented and communicated to the relevant parties and implementing partners and district officials. The close-out process does not only apply to contracts that have reached the completion stage, but to contracts that were terminated before reaching the completion stage. It is important to close a contract, even if the contract gets terminated, as this will help the managing parties to reflect on what can be learned to improve future programmes.

In consultation with the relevant implementing partners and district officials at the province, the contract manager is required to produce a Contract Close-Out Report which should be developed and signed by both the delivering (implementing partners) and accepting parties (province) once the contract has concluded. At a minimum, a close-out report should include:

1. Confirmation of the programme closure;
2. Analysis of the contract performance;
3. Signature to confirm acceptance (including conditions if applicable) of the deliverable; and;
4. Lessons learned.

The contract manager will need to determine the contribution that they will require from the province and the implementing partners, based on a contract close-out report, checklist and certificate, and communicate these requirements to each of the DOH officials and implementing partners.

OTHER DOH AND IMPLEMENTING PARTNER RESPONSIBILITIES

The province and the implementing partners are required to contribute to the contract close-out report, as determined by the contract manager. Once the report and contract close-out process are finalised, the DOH officials and implementing partners are required to sign the contract close-out certificate.

TEMPLATES AND RELEVANT DOCUMENTS

The table below provides a summary of the templates the contract manager will use to execute tasks discussed in this chapter.

Table 13: Summary of duration chapter templates and relevant documents

Activity/Contract Item	Templates	Relevant Documents
Duration	N/A	N/A
Contract Close-Out	Contract close-out report template Contract close-out checklist Contract close-out certificate	N/A

2.14. ANNEXURE

2.14.1. ANNEXURE 1

VMMC operational readiness checklist

VMMC OPERATIONAL READINESS CHECKLIST			
Prepared by district/contract manager:		District:	
Name of facility manager:		Date Prepared:	
Province:		Contact Number/Email:	

Tick	Actions Items
	Get a copy of the signed RT35 contract and familiarise yourself with the terms of reference.
	Get a copy of the signed SLA contract(s) and familiarise yourself with the terms of reference.
	Confirm date of kick-off meeting arranged by province.
	Get a copy of the Inception Report submitted to the province by the implementing partners.
	Schedule a district meeting with the implementing partner(s) and prepare for the following, although not limited: • Review of the Inception Report, where necessary; • Site allocation; • Scheduling of Site Readiness Assessment.
	Supervise and support the implementing partners in the completion of the Site Readiness Assessment using the site readiness assessment tool provided in this Annexure.
	Ensure that the implementing partner passes the Site Readiness Assessment based on the non-negotiables in the assessment tool.
	Confirm Service Level Management and Reporting schedule with relevant district officials and implementing partners using a RACI Matrix Template that the contract manager can develop. This includes schedules for monitoring, reporting, and quality assurance assessments for the contract manager and implementing partners.
	Establish a preliminary schedule of meetings between the implementing partners, province and district.
	Follow up on the implementing partner Inception Report and any actionable items in it.

2.14.2. ANNEXURE 2

- VMMC districts and targets
- Implementing partners' reporting obligations
- Implementing partners' key personnel and their key competencies in accordance with the RT35

Table 14: VMMC districts and targets

Province	District	VMMC Targets
Eastern Cape	Sarah Baartman	2198
	Joe Gqabi	1735
	Nelson Mandela	5519
Free State	Fezile Dabi	6739
	Motheo/Mangaung	11099
	Xhariep	1993
Gauteng	West Rand	13528
Kwa-Zulu Natal	Amajuba	7587
	iLembe	9922
	uMzinyathi	7296
	uMkhanyakude	9909
Limpopo	Sekhukhune	7037
	Vhembe	8364
	Waterberg	4465
Mpumalanga	Gert Sibande	18145
North West	Dr R.S. Mompati	5461
Northern Cape	Frances Baard	6282
	JT Gaetsewe	4030
	Namakwa	2295

Table 15: Implementing partners' reporting obligations

<table>
<tr><th>Reporting Period</th><th>Required Report(s)</th></tr>
<tr><td>Once-Off</td><td>(1) Inception Report (see RT35, Section 3.1.4.1 and SLA, Section 11.1):
The implementing partner is required to submit this report to province after the initial meeting. To aid with monitoring, the contract manager should familiarise themselves with the submitted report which details the implementing partners' detailing of the work plan, key activities and timelines for the work.
(2) Site Readiness Assessment Report.</td></tr>
<tr><td>Monthly</td><td>(3) Performance Report (see RT35, Section 3.1.4.3 and SLA, Section 11.3):
Outlines the number of circumcisions conducted by the contracted general practitioners (GPs).</td></tr>
<tr><td>Quarterly</td><td>(4) Quarterly Reports (see RT35, Section 3.1.4.2 and SLA, Section 11.2):
Report provides a summary of operations and progress, including: challenges, strengths and recommendations; submitted to the VMMC programme at national, provincial and relevant district.</td></tr>
<tr><td>Biannually</td><td>(5) Information Reports (see RT35, Section 24.1.1):
All implementing partners are required to submit information reports regarding the number of districts they have entered into service level agreements with, including the number of procedures and values thereof, via email on a six-monthly basis to NT. The contract manager is required to facilitate this process and validate the information in the report before submission to NT.
See Section 24.1.1 of the RT35 for a reporting timeline.
RT35 (Section 24.1.1) implementing partner information reports timeline:
<table>
<tr><th>Period</th><th>To reach the office on the following dates:</th></tr>
<tr><td>1 November 2019 - 30 April 2020</td><td>10 May 2020</td></tr>
<tr><td>1 May 2020 - 31 October 2020</td><td>10 November 2020</td></tr>
<tr><td>1 November 2020 - 30 April 2021</td><td>10 May 2021</td></tr>
<tr><td>1 May 2021 - 31 October 2021</td><td>10 November 2021</td></tr>
<tr><td>1 November 2021 - 30 April 2022</td><td>10 May 2022</td></tr>
<tr><td>1 May 2022 - 31 October 2022</td><td>10 November 2022</td></tr>
<tr><td>1 November 2022 - 31 March 2023</td><td>10 April 2023</td></tr>
</table>
</td></tr>
</table>

Table 16: Implementing partners' key personnel and their key competencies in accordance with the RT35

Key Personnel	Key Responsibility	Key Required Competency
Chief Executive Officer (CEO)	Responsible for overall technical leadership and management of the contract and will serve as the principal liaison with the province.	• Degree in management, international development, public health policy; • At least 10 years of relevant experience in planning, managing, leadership and evidence-based decision making in VMMC or HIV/AIDS service delivery programmes preferably in South Africa.
Senior Technical Advisor	Works under the direction of the CEO to design, implement and manage all technical aspects of the programmes and to provide regular support and mentorship to all service delivery sites.	• MBChB or four years Professional Nursing degree; • Proof of registration with the HPCSA; • At least 10 years of experience working in HIV/AIDS, VMMC, preferably in South Africa.
Director, Financial Management and Operations	Responsible for overall financial management and administration of the contract.	• Degree in Financial Management, Business Administration, Finance, Accounting or other relevant field, or a Bachelor's or Certified Accounting degree with 10 years of experience; • Five years of relevant government finance working experience; • 10 years accounting, operations and financial management of large-scale, governmental programmes.
Senior Monitoring and Evaluation Advisor	Leads the monitoring and evaluation for this programme.	
Demand Creation Advisor	Leads the planning and implementation of demand creation activities for this programme.	
QA Manager	Leads the quality assurance management of the VMMC programme.	

2.14.3. ANNEXURE 3

- Contract Risk Management Process
- Risk Form
- Risk Register
- Anticipated Risks Register

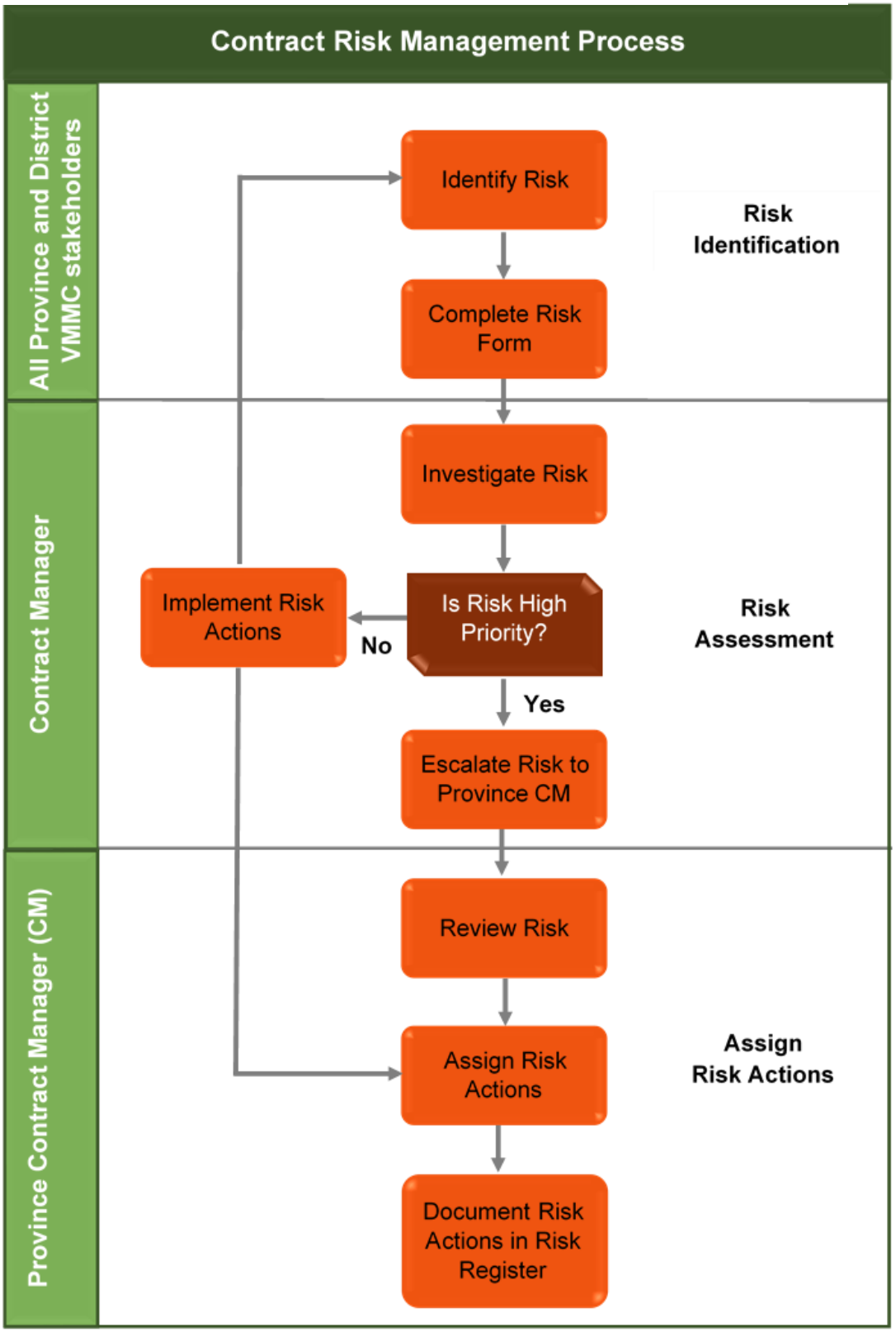


Figure 13: Contract risk management process

Table 17: Risk Form

RISK FORM		
PROJECT DETAILS		
Project Name:		
Project Number:		
Project Manager:		
RISK DETAILS		
Risk ID:	[Unique identifier assigned to this risk]	
Risk raised by:	[Name of person who is raising this risk]	
Date raised:	[Date of completion of this form]	
Risk description: *Briefly describe the identified risk and its likely impact on the project (e.g. scope, resources, deliverables, timescales and/or budgets), should it occur.*		
Risk Likelihood: *Describe and rate the likelihood that the risk will eventuate (i.e. low, medium or high).*		Risk Impact: *Describe and rate the impact on the project if the risk eventuates (i.e. low, medium or high).*
RISK MITIGATION		
Recommended preventative actions: *Describe briefly the actions to be taken to prevent the risk from eventuating:*		
Recommended contingent actions: *Describe briefly the actions to be taken if the risk eventuates, to minimise its impact on the project:*		
Supporting documentation: *Reference any supporting documentation used to substantiate this risk:*		
Signature: _____	Date: _____ / _____ / _____	
PLEASE FORWARD THIS FORM TO THE PROJECT MANAGER FOR ACTION		

Table 18: Contract risk management risk register

RISK REGISTER

District name:

Name of contract manager: _____

Risk Summary				Description					Preventative Actions			Contingency Actions		
ID	**Date Raised**	**Raised By**	**Received By**	**Description of Risk**	**Description of Impact**	**Likelihood Rating**	**Impact Rating**	**Priority Rating**	**Preventative Actions**	**Action Resource**	**Action Date**	**Contingency Actions**	**Action Resource**	**Action Date**

Table 19: Contingency planning – anticipated risks plan

ANTICIPATED RISKS PLAN										
Project Stage	**ID.**	**Anticipated Risk**	**Anticipated Impact**	**Likelihood Rating**	**Consequence Rating**	**Impact Rating**	**Preventative/ Mitigation Action**	**Action Resource**	**Contingent Actions**	**Action Resource**
(1) Planning										
(2) Execution										
(3) Post-Execution										

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

National Treasury Transversal VMMC Contract |

3. GUIDANCE NOTE FOR RT35 SLA

Version 1 (August 2020)

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

To: Provincial or District Department of Health (PDoH/ DDoH)

From: National Department of Health (NDoH)

Date: 13 August 2020

Re: **Guidance note for RT35 SLA finalisation**

3.1. CONTRACTING

When contracting for the government through government bids, contracts and orders, there are certain general conditions/best practices that need to be adhered to post awarding the contract. This is to ensure that all parties involved in the contracting process are familiar with the rights and obligations of all the parties involved in doing business with the government.

It is important to note that general conditions of contract will form part of all bid documents and they may not be amended. Apart from the general conditions of a contract, there are also special conditions of contract (SCC) relevant to a specific bid that should be enforced after the contract has been awarded. The SCC should be compiled separately for every bid. SCC are used to supplement the general conditions of a contract. Whenever there is a conflict regarding the contract, the provisions in the SCC will prevail.

A checklist of what needs to be in place once the contract has been awarded are highlighted below.

Figure 1: Contract Checklist[5]

✓	**Once the contract has been awarded, the following will be in place:**
	1. Contract ID is assigned
	2. Contract classification for management purposes has been done
	3. Budget, implementation and in-year monitoring structure in place
Contract oversight structures	
	4. Supplier / buyer / stakeholder induction completed
	5. Contract manager appointed
	6. Steering group and other advisory and oversight structures in place
	7. Handover from bid and award stage to contract management
	8. Contract management plan in place
Contract documentation system	
	9. Original signed hard copy contract on file
	10. Electronic copy of original signed contract on file (PDF format)
	11. Key information and trigger points recorded in the contract management system
✓	**Once the contract has been awarded, the following will be in place:**
Appropriate supplier relationship structures	
	12. Roles and responsibilities of supplier, contract owner, and contract manager
	13. Regular meeting dates set (monthly / quarterly / annually)
Performance management systems	
	14. Performance management processes and metrics agreed with stakeholders prior to contract commencement
	15. Performance management metrics consistent with institution's strategic objectives
	16. Performance reviews set (monthly / quarterly / annually) and documentation defined
Risk management plan	
	17. Risk identification and assessment completed
	18. Potential risk response documented
	19. Potential risk response documented
Other processes understood by all parties	
	20. Payment or collection processes
	21. Incentives, penalties (remedial action) processes

[5] Source: National Treasury (2010) *Contract Management Guideline*

3.2. THE SUPPLIER AND THE PURCHASER

There are certain supplier guidelines that need to be followed when the contract has been awarded to a certain supplier[67]: In this specific instance, the respective Provincial and District Department of Health are the purchasers of the service, while the VMMC service provider is the supplier.

- The supplier (VMMC service provider) is not permitted, without the purchaser's (Provincial and District Department of Health) prior written consent, to disclose the contract, or any provision thereof, or any specification, plan, drawing, pattern, sample, or information furnished by or on behalf of the purchaser in connection therewith, to any person other than a person employed by the supplier in the performance of the contract. Disclosure to any such employed person shall be made in confidence and shall extend only as far as may be necessary for purposes of such performance.
- The supplier is not permitted, without the purchaser's prior written consent, to make use of any document or information mentioned in GCC clause 5.1 except for purposes of performing the contract.
- The supplier shall permit the purchaser to inspect the supplier's records relating to the performance of the supplier and to have them audited by auditors appointed by the purchaser if so required by the purchaser.

A **Service Level Agreement (SLA)** between a supplier and purchaser notes certain requirements for the agreement/contract to be valid. The requirements are highlighted in the table below.

[6] Parliament of South Africa (2010). *Conditions of a contract.*

[7] Party who the contract was awarded to

Table 20: Checklist requirements for RT35 SLA[8]

✓	Requirements for the RT35 SLA
	The SLA/contract must be signed in two originals. It constitutes the sole record of the agreement between the parties in regard to the subject matter hereof. Each party to retain one of the two signed originals.
	No party shall be bound by any representation, expressed or implied, warranties, promises or the like, not recorded within the SLA/contract, incorporated as an Annexure or otherwise reduced to writing and signed by or on behalf of the parties.
	The SLA/contract must supersede and replace prior commitments, undertakings or representations, whether oral or written, between the parties in respect of the subject matter of the SLA/contract.
	No relaxation of the terms of the SLA/contract and no indulgence which one party may grant to the other will in any way operate as an restriction against the former party or be deemed to be a waiver of its rights, or in any other way limit, alter or prejudice those rights.
	Each person **signing the SLA/contract for and on behalf of a party** hereby warrants in his official capacity that he is duly authorized by such party to do so.

In the context of VMMC, **a service-level agreement (SLA) defines the level of service expected by the province/district from a service provider**. It lays out:

(a) the metrics by which that service is measured,

(b) the remedies or penalties, if any, should the agreed-on service levels not be achieved.

The SLA includes the components noted in the table below.

Table 21: Components of SLA[9]

SLA Components	Brief Description
The purpose and objectives of the SLA	The purpose of the SLA is to establish the VMMC service delivery arrangement between the PDoH and service delivery partner name by ensuring that the objectives of the NDoH and PDoH are met. The main objective of the SLA is to provide VMMC services in District name under a direct contract between the province name DoH and service delivery partner name.

[8] Source: Service Level Agreement: The Government of the Republic of South Africa through its PDoH

[9] Source: Service Level Agreement: The Government of the Republic of South Africa through its PDoH

Detailed description of services and products to be delivered	A clear and detailed description of the services and products to be delivered by the service provider that is hired by the DoH.
Payment of the service	All payments due to the service provider will be made at a specific date according to the invoices submitted by the service delivery partner name. Reconciliation of all the invoices should occur at the close of the agreement.
Duration	This involves a clear date of commencement of the SLA and date of terminations. The PDoH reserves the right to extend the SLA with the service delivery partner on rates and terms that the parties agree upon.
Appointment	This is when the PDoH appoints a service delivery partner. With the signing of the SLA, the service provider accepts such appointment to provide the services outlined within the agreement.
Applicability of other documents	In an instance when there is a conflict between the provisions of any of the documents and the SLA, the provisions within the SLA shall take precedence over the provisions of such other documents.
Obligations of the service provider	This entails the services and products that the service provider agrees to undertake within the conditions stipulated in the SLA.
Roles and responsibilities of the PDoH	The PDoH has to manage the interface between the structures in the PDoH and the service delivery partner. The PDoH has to monitor the service deliverables, outputs, and the progress of service delivery as noted in the SLA.
Service level management and reporting	The Service Provider is required to present an inception report, after an initial meeting with the PDoH, detailing the work plan, key activities, and timelines for the work (to be agreed upon with the PDoH). Quarterly and performance reports which provide a summary of operations and progress, including challenges, strengths, and recommendations must be submitted to the MMC Program of the NDoH and PDoH.

Terms of payment, price adjustment and invoices	This details the terms of payment to the service provider, any adjustments of the terms of payment.
Performance and penalties	The service delivery partner agrees to perform the services in accordance with the service standards outlined in the SLA. The PDoH is entitled to impose any penalties for late or defective performance according to the agreed terms.
Assignment, cession and delegation	Assignment, cession and/or delegation of any rights and obligations respectively under this SLA to any third party shall be dealt with in terms of the PDoH policy. The SLA is also binding on the successors in title, assignees, and administrators of the respective parties.
Intellectual property (IP)	IP created under the SLA belongs to the PDoH. This IP clause shall survive until termination of the SLA.
Confidentiality	The parties agree to keep confidential and not to disclose to third parties any information provided by either party or as a witness by that party or its employees in the course of performance of services under the SLA unless the party concerned has received prior written consent of the other party to make such disclosure.
Force majeure	Failure of any part of the parties to fulfill any of its obligations under the SLA due to force majeure shall be dealt with.
Breach and termination	This is in an event where either party breaching any provision of the Agreement (“the defaulting party”) and failing to remedy such breach within a specified time. The aggrieved party shall be entitled to either: cancel the agreement; or seeking specific performance of the defaulting party’s obligation in terms of the Agreement. The aggrieved party has a right to claim such damages.
Settlement of disputes	Any disputes arising from the interpretation, application or implementation of the SLA shall be resolved by way of negation and the parties to the dispute shall attempt in good faith to come to an agreement in relation to the disputed matter, failing which the parties agree to the fast-track dispute mechanism, failing which an arbitrator shall be appointed by agreement, whose decision shall be final and binding.

