Voluntary Medical Male Circumcision:
Project 300K Winter Campaign 2018
South Africa

April 1st – July 31st, 2018

health
Department:
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Contents

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AE	Adverse Event
CDC	Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CMT	Community Media Trust
COP	Country Operational Plan
CQI	Continuous Quality Improvement
DATIM	Data for Accountability, Transparency and Impact Monitoring
DHIS	District Health Information System
DOD	Department of Defence
DMPPT	Decision-Makers Program Planning Toolkit
DVA	Data Variance Analysis
EC	Eastern Cape
EQA	External Quality Assessment
FMT	Facility Mapping Tool
FS	Free State
FY	PEPFAR Fiscal Year
GP	Gauteng Province
GP	General Practitioner
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
KZN	KwaZulu-Natal
LP	Limpopo
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
MP	Mpumalanga
NC	Northern Cape
NDoH	National Department of Health
NW	North West
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
QA	Quality Assurance

RTC	Right to Care
SLA	Service Level Agreement
STI	Sexually Transmitted Infection
TB	Tuberculosis
THC	TBHIV Care
TMI	Traditional Male Initiation
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WC	Western Cape Province

Executive Summary

- This report details the activities undertaken to achieve 300 000 voluntary medical male circumcisions (VMMCs). The 300K Winter Campaign was led by the National Department of Health (NDoH) and funded by both PEPFAR and the NDoH Conditional Grant.

- The support of the National and Provincial Departments of Health, PEPFAR funding agencies (United States Agency for International Development and Centers for Disease Control and Prevention), PEPFAR implementing partners and the Bill & Melinda Gates Foundation are gratefully acknowledged.

- The key areas of work in the 300K Campaign are detailed below. These reflect the key points in each pillar of the project.

Program Partners (Section One):

- A matrix management structure, led by NDoH, was used for Project 300K to ensure accountability for achieving campaign objectives at national, provincial and district service delivery levels through each partner consortia.

- The matrix management structure was developed due to the need for NDoH to coordinate VMMC partners and establish effective communications & coordination. These structures promoted accountability, bi-weekly performance monitoring and analyses, and the identification of challenges, remedial actions and best practices.

- Operational challenges that arose during the 300K Campaign were limited and were largely mitigated through cooperation, coordination of VMMC activities, and program leadership.

- CDC partners experienced delays in the initiation of VMMC activities arising from partner transitions within respective districts resulting in the stoppage and subsequent delay of service delivery.

Management & Organization (Section Two):

- The management and organization of Project 300K was led by the NDoH.
- Partner data was analyzed to evaluate performance, identify challenges and promote good practices. These practices were disseminated among all implementing partners during bi-weekly 300K Campaign meetings.

- Numerous analytical tools were developed and implemented to monitor and evaluate partners' performance against targets and data reporting quality.

- Increased partner collaboration facilitated partners' performance through the communication of effective strategies and effectual demand generation initiatives.

Demand Generation (Section Three):

- Social mobilization efforts were crucial in creating demand and promoting VMMC uptake in targeted districts. Trained social mobilizers were deployed and established in districts depending on demand generation requirements and needs of each district. Successes and failures of demand generation initiatives are detailed in Section Three.

- Other successful demand generation initiatives as well as underperforming ones have been included.

Program Constraints (Section Four):

- Programmatic constraints that hindered optimum performance are outlined and discussed. Predominant constraints pertained to data reporting quality and gaps in data processes among implementing and prime partners.

Performance Results (Section Five):

- The quantitative results of Project 300K are reported and systematically analyzed. Results are disaggregated by district, province and month.

Challenges and Best Practices (Section Six):

- All developments and activities that were instrumental in ensuring the successful implementation of Project 300K are discussed in Section Six.

Recommendations (Section Seven):

- Recommendations and ways forward informed by the challenges and successes of Project 300K are outlined in Section Seven.

INTRODUCTION AND BACKGROUND

The South African National Department of Health's (NDoH) VMMC Program was established in 2010 and has done over 3.6 million circumcisions since inception. Historically, performance peaked at 539 892 VMMCs in 2017/2018 since program inception. In South Africa, the winter season (April to July) was found to have the highest rate of VMMC uptake, contributing approximately 50-60% of the annual VMMC target. Thus, targeted initiatives that boost program performance during this period are essential to meet the high demand for services and to substantially increase VMMC numbers.

Last year (2016/2017) the winter campaign was listed as Project 281K, which was the required to meet the PEPFAR target. By the 281K project conclusion, a total of 296 850 VMMCs were completed nationally; representing a substantial improvement in performance.

The development and implementation of Project 300K aimed to build on the considerable gains made during Project 281K and maximize on the increased uptake of VMMC during the winter season. Subsequently, NDOH devised and initiated a second campaign to further accelerate and scale-up VMMC and increase uptake among priority target populations, i.e. HIV-negative males aged 15 to 34 years. Project 300K further aimed for higher VMMC impact and HIV infections averted while testing the potential for winter campaigns to achieve higher numbers of VMMCs than other times of the year. As a result, stakeholders collectively oversaw the achievement of a total of 310 987 VMMCs between April 1 and July 31, 2018. This represents an overachievement of 3% of the total target of 300 000 and a 5% increase from Project 281K's total performance. The analyses in this report have been done using partner reported data rather than data submitted into DHIS. As a result, VMMC numbers in partner reported data is substantially higher than that of DHIS due to delayed partner reporting into the DHIS.

The good practices related to Project 300K are identified and discussed in this report to incorporate the processes that increased the capacity and program performance overall. The lessons learned, challenges experienced and the effect thereof on project performance are additionally identified and discussed at each stage of implementation.

1. PROGRAM PARTNERS

Prime implementing partners were responsible for the coordination of implementing partners and service delivery partners within their consortia as well as district-specific VMMC interventions of these organizations. Some prime partners were additionally responsible for the delivery of VMMC services.

The district in which each prime and implementing partner was operating is documented in Table 1 below.

Partners and Districts

PRIME PARTNER	SUPERVISED DISTRICTS	
AURUM	• Ekurhuleni • City of Johannesburg • City of Tshwane • Sedibeng • eThekwini • King Cetshwayo • Ugu • uMgungundlovu • uMkanyakude • uThukela • Sekhukhune (RT35) • Vhembe • Waterberg (RT35)	• Gert Sibande • Nkangala • Frances Baard (RT35) • JT Gaetsewe (RT35) • Namakwa (RT35) • ZF Mgcawu (RT35) • Pixley ka Seme (RT35) • Dr Kenneth Kaunda • Dr Ruth Segomotsi (RT35) • Ngaka Modiri Molema • West Coast (RT35)
TB/HIV Care Consortium	• Amathole • Alfred Nzo • Buffalo City • Chris Hani • Joe Gqabi (RT35) • Nelson Mandela Bay (RT35) • Oliver Tambo	• Sarah Baartman (RT35) • Thabo Mofutsanyana • eThekwini • Harry Gwala • Central Karoo (RT35) • Eden (RT35) • Overberg (RT35) • West Coast (RT35)
URC	• Lejweleputswa • Ekurhuleni • City of Johannesburg • City of Tshwane • Sedibeng • eThekwini • Ugu	• uMkanyakude • Zululand • Capricorn • Mopani • Ehlanzeni • Bojanala Platinum
SFH	• Buffalo City • Chris Hani • Harry Gwala • eThekwini • uMgungundlovu • City of Cape Town	

JHPIEGO	• eThekwini • King Cetshwayo • Ugu • uMgungundlovu • uMkanyakude • uThekela
Right to Care Consortium	• Amathole • Alfred Nzo • Oliver Tambo • Thabo Mofutsanyana • Nkangala • Dr Kenneth Kaunda • Ngaka Modiri Molema
JGALT EXPRESS	• West Rand (RT35) • Amajuba (RT35) • iLembe (RT35) • uMzinyathi (RT35) Cape Winelands (RT35)

Table 1

1.1. Partner Transitions and Delays

Certain challenges prevented the timely implementation of VMMC activities in several districts. Prior to Project 300K, CDC contracted new partners to provide VMMC services, this resulted in previously-contracted partners having to transition out of CDC districts. TB/HIV Care and Aurum transitioned out of various districts and were replaced by Right to Care (RTC), Society for Family Health (SFH) and JHPIEGO. These partner transitions within CDC districts and contractual delays resulted in the disruption of service delivery and the delayed achievement of weekly and monthly targets. This was especially so in high target provinces such as KwaZulu-Natal (KZN).

