Medical Male Circumcision
Baseline Assessments Report

Department of Health & Clinton Health Access Initiative, Inc.

Submitted by: AQUITY Innovations

4 August 2017

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

CLINTON
HEALTH ACCESS
INITIATIVE

AQUITY
INNOVATIONS
Access and Quality through Innovations and Technology

ACKNOWLEDGEMENTS

AQUITY Innovations would like to acknowledge the MMC coordinator and MMC teams from the National Department of Health, KwaZulu-Natal Provincial Department of Health for their support, leadership during the baseline assessment and the Continuous Quality Improvement follow-on visits to selected facilities in KwaZulu-Natal. The cooperation and support received from various MMC and HAST District Coordinators in the nine targeted districts of KwaZulu-Natal made this work possible. The assessment was made even more successful and productive through their active participation in the baseline assessment process itself. The assessment team received technical support, guidance and logistical support from MMC coordinators and staff from CHAI which made this assessment a success. Appreciation also goes to facility managers and their teams, without whose cooperation, this assessment would not have been possible. In many districts and facilities that the assessment team went to, the cooperation of various implementing partners who are mentioned in this report, is acknowledged. Not only did they display commitment to their work but they also cooperated with the assessment team and welcomed interventions and feedback aimed at improving MMC service delivery.

This report was prepared by AQUITY Innovations NPC. The project was was funded by Clinton Health Access Initiative, Inc.

Design and layout: www.itldesign.co.za

Medical Male Circumcision
Baseline Assessments Report

Department of Health & Clinton Health Access Initiative, Inc.

CONTENTS

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

CLINTON
HEALTH ACCESS
INITIATIVE

AQUITY
INNOVATIONS
Access and Quality through Innovations and Technology

ACRONYMS

AIDS	Acquired immunodeficiency syndrome
AE	Adverse events
AFC	Assess, feedback and coach
CHAI	Clinton Health Access Initiative, Inc.
CHC	Community health center
CME	Continuous medical education
CQI	Continuous quality improvement
HAST	HIV&AIDS, STI and TB
HCT	HIV counseling and testing
HIV	Human immunodeficiency virus
IEC	Information, education and communication
MMC	Medical male circumcision
NDoH	National Department of Health
PMDS	Performance Management Development System Performance Management Development System
P/N	Professional nurse
QA	Quality assurance
SACTWU	Southern African Clothing & Textile Workers' Union
SOPs	Standard operating procedures
SRH	Sexual reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
WHO	World Health Organization

EXECUTIVE SUMMARY

As part of efforts to ensure provision of safe male circumcision in South Africa, AQUITY Innovations was contracted by the Clinton Health Access Initiative, Inc., to provide support services to the National Department of Health by conducting Medical Male Circumcision baseline assessments in selected facilities in KwaZulu-Natal. These assessments are part of the MMC Directorate's efforts to strengthen and scale up Continuous Quality Improvement activities nationally.

Goals and objectives: The overall goals of the MMC baseline assessments were to gain an understanding of how to measure and improve the current quality of MMC services, to establish the level of MMC service delivery and determine gaps in the content of care. The outcome of these assessments will also inform areas of prioritization and the necessary interventions required. The outcomes of these assessments will further be used by the NDoH as a benchmark to determine if MMC sites benefited from interventions following CQI implementation.

Goals of the MMC baseline assessments were:

- To improve overall delivery of MMC services.
- To ensure the safe provision of services through utilization of evidence-based interventions.

The objectives of the baseline assessments were to:

- Identify existing site level gaps and challenges.
- Determine if the MMC facilities meet the acceptable minimum standards of care.
- Use the findings to inform interventions for strengthening the programme.

Target Sites: A total of 92 MMC sites were identified for the baseline assessment. In selecting these sites, the NDoH gave priority to PEPFAR transitioned districts and those facilities not already receiving any CQI support. The baseline assessment was conducted in 86 facilities and of these, 6 received a follow-on CQI visit to keep the total number of sites visited for assessment at 92. Wherever possible, AQUITY conducted these assessments in close collaboration with the assigned MMC Project Management Unit Coordinator from province or district level.

Method and Approach to assessment: The assessment approach adopted by the AQUITY team was the Assess, Feedback and Coach approach to conducting the baseline assessment. This three-pronged developmental approach required the assessment team to utilize the assessment process not only to identify gaps in MMC service delivery but to identify strengths and provide immediate feedback and encouragement to maintain the standards. The team provided immediate feedback on identified gaps and, wherever possible and appropriate, guided the facility staff to address gaps on-site or develop a plan on how to address those gaps post assessment.