Amendment of this SLA	Any variation, addition, or amendment of the SLA, shall be dealt with by the parties involved.
Indemnity	The Service Provider hereby indemnifies and holds the PDoH harmless against any claims of any nature whatsoever and however arising out of any respective individual willful or negligent act or omission by the Service Provider.
Fraud and corruption	Should any party of the SLA and/or any third party involved directly or indirectly in the SLA, has performed or contemplated performing an act of fraud or corruption, the SLA shall terminate immediately, and the innocent party shall be entitled to invoke the remedies available to it contained in the SLA as well as to proceed against any and all individuals in their personal capacity who performed the corrupt act. This clause shall survive until the termination of the SLA.
Audits and inspections	The parties agree that PDoH may, through their internal or external auditor - Undertake a complete audit of service delivery partner's financial records pertaining to this program to confirm the accuracy of transactions, and/or the inflow of payments to or from various sources and calculation of reserves.
Domicilia and notices	The service delivery partner has to state who it chooses as its *domicilia citandi et executandi* for all purposes arising from the SLA.
Governing law	The SLA is governed by the law of the Republic of South Africa.
Authority	Each person signing the SLA for and on behalf of a party hereby warrants in their official capacity that they are duly authorised by such party to do so.

Counterpart signing of the SLA	The parties agree that the SLA may be signed at different times and in different places, and in copy provided the content of the SLA and signatures are exact replicas (counterparts) of the originals when put together. The signed SLA's when put together shall constitute a binding agreement between the parties.

Self-reflection after working through the SLA components:

1. The sections I should especially take note of are: _____
2. The sections I do not fully understand yet: _____

3.3. SLA CLAUSES TO COMPLETE

There are a number of specific clauses that need to be completed in the VMMC provincial/district SLA, for this to be considered an executed SLA. These are listed in the table below.

Table 22: Clauses requiring input to complete SLA

Clause No.	Clause	✓
4.3.1	service delivery partner name acknowledges and agrees that PDoH may, in consultation with service delivery partner name and with reasonable cause (consistent and significant failure to meet program targets or Program QA standards and the minimum package of services for VMMC or incurring a high number of AEs exceeding 2% per site per quarter) amend and/or adjust the amount, time and/or conditions of payment of any of the funds granted to service delivery partner name under the SLA. PDoH may not adjust downwards the agreed amount per circumcision as outlined in National Treasury Contract RT35-2019 signed on_____.	
4.3.2	Subject to the terms and conditions of this Agreement and in consideration for service delivery partner name compliance with its obligations in terms of this Agreement, PDoH hereby approve an amount of _____(in words) per procedure on a monthly basis for the period [ENTER DATE] and will continue until [ENTER DATE] in accordance with the budget.	
6.1	This SLA shall notwithstanding the date of signature become effective on the date of commencement being [ENTER DATE] and shall endure for a period of 3 years until [ENTER DATE].	
12.1	service delivery partner name will be offered a payment of _____ per circumcision, subject to clause 13, as per negotiations with the Provincial Department of Health.	
12.2	The approved payment amount in this Agreement shall be adjusted by CPI on the 1st and 2nd anniversary (i.e. [ENTER DATES]) of this Agreement.	
14.1	Assignment, cession and/or delegation of any rights and obligations respectively under this SLA to any third party shall be dealt with in terms of the PDoH policy of _____	
17	Failure of any part of the parties to fulfill any of its obligations under this SLA due to force majeure shall be dealt with in terms of _____.	
20	Any variation, addition or amendment of this SLA, shall be dealt with in terms of _____.	
25	DOMICILIA AND NOTICES	

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

National Treasury Transversal VMMC Contract |

4. CONTRACTING GPS

Version 1 (June 2020)

Contents

ABBREVIATIONS ..... **xii**
PURPOSE/OBJECTIVES OF THESE GUIDELINES **13**
CONSIDERATIONS FOR SELECTING GPS **13**
OBLIGATIONS OF THE GP **13**
NATIONAL VMMC PROGRAM POLICY VIOLATIONS **15**
CONSEQUENCES FOR POLICY VIOLATIONS.....4
OPERATIONAL READINESS REQUIREMENTS **17**
Admin requirements **17**
Process requirements **17**
Approvals and structural requirements **18**
SOPs, guidelines, policies and job aids **18**
Infrastructure ..... Error! Bookmark not defined.
Supplies, equipment and consumables **19**
EMERGENCY SUPPLIES **21**
Equipment and instruments **21**
Intravenous infusion **22**
Emergency drugs **22**
Disposable commodities **22**
CONTACT PERSON: **24**
REFERENCES **25**

ABBREVIATIONS

AE	Adverse event
CQI	Continuous quality improvement
DoH	Department of Health
GP	General practitioner
GPP	Good Pharmacy Practice
HPCSA	Health Professional Council of South Africa
HTS	HIV testing services
IPC	Infection prevention and control
M&E	Monitoring and evaluation
OTH	Online Training Hub
QA	Quality Assurance
SARS	South Africa Revenue Service
VMMC	Voluntary medical male circumcision
WHO	World Health Organization

4.1. PURPOSE/OBJECTIVES OF THESE GUIDELINES

The Voluntary Medical Male Circumcision (VMMC) general practitioner (GP) contracting guidelines have been compiled to ensure that GPs provide MMC services in a safe, efficient and cost-effective way. The quality of services provided by GPs will be monitored and maintained at very high levels by District, Provincial and National VMMC Managers.

4.2. CONSIDERATIONS FOR SELECTING GPS

It is required that when selecting GPs to partner with, organisations must **aim to broaden their reach to as wide a catchment area as is feasible, by selecting partners in different areas of the city**. Contracting of many GPs in the same area splits the access points of clients looking for VMMC services. This could mean lower client volumes-to-site/clinics ratios, and in this scenario the practices may not benefit from economies of scale of high-volume client flow and the sustainability of the model maybe jeopardized.

The GP practice should **have adequate electronic management systems in place to be able to adhere to stringent requirements and quality standards**, and offer a comprehensive package of the minimum services required by the Department of Health. **This system must be auditable**.

It is a requirement to contract GPs that **have undergone accredited VMMC training and deemed proficient in providing VMMC and other HIV prevention services**.

The GP must **have a trained and certified HIV Counsellor employed or contracted to offer and perform HIV testing services (HTS)** according to the National HTS testing guidelines and algorithm.

4.3. OBLIGATIONS OF THE GP

Regulations and compliance

1. To **comply with all applicable South African Government regulations** including all the applicable requirements and guidelines relating to the National VMMC programme such as reporting and external quality assurance assessments, including data quality assessments and continuous quality improvement activities.

2. To **be solely responsible for ensuring that they keep themselves fully informed** of any amendments, variations and/or additions to the World Health Organization (WHO) and South African Department of Health (DOH) National Guidelines relevant to the provision of VMMC services.
3. To **ensure that quality Monitoring and Evaluation (M&E) records and systems are maintained** in compliance with DoH reporting standards.
4. To **comply with occupational and environmental health and safety processes** that meet legislative requirements.
5. To **adhere to DoH VMMC infection control and waste management protocols**.

Data and information

6. To **keep confidential all information, records, tests or disclosures of a medical or personal nature**, relating to the client during the course of rendering any service to them. GPs are however required to release information to relevant bodies during investigation of adverse events (AEs) or for further clinical management of the client.
7. To **demonstrate accountability** in terms of maintaining private medical records of patients including HIV status.

Services to clients

8. To **ensure access to and create demand for VMMC services among males between the ages of 15-34 years of age**, including site-specific social mobilization and collaboration with community and clinic-based partners that can help build demand.
9. To **provide VMMC services to eligible males** who are 10 years of age and older, and **ensuring that the required informed consent processes are in place** and obtained according to the quality standards set out in the WHO and DoH VMMC implementation and clinical guidelines.
10. To **offer HTS to 100% of the VMMC clients** as part of the MMC service and **ensure referral of HIV positive clients for treatment and care services**. However, HIV testing is not compulsory to receive VMMC.
11. To **educate clients on the benefits of VMMC** using DoH approved materials and guidelines referenced by this statement to **improve clients' knowledge about the partial protective effect of VMMC and the need for safe sexual practices** following MMC through the use of condoms, having one sexual partner and other safe sex strategies.
12. To **provide pre- and post- VMMC counselling**, including informed consent for VMMC, abstinence counselling during the healing period including risk reduction counselling.

Quality control

13. To **ensure that all AEs are properly managed and accurately reported**. Should it emerge that AE's have not been adequately reported, the contract between the appointed service provider may be terminated immediately at the discretion of DoH.

14. To **ensure the use of clinical algorithms and quality standards as per the WHO and NDoH VMMC clinical guidelines** for the management and performance of MMC surgical and device-based procedures.
15. To **ensure access to follow-up services** of two (2), seven (7) and fourteen (14) days after the provision of VMMC services to all patients.

Staffing

16. To **provide appropriate and adequate staffing as well as on-going training, mentoring and supervision of staff** to ensure high quality delivery of the minimum package of VMMC services.
17. To **ensure that all staff have enrolled and completed training** with the Online Training Hub (OTH) system.
18. To **ensure that all staff working in the practice have legally binding written contract of employment** that include reference to normal working hours, total remuneration, leave policy, and all other terms and conditions of employment.
19. To **ensure that all staff are and remain registered with all applicable professional health councils, authorities and/or bodies** in accordance with all applicable laws and regulations. Copies of proof of such registration in respect of all or any of the staff shall be made available to the DoH upon request.

4.4. NATIONAL VMMC PROGRAM POLICY VIOLATIONS

The following constitute National VMMC policy violations:

Data and reporting

1. No written informed consent retained for clients or parental/guardian consent for minor clients
2. No immediate reporting of any death or severe adverse event as per protocol in Appendix A
3. Double counting VMMC reported to different stakeholders or falsifying records (e.g. reporting ghost VMMCs)
4. Removing MMC source documents from DoH facilities or any other VMMC site where they were performed at

Services to clients

5. HIV testing not conducted as recommended (HIV testing is not compulsory)
6. VMMC performed in clients aged <10 years
7. To only use surgical methods and devices approved and/or pre-qualified by WHO and the NDoH. All circumcisions regardless of age of client should be conducted using the dorsal slit method
8. Clients not receiving written instructions on recommended post-procedure wound care that explicitly address the risk of wound infection including the danger of using traditional remedies for wound care

Quality control

9. The use of sedation or general anaesthesia during a VMMC surgical procedure
10. Absence of evidence of any client post circumcision follow-up conducted
11. Absence of emergency supplies, equipment and no evidence of VMMC Emergency preparedness training for staff on site
12. Not maintaining clinical skills as demonstrated through participation in routine trainings (e.g. procedure refresher and emergency management training every 2 years) or using untrained support staff to deliver the package of VMMC services (e.g. using a layperson to perform HTS)
13. Not adhering to infection prevention and control (IPC) practices illustrated by poor scoring on the IPC Quality Standard of <60%. Scoring between 60 - 85% will require In-service training by IPC Coordinators.
14. Failure to engage in continuous quality improvement (CQI) visits or failure to make improvement on remedial actions between CQI visits

4.5. CONSEQUENCES FOR POLICY VIOLATIONS

Should a policy violation be identified by District CQI team members the appointed Service Provider will be notified and an action plan summary should be shared with the District CQI teams and the service provider will be obligated to take immediate remedial action. This remedial action shall take the form of: remedial training, mentoring and supervision by the Service Delivery Partner(s) clinical staff and the District CQI team members to ensure high quality service.

Providers should conduct regular in-service trainings on MMC service delivery guidelines and protocols and should include clinical guidelines, HIV and MMC counselling guidelines, In-service communication guidelines as well as wound care and follow-up guidelines using approved NDoH guidelines and SOPs.

The appointed service provider shall agree to take part in CQI activities and ensure that all recommendations to address identified gaps are addressed within the agreed timeline. Failure of which shall constitute a breach of this Contract.

If there is no reporting of any severe notifiable AEs, the Contract between the appointed Service Provider can be terminated immediately at the discretion of PDoH.

The NDOH have outlined consequences for policy violations as per national GP contracting guidelines and RT35 stipulations, which takes the stance of suspending services or blacklisting GPs until corrective measures have been satisfactorily implemented.

Failure by an MMC provider to satisfactorily implement any of the stipulated remedial actions will result in the immediate termination of services by the National Department of Health.

4.6. OPERATIONAL READINESS REQUIREMENTS

Can you tick off each of the following operational readiness requirements?

1. Admin
2. Process
3. Approvals & Structural
4. SOPs, Guidelines, Policies, and Job Aids
5. Infrastructure
6. Supplies, Equipment, and Consumables

4.6.1. Admin requirements

☑	Medical degree (MBChB or equivalent)
	Valid registration with the Health Professional Council of South Africa (HPCSA)
	Valid and adequate medical indemnity insurance
	Valid dispensing license as issued by DoH as the practice will be participating in dispensing activities
	Valid and adequate business or property insurance that cover medicine stock losses due to fire, storms, theft and other events
	Valid tax clearance certificate issued by the South Africa Revenue Service (SARS)
	VMMC OTH certificate with evidence of MMC surgical mentorship
	Competency Training certificate in VMMC surgical procedure (not older than 2 years)
	Facility readiness assessment report
	Bank details

4.6.2. Process requirements

☑	The practice should be operational a minimum of 20 hours per week
	All GPs must be provided with targets
	Proper administrative processes are in place that demonstrate effective financial, personnel, asset and information management
	There is a proper filing system that demonstrates good record-keeping
	Proper stock management and dispensing processes are followed according to Good Pharmacy Practice (GPP). These processes include ordering, receiving, issuing, security, control and disposal
	A minimum level of occupational and environmental health and safety processes are in place to meet legislative requirements

4.6.3. Approvals and structural requirements

☑	Approved by District DoH or relevant funder

4.6.4. SOPs, guidelines, policies and job aids

☑	National VMMC Guidelines
	Informed Consent Process
	VMMC Surgical Manual (WHO or National)
	VMMC Register
	Client Record Forms
	Guidelines and Protocols for Medical Emergencies
	Anaesthetics Dosing Guidelines
	Immediate Post-Operative Care
	Post-Operative Follow-up Protocol
	Post-Operative Wound Care Written Instructions
	Adverse Event (AE) Prevention and Management Guidelines
	Adverse Event (AE) Reporting Flow
	Adverse Event (AE) Register
	HIV/AIDS Risk Reduction Counselling guidelines
	HIV Testing Services Guidelines
	HIV Testing Services Register
	STI Diagnosis and Treatment
	TB Screening Guidelines
	Infection Prevention and Control Guidelines
	Blood-borne Pathogen Exposure, including Post-exposure Prophylaxis (PEP) Guidelines
	Waste Management Guidelines
	Patient Rights Charter
	Staff Job Descriptions
	Minutes from Quality Improvement Team Meetings
	Inventory (Stock) cards

4.6.5. Infrastructure

☑	Reception area
	Doctors consulting rooms
	Private counselling rooms
	Pre-op examination room
	Operating room with scrubbing area
	Recovery room/space
	Storage space for supplies
	Fit-for-purpose dispensary that meets temperature, access, fire safety, receiving of medicines, delivery and refrigeration requirements (for dispensing doctors)
	Waste management area
	Adequate water supply
	Adequate lighting
	Internet access
	Security for staff and patients
	Clean environment
	Accessible to people with disabilities

4.6.6. Supplies, equipment and consumables

☑	VMMC kits (according to NDoH specifications and from DoH approved suppliers)
	Lignocaine (1% or 2%) and/or Marcaine (0.5%)
	Disposable needles (23G and 24G)
	Disposable syringes (5ml, 10ml, and 20ml)
	Disposable cannulas (16G, 18G and 20G)
	Gloves (examination, surgical, and utility of different sizes)
	Plastic disposable aprons
	Waste bins (for contaminated and non-contaminated waste)
	Colour-coded bin liners (red and black)
	Sharps disposal containers
	Decontamination buckets
	Handwashing/rub facilities at appropriate places
	Iodine/Betadine solution
	Alternative to Betadine in case of allergies to Betadine (savlon)

	Chlorine/sodium hypochlorite (Jik)
	Soap (plain/medicated/detergent)
	Hand towels/disposable paper towels
	Wall thermometer at all appropriate service areas
	Daily updated Temperature control charts
	HIV testing kits
	HIV testing quality control samples
	Fridge for HTS Quality Control serums
	Freezer for the temporary storage of foreskins prior to disposal by accredited service providers
	Air conditioners
	Surgical beds
	Diathermy machine
	Anaesthetic (“bedside”) trolley with a drawer
	Mayo trolley or surgical instruments trolley

4.7. EMERGENCY SUPPLIES

Can you tick off each of the following emergency supplies?

1. Equipment & Instruments
2. Intravenous Infusion
3. Emergency Drugs
4. Disposable Commodities

4.7.1. Equipment and instruments

Emergency Trolley or emergency jump bag with the following contents:

☑	Ambubag - Adult (A) - complete set
	Ambubag - Paeds (P) - complete set
	Baumanometer
	Cuffs - Adult
	Cuffs - Paediatric or smaller cuff
	ET Tubes adult - Size 7
	ET Tubes adult - Size 8
	ET Tubes adult - Size 9
	ET Tubes paediatric - Size 5
	ET Tubes paediatric - Size 6
	Glucometer
	Glucometer Test Strips
	Introducer - Adult
	Introducer - Paediatric
	K Y Jelly tube 100ml
	Laryngoscope blade set - Adult
	Laryngoscope blade set - Paediatric
	Stethoscope
	Magills forceps - Adult
	Magills forceps - Paediatric
	Oropharyngeal airways sets - A/P
	Oxygen masks - Adult
	Oxygen masks - Paediatric
	Oxygen cylinder (with regulator)

	Pocket Masks
	Pulse Oximeter
	Scissor - Plain/Unsterile
	Suction Machine
	Suction tubes
	Yankauer suction tips
	Torch - Pencil
	Tourniquet
	Different sizes urinary catheters

4.7.2. Intravenous infusion

☑	Ringer Lactate 1L
	Dextrose 5% 200ml
	Sodium Chloride 1L
	Sodium Chloride 200ml

4.7.3. Emergency drugs

☑	Adrenalin 1mg/ml ampoule
	Atropine 0.6mg/1ml ampoule
	Dextrose 50% 20ml
	Lorazepam 4mg/ml amps
	Promethazine
	Solucortef 100mg

4.7.4. Disposable commodities

☑	Unsterile Gloves (Size - large)
	Gauzes Sterile
	IV administration set - A
	IV administration set - P
	Jelco needle (Blue) - 22G

	Jelco needle (Green) - 18G
	Jelco needle (Grey) - 16G
	Jelco needle (Pink) - 20G
	Micropore
	Needles (Black
	Needles (Blue)
	Needles (Green)
	Syringes 20ml
	Syringes 10ml
	Syringes 5ml
	Transparent drip plaster /Tergaderm
	Webcol/Alcohol swab

Please note: The supplies, equipment and consumables listed above are basic minimum requirements for a GP to perform safe MMC. Some consumables that are not listed above but required for various functionalities shall, within reasonable capacity, fall under the GP's contractual obligation.

4.8. CONTACT PERSON

Mr Dayanund Loykissoonlal

Programme Manager: Medical Male Circumcision (VMMC)

National Department of Health

HIV Prevention Strategies

HIV and AIDS & STI Cluster

Tel: (012) 395 9186

Email: Dayanund.Loykissoonlal@health.gov.za

Fax: 086 6329 322

4.9. REFERENCES

1. South African National Medical Male Circumcision Guidelines 2016 (or as amended)
2. NDOH VMMC Adverse Event Management and Reporting Standard Operating Procedure
3. National HIV Testing Services (HTS) Policy 2016

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

National VMMC programme |

5. COORDINATION TOOLKIT

Version 1 (July 2020)

Contact person

Mr Collen Bonnecwe

Medical Male Circumcision Programme Director, National Department of Health

Email	collen.bonnecwe@health.gov.za
Telephone	+27 12 3958021
Mobile	+27 82 4405118

Mr Dayanund Loykissoonlal

Medical Male Circumcision Programme Manager, National Department of Health

Email	dayanund.loykissoonlal@health.gov.za
Telephone	+27 12 3959186
Mobile	+27 71 6033144

TABLE OF CONTENTS

ACRONYMS

1. INTRODUCTION 1

1.1. OVERVIEW 1
1.2. EFFECTIVE COORDINATION AND VMMC PROGRAMME SUCCESS 2
1.3. ENVISIONED SUCCESS OF THE VMMC PROGRAMME 2
1.4. INDICATORS OF THE SUCCESS OF THE VMMC PROGRAMME 2
1.5. PURPOSE AND AUDIENCE 3
1.6. OBJECTIVES 3

2. PROGRAMME COORDINATION 4

2.1. WHAT IS STAKEHOLDER COORDINATION? 4
2.2. WHO SHOULD MANAGE STAKEHOLDER COORDINATION? 5
2.3. COORDINATION AT DIFFERENT LEVELS 5

3. PROCESS OF COORDINATING THE VMMC PROGRAMME 6

3.1. OVERVIEW OF THE COORDINATION PROCESS 6
3.2. PLANNING 7
3.2.1. STEP 1: SITUATION ANALYSIS 7
3.2.2. WHEN TO CONDUCT A SITUATION ANALYSIS 7
3.2.3. STEP 2: STAKEHOLDER MAPPING 8
3.3. IMPLEMENTATION 9
3.3.1. STEP 3: CAPACITATE KEY PEOPLE RESPONSIBLE TO FACILITATE OWNERSHIP OF THE PROGRAMME 9
3.3.2. STEP 4: STAKEHOLDER ANALYSIS 10
3.3.3. STEP 5: STAKEHOLDER ENGAGEMENT PLAN 11
3.3.4. STEP 6: COORDINATION STRUCTURE 12
3.4. MONITORING AND EVALUATION 19
3.4.1. STEP 7: MEASURING COORDINATION EFFECTIVENESS 19
3.4.2. VMMC PROGRAMME CUSTODIAN EFFECTIVENESS 19

4. CONCLUSION 20

List of tables

Table 1: Personnel to lead the stakeholder coordination at different levels 5

Table 2: Checklist of relevant VMMC operational documents 9
Table 3: Checklist of key VMMC strategic documents 10
Table 4: Overview of steps to conduct an effective coordination meeting 13
Table 5: Roles and responsibilities of coordination meeting attendees 14

List of figures

Figure 1: Process of coordination 6
Figure 2: Example of a stakeholder mapping template 8
Figure 3: Stakeholder analysis matrix 11
Figure 4: Example of a stakeholder engagement plan 11
Figure 5: Meeting invite template 15
Figure 6: Minute taking checklist 17
Figure 7: Meeting minutes follow-up email 18

List of boxes

Box 1: Key to toolkit sections 3
Box 2: Definition of stakeholder coordination 4
Box 3: VMMC programme stakeholders 4
Box 4: Levels of coordination 5
Box 5: Definition of situation analysis 7
Box 6: Additional literature on situation analysis 7
Box 7: Definition of stakeholder mapping inquiry 8
Box 8: Stakeholder mapping template 8
Box 9: Definition of stakeholder analysis 10
Box 10: Definition of a task team 12
Box 11: Function of task teams 13
Box 12: Definition of minutes 16
Box 13: Meeting effectiveness assessment tool 19

ACRONYMS

QA	Quality Assurance
CQI	Continuous Quality Improvement
DG	Demand Generation
DOH	Department of Health
GP	General Practitioner
HAST	HIV/AIDS, STIs and TB
HIV	Human Immunodeficiency Virus
KPA	Key Performance Agreement
KPI	Key Performance Indicators
M&E	Monitoring and Evaluation
NDOH	National Department of Health
PEPFAR	United States President's Emergency Plan for AIDS Relief
PD	Programme Director
PM	Programme Manager
RT35	National Treasury Transversal Contract
SLA	Service Level Agreement
STI	Sexually Transmitted Infection
SOP	Standard Operating Procedures
TB	Tuberculosis
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

5.1. INTRODUCTION

OVERVIEW

In 2010, the South African Government initiated the Voluntary Medical Male Circumcision (VMMC) programme as part of the country's HIV prevention strategy, based on compelling evidence that VMMC reduced men's risk of becoming infected with HIV by approximately 60%[10].