Transition plans were put in place by several partners that outlined the transition process from one partner to another in each district which in turn facilitated a smoother transition process. Conversely, the transition process between other partners and negotiation of service delivery responsibility proved to be an arduous task resulting in sub-optimal VMMC performance. Districts in which partners were already established performed better than districts in which partners were transitioning in and out of. Districts that partners transitioned in and out of are listed in Table 2 below.

Transitions by Partner and District

Province	District	Old partner	New Partner
Eastern Cape	Amathole	THC	RTC
	Alfred Nzo	THC	RTC
	Buffalo City	THC	SFH
	Chris Hani	THC	SFH
	OR Tambo	THC	RTC
Free State	Thabo Mofutsanyane	THC	RTC
KZN	eThekwini	THC/Aurum	JHPIEGO, SFH
	King Cetshwayo	Aurum	JHPIEGO
	Ugu	Aurum	JHPIEGO
	uMgungundlovu	Aurum	JHPIEGO/SFH
	uMkhanyakude	Aurum	JHPIEGO
	uThukela	Aurum	JHPIEGO
Mpumalanga	Nkangala	Aurum	RTC
North West	Dr. Kenneth Kaunda	Aurum	RTC
	Ngaka Modiri Molema	Aurum	RTC
Western Cape	City of Cape Town	Aurum/THC	SFH/JHPIEGO

Table 2

The rescheduling of meetings between certain partners, district and provincial officials and the late signing of memoranda of understanding (MOU) and service level agreements (SLA) resulted in further VMMC operational delays. Despite resources being in place in districts, partners were required to strategically engage with district and province officials to commence delayed operations. These challenges were especially prominent in the City of Cape Town, Western Cape (WC) in which VMMC services only started half way through the campaign. Buffalo City, Eastern Cape (EC), experienced the longest delay in service delivery, with activities commencing 15 weeks after Project 300K's commencement date.

Performance was similarly set back in eThekwini, a high target district, due to Aurum and THC transitioning out. Partners further reported experiencing difficulties negotiating the traditional landscape in eThekwini as a result of a hesitancy among men to uptake VMMC services. It was important for NDoH and partners to continually engage and partner with traditional leaders and celebrities to advocate for VMMC within KZN.

These issues had a major impact on the number of VMMCs done during April and May. Partners were unable to start activities until MOUs had been signed, thus VMMC performance in April was largely affected by these delays, with only 52% of the April target being met. Districts in which VMMC activities were delayed and commenced after 1 April are listed in Table 3 below.

Late Start Districts

District	Start Date	Partner	District	Start Date	Partner
Buffalo City	9 July	*PSI/SFH*	**uMkhanyakude**	7 May	*JHPIEGO*
City of Cape Town	18 June	*JHPIEGO*	**uThukela**	7 May	*JHPIEGO*
Amathole	18 June	*RTC*	**King Cetshwayo**	7 May	*JHPIEGO*
O R Tambo	11 June	*RTC*	**Cape Winelands**	30 April	*JGALT*
Pixley Ka- Seme	11 June	*AURUM RT35*	**West Rand**	30 April	*JGALT*
Dr Kenneth Kaunda	4 June	*RTC*	**iLembe**	30 April	*JGALT*
Ngaka Modiri Molema	1 June	*RTC*	**Umzinyathi**	30 April	*JGALT*
eThekwini	28 May	*THC CDC*	**Amajuba**	30 April	*JGALT*
Alfred Nzo	21 May	*RTC*	**Nkangala**	23 April	*RTC*
Sarah Baartman	21 May	*THC RT35*	**West Coast**	16 April	*THC RT35*
Ugu	14 May	*JHPIEGO*			*AURUM RT35*
Harry Gwala	14 May	*PSI/SFH*	**Namakwa**	16 April	*AURUM RT35*
Joe Gqiba	14 May	*THC RT35*	**City of Johannesburg**	16 April	*AURUM CDC*
Thabo Mofutsanyane	14 May	*RTC*	**Chris Hani**	-	*PSI/SFH*
uMgungundlovu	7 May	*JHPIEGO*			

Table 3

When compared to the April performance of Project 281K, 59% fewer VMMCs were done in April during Project 300K. This underperformance is indicative of the disruptions in service delivery caused by partner transitions. In order to increase VMMC performance following the transitions, partners appointed field mobilizers, dispatched roving teams and further engaged with general practitioners. Performance then increased during May and substantially increased during June. When compared to the May performance of Project 281K, 12 527 VVMCs (36%) more VMMCs were done in May during Project 300K. Likewise, 70 787 VMMCs (93%) more were done in June during Project 300K than June, during 281K. In July 148 214 VMMC's were done during Project 281K, as compared to 85 335 circumcisions done during Project 300K. The primary reason for the difference in trends over the two-year period, can be attributed to the winter school holidays, which began earlier in June 2018 when compared to 2017.

1.2. RT35 Contracts

In 2015, PEPFAR announced their gradual reduction of support and greater focus on high priority districts within the South African VMMC program[1]. As a result, there has been increased pressure for the VMMC program to transition away from external funding towards long-term full government ownership. In response, a portion of the partners were awarded RT35 contracts by the NDoH, utilizing conditional grant funding from National Treasury for a three-year period — November 2016 to October 2019. These contracts were awarded to AURUM, THC and JGALT. Although the VMMCs done in RT35 districts contributed towards Project 300K's performance, these numbers were often lower than districts in which PEPFAR partners were operating. The low number of VMMCs in RT35

[1] Country Operational Plan (COP) 2015

districts was partly attributed to the saturation of the target population, which was the original rationale for PEPFAR's retraction.

Partners experienced several challenges that impeded VMMC performance in RT35 districts. Primarily, delayed payments or non-payments for VMMC services significantly hindered service delivery, resource mobilization and procurement. This was experienced in the Northern Cape (NC), North West (NW), KZN, and EC.

Deferred signing of MOUs by provinces further delayed VMMC activities with some districts only commencing activities in May and June. In order to ensure effective service delivery and promote the sustainability of the VMMC program, issues regarding payments to implementing partners were addressed and rectified with the provincial departments of health. All RT35 partners experiencing issues with non-payment since 2016 (due to various reasons) which were then resolved during 2018.

The adaptability of service delivery models, redistribution of resources, and increased collaboration among partners mitigated some of the challenges associated with partner transitions and delayed starts. The coordination of VMMC activities between partners and NDoH was necessary in ensuring the successful performance of Project 300K.

2. MANAGEMENT AND ORGANISATION

Project 300K necessitated the development of an accelerated scale-up plan similar to that of Project 281K, which took place during the course of the previous winter period (2017). This plan aimed to build on the progress made during Project 281K while capitalizing on the increased uptake of VMMCs during the winter period. Continuous coordination by NDoH and guidance of partners was required to negotiate access with provincial and district DoH officials, establishing collective management structures. These structures emphasized fluid communications between partners, PEPFAR officials and NDoH. Leadership from NDoH was important in the promotion of accountability, bi-weekly performance analyses, timely dentification of challenges and monitoring of remedial action.

2.1. National Strategy and Implementation

Project 300K aimed to increase the national uptake of VMMCs through the delivery of quality services, improved program data collection structures and coordinated management structures. In order to facilitate these processes, NDoH, PEPFAR and CHAI collaborated on program implementation and coordinated communication between partners by implementing bi-weekly meetings. Partners were required to submit bi-weekly performance data which was monitored, analyzed and disseminated by NDoH and CHAI.

Performance trends were tracked to inform district-specific evaluations and where necessary, suggest remedial interventions. Additional coordination meetings were

scheduled, as required with partners and NDoH, to discuss and address program impediments and collectively develop strategies to resolve issues.

These continual meetings facilitated collaboration, program accountability and sharing of data and data analysis processes. It further allowed for the rapid identification, discussion and resolution of challenges, in partnership with NDoH. Moreover, the identification and dissemination of best practices was instrumental in facilitating communications and informing program management.

2.2. Internal Developments and Traditional Male Initiation (TMI) Challenges

2.2.1. Partner Collaboration

The coordinated implementation and management of Project 300K demanded increased collaboration between partners to improve performance in low performing districts and, where required, facilitate the reallocation of resources as well as improve demand generation activities.

In districts where targets were not reached, partners negotiated the reallocation of both targets and resources to other partners who were better equipped to operate in sub-optimal performing districts. Such partnerships allowed for the redistribution of VMMC resources and services from underperforming WC districts to KZN, where the potential of VMMC to impact on HIV incidence is high. It further allowed for partners to maximize on best practices within KZN districts such as the implementation of VMMC camps which were found to increase uptake.

Similarly, AURUM redistributed targets from low performing Gert Sibande to Nkangala in Mpumalanga (MP) to increase overall performance. Improved communication between partners to coordinate VMMC activities within problematic districts further increased VMMC performance.