Facilities were assessed on adherence to minimum quality standards through various methods, including interviews with facility staff, interviews with providers and implementing partner teams and through observation of providers when performing their duties in relation to MMC services. Client files and MMC records were reviewed. Using a harmonized MMC baseline tool eight standards assessed; these ars follows:

LEADERSHIP AND PLANNING

MANAGEMENT SYSTEMS

SUPPLIES, EQUIPMENT, ENVIRONMENT AND EMERGENCY

REGISTRATION, COMMUNICATION TO CLIENTS AND INFORMATION EDUCATION AND COMMUNICATION

INDIVIDUAL COUNSELLING AND HIV TESTING FOR MMC CLIENTS

MONITORING AND EVALUATION

MALE CIRCUMCISION SURGICAL PROCEDURE (AND OR DEVICE TARA KLAMP)

INFECTION PREVENTION

KEY FINDINGS:

- Three districts performed above the provincial average of 75% across all standards assessed. The highest performance being reported under procedure, device, infection control and supplies ranking high with an average of 87% being achieved. Poor results on leadership and planning as well as monitoring and evaluation weighed down the overall performance of the district from a consultative support to the light support grade.
- Overall performance on each of the standards was as follows:
  - *Leadership and planning:* The overall provincial performance on this standard was a low 46%. Five districts scored between 30% and 47% and these were: Amajuba, eThekwini, uMkhanyakude, uMgungundlovu and uMzinyathi districts. Four districts, namely iLembe, King Cetshwayo, Ugu and Zululand, scored between 50% and 60%.
  - *Management systems:* The overall provincial performance on this standard was average, ranging between 53% and 80%. Ugu, eThekwini, Amajuba, uMgungundlovu, uMkhanyakude, uMzinyathi, iLembe and King Cetshwayo scored between 53% and 76%. Zululand performed well at 80%.
  - *Registration, communication with clients and IEC material:* The overall score of the province under this standard was 73%. The lowest scoring district was Amajuba (60%) and the highest was King Cetshwayo (86%). The rest of the districts averaged from 60% to 73%.
  - *Individual counseling and HIV testing for MMC clients:* The overall provincial score under this standard was a high 85%. Eight districts scored well, with scores ranging from 82% to 92%. Only one district (Amajuba) had a relatively low score of 67%.
  - *Monitoring and evaluation:* The provincial performance on this standard was an average 56%. District scores ranged between 44% and 66%. The lowest scoring district was Ugu with 44%, followed by uMkhanyakude at 48%. Ugu had four out of seven facilities scoring under 40%. The highest score was Verulam Clinic in eThekwini (97%), compared to the district score of 52%.
  - *Supplies, equipment, environment and emergency:* The overall provincial performance on this service standard was 82%, with facility performance ranging between 75% and 88%. Three districts, namely, Amajuba, King Cetshwayo and Ugu, scored between 75% and 79%.
  - *Male circumcision surgical and device (Tara KLamp):* The overall provincial performance for Male Circumcision Surgical under this standard was a high 89%. Seven districts scored extremely well, with scores ranging from 90% to 98%. The other two districts had scores ranging between 80% (Amajuba) and 69% (Ugu). With regards to the device, four facilities were using the device in the form of the Tara KLamp, with three facilities in the Ugu district and one in uMgungundlovu district. The scores ranged between 86% and 100%.
  - *Infection prevention:* Eight districts performed well, scoring between 82% and 92%. The other district (uMkhanyakude) had an average score of 79%.

KEY RECOMMENDATIONS FOR THE NDOH IN COLLABORATION WITH THE KZN PROVINCIAL MMC TEAM ARE:

- To conduct a comprehensive provincial MMC infrastructural audit of facilities assessed in order to develop an infrastructure improvement plan to address space and other infection prevention gaps identified.
- Development of a comprehensive training package for facility managers and staff involved in MMC service delivery. This training should also cover critical guidelines and policies for MMC. Cross-pollination of ideas and working methods may be achieved during district training workshops.
- To conduct urgent training for facility clinical staff on basic and advanced life support, including appropriate use of emergency trolley equipment and drugs.
- Improve MMC data collection and reporting activities by developing a comprehensive MMC Register covering booking information, follow-up and AEs.
- Development of a provincial client follow-up and AE surveillance systems with a tracing and tracking element for all clients who have undergone the procedure at different facilities. Such a system would assist in mitigating AEs.
- Urgently develop MMC IEC materials for both MMC and sexual reproductive health, SOPs and job aids for different categories of staff involved in MMC service delivery.
- Develop a protocol for managing MMC stakeholder relations and cooperation at facility level.
- Establish district-based MMC CQI teams in order to address gaps identified during the baseline assessment process and to promote adherence to MMC standards.

1. INTRODUCTION

As part of efforts to ensure provision of safe male circumcision in South Africa, AQUITY Innovations (hereafter referred to as AQUITY) was contracted by the Clinton Health Access Initiative, Inc. (CHAI), to provide support services to the National Department of Health (NDoH) by conducting Medical Male Circumcision (MMC) baseline assessments in selected facilities in KwaZulu-Natal. These assessments are part of the MMC Directorate's efforts to strengthen and scale up Continuous Quality Improvement (CQI) activities nationally.

AQUITY is a Section 21 not-for-profit organization established in 2010 and based in Pretoria, with an overall mission to improve the quality of health and social services in Southern Africa. AQUITY's focus is on designing programme evaluations, assessments, developing innovative technological health and social development solutions, health training and facility mentorship, health communication and behavior change programmes and research activities on various components of development, but in particular on public health issues such as tuberculosis (TB), HIV/AIDS and diabetes mellitus. AQUITY also has previous experience in conducting MMC baseline assessments.