Moreover, epidemiological modelling indicated that if countries with high HIV prevalence scaled-up VMMC, HIV incidence rates would be significantly reduced[11].

Following the adoption of this evidence, South Africa embarked on an ambitious goal to circumcise 80% of HIV-negative men to contribute toward the country's HIV epidemic control[12].

To achieve this, the National Department of Health (NDOH) took ownership of the VMMC programme and set systems in place to ensure that the programme is domestically funded and quality services are provided.

One of the important successes of the VMMC programme has been the careful planning and strong coordination led by the Department of Health (DOH) at all levels. This has further ensured that there is a shared vision of the VMMC programme among influential stakeholders, the DOH, and VMMC service providers.

This toolkit provides a guide for planning and coordinating a nationwide VMMC programme in South Africa, with the goal of integrating the programme into the wider healthcare system and ensuring that it forms part of universal healthcare coverage.

[10] Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R, Puren A (2005) Randomized, Controlled Intervention Trial of Male Circumcision for Reduction of HIV Infection Risk: The ANRS 1265 Trial. PLoS Med 2(11): e298..

[11] Njeuhmeli E, Forsythe S, Reed J, Opuni M, Bollinger L, Heard N, et al. (2011) Voluntary Medical Male Circumcision: Modeling the Impact and Cost of Expanding Male Circumcision for HIV Prevention in Eastern and Southern Africa. PLoS Med 8(11): e1001132..

[12] South African National AIDS Council. (2017). The National Strategic Plan for HIV, TB and STIs, 2017-2022. Pretoria: South African National AIDS Council.

EFFECTIVE COORDINATION AND VMMC PROGRAMME SUCCESS

In simple terms, coordination is "the act of working together harmoniously"[13] . For the VMMC programme, continuous coordination with key stakeholders and the DOH provides a forum to share challenges and successes and align efforts to ensure a sustainable and successful programme.

Effective coordination further encourages the successful implementation of the programme as it ensures a shared vision among all stakeholders. This results in a sense of ownership and responsibility towards the programme's goals and objectives.

The buy-in of government leadership at all levels is critical for the successful coordination and the sustainability of the programme because once those in leadership take ownership of it, the rest of the key stakeholders will follow suit.

ENVISIONED SUCCESS OF THE VMMC PROGRAMME

The long-term vision of the VMMC programme is to become sustainable, government-led, with quality services being provided even after external funding has ceased. The National VMMC Strategy 2020-2024 defines the sustainability of the programme as: "the routine provision of VMMC services within a holistic, comprehensive healthcare model, contributing towards universal healthcare coverage"[14].

INDICATORS OF THE SUCCESS OF THE VMMC PROGRAMME

- The programme is government-led;
- The programme is fully funded from a variety of sources that are utilised sustainably with greater domestic responsibility for financing;
- All stakeholders at all levels take ownership of the programme;
- There is adequate capacity and implementing staff receive the necessary support to implement the programme;
- There is evidence-based planning, where data is used for decision making rather than for reporting purposes only;
- There is high programme coverage delivered at a high quality.

[13] Malone, T and Crowston, K. (1990) What is Coordination Theory and How Can it Help Design Cooperative Work Systems. Retrieved from https://dspace.mit.edu/bitstream/handle/1721.1/2396/SWP-3402-23946901-CCSTR-112.pdf?sequence=1

[14] The National VMMC strategy 2020-2024

PURPOSE AND AUDIENCE

The purpose of this stakeholder coordination toolkit is to provide step-by-step guidance to coordinate a sustainable national VMMC programme and to ensure that all the relevant stakeholders are engaged to facilitate the scaling-up of quality VMMC services.

The intended audience of this toolkit is the DOH and representatives from international development agencies, VMMC implementing partners and organisations and countries aiming to implement a large-scale programme such as the South African VMMC programme.

This toolkit can be used as a basis to plan for and engage programme stakeholders at a national or sub-national level.

Box 1: Key to toolkit sections

How to use this toolkit for each section and what to look out for		
Definitions and references	The magnifying glass will give you a snapshot of the definition of the section you are reading.	
Roles and responsibilities	The tasks and responsibilities for specific stakeholders or role players involved.	
Templates, toolkits and relevant documents	Where templates, toolkits or supplementary documents are available, reference is provided.	

OBJECTIVES

This toolkit sets out to:

- Provide an overview of what coordination of the VMMC programme entails;
- Provide a step-by-step guide for planning and implementing stakeholder coordination; and
- Provide tools to implement and measure the success of the coordination of the programme.

5.2. PROGRAMME COORDINATION

For this toolkit, coordination is limited to stakeholder coordination. This section provides a brief overview of coordination and sets the scene for all other sections that follow.

WHAT IS STAKEHOLDER COORDINATION?

Box 2: Definition of stakeholder coordination

Stakeholder coordination of the VMMC programme is the act of bringing together different people and organisations with a vested interest in VMMC to facilitate the smooth functioning of all the elements of the programme to ensure that the programme's goals and targets are met at a high-quality standard.

Stakeholder coordination is a continuous process that continues throughout the lifecycle of a programme. Engaging and working with multiple people and entities is vital to ensure the programme's success. Stakeholder coordination entails planning, implementing, and monitoring key activities to ensure that quality services are provided. Coordination brings experts with different skillsets together to inform the programme's continuous progress.

Stakeholders are those individuals or organisations with the ability to influence the success or failure of the programme, as well as those who are affected, directly or indirectly, by decisions made about the programme. For the VMMC programme, this includes but is not limited to:

Box 3: VMMC programme stakeholders

Development agencies: e.g. World Health Organization (WHO), United States President's Emergency Plan for AIDS Relief (PEPFAR);

Service providers funded domestically (via the provincial General Practitioner (GP) or National Treasury Transversal (RT35) contracts), or externally (via PEPFAR- otherwise referred to as implementing partners)

Other related stakeholders: HIV and AIDS, STI, TB (HAST) staff, VMMC coordinators, Monitoring and Evaluation (M&E) officers, traditional leaders, community mobilisers, and the private sector etc.

The success of the programme will highly depend on the buy-in, commitment and involvement of identified key stakeholders. Buy-in means that those engaged take ownership of their role within the programme and perceive the success of the programme as their responsibility.

Key requirements for successful stakeholder coordination include:

- Political commitment and strategic mandate;
- Strong lead agency;
- Continuous stakeholder engagement;
- Intersectoral coordination;
- Clear scope; and
- Proper communication channels.

WHO SHOULD MANAGE STAKEHOLDER COORDINATION?

In the case of a nationwide programme such as the VMMC programme, the NDOH must take full ownership of coordinating the programme, hence a focal point from DOH should be designated for such a task at all levels. A national committee should be established to coordinate the programme and the NDOH VMMC or HAST programme director (PD) should lead this committee.

The person appointed to take the lead in programme coordination should be well versed in VMMC, procedures and regulations within all the government levels, and the country setting in which the programme will be taking place. This makes the process of identifying and engaging stakeholders easier and ensures buy-in from all involved.

COORDINATION AT DIFFERENT LEVELS

Coordinating a programme should be done at provincial, district and sub-district/local area municipality levels. Leaders and committee members should be appointed, with a shared vision of scaling VMMC nationally and ensuring its integration into the broader healthcare system.

Box 4: Levels of coordination

National level: The PD should lead the stakeholder coordination. The programme manager (PM) will support the PD and as such some tasks can be delegated to the PM.

Provincial level: The VMMC director (if available) or the HAST manager should lead this process.

District level: A VMMC/HAST coordinator should lead the coordination activity.

Table 23:

Personnel to lead the stakeholder coordination at different levels

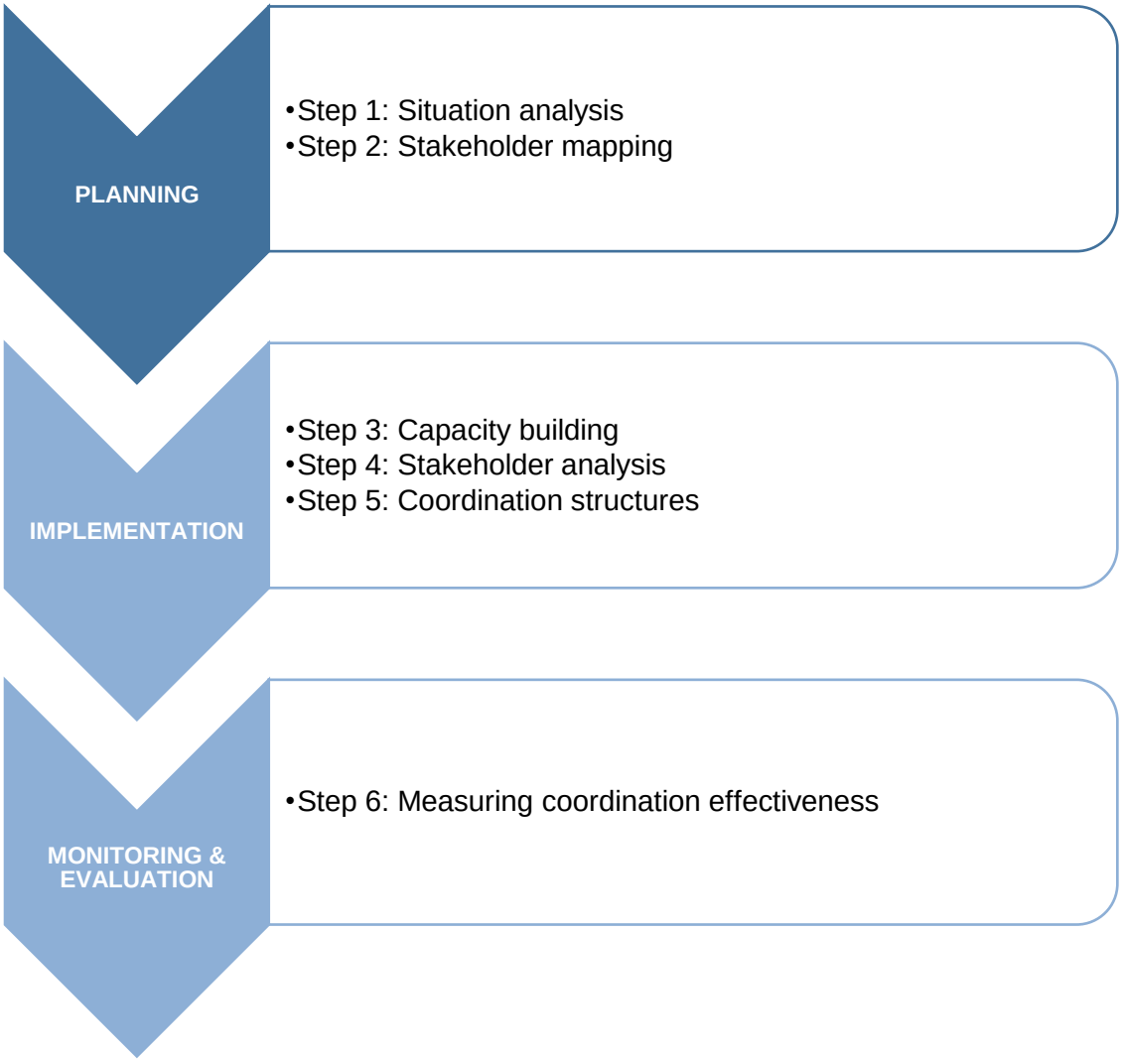
	District	Provincial	National
Responsible	VMMC/HAST coordinator	VMMC director or the HAST manager	The VMMC Programme Director
Delegate		Deputy Director: HAST provincial coordinator	VMMC programme manager

5.3. PROCESS OF COORDINATING THE VMMC PROGRAMME

OVERVIEW OF THE COORDINATION PROCESS

Coordination has three main phases, which are outlined in Figure 14.

Figure 14: Process of coordination



PLANNING

STEP 1: SITUATION ANALYSIS

Box 5: Definition of situation analysis

A **situation analysis** is a process of gathering and analysing information to guide the programme development and implementation.

Situation analysis is an important step to better understand the context and environment in which the programme is to be implemented, and should include attitudes, beliefs, and practices, country policies, and regulatory framework, as well as the healthcare system readiness. It helps district, sub-district and local area municipalities determine the current status of VMMC services and activities in the country, and provides an opportunity to identify areas for improvement.

Gathering information to inform the situation analysis can be done through desktop reviews of relevant programme reports, key informant interviews, surveys, observations, and policy analysis.

It is important to note that the findings of the situation analysis do not all have to be addressed simultaneously or immediately. Rather, issues should be prioritised according to their impact on the success of the programme.

Box 6: Additional literature on situation analysis

View the following documents related to situation analysis:

- The WHO: a comprehensive Male Circumcision Situation Analysis Toolkit[1] for use at a national level.
- UNAIDS, in collaboration with the Global Prevention Coalition: a set of tools to assist countries in assessing and monitoring the progress of their HIV prevention programmes.
- The VMMC Prevention Self-Assessment Tool which can be accessed at the United Nations HIV Prevention Coalition (hivpreventioncoalition.unaids.org)

WHEN TO CONDUCT A SITUATION ANALYSIS

Where you are in the programme implementation process will determine when you need to do the situation analysis and which area you should focus on. As a general principle, a situation analysis should be conducted during the inception phase of any new programme. For programmes that are already in implementation, it is important to update the situation analysis every two years or when there is a significant change in policy or guidelines, a major donor and/ or implementing partners.

STEP 2: STAKEHOLDER MAPPING

Box 7: Definition of stakeholder mapping inquiry

A stakeholder mapping inquiry is used to map out the organisational structure of the system, identify individuals in these positions and identify key decision-makers and influencers in the system.

In addition, stakeholder mapping helps to develop an understanding of what functions can be leveraged to help ensure robust integration of coordination and management functions within VMMC.

A mapping inquiry involves structured interviews with a few key individuals in the healthcare system. A mapping meeting should be conducted with the NDOH first, and mapping interviews should also be held at provincial levels to better inform the provincial and district levels of the map. Other informal discussions can be conducted throughout the programme to iterate the map and take on an agile approach to stakeholder engagement.

The mapping interviews interrogate the following characteristics with VMMC stakeholders at national, provincial and district levels:

- **Relationships**: Different relationships within the network; the dynamics of these relationships; mapping out the reporting lines within the network, including decision-making pathways.
- **Characteristics**: Characteristics of stakeholders in the network, which may impact on the effectiveness and efficiency of the programme to understand what characteristics and work should be cultivated in current and future programme staffing.
- **Knowledge and background**: Capabilities of stakeholders in the network, including the expected level of education and relevant experience that may impact on efficiency.

Box 8: Stakeholder mapping template

A stakeholder mapping template has been included in the attachments and is displayed below.

Figure 15: Example of a stakeholder mapping template

Please use the check box below to guide questions and provide rankings
These questions and rankings will be asked for each individual identified

Relationship	Who does this individual report to?	*[Choose from: National / Provincial / District / PEPFAR-funded partner / SA-funded partner / Other HIV programmes / Other government departments / Civil society / traditional leaders]*	*[Name / organization]*	What are the dynamics of this relationship?	*[On a scale on 1-4 rank the positive extent of this relationship, with 1=very poor; 2=poor; 3=good; 4=very good]*
	Who reports to this individual?	*[Choose from: National / Provincial / District / PEPFAR-funded partner / SA-funded partner / Other HIV programmes / Other government departments / Civil society / traditional leaders]*	*[Name / organization]*	What are the dynamics of this relationship?	*[On a scale on 1-4 rank the positive extent of this relationship, with 1=very poor; 2=poor; 3=good; 4=very good]*
	What other reporting lines is this individual responsible for?	*[Choose from: National / Provincial / District / PEPFAR-funded partner / SA-funded partner / Other HIV programmes / Other government departments / Civil society / traditional leaders]*	*[Name / organization]*		

IMPLEMENTATION

STEP 3: CAPACITATE KEY PEOPLE RESPONSIBLE TO FACILITATE OWNERSHIP OF THE PROGRAMME

Ensuring that there are sufficient and well-equipped human resources to lead and manage the VMMC programme at all provincial, district and sub-district levels is critical to its success. This also facilitates ownership by the NDOH and the sustainability of the programme.

RECRUITMENT

In some districts, it is possible to recruit and place staff into vacant, funded DOH positions to ensure that the DOH can implement and manage the programme. Programme strategy, guidelines, standard operating procedures (SOPs) and policies must be made publicly available for reference (see table 3). Furthermore, the responsibilities and duties relating to VMMC must be explicitly stated as indicators in each individual's key performance agreement (KPA) to enable accountability and performance management.

TRAINING/UPSKILLING

VMMC/HAST programme managers and coordinators must be capacitated to fully execute the national VMMC guidelines. PMs must, at a minimum, be equipped to develop, monitor and evaluate the following programmatic plans, reports and tools:

Table 24: Checklist of relevant VMMC operational documents

PMs should be equipped to monitor the implementation of the following plans:	
✓	**VMMC micro-plans**: VMMC micro-plans are results-based plans for specific areas of service delivery.
✓	**District Continuous Quality Improvement (CQI) plans:** A CQI plan is a roadmap for improving VMMC services, processes, capacity, and outcomes. It guides VMMC implementers and stakeholders through the process of monitoring services and using data as part of everyday practice to improve services provided.
✓	**District demand generation (DG) plans:** A DG plan is a targeted plan of demand generation activities at the district level to attract eligible men within the age pivot**.**
✓	**M&E framework:** A M&E framework describes the indicators used to measure the programme's success.
✓	**Operational plan**: An operational plan is a detailed plan mapping out all the processes required for the programme to succeed. These plans clearly describe the task and targets, the person responsible for that task and the deadline.

Table 25: Checklist of key VMMC strategic documents

The following programme strategy documents are available for download on Knowledge Hub	
✓	National VMMC strategy
✓	South African National Guidelines for Medical Male Circumcision
✓	VMMC transversal contract management framework
✓	South African National Medical Male Circumcision Demand Generation Strategy
✓	National VMMC Data Quality Assessment Strategy
✓	National VMMC Quality Assurance (QA) framework
✓	National VMMC Data Management Protocol/Data Working Practice Guidelines

Depending on the results of the situation analysis, some existing VMMC programme staff may need new or refresher training. The DOH has a Knowledge Hub[15] with up to date information and policies for reference. The Clearinghouse on Male Circumcision for HIV Prevention[16] has a repository of regional and global resources that can be used. PMs should also collaborate with their nearest Regional Training Centres to guarantee continuous education, professional development, and training for all VMMC clinical, administrative, and management staff.

STEP 4: STAKEHOLDER ANALYSIS

After conducting a situation analysis and identifying key stakeholders through mapping, the next step is to conduct a stakeholder analysis.

Box 9: Definition of stakeholder analysis

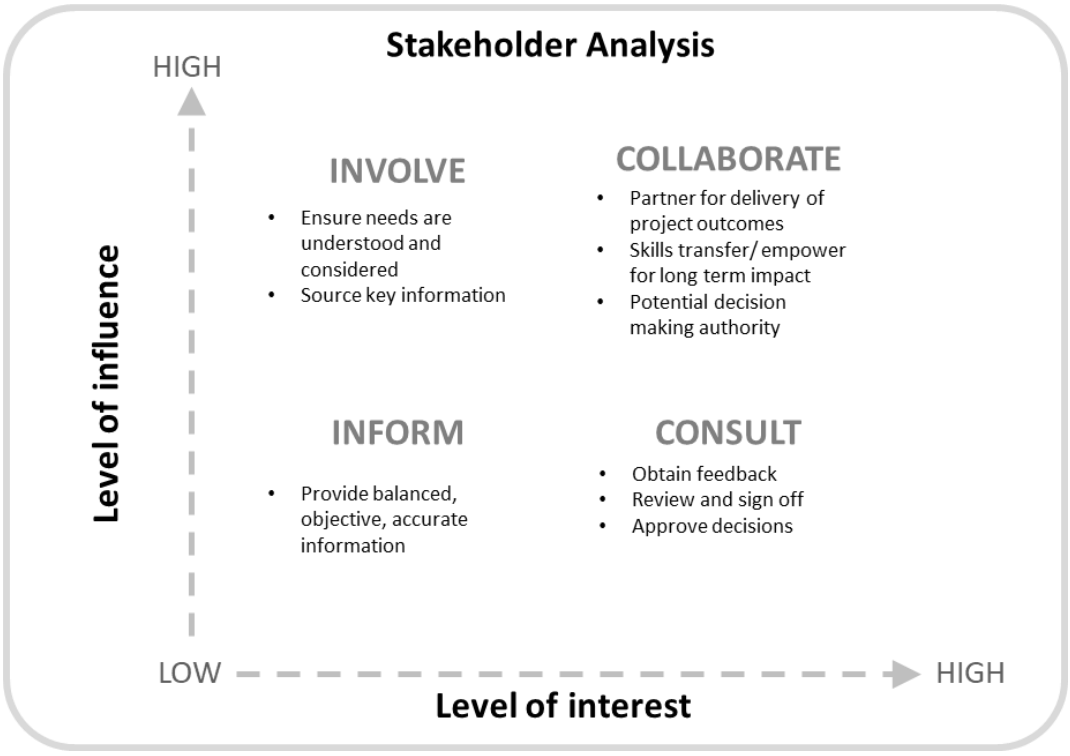
Stakeholder analysis is a process of categorising stakeholders according to their level of influence and interest in the programme and identifying supportive and opposing stakeholders.