Despite regular communications in bi-weekly meetings, attendance was often low as partners were required to deal with persistent challenges on the ground, stemming from late initiation of VMMC services and delayed signings of several provincial and district MOUs. The prompt review of program impedances ensured district-specific and data-driven interventions and strategies were implemented to enable the mobilization of resources. These included the establishment of weekly reviews by CDC to further implement and monitor remedial actions.

2.2.2. VMMC in TMI Settings

Negotiating with local stakeholders was essential to promoting VMMC activities in TMI predominant areas, collaboration with TMI leaders and safe quality practices. Partners aimed to offer safe and effective VMMC services in a culturally appropriate setting that allows for the promotion of HIV prevention within traditional environments. Establishing

relationships of trust between partners, healthcare providers and traditional leaders facilitated the promotion of medical circumcisions and its subsequent health and safety benefits. Additionally, this collaboration and support was important for negotiating the integration of VMMC with traditional rites of passage and initiations. Partners had to ensure that traditional leaders adequately understood the purpose of VMMC — that it is the promotion of safe circumcision practices and not the replacement of traditional practices.

Discussions and negotiations were especially important in underperforming districts in EC and WC, such as Amathole, Oliver Tambo and the City of Cape Town, in which VMMC activities only commenced in June. Contractual issues in EC further contributed to the delayed start there. The capitalizing of existing strong relationships with TMI leaders in districts such as Nkangala, MP, facilitated VMMC uptake in TMI predominant areas. The collaboration of partners with PDoH was crucial in ensuring challenges were adequately addressed and tensions with traditional leaders negotiated. The development of tensions amongst several traditional leaders in the EC in response to VMMC activities resulted in the temporary delay of service delivery by Right to Care in the Oliver Tambo, Alfred Nzo & Amatole districts. However, activities within the Amatole district increased significantly from July onward. In the Buffalo City and Chris Hani districts, no circumcisions were conducted during the winter campaign due to unsigned SLA's between these respective districts and the partner - Society for Family Health. The mitigation of these tensions by NDoH was crucial in ensuring the prompt recommencement of VMMC activities in affected districts.

2.2.2.1. Challenges in the Traditional Sector

The 300K project set clear parameters for what constituted a medical circumcision versus a traditional circumcision. In some provinces, this has led to misconceptions and accusations about the purpose of the 300K program and the impact that this has on the traditional initiation activities. While many of the allegations from traditional leaders lacked evidence, VMMC operations were disrupted in particular districts during the winter period. Prime partners and NDoH collectively developed proactive strategies to engage with traditional leaders and address these issues. NDoH provided partners with additional assistance and guidance in outlining ways to negotiate the TMIs in traditional districts, interact with traditional leaders and stakeholders and integrate VMMC activities with TMI. Partners were instructed to reallocate VMMC services to high-impact districts unaffected by disruptions such as KZN, while NDoH investigated allegations and negotiated terms with select traditional leaders.

To avoid these challenges that arose from working with and negotiating with selected TMI leaders and practitioners, it was important that partners ensured they had received written agreement from traditional leaders to operate in traditional sectors and that this documentation was shared with NDoH. Partners and NDoHs' increased efforts to engage with provincial officials in Limpopo (LP) and MP further promoted VMMC activities within TMI predominant areas.

2.2.3. Service Delivery Models in TMI Settings

The delivery of VMMC activities within the traditional sector is facilitated by various service delivery models implemented by both partners and districts. In TMI predominant districts such as Vhembe (LP) and Nkangala (MP), teams were assembled by partners and NDoH to supervise TMI initiations and provide medical assistance to doctors (male doctors and nurses acceptable to the TMI leaders and practitioners) conducting the circumcisions. District and partner compiled teams usually consisted of medical doctors and nurses who performed medical screening, monitored vitals and monitored Adverse Events (AEs). In Mpumalanga, the Ingoma Forum, a traditional leader council, was used as a platform to negotiate working within the traditional sector and recruit clients for TMIs. The forum additionally provided training and support to traditional doctors to conduct safe MMC's in a traditional setting. Partners operating within these areas established partnerships with Ingoma Forum to increase the uptake of circumcision. In districts such as Nkangala, subdistrict coordinators regularly communicated with traditional initiation school leaders to collaborate and monitor VMMC activities. These models were found to be effective in ensuring quality MMC's were undertaken in TMI settings generally associated with high AE rates.

3. DEMAND GENERATION

Throughout the course of Project 300K, a range of targeted demand generation initiatives were implemented by each partner based on resource availability. Initiatives were predominantly focused on social mobilization but also included small to mass media strategies. Despite funding constraints, demand generation initiatives involved partners utilizing localized targeted strategies, aimed at increasing VMMC uptake. Good practices and challenges were collectively identified by partners and NDoH and discussed at the bi-weekly performance meetings. Table 4 outlines the demand generation initiatives implemented during Project 300K below.

Demand Generation Initiatives for Project 300K

Type of Initiative	Description	Initiative	Local Partner
Small Media	• Smaller messages used to target certain populations within the country	• Advertising near taxi ranks and clinics • ManUp branded drifting car • Pamphlets and informational flyers • Community targeted radio stations • VMMC road shows	Community Media Trust (CMT) URC
Online Media	• Initiatives that use online platforms to spread information and to advertise to populations that are frequent online users	• Using social media platforms sites • Social media adverts (Soka Ndoda music video) • Advertising online	CMT URC

Inter-personal communication	• Spreading information and messages about VMMC to targeted community groups by the use of workshops, training, social mobilizations and counselling	• Educational workshops • Community counselling • Targeting farms, mines and businesses. • VMMC drama acts	TB/HIV Care, Right to Care URC Get Down Productions

Table 4

Demand generation initiatives were focused on areas where large numbers of men were uncircumcised, particularly in high-burden districts. Understanding the geographical areas in which priority men were located was essential for the development and implementation of targeted demand generation activities. These areas included educational, correctional and religious institutions as well as workplaces and the Department of Defence (DOD). Successful demand generation activities included social mobilization, partnerships with traditional leaders and information sharing at clinics.

Developments during Project 300K highlighted the need for the dissemination of demand generation and data monitoring guidelines and strategies among provincial and district officials and partners. The demand generation strategy and reports of district-specific activities to districts, provinces and partners were circulated to build on best practices and mitigate challenges.

3.1. Partnerships with Traditional Leaders and VMMC Champions

Partnerships with, and championing by traditional leaders, facilitated the promotion of VMMC within several districts. The engagement of traditional leaders was especially important in areas where male circumcision was associated with cultural practices. Hence, it was important to establish relationships of trust with healthcare providers and traditional stakeholders through open communication channels and constant engagement on VMMC. This ensured that leaders understood VMMC processes and medical benefits compared to TMI, including education on wound care and safe sex practices.

Traditional leaders acting as VMMC ambassadors promoted the integration and uptake of VMMC into the traditional sector in KZN. This included the King, Goodwill Zwelithini kaBhekuzulu as well as Prince Nhlanganiso Zulu.

Similar to the engagement of traditional leaders to advocate for VMMC within their respective communities, the collaboration with VMMC champions such as influential community members and celebrities, increased awareness of VMMC and the health benefits. Community Media Trust partnered with celebrity singer and songwriter Khuzani to write, film and produce a song and music video in which listeners were informed of VMMC and called to action. This was then published on Facebook.

3.2. Social Mobilization

The implementation of social mobilization during Project 300K was the most effective in generating demand for VMMC with the highest conversion rates; as an interpersonal communication (IPC) strategy, it formed the cornerstone of VMMC demand generation activities.

Project 300K saw a shift in focus on the strategies used to create demand within districts. Due to significant budget cuts and subsequent financial constraints, there was a lack of mass and small media initiatives as compared to Project 281K during 2017. As a result of a reduction in USAID funding of demand generation initiatives, no television (TV) or radio PSAs were used during Project 300K and other mass media initiatives were set to commence after the winter period, when VMMC uptake is low.

Rather, partners predominantly focused on low level targeted initiatives in specific districts. Partners expanded their use of mobile units, recruiters and social mobilizers to reach VMMC targets. Despite scaling down high-level, mass media initiatives, VMMC uptake increased substantially. Social mobilization initiatives presented with the highest conversion rate of number of people reached to actual VMMCs done than other initiatives, thus had a high impact on increasing VMMC uptake.