The information gathered through this process will then be used to assess how the interests of those stakeholders should be addressed in the programme. The figure below shows how to categorise the stakeholders to help inform the appropriate level of engagement to have with them. A stakeholder analysis tool has also been attached to assist in the process of categorising stakeholders.

[15] DoH Knowledge Hub/ e-Library https://www.knowledgehub.org.za/

[16] Clearinghouse on Male Circumcision https://www.malecircumcision.org/

Figure 16: Stakeholder analysis matrix



STEP 5: STAKEHOLDER ENGAGEMENT PLAN

The next step is to develop a stakeholder engagement plan which will help with identifying the purpose, needs and appropriate channel to communicate with each relevant stakeholder. An engagement plan is included in the attachments.

Figure 17: Example of a stakeholder engagement plan

Stakeholder Engagement Plan									
Project Name: South African VMMC Programme					Date:				
Title	First Name	Surname	Position	Organisation/ Dept/Team	Engagement Strategy				
					Objective	Channel	Frequency	Responsible	Content

PMs should then implement engagement activities according to the plan.

The identified stakeholders must be provided with a clear description of what is expected of them. It is recommended that:

- Terms of reference, service level agreements (SLAs) and memoranda of understanding, clarifying the partners' objective, roles and responsibilities as they relate to the VMMC programme, should be signed between the DOH and all external stakeholders.
- Partners should be orientated on key programmatic policies and plans and advised to align theirs accordingly.
- Joint-planning between the DOH and partners should be prioritised, and partner inputs and contributions should be captured in annual DOH plans, including CQI plans, DG plans, M&E plans, and business plans.

STEP 6: COORDINATION STRUCTURE

The following section guides programme managers on how to establish and maintain coordination structures at national and sub-national levels.

Box 10: Definition of a task team

A task team is a small group of technical experts or influential stakeholders who routinely discuss and make decisions to guide the operational implementation of a programme.

VMMC TASK TEAMS

The NDOH recommends that VMMC task teams be formed at all levels to review guidelines, data, and policies on VMMC to inform the programme, and track programme issues and ensure that solutions are documented and followed up.

The main topics that the task teams will focus on are:

- Stakeholder management;
- Target setting;
- Quality;
- Performance; and
- Other operational issues that may emerge throughout the life cycle of the programme.

The composition of the task team will be informed by the stakeholder analysis conducted at the beginning of implementation and through engagements with the leadership at all levels, however, this should ideally include technical people implementing the programme. While there will be a larger group of stakeholders who will be engaged at salient points of the project cycle, the core task team should meet regularly.

Box 11: Function of task teams

VMMC task teams are not meant to reinforce a vertical programme structure or replace HAST or nerve centre or other integrated programme management meetings. Instead, they supplement the wider programme management meetings by ensuring that challenges affecting the programme are addressed as they occur and specific solutions are identified and tracked. This way, the wider HAST platforms can be reserved for resolving more complex problems that require cross-programme coordination.

COORDINATION MEETINGS

It is recommended that task teams meet regularly. It would be ideal for them to meet every two weeks during the intensive project planning phase, during the phasing in of significant policy changes, and in any crisis management e.g. pandemic response, donor and partner transitions or during campaigns, etc. The teams should thereafter meet once a month during the project implementation phase.

These task team meetings should be held at national, provincial, and district levels. Commitment to these meetings by invited stakeholders should be included as a requirement in partner SLAs.

This is not to suggest that stakeholder coordination must be conducted solely via formal meetings - PMs can explore other engagement platforms such as community dialogues, emails, and mailers. However, for effective programme management, stakeholders must meet regularly for discourse, risk mitigation, and issue resolution.

STEPS TO CONDUCTING AN EFFECTIVE COORDINATION MEETING

The following are steps to conducting effective coordination meetings.

Table 26: Overview of steps to conduct an effective coordination meeting

To ensure effective coordination meetings	
Before the meeting	
✓	Identify roles and responsibilities
✓	Compile meeting agenda
✓	Send out meeting invitations
During the meeting	
✓	Apply best practices for conducting an effective meeting
✓	Take minutes
After the meeting	
✓	Share minutes and action items with all meeting participants

BEFORE THE COORDINATION MEETING

IDENTIFY ROLES AND RESPONSIBILITIES

First, PMs must identify the key decision-makers and operations staff that need to attend the meeting, and clarify why they need to be there. This exercise will assist the PM in assigning roles and responsibilities to each identified meeting participant, guided by the stakeholder mapping analysis and engagement plan.

Table 27: Roles and responsibilities of coordination meeting attendees

STAKEHOLDERS TO ATTEND	ROLES AND RESPONSIBILITY
Programme coordinator/manager	✓ Chairs the meeting ✓ Set meeting agenda
Programme administrator	✓ Sets up calendar invitation ✓ Manages the RSVPs ✓ Takes minutes ✓ Shares minutes, agenda and supporting documents
HAST representative	✓ Oversight and integration
Donor agency	✓ Guidance about decision-making and funding
Service provider	✓ Operational alignment ✓ Problem-solving
M&E	✓ Reporting financial and non-financial data ✓ Highlight performance gaps and successes
DG/ACSM representative	✓ Reporting back on activities. Both the DG and QA representatives are called in as needed, for instance, if there is a campaign (DG) or internal or external assessments (QA) to plan
QA/QI representative	

MEETING INVITATION

Meeting invitations must be sent out to identified-participants at least two weeks in advance, followed up by a calendar invitation to prompt them to attend.

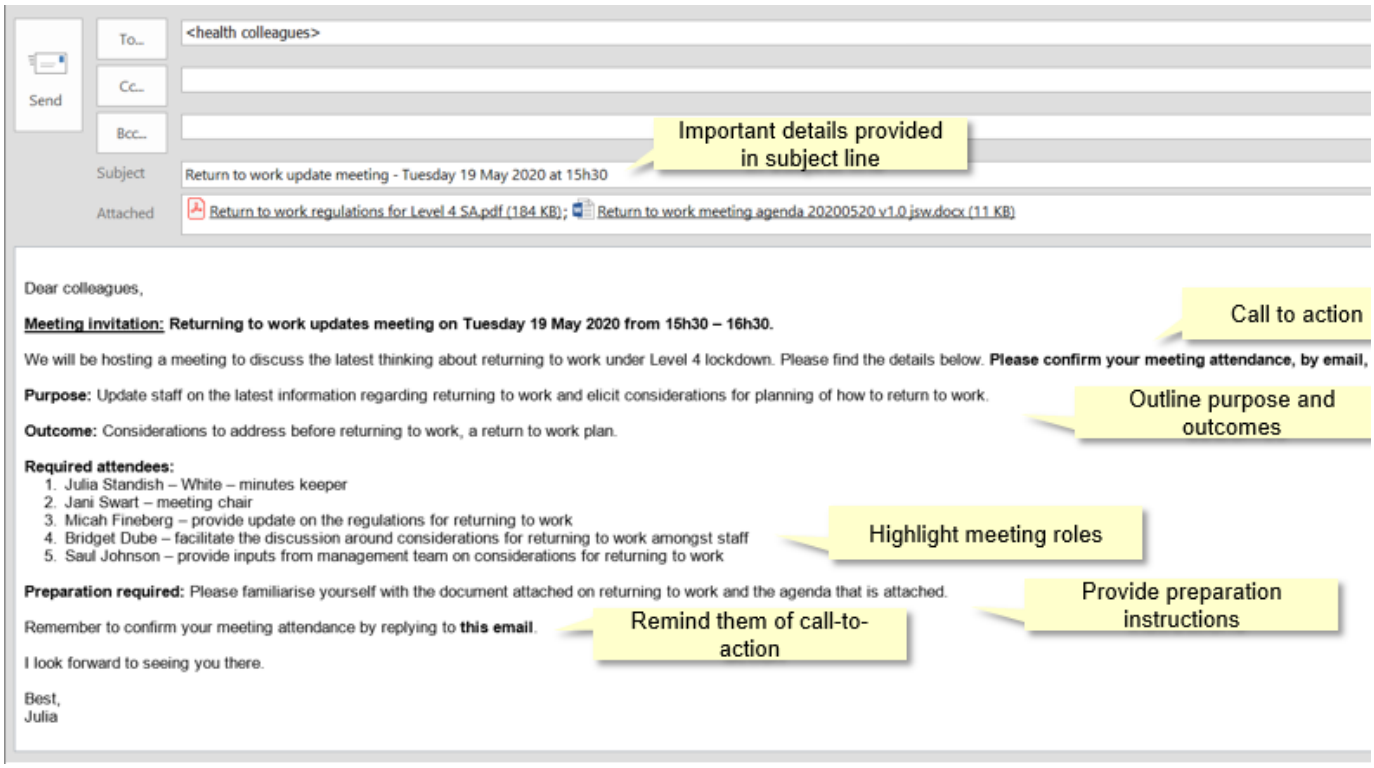
The meeting invitation should include:

- Date, time, and place;
- Purpose of the meeting;
- The intended outcome of the meeting;
- Roles and responsibilities of those invited;

- Required participants;
- Preparation needed before the meeting; and
- Pre-reading documents and agenda should also be shared as attachments.

The programme administrator can block out future meeting dates in the calendar for up to one year, and just send reminder emails with agenda and other pertinent information at least one week prior to each session. A task team meeting invitation template is shared in the figure below.

Figure 18: Meeting invite template



DURING THE COORDINATION MEETING

Below are some tips on how the meeting chair can effectively conduct the meeting:

- Start on time, even if someone is late. Leaders are responsible for establishing habits and team discipline.
- Introduction: Give everyone a turn to share what is going well in their work or their lives.
- Be clear about the purpose and desired outcomes of the meetings. For example, will ideas suffice or does the team need to reach decisions?
- Facilitators connect participants, protect them from one another, and equalise the group for the duration of the meeting.
- At the end of the meeting, summarise meeting accomplishments and decisions, and recap the next steps. Although this may seem tedious, it does contribute to productivity and a sense of accomplishment.

- Depending on the type of meeting, reflect on the meeting, and give each other positive feedback.
- Close off with what you want people to remember and keep it positive! People tend to draw positive conclusions from information presented positively.

MINUTE TAKING

Box 12: Definition of minutes

Meeting discussions must always be transcribed and distilled into **minutes**. Once adopted, minutes are considered a written representation of meeting discussions, and are considered to be legal documents.

While not everything discussed in the meeting should be minuted, the following information must always be documented:

- What was achieved at the meeting;
- What decisions were made at the meeting;
- What actions were agreed – and to whom it was assigned and the deadline; and
- Next steps and any date for a follow-up meeting if agreed.

The minute taker may obtain an audio recording of the meeting to aid in transcription, however, it is important that prior consent is sought from participants, and provided (preferably in writing), and that the recording is not used for any other purpose other than to augment the minute taker's notes. The figure below is a checklist for effective minute-taking. This tool will ensure that minute takers have followed the right protocols to deliver an accurate, quality and useful output.

Figure 19: Minute taking checklist

	As the minute-taker, I have completed the following:
Prior to the meeting	
	1. Consult chairperson/convener on the context and purpose of the meeting
	2. Obtain agenda to base minutes on topics to cover
	3. Obtain a list of invitees to tick-off attendees and include a list in the minutes
	4. Identify possible annexures/documents to be circulated afterwards
During the meeting	
	5. Tick-off attendees as they enter the meeting
	6. Make notes of outcomes reached, decisions taken, action items to be achieved before next meeting
	7. If responsible for setting up and sending out the next agenda, anticipate agenda items for the next meeting
After the meeting	
	8. Compile minutes as soon as possible
	9. Send a draft to chairperson/convener for approval
	10. Send meeting minutes email + minutes + appendixes to all invitees
	11. After the deadline for the amendment and adoption of minutes, save a PDF copy of the minutes

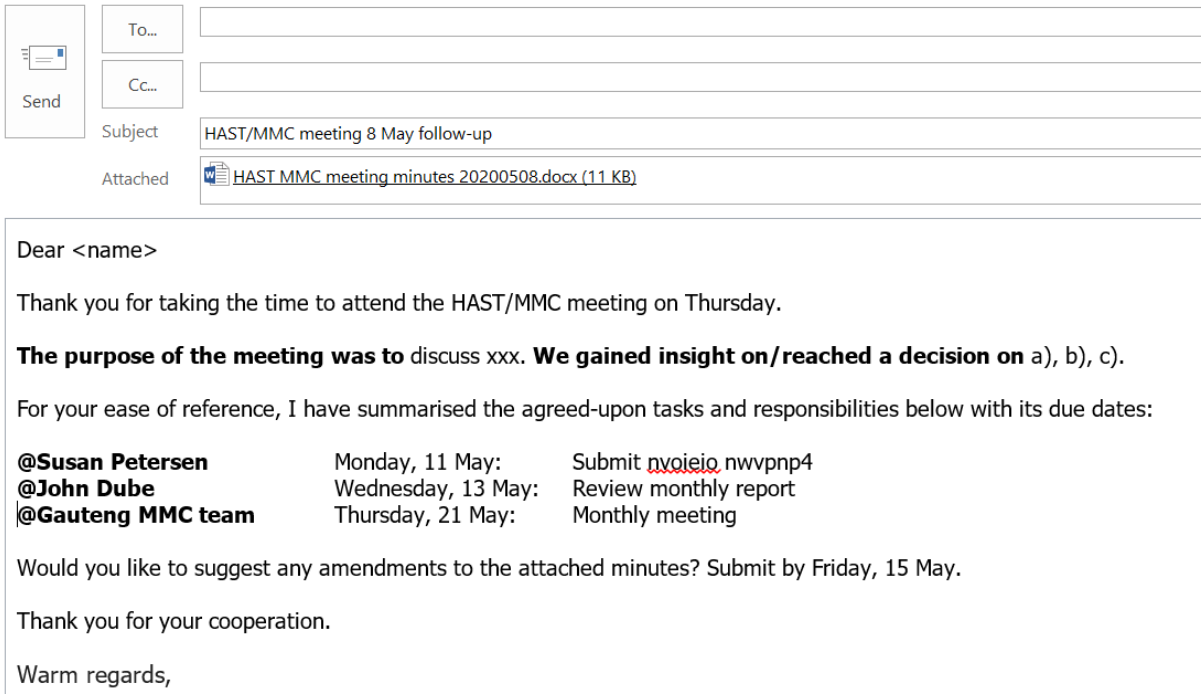
AFTER THE COORDINATION MEETING

After the meeting, the minutes of the meeting should be sent out to all the attendees to allow for inputs and to ensure that everyone agrees with what has been documented. In the email sent with the meeting minutes, participants must be reminded of:

- The purpose of the meeting;
- The key decisions/insights reached; and
- Action items due before the next meeting.

A meeting minutes email template is shared in the figure below.

Figure 20: Meeting minutes follow-up email



Proposed turnaround time for sharing the meeting minutes are:

- A one-hour meeting: minutes shared within 24 hours
- A two-hour meeting: minutes shared within 48 hours
- A half- or full-day meeting: minutes shared within one week

MONITORING AND EVALUATION

STEP 7: MEASURING COORDINATION EFFECTIVENESS

TASK TEAM EFFECTIVENESS

The VMMC task team is formed to serve a specific purpose. As such, it is important to routinely assess whether the team is living out that purpose, and use that information as a basis to deliberate effective course correction measures.

Box 13: Meeting effectiveness assessment tool

A meeting effectiveness assessment tool included in the appendices can be used for this task. This meeting assessment tool tracks whether task team meetings are effective in achieving their mandate.

If meetings are deemed *ineffective*, the following corrective actions could be taken to resolve this:

- Reassess the composition of the team and determine if the relevant stakeholders/decision-makers are present.
- Confirm that the task team has the correct mandate and that this is reflected in their terms of reference/SLA and KPAs.
- Ensure the task team is receiving the appropriate political support and buy-in from programme leadership.

VMMC PROGRAMME CUSTODIAN EFFECTIVENESS

Including VMMC as part of the programme custodian's key performance indicators (KPIs) and KPAs ensures accountability. This will also provide insight on how the programme is being implemented and further indicate its sustainability, as including VMMC activities as part of the custodian's key performance indicators will emphasise that it is integrated into the healthcare system. These should be reviewed regularly.

5.4. CONCLUSION

In summary, VMMC programme stakeholders can be coordinated by following these key steps:

- Conduct a situation analysis to identify programme challenges and plan for mitigating actions.
- Capacitate the custodians of the VMMC programme and put systems in place to ensure that there is accountability and ownership of the programme.
- Conduct stakeholder mapping and analysis to identify key stakeholders and ensure constant engagement with them.
- Continuous engagement and communication are key to coordination and ensuring that the objectives of the programme are achieved.
- Routinely monitor and evaluate the effectiveness of coordination structures in delivering its mandate.

Self-reflection after working through the toolkit:

3. The sections I found most insightful were: _____
4. The sections I should revisit are: _____
5. The idea of stakeholder coordination makes me feel: _____

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

National VMMC programme |

6. DATA TOOL TRAINING MANUAL

Version 2 (July 2020)

Contact person

Mr Collen Bonnecwe

Medical Male Circumcision Programme Director, National Department of Health

Email collen.bonnecwe@health.gov.za
Telephone +2712 3958021
Mobile +27 82 4405118

Mr Dayanund Loykissoonlal

Medical Male Circumcision Programme Manager, National Department of Health

Email dayanund.loykissoonlal@health.gov.za
Telephone +27 12 3959186
Mobile +27 71 6033144

TABLE OF CONTENTS ..... Error! Bookmark not defined.
ACRONYMS iii
1. Introduction 4
1.1. Purpose 4
2. VMMC data requirements 5
3. Tools used 6
3.1. DHMIS policy 6
3.2. Client intake form 6
3.3. Vmmc register 8
3.4. Monthly summary sheet 9
3.5. Data reciept form 10
3.6. Dhis input 11
4. Training curriculum and approach 12
4.1. Session one: intoduction to the DHMIS policy and working practice guidelines 12
4.2. Session two: client intake form 12
4.3. Session three: Vmmc register 12
4.4. Session four: Monthly reporting 12
4.5. Quality assurance tools 13
5. Proposed attendees 14
Annexure 1: Proposed agenda 15
Annexure 2: Evaluation of training 15
Annexure 3: Job aids 17

List of tables

Table 1: Roles and responsibilities as per DHMIS policy 5
Table 2: Target audience 14

List of figures

Figure 1: DHIMS policy 6
Figure 2: Client intake form 7
Figure 3: VMMC register 8
Figure 4: Monthly summary sheet 9
Figure 5: Data receipt form 10
Figure 6: DHMIS input 11

List of boxes

Box 1: Data management toolkit 4

ACRONYMS

AE	Adverse Event
DHIS	District Health Information System
DHMIS	District Health Management Information Systems
DoH	Department of Health
HAST	AST: HIV and AIDS, sexually transmitted infections (STI)/tuberculosis (TB)
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
MMC	Medical Male Circumcision
NDoH	National Department of Health
OU	Organisational Unit
PoE	Portfolio of Evidence
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TB	Tuberculosis
VMMC	Voluntary Medical Male Circumcision

6.1. INTRODUCTION

The National Department of Health (NDoH) has implemented the Voluntary Medical Male Circumcision (VMMC) programme as part of its combination HIV prevention of strategy. The national VMMC programme data management is governed by the District Health Management Information Systems (DHMIS) Policy and Standard Operating Procedure (SOP). The DHMIS SOP stipulates how data is managed at all levels of the Health Information System (HIS).

Purpose

Data management is an important pillar in programme management, as it provides evidence for programme planning, monitoring and implementation. The data tool training manual has been developed to map out the processes of training and orientation of Public Health workers on data collection, collation and use in programme implementation. The training manual focuses specifically on the VMMC programme and the tools that govern the information management within it.

Data verification is another important process to ensure that VMMC data is captured accurately. There is a separate data verification manual that outlines this process.

1. **To map out the requirements for programme data management.**
2. **To outline the tools used for data management in the VMMC programme.**
3. **To outline the curriculum and training approach for data management training.**

Box 14: Data management toolkit

6.2. VMMC DATA REQUIREMENTS

The VMMC programme manages data as per the DHMIS policy. This includes the responsibility of all cadres involved as well as the timelines for each reporting period. As per the DHMIS policy, the VMMC programme requires Portfolio of Evidence (PoE) to certify the validity of each circumcision conducted.