3.3. Activations and Information Sharing

Public events that aimed to promote VMMC uptake through interaction and the presentation of relatable content to target populations were found to be effective. Likewise, door-to-door information sharing and clinic talks were found to have a high conversion rate of individuals reached to actual VMMCs done. Additional initiatives were required to create demand within rural areas. Accordingly, Get Down Productions developed and implemented targeted activities such as theatre programs in LP, NW and NC provinces. Get Down Productions was introduced by the NDOH to promote VMMC in RT35 districts. These demand generation activities were primarily centered on community involvement. Additionally, Community Media Trust (CMT) introduced the ManUp branded drifting car, which was on display at a Youth Day celebration in Mitchells Plain, WC, to promote VMMC.

3.4. Underperforming Initiatives

Underachieving demand generation initiatives were often characterized by inflexible and unmeasurable designs. These designs were generally reliant on rigid forms of communication such as small media initiatives. Although radio talks reached more individuals, there was a low conversion rate from people reached to VMMCs done. Similarly, school presentations reached a large population but converted to a low number of VMMCs. Despite media activities on social media platforms such as Facebook and Whatsapp reaching a large population, very few VMMCs were converted from such activities.

4. PROGRAM CONSTRAINTS

4.1. Facility and Quality Constraints

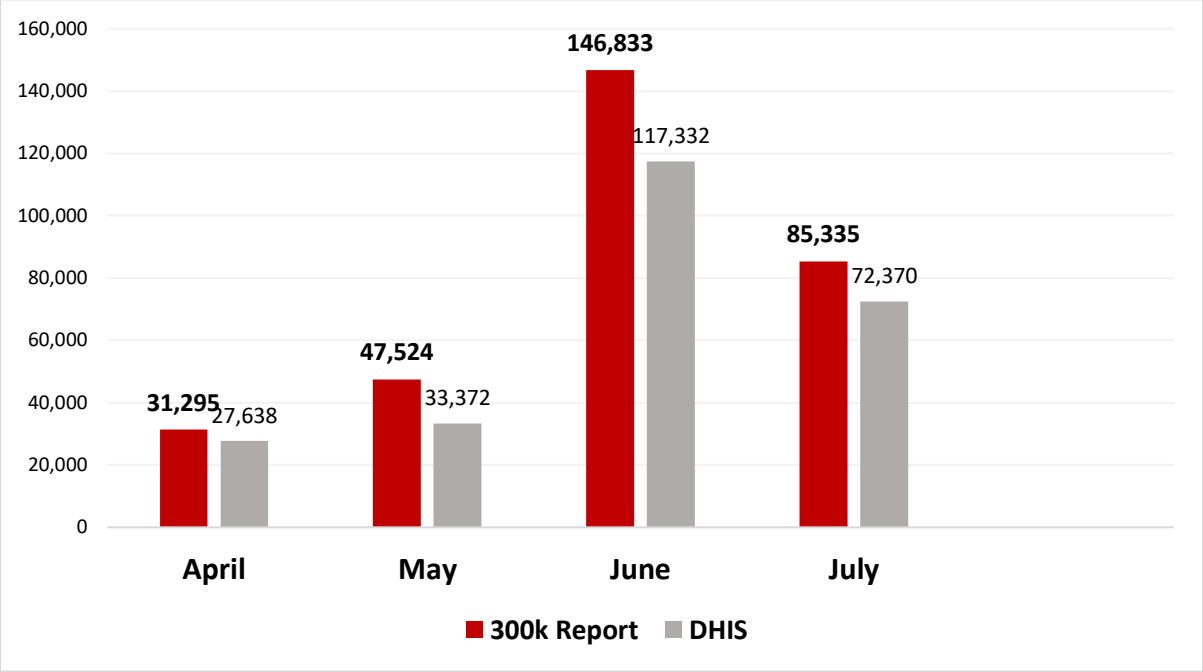
The accelerated uptake of VMMC during the course of Project 300K impacted numerous facilities and clinics. Challenges in procuring staff and materials was partly associated with the large influx of VMMC clients, non-payment of RT35 partners and delayed VMMC activity commencement. Facility staff were further required to work overtime in some facilities in KZN with high demand without receiving reimbursement. RT35 partners in EC did not have sufficient resources or allocated budget to pay facility staff for overtime work. Additionally, a lack of capacity in several local facilities resulted from the increased demand of VMMC in rural areas within LP and MP.

Safety and quality control standards presented additional constraints to the rollout of Project 300K. A series of CQI and EQA assessments were conducted in May 2018, in USAID facilities in NW, Free State (FS), KZN, MP and GP. One URC facility in Limpopo was shut down and one operation in the FS was suspended due to substandard quality of facilities and nonadherence to VMMC guidelines and protocol.

4.2. Data Constraints

During Project 300K, performance indicated a spike in PEPFAR data that was not reported in DHIS. This was found in monthly comparisons of PEPAR data submissions by means of a data variance analysis. This increase in unreported data first appeared during FY 2017/18. Initial estimations were that the difference between DHIS and DATIM stood at 60 275underreported VMMCs into DHIS during Project 300K. The variation in data received during winter campaigns is partly attributed to the length of time it takes for partners to collect, verify and report data. Although data was verified and updated fortnightly by partners, the continued trend of data variance points to issues in data collection and reporting systems.

Project 300K vs DHIS Report



Graph 1

4.2.1. Data Quality and General Practitioners

The data discrepancies found were largely a result of poor or non-existent reporting and/or recording of VMMC data and non-compliance with NDoH reporting guidance & practices.

Substandard data quality was predominantly attributed to inaccurate data records, a lack of VMMC registers at facilities and inefficient communication between facilities, districts and partners. Despite it being stressed throughout the course of Project 300K that several facilities lacked VMMC registers, this issue was not adequately addressed by partner agencies.

Issues in data reporting and quality were predominantly found among partner-contracted general practitioners (GPs). The slow implementation or non-use of data reporting tools such as the Facility Mapping Tool (FMT) and Data Receipts contributed to the substandard reporting of VMMC data and data discrepancies between DHIS and DATIM. In order to improve data quality, partners should ensure all facilities have VMMC registers. All staff should be trained on how to use the VMMC registers and be informed that the register remains at the facility at all times. Training should additionally include the accurate collection of data. Staff should then be required to undertake monthly data verification exercises.

5. PERFORMANCE RESULTS

5.1. PEPFAR & RT 35 Target Setting and Allocations

A target of 398 627 VMMCs had been set by all PEPFAR partners and RT35 partners as indicated in Table 5 below[2]:

Partner Targets

PARTNER	300K Target
JGALT	28 400
THC	22 211
AURUM	91 472
URC	133 464
RTC	34 660
JPHIEGO	43 697
PSI/SFH	44 723
TOTAL	**398 627**

Table 5

Historically approximately 58% of VMMCs have been done during the winter period (April-July). The PEPFAR COP 17 target was set at 581 653 from October 2017 to September 2018; 347 792 for CDC and 233 861 for USAID. Of the USAID-URC COP 17 target, 57% (133 464) was allocated to the winter campaign. Of CDC COP 17 target, 56% (193 369) was allocated to the winter campaign.

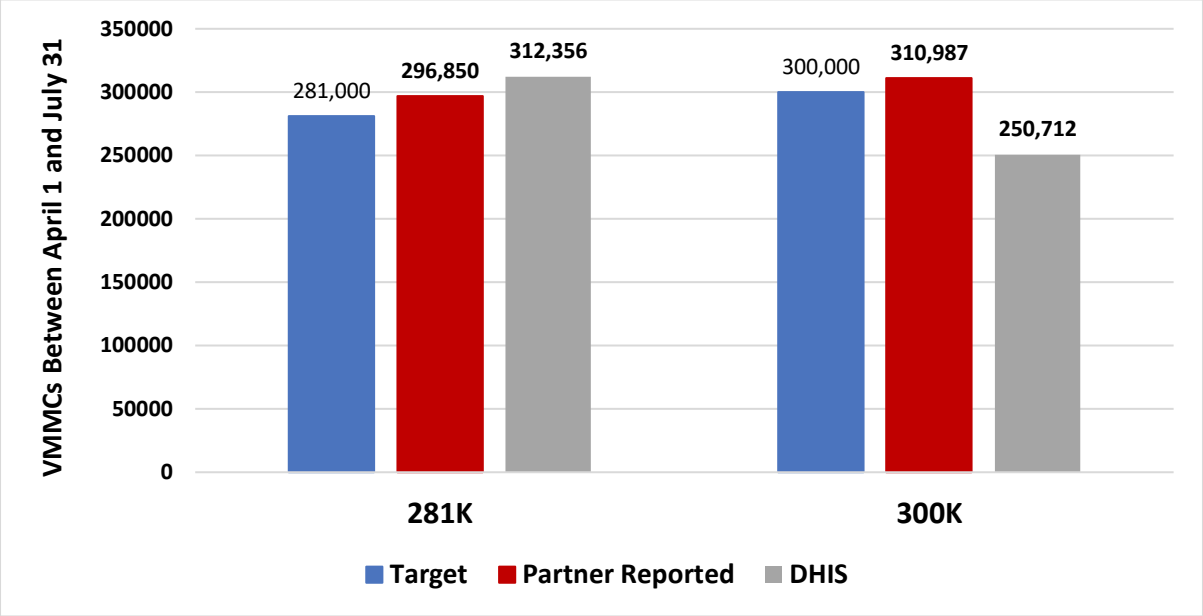
5.2. Overall Performance

During the Project 300K winter campaign a total of 310 987 VMMCs were conducted between April 1 and July 31 in FY 2018/19; exceeding the target of 300 000 by 3.5%. A total of 14 137 more VMMCs were done during Project 300K than Project 281K. These totals are calculated based on partner submitted data and not the data reported to DHIS. Please note that the data used in these analyses requires further validation and being finalised by partners.

Since a total of 85 367 VMMCs were not reported into DHIS during the course of 300K, the totals reported by PEPFAR is much higher than those reported by DHIS. If DHIS data is used, then 225 620 VMMCs were conducted, missing the target by 25%. The underreporting of data points to larger issues in partner data reporting and verification systems and will be discussed later, along with remedial actions.

[2] Although this target exceeds the target set for Project 300K, analyses in this report have been done using the target of 300 000.

Total Project 300K VMMCs Plotted with 281K Total



Graph 2

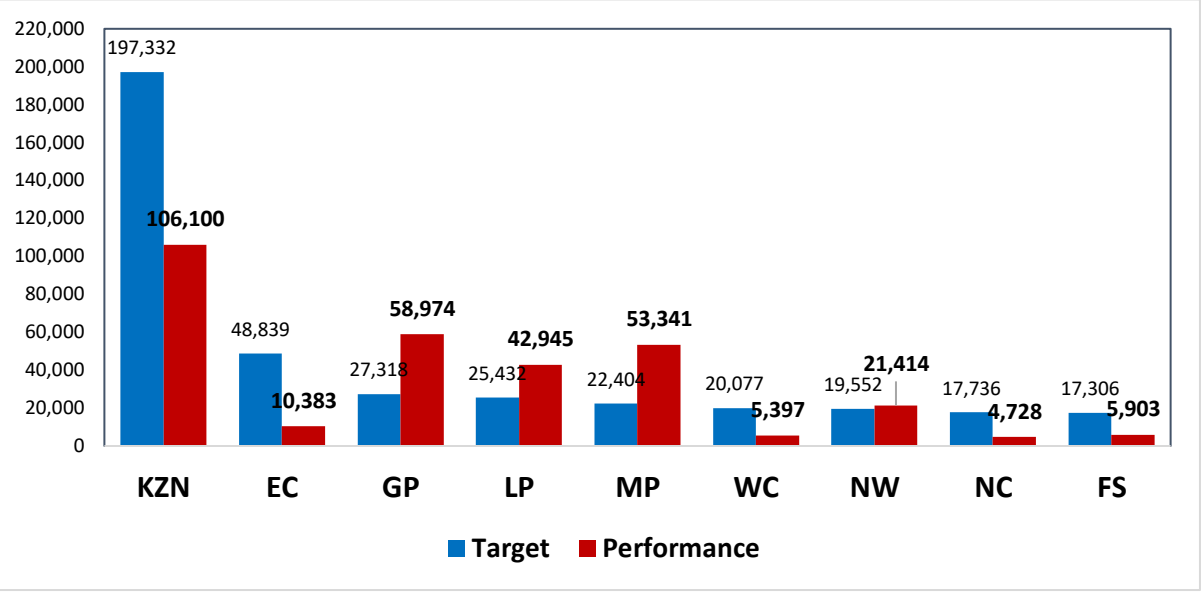
While the number of total VMMCs done during Project 300K was high, the gains were not evenly distributed across provinces.

Performance was high in GP and MP with 58 974 VMMCs and 53 341 VMMCs, respectively (Graph 3). Both provinces exceeded their allocated targets; GP by 115% and MP by 138%. Additionally, LP also had high performance, exceeding its target by 69%.

The highest number of VMMCs were done in KwaZulu-Natal (KZN) (Graph 3), reaching 34% of the total 300k performance (106 100 VMMCs). Despite this, performance against target was poor, achieving only 54% of the target. As the epicentre of the HIV epidemic, VMMC performance and impact should be much higher in KZN. Target allocations in eThekwini did not account for the target VMMC population. Furthermore, a saturation analysis was not conducted within the district[3].

[3] Finding from the Provincial Assessments 2018 conducted in Gauteng, KwaZulu-Natal, Limpopo and Mpumalanga provinces.

Project 300K Performance Comparison by Province



Graph 3

According to the National HIV Prevalence Incidence and Behaviour Survey[1] KZN is considered a high impact, high priority province in which the HIV incidence rate is the highest in South Africa. As a result, there is an increased focus of resources and efforts to promote VMMC uptake in the province. The high performance in KZN was partly accredited to this resource mobilization. Improved performance in KZN was further aided by province-specific campaigns such as 1 Millionth Man which has advocated for the urgent uptake of one million VMMCs in KZN since 2009. Although this campaign ended prior to Project 300K's commencement, it significantly contributed to the total number of VMMCs in the province and increased awareness of VMMC activities and benefits among targeted men.

Since MP has the second highest incidence rate in South Africa[1], the provision and scale up of VMMC services in the province was prioritized. Accordingly, MP had the third highest performance during Project 300K with total 53 341 VMMCs. The large increase in VMMC numbers in districts such as Ehlanzeni and Nkangala can be partly attributed to improved coordination with traditional leaders and partners as well as the expansion of VMMC services to populations in TMI predominant areas. In areas outside traditional settings, management and implementation of cross-organizational initiatives among partners facilitated performance by segmenting male populations. The responsiveness to district-specific challenges experienced by partners and coordination of mobile outreaches further promoted performance in outlying districts.

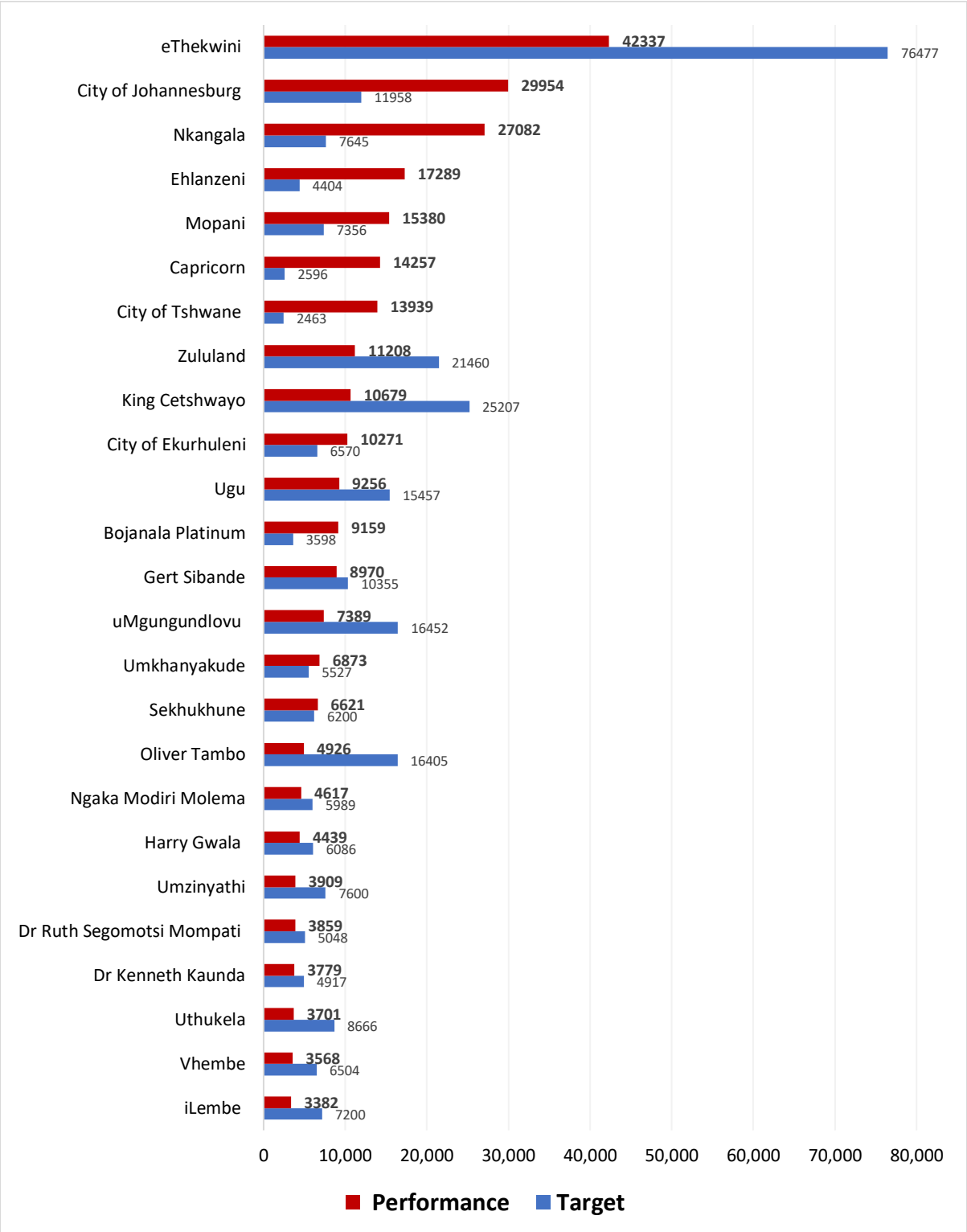
In comparison to the high performing provinces, performance in the remaining provinces was considerably lower, with the least amount of VMMCs done in NC, WC and FS.