The PoE consists of a copy of the client intake form, a copy of the signed consent form, and the carbonated Voluntary Medical Male Circumcision (VMMC) register. The PoE is maintained daily, weekly, and monthly by various cadres. Table 28 below outlines the roles and responsibilities at each Organisational Unit (OU) for each cadre as per the DHMIS policy:

Table 28: Roles and responsibilities as per DHMIS policy

OU level	Staff cadre	Tools	Function
Community-level	Recruiter	Recruitment list	Recording information of clients recruited for VMMC services.
Facility level	Data Clerk	Headcount register Client intake form VMMC register Monthly summary sheet DHIS	Tallying number of clients accessing services Recording client information Tallying clients that received VMMC service Aggregating services conducted Reporting services conducted
	Counsellor	Client intake HTS register	Recording client HIV Testing Services (HTS) details and consent Tallying HTS client data
Facility Level	Nurse	Client intake VMMC register	Record details of triage, pre-op, surgery, post-op, follow-up Recording of aggregated services conducted
	Surgeon	Client intake	Recording surgical details, confirming consent, and confirming details on the form
	Team leader	Client intake VMMC register Monthly summary Data receipt	Review information Confirm statistics Confirm statistics Sign-off statistics
Sub-district	Health Information System (HIS) officer	Data receipt VMMC register DHIS	Confirm services conducted Record statistics on behalf of the site Capture/verify statistics
	HAST: HIV and AIDS, sexually transmitted infections (STI)/tuberculosis (TB) (HAST) coordinator	VMMC register DHIS	Confirm statistics Review data
District Level	HIM Manager	DHIS	Provide programme summary reports

		MMC register	Confirm services provided
	HAST manager	DHIS	Reporting programme performance and provide direction

6.3. TOOLS USED

The DHIMS policy can be found on the Department of Health's (DoH) Ideal clinic website (www.idealhealthfacility.org.za) while all of the other tools mentioned in this section can be found on the DoH's knowledge hub (https://www.knowledgehub.org.za/content/medical-male-circumcision).

6.3.1. DHMIS policy

The DHMIS policy provides guidelines for the management of data from service delivery level to national level. The policy is accompanied by an SOP for each organisational unit which outlines the activities that are required for information management.

Figure 21: DHIMS policy

6.3.2. Client intake form

The client intake form contains client details to be recorded for each of the steps of the VMMC procedure. The form is divided into seven sections, namely:

1. Client information and screening for HIV, TB, STIs and other conditions;
2. Sociomedical history;
3. Physical examination and pre-op care;
4. Surgical procedure and recovery;
5. Post-operative follow-up;
6. Informed consent for HIV testing; and
7. Informed consent for VMMC procedure.

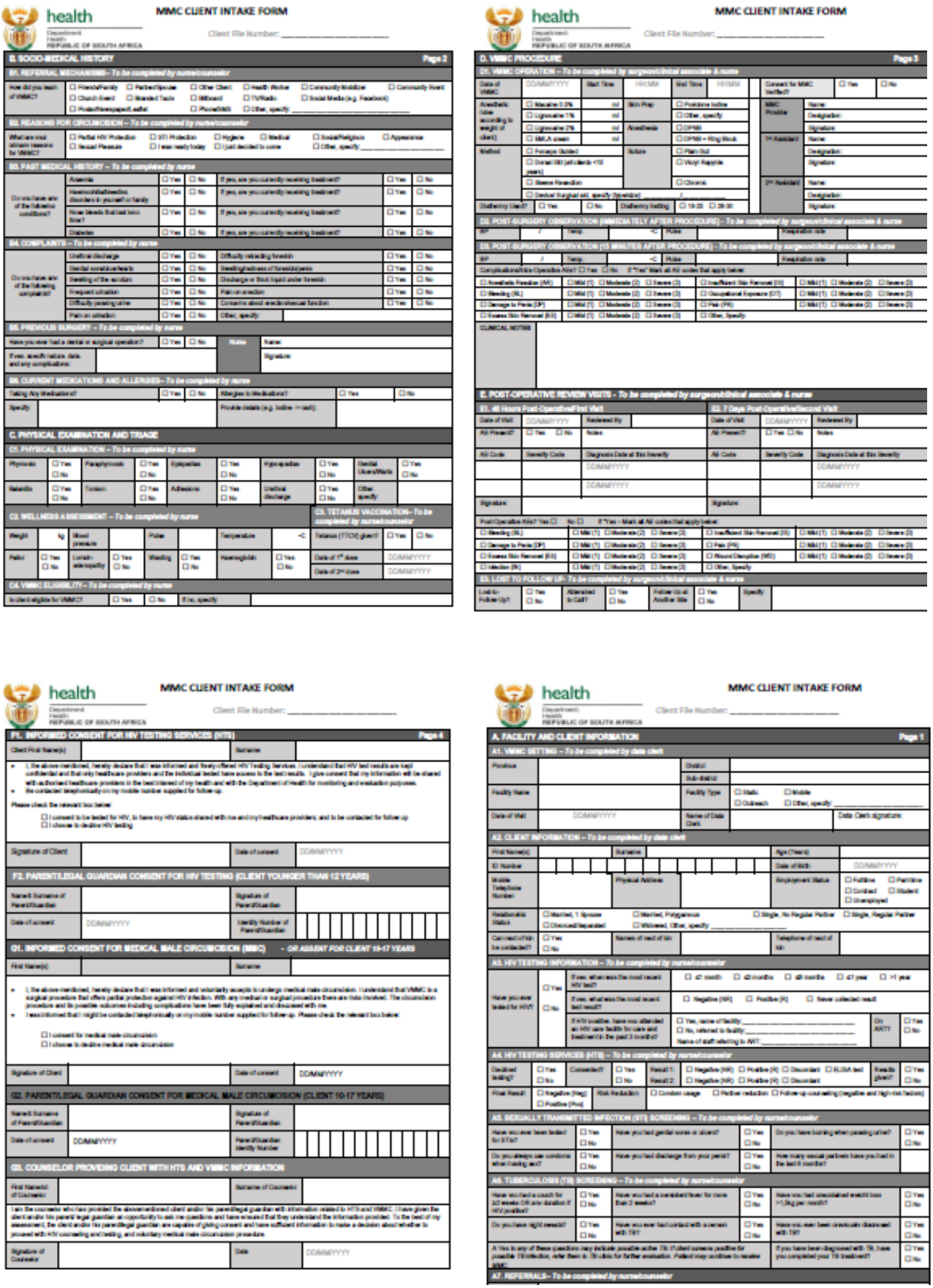
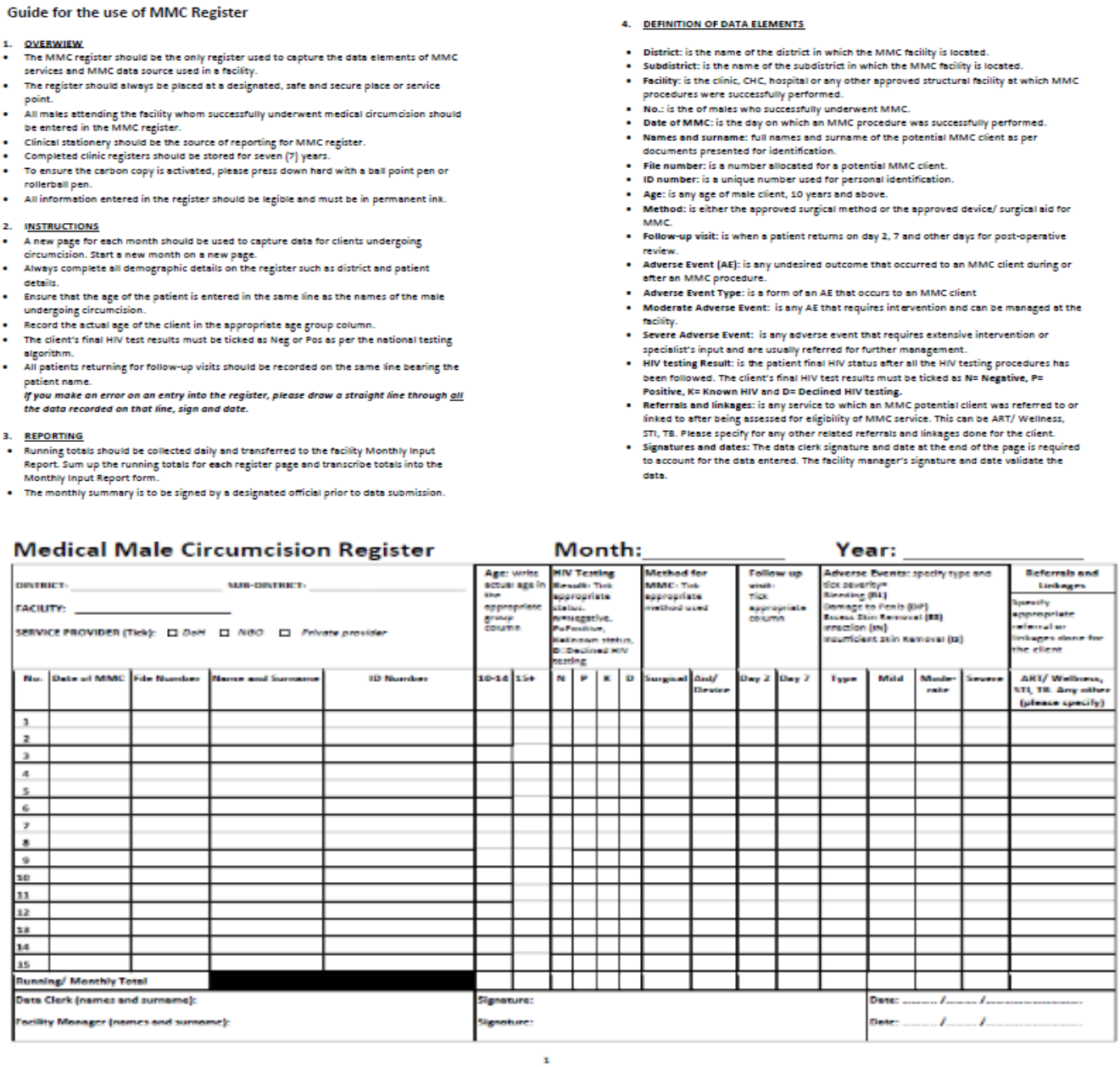


Figure 22: Client intake form

6.3.3. VMMC register

The VMMC register keeps a record of all clients that have undergone the VMMC procedure and is used to report VMMCs monthly. The register forms part of the PoE of services performed. It includes the client file and identity details, the client's age, HIV results, post-operative follow-up visits, and any adverse events (AE).



Guide for the use of MMC Register

1. **OVERWIEW**
- The MMC register should be the only register used to capture the data elements of MMC services and MMC data source used in a facility.
- The register should always be placed at a designated, safe and secure place or service point.
- All males attending the facility whom successfully underwent medical circumcision should be entered in the MMC register.
- Clinical stationery should be the source of reporting for MMC register.
- Completed clinic registers should be stored for seven (7) years.
- To ensure the carbon copy is activated, please press down hard with a ball point pen or rollerball pen.
- All information entered in the register should be legible and must be in permanent ink.

2. **INSTRUCTIONS**
- A new page for each month should be used to capture data for clients undergoing circumcision. Start a new month on a new page.
- Always complete all demographic details on the register such as district and patient details.
- Ensure that the age of the patient is entered in the same line as the names of the male undergoing circumcision.
- Record the actual age of the client in the appropriate age group column.
- The client's final HIV test results must be ticked as Neg or Pos as per the national testing algorithm.
- All patients returning for follow-up visits should be recorded on the same line bearing the patient name.

If you make an error on an entry into the register, please draw a straight line through all the data recorded on that line, sign and date.

3. **REPORTING**
- Running totals should be collected daily and transferred to the facility Monthly Input Report. Sum up the running totals for each register page and transcribe totals into the Monthly Input Report form.
- The monthly summary is to be signed by a designated official prior to data submission.

4. **DEFINITION OF DATA ELEMENTS**
- **District:** is the name of the district in which the MMC facility is located.
- **Subdistrict:** is the name of the subdistrict in which the MMC facility is located.
- **Facility:** is the clinic, CHC, hospital or any other approved structural facility at which MMC procedures were successfully performed.
- **No.:** is the of males who successfully underwent MMC.
- **Date of MMC:** is the day on which an MMC procedure was successfully performed.
- **Names and surname:** full names and surname of the potential MMC client as per documents presented for identification.
- **File number:** is a number allocated for a potential MMC client.
- **ID number:** is a unique number used for personal identification.
- **Age:** is any age of male client, 10 years and above.
- **Method:** is either the approved surgical method or the approved device/ surgical aid for MMC.
- **Follow-up visit:** is when a patient returns on day 2, 7 and other days for post-operative review.
- **Adverse Event (AE):** is any undesired outcome that occurred to an MMC client during or after an MMC procedure.
- **Adverse Event Type:** is a form of an AE that occurs to an MMC client
- **Moderate Adverse Event:** is any AE that requires intervention and can be managed at the facility.
- **Severe Adverse Event:** is any adverse event that requires extensive intervention or specialist's input and are usually referred for further management.
- **HIV testing Result:** is the patient final HIV status after all the HIV testing procedures has been followed. The client's final HIV test results must be ticked as **N= Negative, P= Positive, K= Known HIV and D= Declined HIV testing.**
- **Referrals and linkages:** is any service to which an MMC potential client was referred to or linked to after being assessed for eligibility of MMC service. This can be ART/ Wellness, STI, TB. Please specify for any other related referrals and linkages done for the client.
- **Signatures and dates:** The data clerk signature and date at the end of the page is required to account for the data entered. The facility manager's signature and date validate the data.

Medical Male Circumcision Register **Month:** _____ **Year:** _____

DISTRICT: _____ SUB-DISTRICT: _____

FACILITY: _____

SERVICE PROVIDER (Tick): ☐ GoH ☐ NGO ☐ Private provider

No.	Date of MMC	File Number	Name and Surname	ID Number	Age: Write actual age in the appropriate group column		HIV Testing Result: Tick appropriate status. N=negative, P=Positive, K=known status, D=Declined HIV testing				Method for MMC: Tick appropriate method used		Follow up visit: Tick appropriate column		Adverse Events: specify type and tick severity* Bleeding (BL) Damage to Penis (DP) Excess Skin Removal (ES) Infection (In) Insufficient Skin Removal (IS)				Referrals and Linkages: Specify appropriate referral or linkages done for the client
					10-14	15+	N	P	K	D	Surgical	Aid/ Device	Day 2	Day 7	Type	Mild	Moder-rate	Severe	ART/ Wellness, STI, TB. Any other (please specify)
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			
11																			
12																			
13																			
14																			
15																			
Running/ Monthly Total																			

Data Clerk (names and surname): Signature: Date: ____/____/____

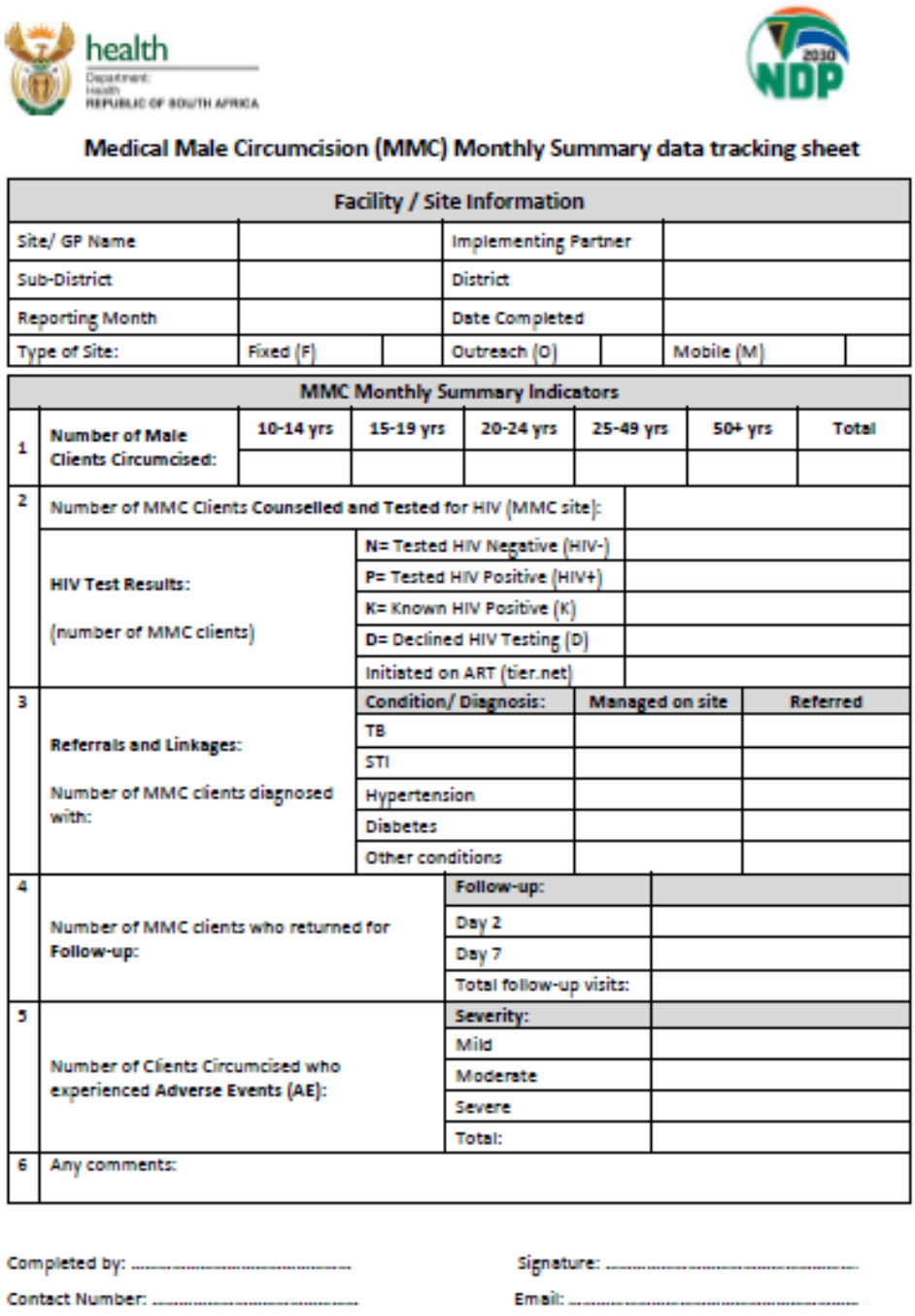
Facility Manager (names and surname): Signature: Date: ____/____/____

1

Figure 23: VMMC register

6.3.4. Monthly summary sheet

The monthly summary sheet provides a summary of the monthly indicators collected in the VMMC programme. Data collected on the summary sheet includes the VMMCs done, HIV tests, screenings done, follow-ups, and any AEs.



Medical Male Circumcision (MMC) Monthly Summary data tracking sheet

Facility / Site Information						
Site/ GP Name			Implementing Partner			
Sub-District			District			
Reporting Month			Date Completed			
Type of Site:	Fixed (F)		Outreach (O)		Mobile (M)	

MMC Monthly Summary Indicators							
1	Number of Male Clients Circumcised:	10-14 yrs	15-19 yrs	20-24 yrs	25-49 yrs	50+ yrs	Total
2	Number of MMC Clients Counselled and Tested for HIV (MMC site):						
	HIV Test Results: (number of MMC clients)	N= Tested HIV Negative (HIV-)					
		P= Tested HIV Positive (HIV+)					
		K= Known HIV Positive (K)					
		D= Declined HIV Testing (D)					
		Initiated on ART (tier.net)					
3	Referrals and Linkages: Number of MMC clients diagnosed with:	Condition/ Diagnosis:			Managed on site		Referred
		TB					
		STI					
		Hypertension					
		Diabetes					
		Other conditions					
4	Number of MMC clients who returned for Follow-up:	Follow-up:					
		Day 2					
		Day 7					
		Total follow-up visits:					
5	Number of Clients Circumcised who experienced Adverse Events (AE):	Severity:					
		Mild					
		Moderate					
		Severe					
		Total:					
6	Any comments:						

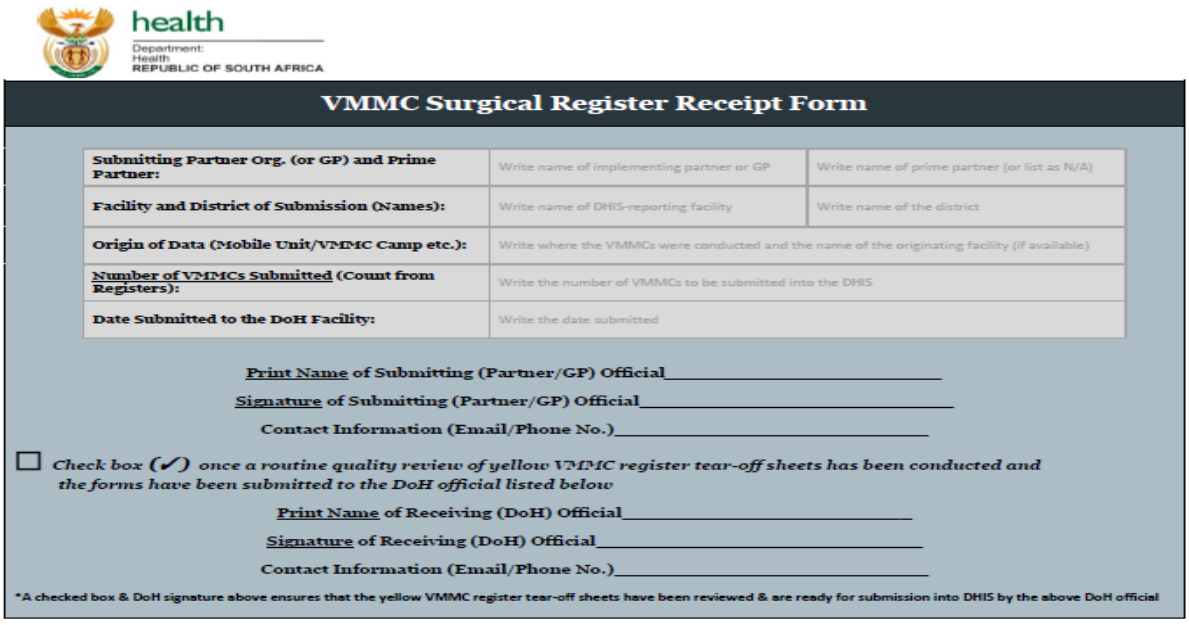
Completed by: ..... Signature: .....

Contact Number: ..... Email: .....