5.3. District Performances

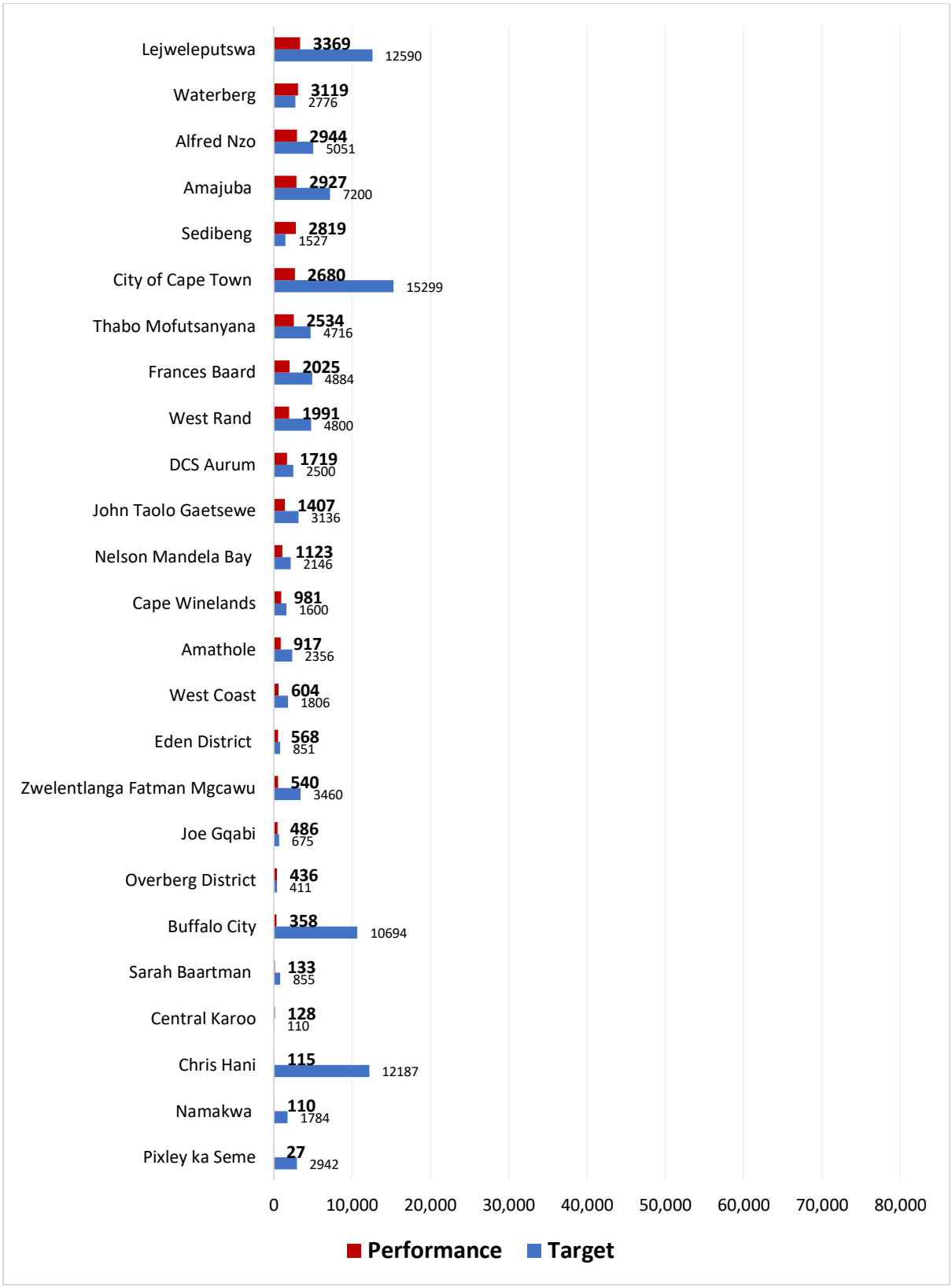
The districts with the highest number of VMMCs done during Project 300K were eThekwini, City of Johannesburg, Nkangala and Ehlanzeni — all of which fall under high priority districts. In eThekwini, the total performance of 42 337 VMMCs greatly exceeded any of the totals in other districts; however, this district only managed to reach 55% of its target. On the contrary, City of Johannesburg exceeded their target by 150%, with a total of 29 954 VMMCs. Likewise, Nkangala exceeded their target by 254% and Ehlanzeni by 293%. The low target allocations for Tshwane and Capricorn meant these districts greatly outperformed their targets by 466% and 449%, respectively. Notably, improved performance was found in Nkangala and can be partly attributed to strengthened partnerships and more efficient coordination with traditional and local leaders.

A total of 14 districts exceeded their allocated target whilst 35 districts missed their target. Most notably, Chris Hani achieved less than 1% of their target. Other marked low performing districts were Pixley ka Seme (1%), Buffalo City (3%), City of Cape Town (18%), Lejweleputswa (27%) and Oliver Tambo (30%); VMMC activities within these districts started in either June or July. It is recommended that reviews be conducted within low performing districts to determine factors inhibiting or impacting VMMC performance, particularly during winter campaigns.

Project 300K Performance Comparison by District



Graph 4.1


Lejweleputswa 3369 12590
Waterberg 3119 2776
Alfred Nzo 2944 5051
Amajuba 2927 7200
Sedibeng 2819 1527
City of Cape Town 2680 15299
Thabo Mofutsanyana 2534 4716
Frances Baard 2025 4884
West Rand 1991 4800
DCS Aurum 1719 2500
John Taolo Gaetsewe 1407 3136
Nelson Mandela Bay 1123 2146
Cape Winelands 981 1600
Amathole 917 2356
West Coast 604 1806
Eden District 568 851
Zwelentlanga Fatman Mgcawu 540 3460
Joe Gqabi 486 675
Overberg District 436 411
Buffalo City 358 10694
Sarah Baartman 133 855
Central Karoo 128 110
Chris Hani 115 12187
Namakwa 110 1784
Pixley ka Seme 27 2942
0
10,000
20,000
30,000
40,000
50,000
60,000
70,000
80,000
Performance
Target