Figure 24: Monthly summary sheet

6.3.5. Data receipt form

The data receipt form is used as evidence that data, which was collected from a non-DoH source, has been reported to a DoH reporting site for DHIS capturing.



health
Department:
Health
REPUBLIC OF SOUTH AFRICA

VMMC Surgical Register Receipt Form

Submitting Partner Org. (or GP) and Prime Partner:	Write name of implementing partner or GP	Write name of prime partner (or list as N/A)
Facility and District of Submission (Names):	Write name of DHIS-reporting facility	Write name of the district
Origin of Data (Mobile Unit/VMMC Camp etc.):	Write where the VMMCs were conducted and the name of the originating facility (if available)	
Number of VMMCs Submitted (Count from Registers):	Write the number of VMMCs to be submitted into the DHIS	
Date Submitted to the DoH Facility:	Write the date submitted	

Print Name of Submitting (Partner/GP) Official_____

Signature of Submitting (Partner/GP) Official_____

Contact Information (Email/Phone No.)_____

☐ *Check box (✓) once a routine quality review of yellow VMMC register tear-off sheets has been conducted and the forms have been submitted to the DoH official listed below*

Print Name of Receiving (DoH) Official_____

Signature of Receiving (DoH) Official_____

Contact Information (Email/Phone No.)_____

*A checked box & DoH signature above ensures that the yellow VMMC register tear-off sheets have been reviewed & are ready for submission into DHIS by the above DoH official

Figure 25: Data receipt form

6.3.6. DHIS input

The DHIS has two methods of input at the service delivery level. The first method is direct online capture using the web portal, which requires internet connection. The second method is to complete an Excel form which can be submitted to an allocated reporting site for capture. This can be a neighbouring facility or a higher reporting unit i.e. sub-district or district.

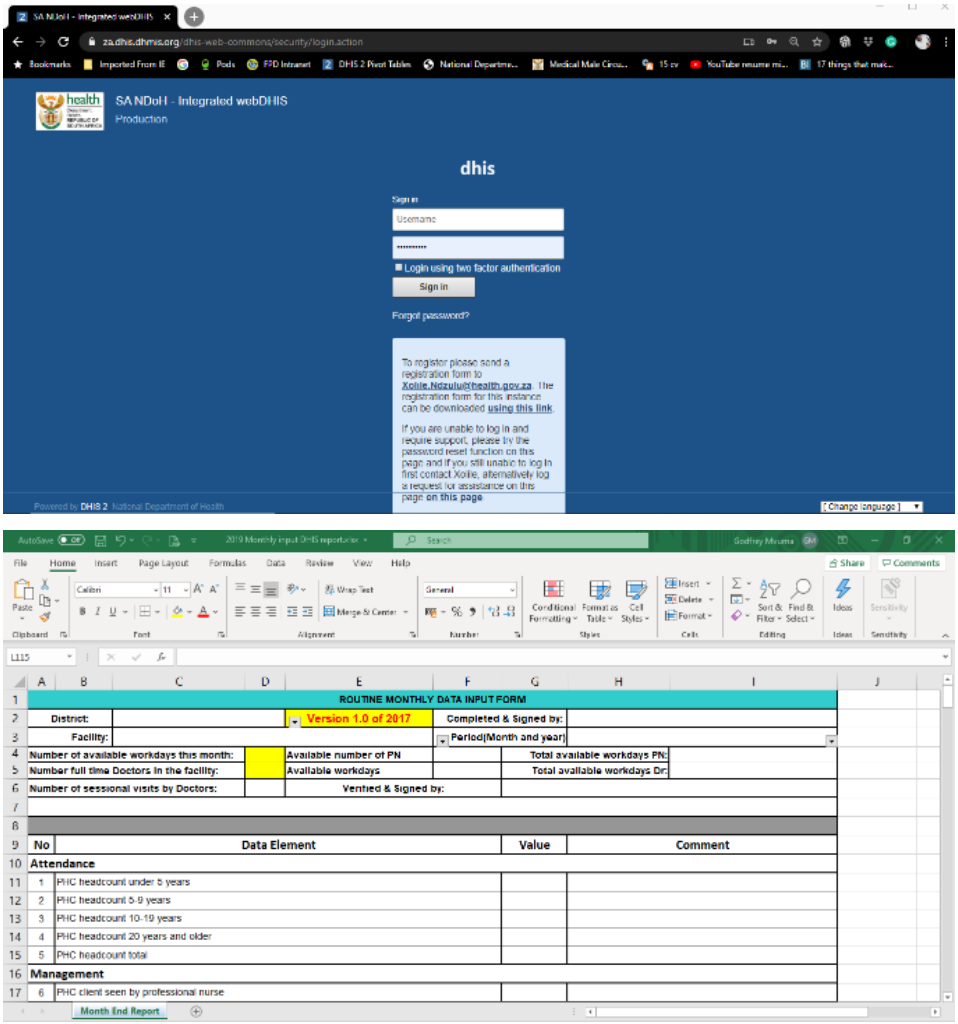


Figure 26: DHMIS input

6.3.7. Training curriculum and approach

The data training covers the tools used in data collection through a detailed explanation of each of the tools as well as when and how to use them in the data management process. The data working practice guideline that outlines the data management process is available on the DoH's Knowledge Hub. (https://www.knowledgehub.org.za/content/medical-male-circumcision). The training is structured to reflect the data journey and the tools used, in the order of use.

6.3.7.1. Session one: introduction to the DHMIS policy and working practice guidelines

The first session of the training introduces the attendees to the DHMIS Policy and Working Practice guidelines for the VMMC programme. The session covers the rationale behind the Working Practice guidelines, and discusses the data procedures and guiding principles. The session also covers the data flow from the service delivery level up to national level. The VMMC programme has various methods of service delivery, which has created different scenarios for data recording and reporting, and the session covers the scenarios and the ways of reporting for each scenario.

6.3.7.2. Session two: Client intake form

The second session covers an in-depth review of the client intake form. It also highlights situations where one would find the information to transcribe onto other registers. This session focuses on different sections, depending on the training group and their levels of interaction with the tool. A substantial amount of time is spent on the client intake form as it is the main source of client-level data for the VMMC programme and it feeds into the other tools.

6.3.7.3. Session three: VMMC register

The third session reviews the VMMC register with its contents and context. This session is broken into the following sections:

- Background of the VMMC register;
- Instructions on how to use the register;
- Definitions and acronyms; and
- A review of the register pages.

6.3.7.4. Session four: Monthly reporting

The fourth session covers the reporting process. The steps covered in the reporting process are:

- Monthly collation of data from the register onto the monthly summary form;
- The data receipt form;
- The DHIS input; and

- The DHIS pivot review.

6.3.7.5. Session five: Quality assurance tools

The final session introduces the tools used for quality assurance indicators at the facility level as well as the reporting of AEs. The tools covered in this session are as follows:

- AE register;
- Follow-up register; and
- Severe and notifiable AE reporting form.

6.3.8. Proposed attendees

Table 29 below summarises the target audience that can benefit from the training. This is not an exhaustive list and can be amended as different cadres are identified. DoH officials can extend an invitation to implementing partners supporting the VMMC programme in their districts.

Table 29: Target audience

Cadre	Rationale
Data capturers/admin clerk	They are responsible for the overall capturing and reporting of data at the service delivery level.
Clinicians and counsellors	They are responsible for collecting data as they interact with the clients while providing services.
Facility managers/team leaders	They are responsible for the data reported at their site and the overall verification of site-level stats.
VMMC coordinators	They are responsible for the overall management of the VMMC programme and assist site-level staff with implementation.
HIS officers/managers	They are the custodians of the data at various levels i.e. sub-district and district. They are also responsible for capturing data on behalf of sites with no DHIS access.
Quality assurance officers/managers	They are responsible for the quality of the programme and they interact with data to evaluate the programme quality.
HAST managers (district/provincial)	They are the custodians of the VMMC programme, at the district and provincial levels.

6.3.9. Annexure

6.3.9.1. Annexure 1: Proposed agenda

The purpose of the agenda is to outline the training and inform managers of what will be discussed in the training so that they can better identify who will be required to attend.

This should be prepared and shared in advance.

Programme: Data management training for VMMC

Date: _____

Time: _____

Venue: _____

Purpose:

- To introduce participants to VMMC data management
- To review the tools used in data collection and reporting
- To equip participants on how to efficiently collate all VMMC data

Agenda Item	Time allocation
Arrival	09:00am – 09:20am
Welcome and introductions	09:20am – 09:30am
Session one: Working Practice guidelines	09:30am – 10:30am
Tea Break	10:30am – 11:00am
Session two: Client intake form	11:00am – 12:30pm
Session three: VMMC register	12:30pm – 13:00pm
Lunch Break	13:00pm – 14:00pm
Session four: Monthly reporting	14:00pm – 14:30pm
Session five: Quality assurance	14:30pm – 15:00pm
Q&A	15:00pm – 15:10pm
AOB	15:10pm – 15:20pm
Way forward	15:20pm – 15:25pm
Closure	15:25pm – 15:30pm

6.3.9.2. Annexure 2: Evaluation of training

VMMC Training evaluation form

District: _____

Training date: _____

Facilitator: _____

The purpose of this evaluation is to help us determine the extent to which the training has met its objective/s and to identify ways to improve future training sessions. We invite you to take a few minutes to complete this short evaluation, which should take you less than five minutes.

Your participation is voluntary, anonymous and confidential.

1. Please indicate the department your job responsibility falls under.

Cadre	**Tick one**
Data capturer/admin clerk	
Counsellor	
Clinician	
Facility manager/team leader	
VMMC coordinator/champion	
HIS officer/manager	
Quality assurance officer/manager	
Other: Specify_____	

2. Please rate the training in terms of its usefulness in the following areas, using the scale below.

1 = Not useful at all 5 = Very useful

Area	**1**	**2**	**3**	**4**	**5**
Useful in your daily work	1	2	3	4	5
Increased your awareness of the gaps and challenges in data management for the VMMC programme	1	2	3	4	5
Increased your willingness to take ownership of data management for the VMMC programme	1	2	3	4	5
Increased your knowledge of data management for the VMMC programme	1	2	3	4	5
Increased your skills (i.e. ability) in data management for the VMMC programme	1	2	3	4	5

3. Please tick your level of satisfaction with the following elements of the data training session:

Element	**Satisfied**	**Dissatisfied**
Comprehensiveness		
User-friendliness		
Alignment with district data management processes and activities		

Element	Satisfied	Dissatisfied
Time-efficiency		

4. Comments and suggestions (including activities or initiatives you think would be useful, for the future):

5. General evaluation questions:

1 = Strongly Disagree 5 = Strongly Agree

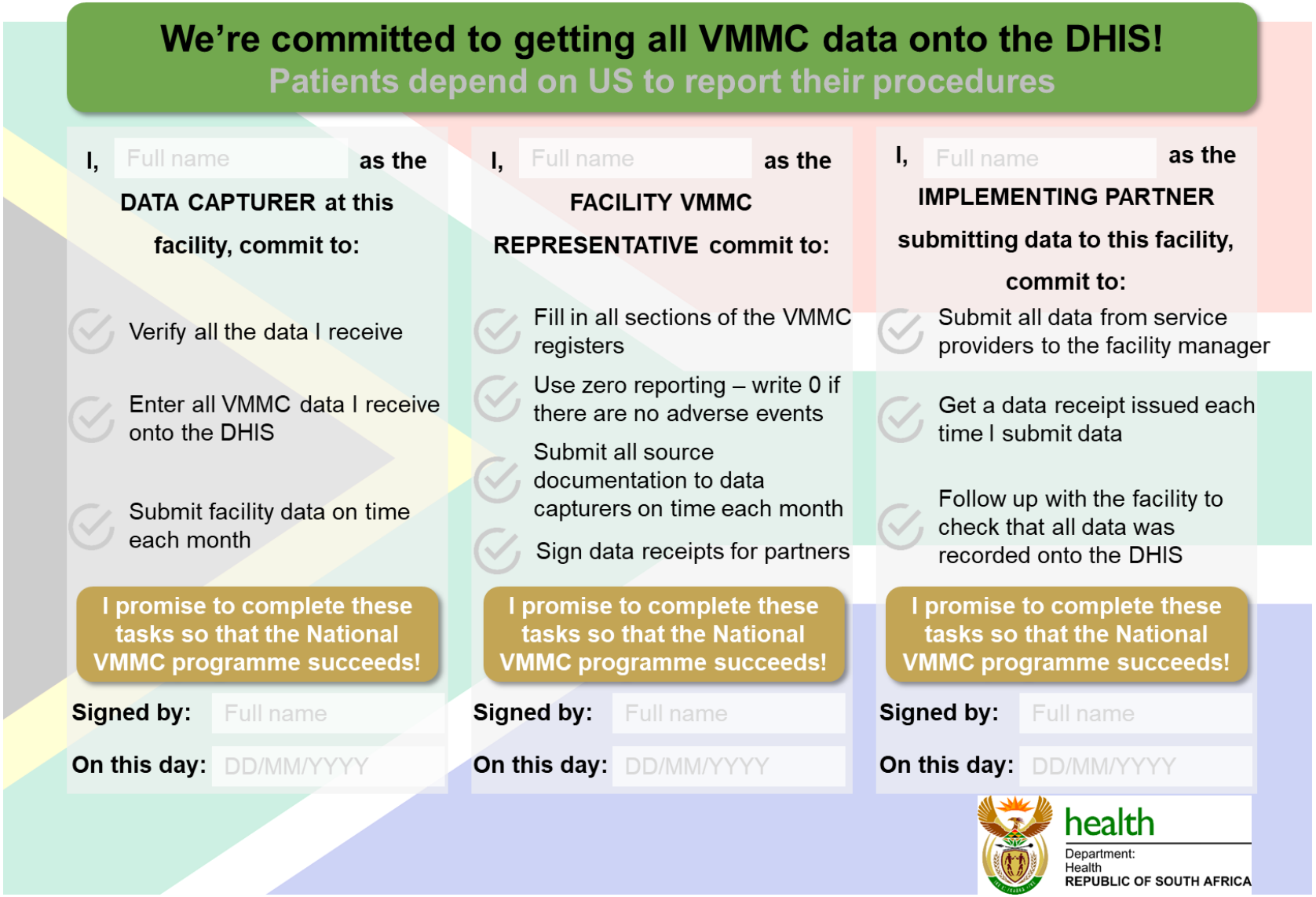
	1	2	3	4	5
The training objectives were clearly defined	1	2	3	4	5
The topics covered were relevant to me	1	2	3	4	5
The content was easy to follow	1	2	3	4	5
The training objectives were met	1	2	3	4	5
Time allocated was sufficient	1	2	3	4	5

Thank you!

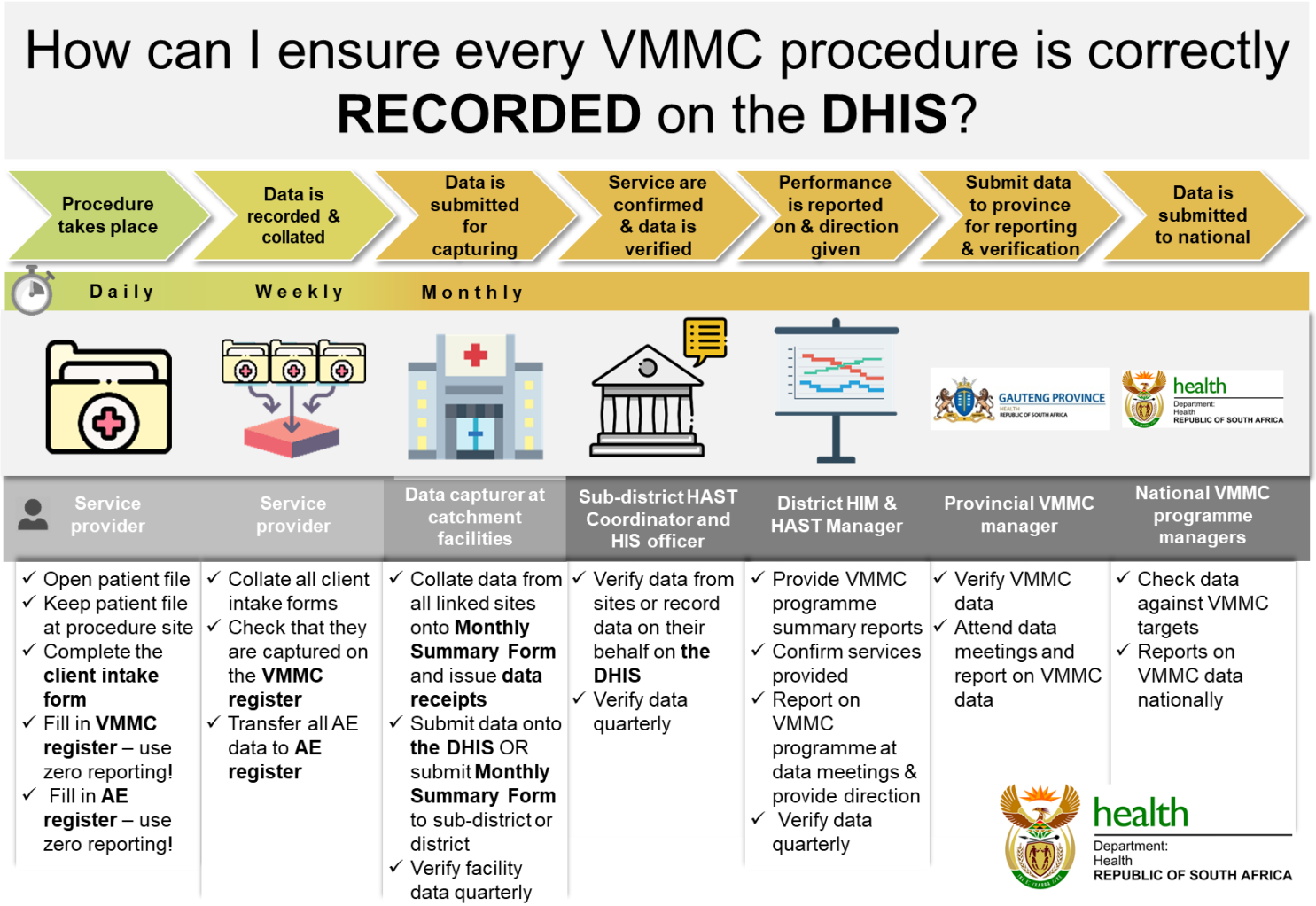
Please return this form to the training facilitators.

6.3.9.3. Annexure 3: Job aids (PLEASE NOTE YOU WILL ALSO RECEIVE A FILE WITH THESE IN PDF FORMAT)

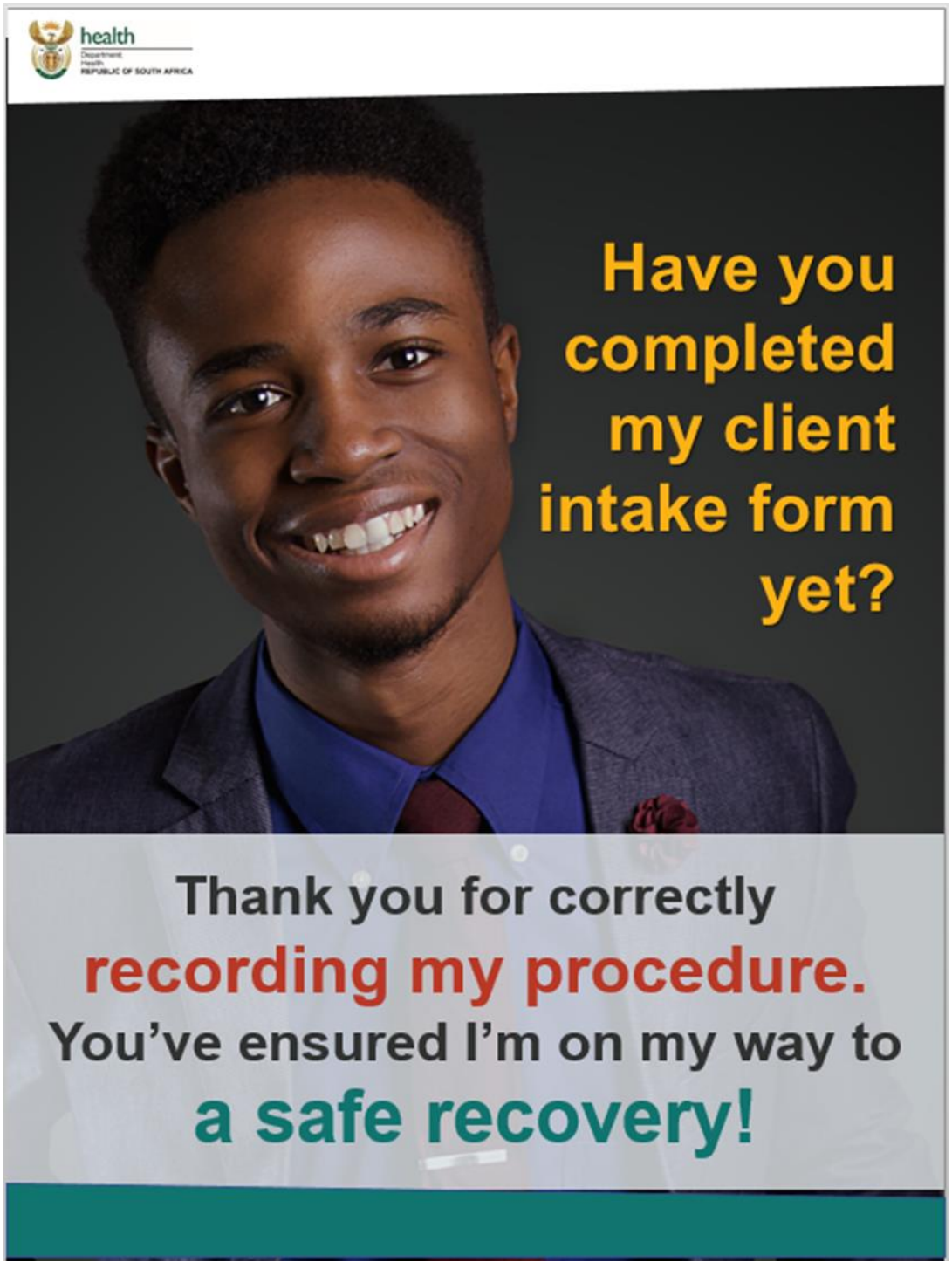
- **Pledge for data capturers, facility VMMC representatives and implementing partners**