Graph 4.2

5.4. Prime Partner Performances

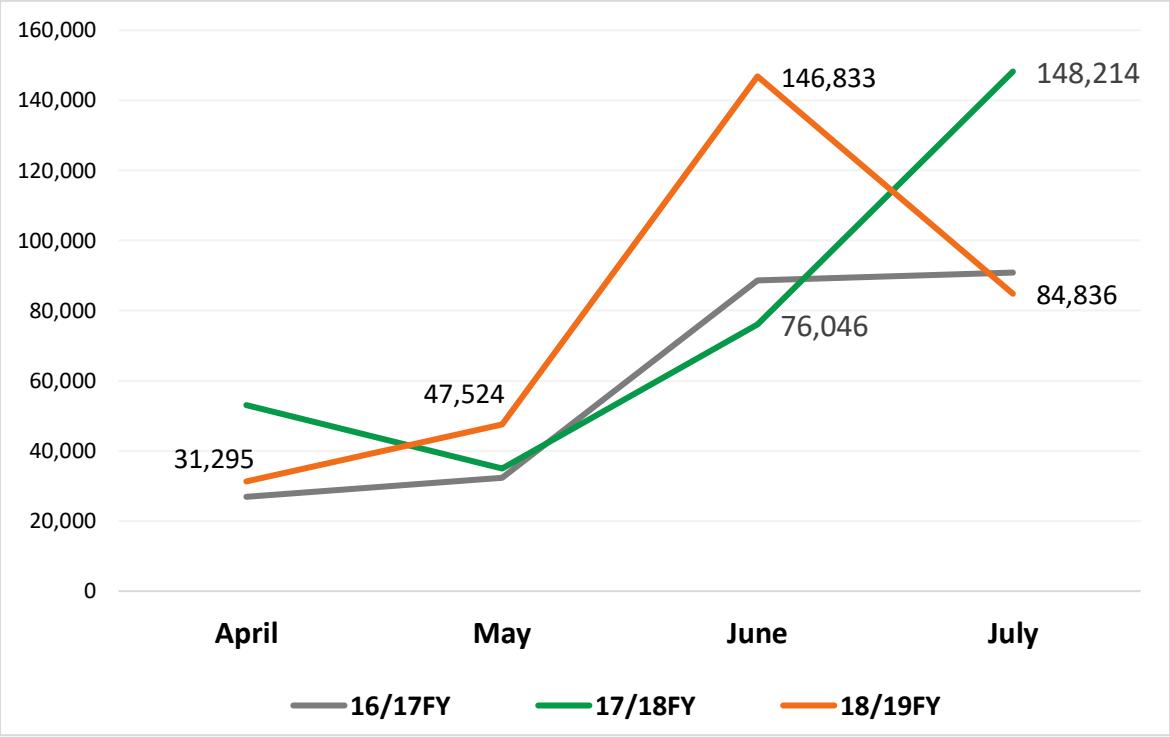
There was substantial variation in VMMC performance among prime partners. Each partner experienced varied challenges and constraints to program implementation. Table 6 depicts each prime partners' targets, VMMC totals, and final percentage against allocated targets.

Prime Partner	Target	Total Circumcisions	Percentage of Target Achieved
USAID	133 464	155 909	117%
CDC	193 369	117 051	61%
RT35(DoH)	71 794	38 027	53%

Table 6

5.5. Winter Period Performance

The number of VMMCs substantially increased over the winter period of May, June and July, compared to other months during all financial years (Graph 5). A total of 225 620 VMMCs were done during the April-July period during Project 300K as reported in DHIS. Historically, this spike in performance coincides with increases in total VMMCs in past financial years for the same May to July period.



Graph 5

As a result of the sizeable increase in performance during the April-July period, efforts and resources are focused during this time period to maximize VMMC uptake. The increase of

facility capacity, operational hours and staff ensured VMMC clinics and facilities were equipped and able to handle the high demand experienced during the winter period.

5.6. July Performance Drop

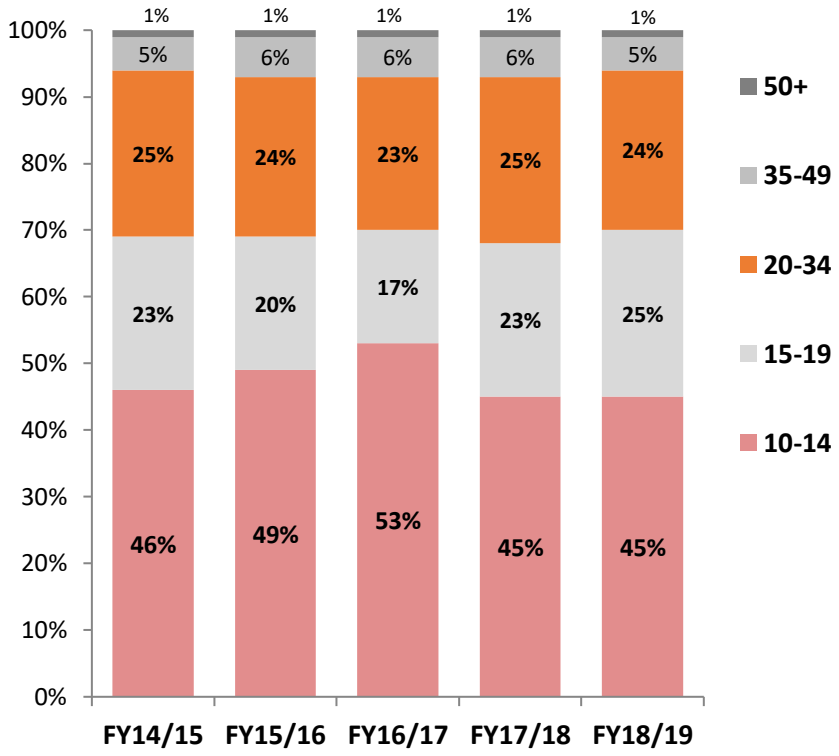
Project 300K saw a significant drop in performance during the month of July compared to June, with a 58% decrease in total VMMCs (Graph 5). The notable decrease in performance during Project 300K can be partly attributed to the correspondence with school holidays during the June month and continued focus on youth. By comparison, performance increased from June to July during FY 2017/18 by 51%. VMMC uptake has been found to be high among the 10 to 14-year age group during school holidays. This was similarly found during the Project 281K campaign where performance rapidly increased during July, when school holidays started.

Despite the spike in performance during June, the rapid decrease in VMMC uptake during July affected performance totals for Project 300K, resulting in targets not being met. It is crucial that efforts be intensified, and resources targeted during low performing months to promote VMMC uptake. Furthermore, it is necessary that the priority age group of 15 to 34-years be targeted over the 10 to 14-year age group.

5.7. Targeted Age Groups

Although the priority age group was 15 to 34-years, 45% of VMMCs were performed on the 10 to 14-year age group (Graph 6). This is still less than the 49% performed on the priority age group but still indicates a lack of focus. Initiatives targeted at 10 to 14-year-olds during the school holidays contributed to the number of VMMCs in this age group. Efforts should be made to refocus initiatives on the priority age group 15-34-years.

Proportion of VMMCs by Age Group



Graph 6

5.7. Data Monitoring

Discrepancies in VMMC data reporting indicated significant problems in data processes and monitoring by partners. Throughout the course of Project 300K, overall VMMC numbers in monthly partner-reported data fluctuated. For instance, at the end of a reporting month, VMMC numbers would either be under- or overreported and would be finalised approximately two or three weeks into the next month. These data fluctuations presented difficulties in analysing data on a weekly and monthly basis and further delayed the immediate response to data challenges.

A month following Project 300K's closure, July data was yet to be verified and final VMMC numbers reported by prime partners. Without finalised data, analyses of VMMC performance against respective targets was hampered, preventing the timely reporting of weekly performance data. Moreover, data was not regularly updated and verified to reflect actual VMMC numbers.

Sub-optimal data reporting quality was a major challenge among partner-contracted general practitioners which largely pertained to incorrect VMMC register usage. Furthermore, a lack of communication, training and guidance from partners exacerbated the gaps in data reporting. The inefficient and irregular monitoring of data collection and reporting practices across the districts worsened data discrepancy challenges. General practitioners were also

found to have an inadequate understanding of data flow processes and were largely unaware of the DHIS facilities they were required to submit data to. Hence, communication channels between partners and general practitioners need to be improved. Partners need to be more involved in data monitoring processes and provide more extensive training on data management, reporting and accountability.

6. LESSONS LEARNT

Numerous developments were instrumental in ensuring the successful implementation of Project 300K, upscaling of the VMMC program and increased uptake of VMMC among priority men. The particular initiatives and structural developments that contributed to Project 300K's substantial gains are discussed below. Conversely, developments that presented as significant challenges and directly impacted program performance are summarised below.

6.1. Successful Developments

6.1.1. Management and Coordination

Redistribution of resources from low performing to high-impact districts such as eThekwini, KZN, in which HIV incidence are high and target population large[1]. Partner and NDoH collaboration facilitated resource reallocations as well as the appropriate allocation of facilities among partners in KZN districts, in which most partners were operating to match the supply with demand.

Additional collaboration with demand generation partners aided in the coordination and integration of initiatives with VMMC service delivery. Daily collaboration between NDoH officials and partnering officials further improved uptake of VMMC among the target population and ensured that solutions to challenges were discussed and implemented as soon as possible. High performing districts conducted weekly meetings with their respective district officials, coordinators and partners to discuss, consolidate and disseminate reports.

6.1.2. Social Mobilization

Despite financial constraints, the adaptability of demand generation initiatives promoted VMMC uptake during Project 300K. There was an increase in partner-contracted social mobilizers within KZN, MP and LP and a focus on social mobilization training.