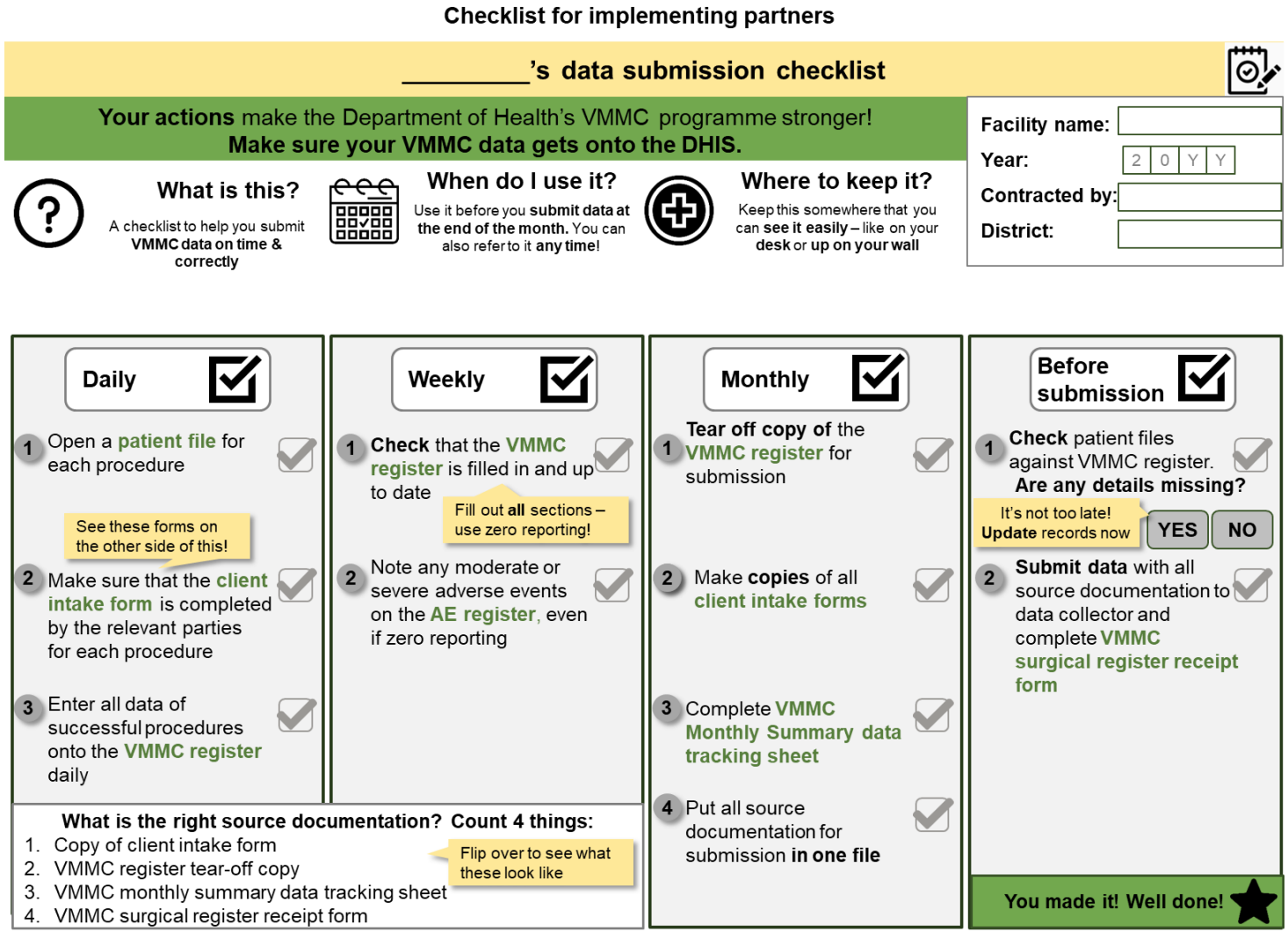
- **Data reporting roadmap for implementing partners, data capturers, VMMC facility representatives, sub-district officials and district officials**



- **Poster for facilities or implementing partners to encourage reporting adverse events**



- **Checklists for implementing partners at facilities for reporting data (2-sided)**



Checklist for implementing partners

_____'s data submission checklist

Your actions make the Department of Health's VMMC programme stronger!
Make sure your VMMC data gets onto the DHIS.

Facility name:
Year: 2 0 Y Y
Contracted by:
District:

What is this?
A checklist to help you submit **VMMC data on time & correctly**

When do I use it?
Use it before you **submit data at the end of the month.** You can also refer to it **any time!**

Where to keep it?
Keep this somewhere that you can **see it easily** – like on your **desk** or **up on your wall**

Daily

1. Open a **patient file** for each procedure
2. Make sure that the **client intake form** is completed by the relevant parties for each procedure
3. Enter all data of successful procedures onto the **VMMC register** daily

See these forms on the other side of this!

Weekly

1. **Check** that the **VMMC register** is filled in and up to date
2. Note any moderate or severe adverse events on the **AE register**, even if zero reporting

Fill out **all** sections – use zero reporting!

Monthly

1. **Tear off copy of** the **VMMC register** for submission
2. Make **copies** of all **client intake forms**
3. Complete **VMMC Monthly Summary data tracking sheet**
4. Put all source documentation for submission **in one file**

Before submission

1. **Check** patient files against VMMC register.
   Are any details missing?
   It's not too late! **Update** records now
   YES NO
2. **Submit data** with all source documentation to data collector and complete **VMMC surgical register receipt form**

What is the right source documentation? Count 4 things:

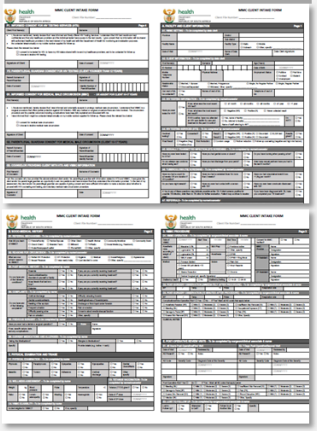
1. Copy of client intake form
2. VMMC register tear-off copy
3. VMMC monthly summary data tracking sheet
4. VMMC surgical register receipt form

Flip over to see what these look like

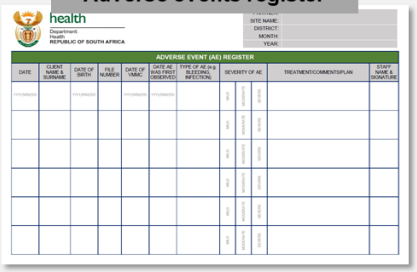
You made it! Well done!

Daily

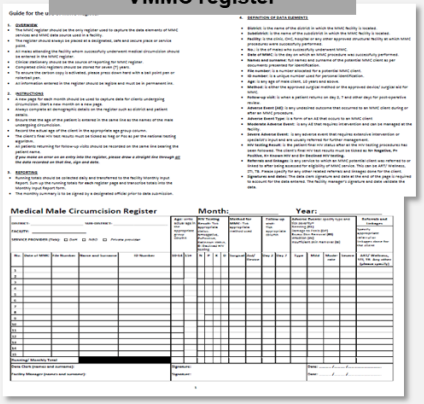
Client intake form



Adverse events register

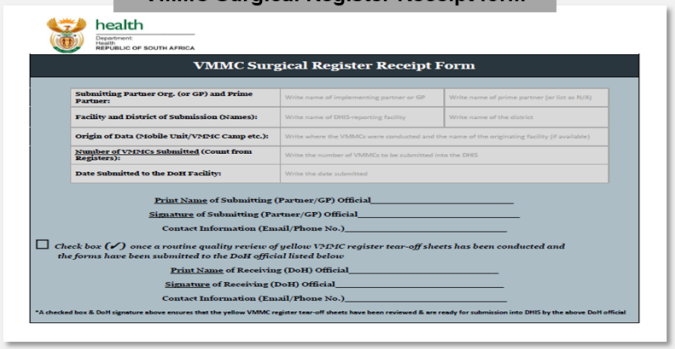


VMMC register



Monthly

VMMC Surgical Register Receipt form



health
Department:
Health
REPUBLIC OF SOUTH AFRICA

VMMC Surgical Register Receipt Form

Submitting Partner Org. (or GP) and Prime Partner:	Write name of implementing partner or GP	Write name of prime partner (or list as N/A)
Facility and District of Submission (Names):	Write name of DHIS-reporting facility	Write name of the district
Origin of Data (Mobile Unit/VMMC Camp etc.):	Write where the VMMCs were conducted and the name of the originating facility (if available)	
Number of VMMCs Submitted (Count from Registers):	Write the number of VMMCs to be submitted into the DHIS	
Date Submitted to the DoH Facility:	Write the date submitted	

Print Name of Submitting (Partner/GP) Official_____

Signature of Submitting (Partner/GP) Official_____

Contact Information (Email/Phone No.)_____

☐ *Check box (✓) once a routine quality review of yellow VMMC register tear-off sheets has been conducted and the forms have been submitted to the DoH official listed below*

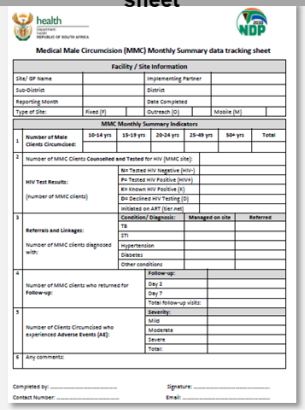
Print Name of Receiving (DoH) Official_____

Signature of Receiving (DoH) Official_____

Contact Information (Email/Phone No.)_____

*A checked box & DoH signature above ensures that the yellow VMMC register tear-off sheets have been reviewed & are ready for submission into DHIS by the above DoH official

VMMC monthly summary data tracking sheet



health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Medical Male Circumcision (MMC) Monthly Summary data tracking sheet

Facility / Site Information			
Site/ GP Name		Implementing Partner	
Sub-District		District	
Reporting Month		Date Completed	
Type of Site:	Fixed [F]	Outreach [O]	Mobile [M]

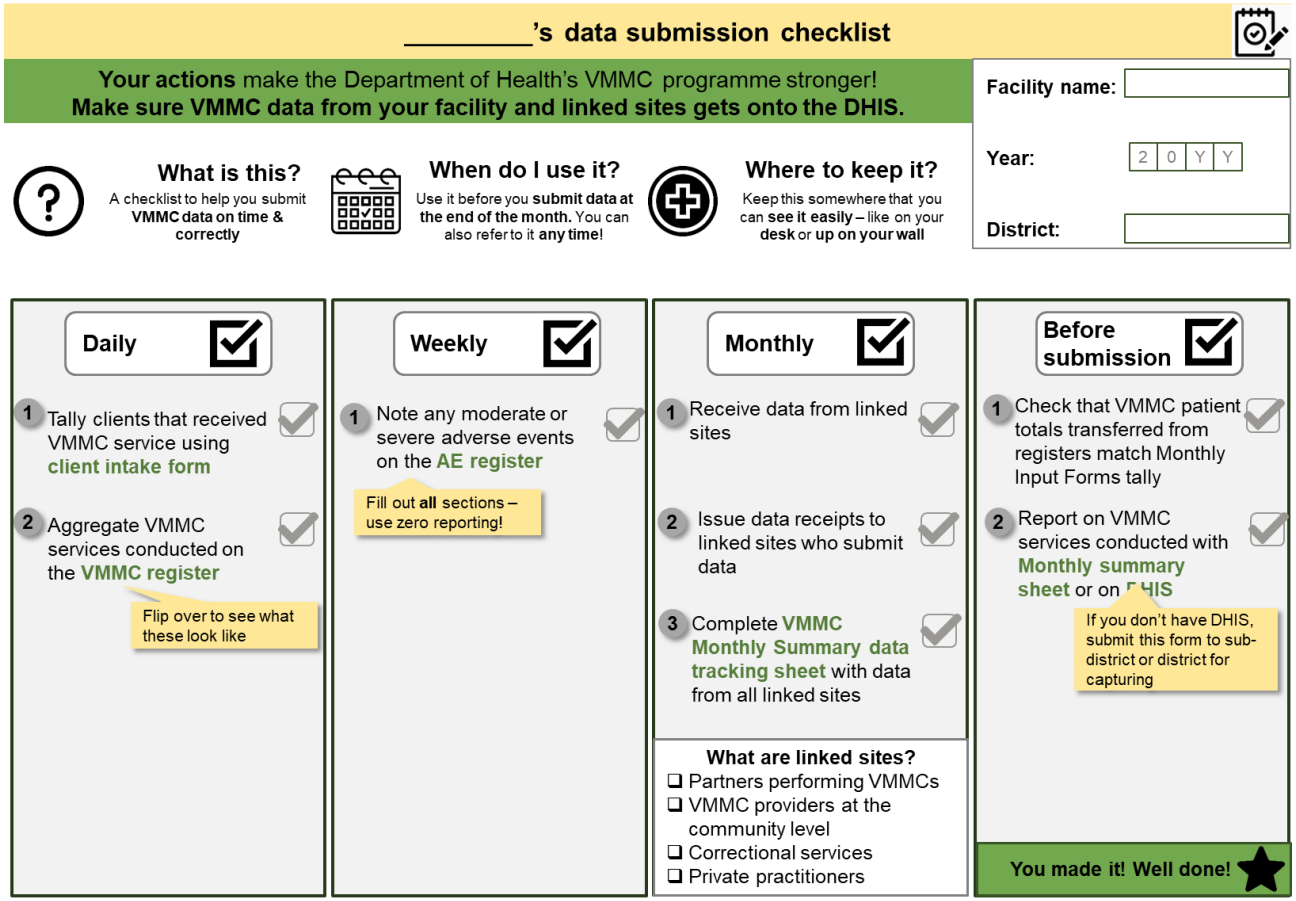
MMC Monthly Summary Indicators							
1	Number of Male Clients Circumcised:	10-14 yrs	15-19 yrs	20-24 yrs	25-49 yrs	50+ yrs	Total
2	Number of MMC Clients Counselled and Tested for HIV (MMC site)						
	HIV Test Results: (number of MMC clients)	No Tested HIV Negative (HIV-)					
		Pre Tested HIV Positive (HIV+)					
		KH Known HIV Positive (K)					
		EH Declined HIV Testing (E)					
		Initiated on ART (Ser.net)					
3	Referrals and Linkages: Number of MMC clients diagnosed with:	Condition/ Diagnosis:	Managed on site	Referred			
		TB					
		STI					
		Hypertension					
		Diabetes					
		Other conditions					
4	Number of MMC clients who returned for Follow-up:	Follow-up:					
		Day 2					
		Day 7					
		Total follow-up visits:					
5	Number of Clients Circumcised who experienced Adverse Events (AE):	Severity:					
		Mild					
		Moderate					
		Severe					
		Total:					
6	Any comments:						

Completed by: ..... Signature: .....

Contact Number: ..... Email: .....

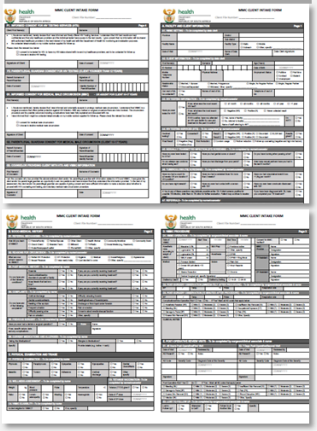
- **Checklists for data capturers at facilities for reporting data**

Checklist for facility data capturers

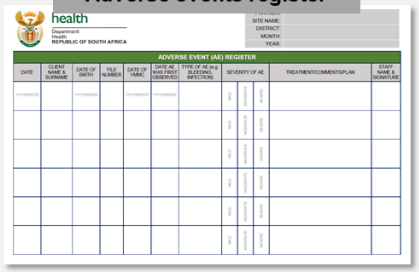


Daily

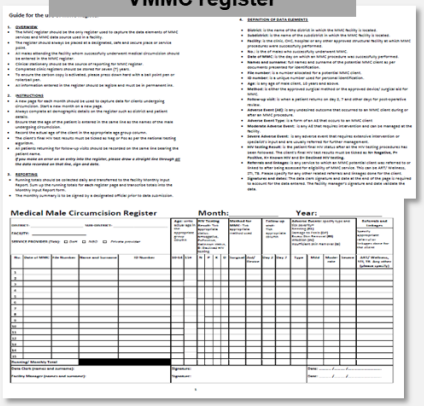
Client intake form



Adverse events register

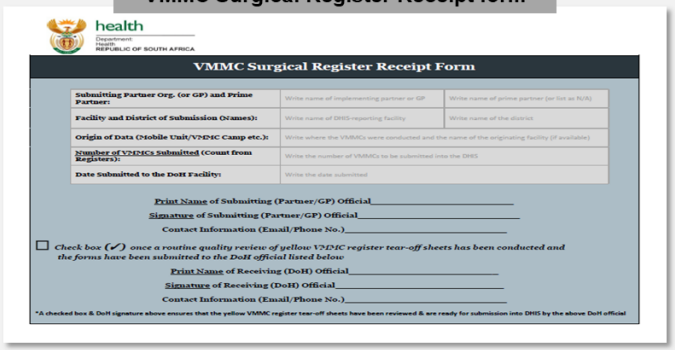


VMMC register

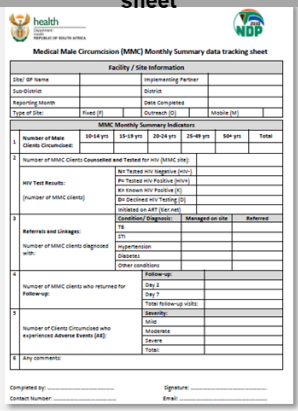


Monthly

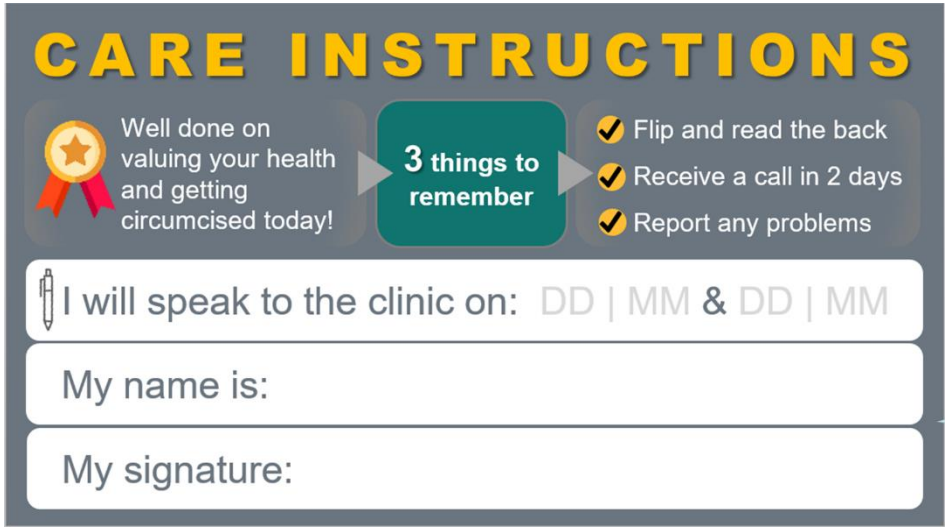
VMMC Surgical Register Receipt form



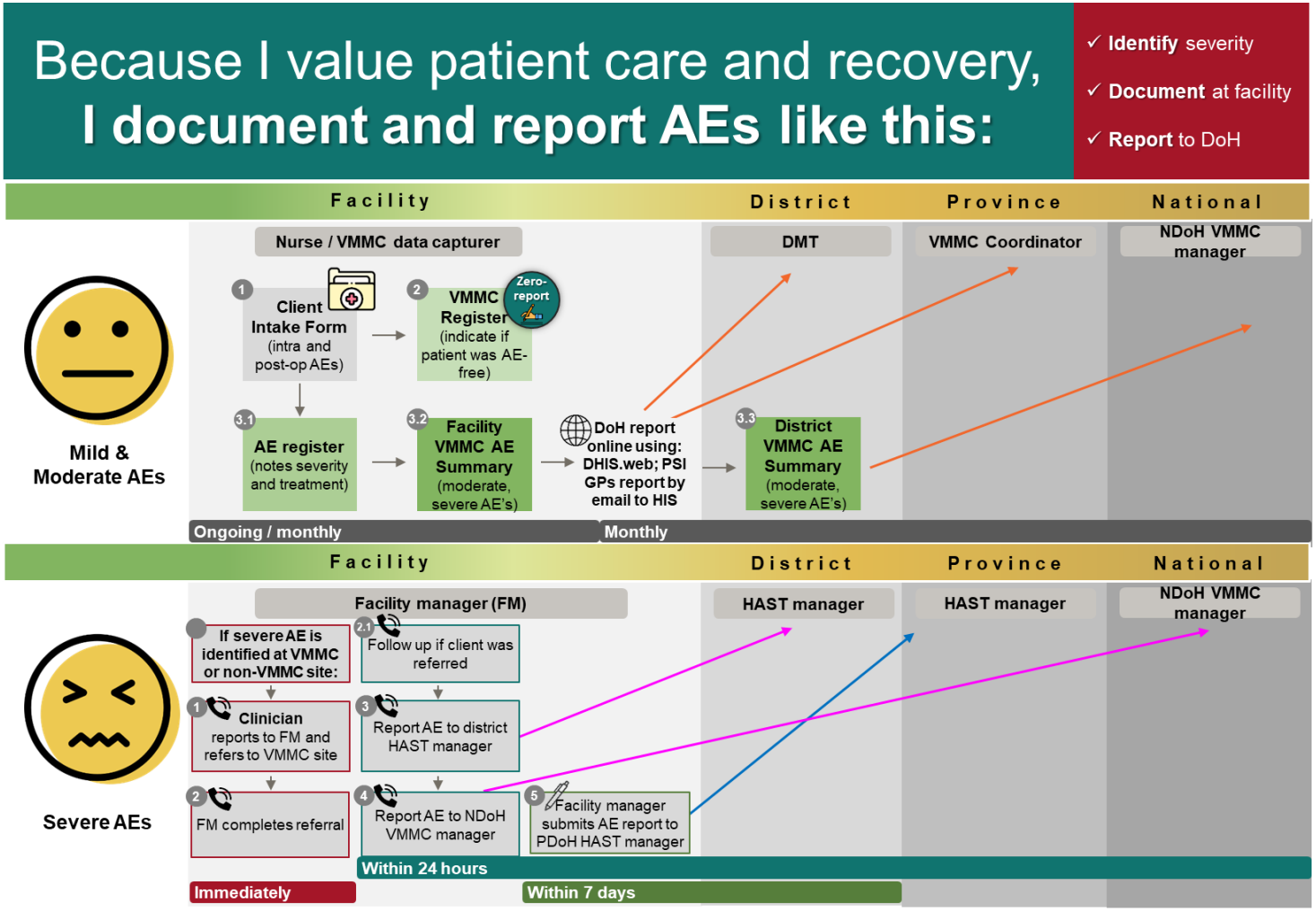
VMMC monthly summary data tracking sheet