The interrelation of government-funded peer educators and partner-funded social mobilisers, both of which were trained to explain the benefits and potential risks involved in the VMMC procedure, were central to coordinating efforts to expand the uptake of VMMC among the target population. This integration maximized the impact of both initiatives and expanded the influence of VMMC information beyond high-burden areas. Thus, adaptability in social mobilization models proved to be effective in improving VMMC uptake, particularly in rural areas.

6.1.3. Flexible Service Delivery Models

The adaptability of service delivery models in response to challenges was instrumental in ensuring the success of Project 300K. Partners increased the number of VMMC camps in districts such as uMgungundlovu and King Cetshwayo, where VMMC uptake was low. The implementation of camps was effective in accelerating the uptake of VMMC services in both high and low performing districts by targeting large numbers of boys over a short period of time. This is reflected in the high VMMC uptake among 10 to 14-year olds during the winter period, accounting for 45% of total VMMCs.

Likewise, the employment of mobile units and localized demand generation initiatives allowed partners to target and reach rural and peri-rural areas previously associated with low performance. Improvements in coordination and transportation enabled easier facility access in areas with low VMMC uptake. The increase in uptake in rural areas impacted data flow processes with KZN, MP and LP having the highest data variance during Project 300K. Furthermore, the integration of the VMMC program with other HIV prevention programs allowed for the provision of comprehensive services including HIV testing, counselling and education[4]. Healthcare providers operating in VMMC facilities and clinics took on a multitude of roles and responsibilities to provide a holistic service and prioritise HIV prevention.

6.1.4. Partnerships with Traditional Leaders

The collaboration with traditional leaders to coordinate VMMC activities mitigated numerous challenges regarding the traditional sectors' resistance to VMMC implementation in TMI areas. The integration of VMMC within TMI camps increased the uptake of VMMC in rural areas such as Vhembe and Nkangala.

6.2. Project 300K Challenges

6.2.1. Demand Generation

Significant reductions in the budget for demand generation activities presented numerous challenges, affecting both interpersonal communication among partners and mass media initiatives. While collaboration between NDoH and partners improved, there remained issues with the coordination and management of social mobilizers and mobilization activities. Increased efforts were required to facilitate more effective communication between stakeholders to address challenges.

The initial underperformance of Project 300K caused further concern regarding whether partners would reach their allocated targets. In response, regular meetings were held by Demand Generation partners and the NDoH Demand Generation manager to discuss demand generation contributions towards Project 300K, strengthening and coordination of

[4] Finding from the Provincial Assessments 2018 conducted in Gauteng, KwaZulu-Natal, Limpopo and Mpumalanga provinces.

initiatives and address the gaps and challenges of current strategies. Demand generation initiatives were further affected by CDC partner transitions.

Partners' delayed or non-submission of demand generation reports resulted in a lack of data-driven, evidence-based analysis of effective demand generation strategies, conversion rates, and successful district-specific initiatives. The non-use of the Monitoring and Evaluation (M&E) tool developed to track demand generation meant the effectiveness of demand generation activities could not be measured. There was a lack of consistency in the reporting of demand generation activities among some partners.

Underperforming and inflexible demand generation activities hindered progress and VMMC uptake in numerous districts and highlighted the need for improved coordination between partners and districts in the implementation of demand generation activities. Insufficient buy-in and slow VMMC uptake further delayed progress in provinces such as EC and WC. These challenges should be considered when developing and implementing demand generation strategies that target the difficult to reach adult male population. It is further recommended that the demand generation scope be focused on populations where impact of VMMC on averting HIV infections is highest.

6.2.2. Problematic and Low Performing Provinces

Delayed starts and partner transitions slowed VMMC performance in several districts. Numerous partners did not increase VMMC performance as they transitioned in to a district. This partly accounted for the decrease in performance compared to the previous year. Partners experienced challenges in NC due to the province withholding payment and/or political unrest and protests; both of which reduced the delivery of VMMC services. Similarly, service delivery in the NW province was often disrupted as a result of protests, slowing VMMC uptake.

HIV incidence were reported to have increased in the EC[1], yet VMMC service delivery and demand generation were either slowed or stagnated. Both WC and EC demonstrated a lack of engagement with partners to implement VMMC services throughout districts. Even though partners (RTC, SFH and JHPIEGO) operating within these provinces had resources in place, VMMC activities could not commence until MOUs and SLAs had been signed.

6.2.3. Failure to Target Adult Men

Project 300K failed to focus on the priority age group (15 to 34-years) by performing only 49% of total VMMCs on this group. VMMC uptake was high among the 10 to 14-year age group (45% of total VMMCs). This partly pointed to a lack of tailored demand generation initiatives targeting the priority age group. The incentives provided to social mobilizers and peer educators did little to dissuade the change of focus to the younger age group. It is recommended that new incentive schemes be developed to ensure that the performance of VMMCs have the greatest possible impact on the priority target.

6.2.4. Communication Challenges

Over the course of Project 300K, performance was hindered by a lack of vertical and horizontal communication among partners. Notably, sporadic communication between implementing partners and facility officials impeded progress and slowed responsiveness to challenges. Inefficient communication between prime partners prevented collaboration and the dissemination of good practices. It is essential that efforts to improve partners' communication be prioritized and expanded to facility and district officials. Reviews should be conducted to define priorities and challenges and implemented in the next campaign.

6.2.5. Facility and Human Resource Capacity

A major hindrance to program performance was the lack of human resources and deficits in facilities' capacity[5]. The use of clinics was often preferred over the use of hospitals for VMMC procedures by clients. In several districts, hospitals performed fewer VMMCs due to the prioritization of other medical services. This impacted the number of VMMCs done and increased the number of clients that were made to wait in long queues. The insufficient number of VMMC staff in facilities made it difficult for existing staff to focus on their defined responsibilities and were often required to undertake additional duties.

7. RECOMMENDATIONS

7.1. Demand Generation Revitalization Workshops

- The first demand generation strategy for VMMC in South Africa was circulated among all stakeholders in June, 2018. Additional revitalization workshops have been completed (post winter campaign) across all 9 provinces to inform and train stakeholders on the strategy's implementation and adaptation of initiatives to complement their respective district needs.
- A focus for impact approach needs to be adopted in order to avert new HIV infections within the 15 to 34-year age group. Demand generation initiatives should be informed by barriers and enablers to VMMC among men aged 15 to 34 years.
- In order to maximize the impact of VMMC resources and efforts on HIV incidence and infections averted, a detailed understanding of the target population is required.

7.2. Moving Towards Program Sustainability

- Provinces should be involved in data management processes to increase responsibility of data monitoring processes and improve government ownership of

[5] Finding from the Provincial Assessments 2018 conducted in Gauteng, KwaZulu-Natal, Limpopo and Mpumalanga provinces.

the VMMC program. This will allow for NDoH to sustain the VMMC program without being over-reliant on external funding and support.

- District and provincial officials should have greater responsibility for the monitoring of data processes to move towards more sustainable data management processes.

7.3. Planning for Transitions

- Improved planning for and coordination of PEPFAR partner transitions in and out of districts is required to ensure that VMMC services are not disrupted.
- Planning should occur three months prior to the transition commencement date and a transition plan be in place to ensure adequate partner readiness.

7.4. Improved Target Setting

- Since district officials are knowledgeable on their respective districts' target populations, their input would be valuable in ensuring appropriate and reasonable targets are sets**.**
- The increased involvement of district officials in target setting practices (including partners) may result in more evidence-based target allocations for districts.
- Planning for winter and summer campaigns should be divided in micro-plans to allow for more targeted planning of campaigns and allocation of resources.

7.5. Increased Training

- Data discrepancies and poor data reporting quality among partner-contracted general practitioners indicated the need for increased training of partners and general practitioners involved in data management processes. Despite tools being in place to improve data collection and reporting, challenges with data quality is still evident

7.6. Increased Human Resources

- The deficit in human resources at VMMC facilities and clinics put strain on already overworked staff members. Increasing the number of nurses, general practitioners and clinical associates will reduce many of these challenges.
- The monitoring and managing of health practitioners' output will require additional admin and data staff.
- The training of professional nurses to conduct VMMCs will alleviate much of the demand placed on general practitioners and clinical associates, especially during the high demand season as suggested by districts
- Investigations into the most efficient and highest impact service delivery models should be done to inform future campaigns.

7.7. Implementation of Surgical Devices

- Marketing surgical aid such as CircumQ to RT35 provinces and districts and the potential introduction to the traditional sector as a surgical aid has the potential to improve quality and reduce safety concerns of TMIs.
- Training on device use and monitoring processes will need to be developed and implemented.

References

1. HSRC. (2014). *South African National HIV Prevalence, Incidence and Behaviour Survey, 2012.* Cape Town, HSRC Press.
2. Country Operational Plan (COP) 2015