- **Post-operative follow-up card for VMMC service providers to give to patients**



- **Adverse events reporting roadmap**



- **Adverse events poster for VMMC service providers**

- **Adverse events reporting reminders – stickers for MMC registers**

Option 1

Option 2

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

National VMMC programme |

7. DISTRICT DATA VERIFICATION MEETING MANUAL

Version 2 (July 2020)

Contact person

Mr Collen Bonnecwe

Medical Male Circumcision Programme Director, National Department of Health

Email	collen.bonnecwe@health.gov.za
Telephone	+2712 3958021
Mobile	+27 82 4405118

Mr Dayanund Loykissoonlal

Medical Male Circumcision Programme Manager, National Department of Health

Email	dayanund.loykissoonlal@health.gov.za
Telephone	+27 12 3959186
Mobile	+27 71 6033144

TABLE OF CONTENTS ..... Error! Bookmark not defined.
ACRONYMS iii
1. Background 4
2. Purpose 4
2.1. District data verification meeting manual 4
2.2. VMMC data verification meetings 5
3. Intended outcomes 5
4. Proposed structure 6
4.1. Scope 6
4.2. Meeting structure 6
5. Proposed attendees 8
6. Roles and responsibilities 9
Appendix 1: Meeting agenda 10
Appendix 2: Meeting presentation 11
Appendix 3: Meeting minutes 12
Appendix 4: District data meeting quarterly questionnaire 13
Appendix 5: Quarterly data verIfication meeting report 14

List of tables

Table 1: Standing meeting agenda items 7
Table 2: Organisation and cadres required at data verification meetings 8
Table 3: Cadres required at Monthly District meetings 8

List of figures

Figure 1: District and implementing partner roles and responsibilities 9

List of boxes

Box 1: Manual Objectives 5
Box 2: The two-point scale used to determine low or high priority for implementing data verification meetings 6

ACRONYMS

AOB	Any Other Business
CQI	Continuous Quality Improvement
DATIM	Data for Accountability Transparency and Impact
DHIS	District Health Information System
DoH	Department of Health
ETT	Extended Task Team
GP	General Practitioner
HAST	HIV and AIDS/STI/TB
HI	Health Information
HIS	Health Information System
HMIS	Health Management Information System
M&E	Monitoring and Evaluation
MMC	Medical Male Circumcision
NDoH	National Department of Health
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PoE	Portfolio of Evidence
RT35	National Treasury Transversal Contract
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBD	To be determined
VMMC	Voluntary Medical Male Circumcision

7.1. BACKGROUND

The national Voluntary Medical Male Circumcision (VMMC) programme in South Africa is led by the National Department of Health (NDoH) and supported by the United States President's Emergency Plan for AIDS Relief (PEPFAR). PEPFAR, through various implementing partners, supports the implementation of the national programme in 27 districts. The non-PEPFAR supported districts are solely funded through National Treasury service providers called the National Treasury Transversal Contract (RT35). As a result, VMMC data is collected and reported into two Health Information Systems (HIS). The NDoH utilises the District Health Information System (DHIS) while PEPFAR utilises Data for Accountability Transparency and Impact (DATIM).

The DHIS collects VMMC data from all data sources in the country, including: government facilities; provincially contracted general practitioners (GPs); RT35 implementing partners; and PEPFAR implementing partners. DATIM collects data from PEPFAR implementing partners only. As such, it is expected that DHIS, as the national system, will accumulate more data in comparison to DATIM. However, historically, DATIM has reflected much higher VMMC figures in comparison to the figures on the DHIS. This indicates that there are discrepancies in reporting between the two systems.

While PEPFAR implementing partners are expected to report into both systems, they have little oversight of the DHIS. Similarly, the NDoH has limited oversight of DATIM. The parallel reporting systems, and limited collaboration between the Department of Health (DoH) and the implementing partners, have led to continuous discrepancies in reported VMMC data in the country. This discrepancy highlights the importance of routine data verification.

PURPOSE

DISTRICT DATA VERIFICATION MEETING MANUAL

Data verification is a critical part of programme implementation and management. The data verification process allows for data across different data sources to be checked for any inaccuracies and to put in place mitigating measures to ensure the accuracy of the data.

This manual outlines the implementation of district data verification meetings which should be implemented to ensure data verification takes place at the district level, regularly, as part of routine programme monitoring.

1. To outline the process and implementation of district data verification meetings.
2. To document templates used during the implementation of the district data verification meetings.
3. To document tools to evaluate the data verification meetings to effectively track learnings during implementation.

Box 15: Manual Objectives

VMMC DATA VERIFICATION MEETINGS

District data verification meetings between the districts and implementing partners are recommended as a mitigating action to allow for regular and strengthened collaboration at the district level. These meetings are envisioned to assist in resolving VMMC data discrepancies in the future.

INTENDED OUTCOMES

The district data verification meetings are designed to:

1. Create a platform for strengthened collaboration between district DoH and implementing partners.
2. Support routine data verification to:
    - eliminate data variances between DHIS and DATIM and;
    - ensure the availability of accurate data for the national programme.

7.2. PROPOSED STRUCTURE

7.2.1. Scope

The goal is to implement the data verification meetings in all 52 districts of South Africa. The roll-out of district meetings should be phased due to the uniqueness of each district and the existing challenges which need to be addressed before the introduction of the data verification meetings.

To assess the readiness of each district, a brief situational analysis should be undertaken by the Health Information (HI) manager of each district. This should be done in collaboration with each district manager and the implementing partners in each district to understand the existing VMMC activities and challenges.

Based on the situational analysis mentioned above, the need to implement data verification meetings can then be prioritised using a two-point scale (high and low) as seen in the box below. The scale helps districts identify whether they require data verification meetings or not.

1. Low - There is an existing data verification platform and it has been identified as adequate (no need for an additional meeting).
2. High There is no existing data verification platform OR The existing data verification platform has been identified as inadequate.

Box 16: The two-point scale used to determine low or high priority for implementing data verification meetings

7.2.2. Meeting structure

The data verification meetings are envisioned to take place monthly, before the broader district meetings (for example: HIV and AIDS, sexually transmitted infections (STI)/tuberculosis (TB) (HAST) unit meetings, and extended task team (ETT) meetings) to prepare for the discussions. Data verification meetings can be conducted as a standalone platform or as part of monthly VMMC implementing partner meetings, where all the cadres associated with service delivery are in attendance. The meeting should take place at the district offices and should be led by the district officials.

Districts and implementing partners will be responsible for preparing data reports/dashboards before these meetings to limit the time spent at the meeting performing verification.

The structure of the meetings is flexible as attendees are encouraged to discuss agenda items which will contribute to effective collaboration and quality data. However, there is a proposed agenda as seen in *Annexure 1.* The agenda should always include the following agenda items:

Table 30: Standing meeting agenda items

Agenda item	Purpose
Performance against targets	To assess the district's performance (as per DHIS) against the district target. This will allow the district to be aware of over, or under, performance; to document lessons learnt; or to come up with catch up plans.
Data variance	Implementing partners and districts to discuss performance data and verify if the numbers align. All outstanding data is to be captured onto DHIS by district data capturers in time for the next meeting. Implementing partners to share at which facility the data was submitted so that DoH can follow-up.
Planning	To discuss mitigating actions to ensure set targets are met.
Way forward	To confirm discussed plans and assign responsible parties and timelines.

Minutes are to be taken during each meeting and distributed to all attendees within two working days. All parties are responsible for actioning items agreed upon in the meetings by the proposed date to ensure the effectiveness of the data verification meetings.

7.3. PROPOSED ATTENDEES

The data verification meetings need to have the relevant parties present. The proposed attendees are listed in the table below.

Table 31: Organisation and cadres required at data verification meetings

Organisation	*Cadres*
Implementing Partner	Programme Manager (initial district meeting)
	Data Manager/Monitoring and Evaluation (M&E) Manager
District	Data Manager
	VMMC Coordinator

The following cadres are required to attend the broader monthly district meetings:

Table 32: Cadres required at Monthly District meetings

Operational Level	*Cadre*	*Responsibility*
District Level	District Information Manager	Custodian of the DHIS
	District HAST Manager	Custodian of the VMMC programme
	Administrator	Responsible for supporting the meeting logistics
Sub-district	HAST Mangers	Responsible for the Programme at sub-district level
	Primary Health Care (PHC) Supervisors	Oversee facility activities
	Information Officers	Responsible for the Sub-district data
Site-level	Facility Managers	Responsible for all activities conducted in the facility
	VMMC Champions	Oversee site-level VMMC activities
	Data Capturers	Responsible for capturing data onto the DHIS
Implementing Partners	Programme Managers	Responsible for the VMMC programme
	Information Managers	Responsible for the collection, collation and reporting of data
	Continuous Quality Improvement (QI) Managers	Ensuring overall programme quality as well as data quality
	Site Supervisors	Oversee services at the site-level, (usually also conducts VMMCs at the site)

7.4. ROLES AND RESPONSIBILITIES

The figure below indicates each district official and implementing partner's role in the district verification meetings.

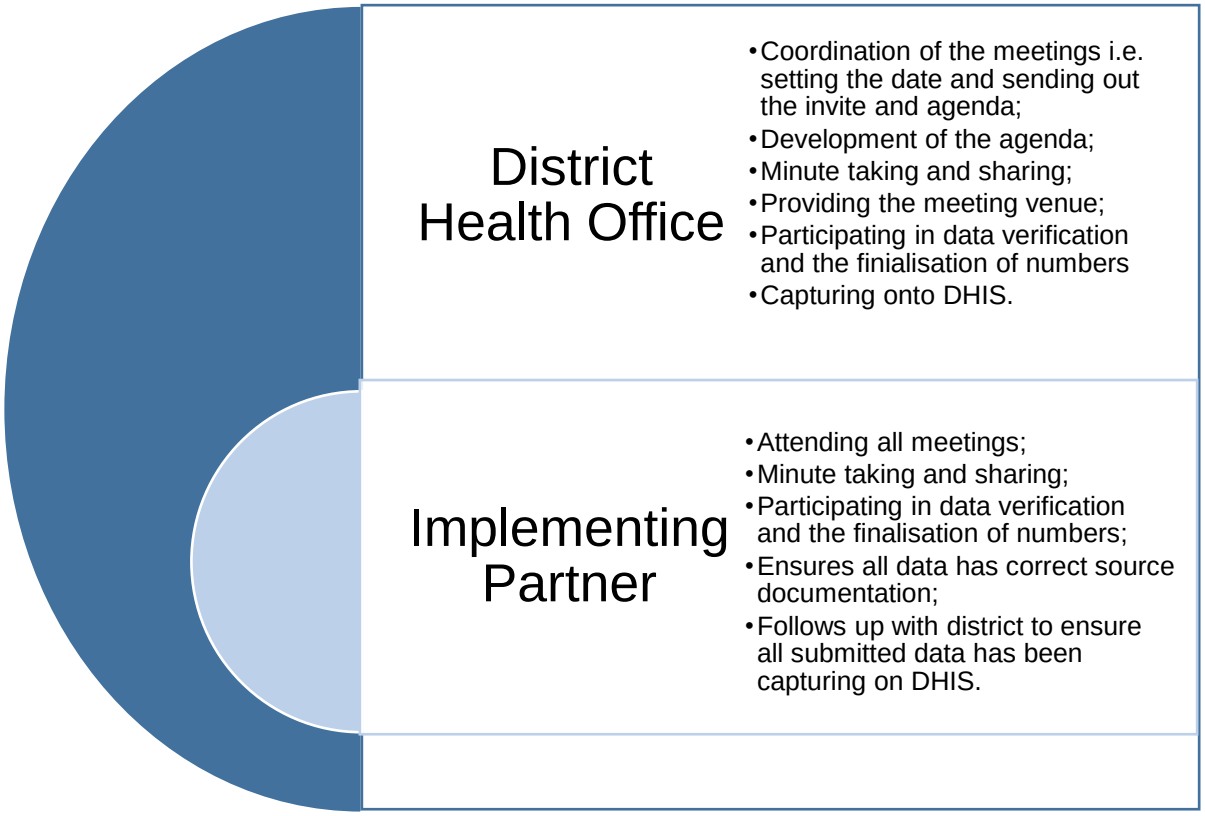


Figure 27: District and implementing partner roles and responsibilities

7.5. APPENDIX

7.5.1. Appendix 1: Meeting agenda

The purpose of the agenda is to prepare all district officials and implementing partners for the discussion. This should be prepared and shared by DoH in advance for every meeting.

Programme: Voluntary Medical Male Circumcision (VMMC)

Meeting: Monthly Data Verification Meeting

Date: _____

Time: _____

Venue: _____

Required attendance: District, Implementing Partners

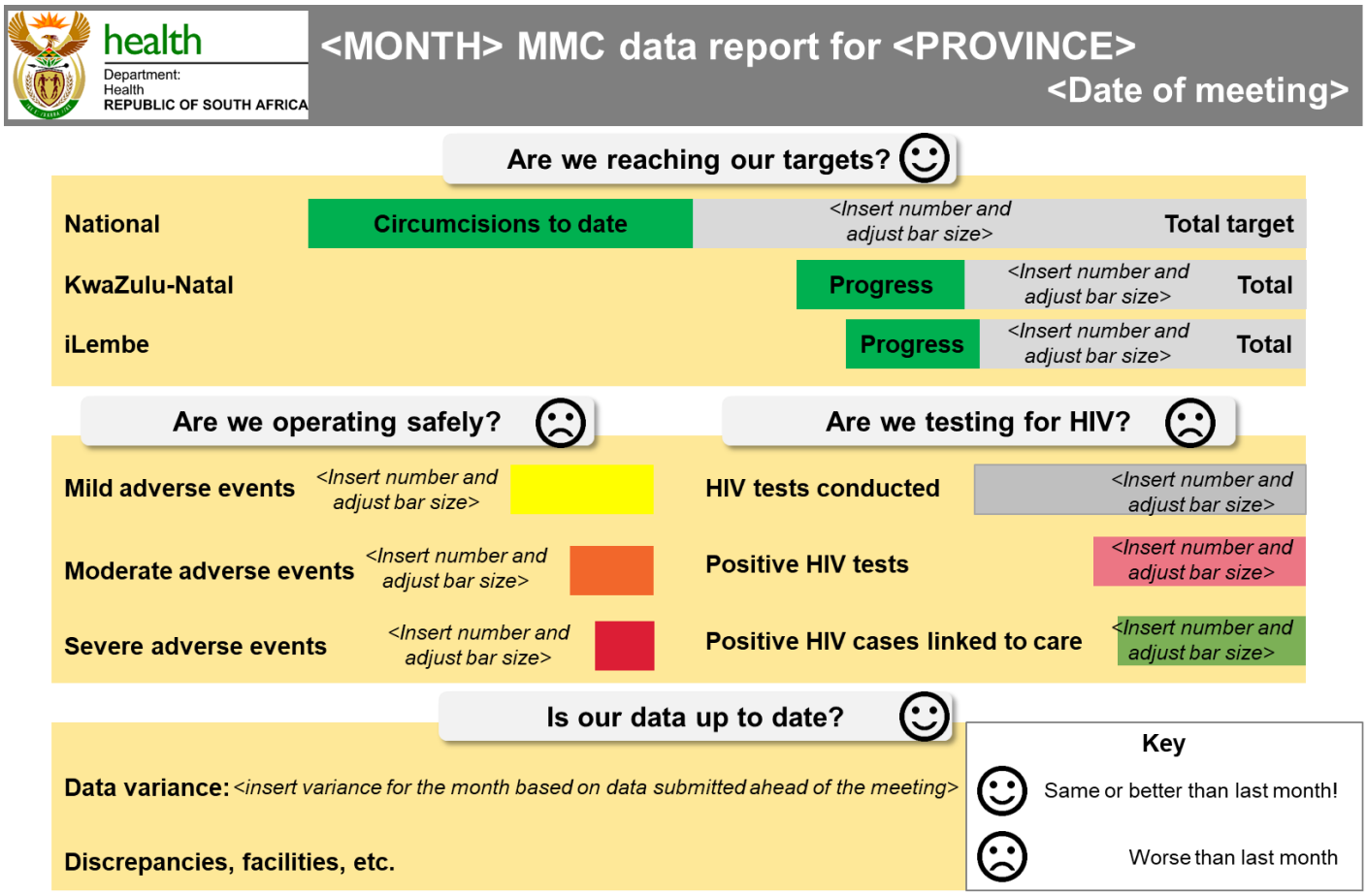
Purpose:

- To raise and address data challenges;
- To discuss and document lessons learned and best practices concerning data;
- To ensure effective VMMC programme planning and use of available VMMC data.

Agenda Item	Facilitator
Welcome and Introductions	District
Performance against Targets	TBD
Data Variance	TBD
Planning	TBD
Way Forward	TBD
AOB	TBD
Closure	District

7.5.2. Appendix 2: Meeting presentation

The purpose of the presentation is to guide the discussion using visuals to help with understanding.



7.5.3. Appendix 3: Meeting minutes

The purpose of the meeting minutes is to capture all discussions held (as per the headings in the agenda) and action items discussed. It assists all attendees to be accountable for the developments.

Minutes are to be captured at all meetings by the nominated party (can revolve) and shared to all who attended 48 hours after the discussion.

Programme: Voluntary Medical Male Circumcision (VMMC)

Meeting: Monthly Data Verification Meeting

Date: _____

Time: _____

Venue: _____

Attendees: _____

Apologies: _____

Performance against targets:

Data variance:

Planning:

Way forward:

Any Other Business (AOB):

Action Items:

Items	Person Responsible	Due date

Date of Next Meeting:

7.5.4. Appendix 4: District data meeting quarterly questionnaire

A quarterly qualitative questionnaire has been developed to assess the effectiveness of these meetings and their ability to meet the objectives.

This questionnaire should be printed out and completed at every third data verification meeting (one per quarter) by all attendees and analysed quarterly to document lessons learned and improve the meetings.

DISTRICT DATA MEETING QUARTERLY QUESTIONAIRE

Objective 1: Create a platform for strengthened collaboration between district DoH and implementing partners

1. Do all the relevant district officials and implementing partners always attend the monthly meetings?
    a. Please provide suggestions for ensuring all district officials and implementing partners attend if this is a challenge OR lessons on how to get all district officials and implementing partners to attend if this has been a success.
2. Do the relevant district officials and implementing partners prepare their data and points for discussion before the meeting?
    a. How can preparation for the meetings be more effective?
3. How is the meeting creating an effective platform for collaboration with all district officials and implementing partners?
    a. What is currently working well during the meetings?
    b. What are the current challenges experienced during the running of the meetings?

Objective 2: Support routine data verification

1. How can the meetings be used more effectively for data verification?
2. Are all district officials and implementing partners aware of their role in data verification and how have they been able to provide required inputs?
3. How are the identified challenges dealt with effectively?
4. Can you share any lessons for solving data issues which can be documented as lessons learned?
5. How have the meetings helped decrease the variance between DHIS and DATIM this quarter?

7.5.5. Appendix 5: Quarterly data verification meeting report

This report is envisioned to be a summary of the feedback from all district officials and implementing partners, the key audience is the district officials and implementing partners attending the data verification meeting. One report should be compiled with all district learnings and the responses disseminated, within two weeks of collecting the questionnaire, for knowledge sharing purposes.

The report outline is detailed below:

Cover Page:

Acronyms:

Background:

Purpose:

Findings:

Objective 1: Create a platform for strengthened collaboration between district DoH and implementing partners.

Challenges:

Successes:

Objective 2: Support routine data verification.

Challenges:

Successes:

Recommendations/Way forward:

8. SUMMARY

Well done! You've reached the end of your guidance document! Here's a quick recap of the different sections. Take 5 minutes to write down the key points from each section that you'd like to remember.

Section 1: Introduction & purpose

Do you have any goals that you'd like to set for this journey? Or anything in particular that you'd like to learn from reading this? Write them down here.

My goals & learning

Section 2: Contract management framework

Think about what was the most helpful in this framework. Make a note of the section and page number to return to it later.

Things I want to remember and return back to

Section 3: How to contract GPs

Write down any useful tools that you'd like to use or any important points to remember for this process.

Tools I'd like to use or points to remember

Section 4: Coordination toolkit

This had a lot of helpful information for day-to-day coordination. Take note of the most helpful tips that you'd like to implement.

Tips that I'm going to introduce in my work

Section 5: Data tools training manual

This provided a lot of information on how to use all the data tools. It has guidance on each tool. Take note of anyone else who you could share this information with.

I will be sharing this information with these colleagues

_____
_____
_____
_____

Section 6: District data verification meetings manual

This can make monthly meetings much easier! Take note of the useful tips and write down how you can help to implement them.

The tips that I will be introducing are

_____
_____
_____
_____

Thank you for making it to the end of this information pack!

Refer back to it anytime.

Thank you for participating in keeping South Africans healthy and safe!