CHAI is a global health organization committed to strengthening integrated health systems in the developing world and expanding access to care and treatment for HIV/AIDS, malaria and TB. CHAI's solution-oriented approach focuses on improving market dynamics for medicines and diagnostics; lowering prices for treatment; accelerating access to life-saving technologies; and helping governments build the capacity required for high-quality care and treatment programmes.

2. PROJECT GOALS, OBJECTIVES AND DELIVERABLES

The overall goals of the MMC baseline assessments were to gain an understanding of how to measure and improve the current quality of MMC services, to establish the level of MMC service delivery and determine gaps in the content of care. The outcome of these assessments will also inform areas of prioritization and the necessary interventions required. The outcomes of these assessments will further be used by the NDoH as a benchmark to determine if MMC sites benefited from interventions following CQI implementation.

Specific goals of the MMC baseline assessments were:

- To improve overall delivery of MMC services.
- To ensure the safe provision of services through utilization of evidence-based interventions.

The objectives of the baseline assessments were to:

- Identify existing site level gaps and challenges.
- Determine if the MMC facilities meet the acceptable minimum standards of care.
- Use the findings to inform interventions for strengthening the programme.

The following project deliverables were expected from AQUITY:

- Baseline assessments conducted in a total of 92 facilities using a harmonized standard CQI tool.
- Copies of monthly facility reports detailing successes, challenges, site level gaps, provisional interventions recommended and a scoresheet for each site assessed.
- Final combined report and dashboard of all facilities assessed.

3. METHOD AND APPROACH

3.1 Project implementation site and targets

A total of 92 MMC sites were initially identified for the baseline assessment. In selecting these sites, the NDoH gave priority to PEPFAR transitioned districts and those facilities not already receiving any CQI support. However, during the course of the assessment process, 6 of these were found to be not performing any MMC and therefore not active sites for assessments. Following consultations with involved stakeholders, it was decided that 6 of the facilities be chosen from those that the baseline assessments and be subjected to a single CQI support visit to determine if there had been any changes in performance on those service areas where gaps had been identified during the initial baseline assessment. This would then keep the total number of 92 sites. Wherever possible, AQUITY conducted these assessments in close collaboration with the assigned MMC Project Management Unit Coordinator from province or district level.

Table 1: No of MMC sites assessed by category and district

District	No. of Hospitals	No. of CHCs	No. of Clinics	No. of CQI follow-on visits	Total
Amajuba	2	1	8	3	14
eThekwini	4	-	15	1	20
iLembe	4	2	8		14
King Cetshwayo (formerly uThungulu)	5	1	-		6
Ugu	1	1	5		7
uMgungundlovu	3	2	6	1	12
uMzinyathi	2	1	8	1	12
uMkhanyakude	-	-	4		4
Zululand	2	-	1		3
Total	**23**	**8**	**55**	**6**	**92**

Refer to Annexure 1 for full list of facilities.

3.2 Preparations and assessment Methodology

AQUITY was introduced to the NDoH MMC team on the 7th March 2017. At that meeting, the Department undertook to arrange to introduce AQUITY to the Provincial MMC team. That introductory meeting took place on the 15th March 2017. The provincial MMC Coordinator and the team welcomed AQUITY and undertook to assist in making appointments with a few facilities to kick-start the assessment process during the month of March.

3.3 Assessment Tools

During the month of March, AQUITY worked on harmonizing the assessment tool which was provided by the NDoH. This harmonized tool was subsequently approved by the Department. AQUITY also developed the following tools:

a. Excel Spreadsheet Capturing Module of the assessment tool.
b. MMC Dashboard which calculates the overall scores obtained by the facility for each standard. The dashboard indicates performance by showing areas of under-performance (i.e. an area requiring urgent corrective action); moderate performance (when the performance is fair but with areas for improvement); and good performance (i.e. best practice requiring ongoing sustainability to adherence to the high standards of performance).
c. Action Plan matrix which is used to document any gaps identified during an assessment for each standard. This tool is used to provide feedback to the facility management team on the day of assessment.

3.4 Assessment Team

The AQUITY assessment team was made up of individuals with varying levels of experience, from working in MMC projects to having vast experience working in other health programmes at district and provincial levels. The assessment team was made up of six provincial coordinators who had clinical backgrounds and had experience with assessments, evaluations and were knowledgeable about HIV programming and MMC programmes at facility level. They also had management experience and had previous experience in coaching and mentoring staff. The team was supported by a technical team with a wide range of expertise including counseling, organizational development, monitoring and evaluation, data capturing, policy development, training and capacity development. The assessment team was also oriented on conducting this baseline assessment. Teams visiting facilities were made up of three members. Where dates of site visits made it impossible for coordinators to work in a team of three, they worked in pairs, with added support from non-clinical and technical support team members. At all times during the assessment, AQUITY ensured that only members with clinical experience were assessing areas of Infection Control, Surgical Procedure, Emergency and Environment, Medicines and Commodities. This was also made possible by ensuring that two members with clinical experience were part of the team at all times.

3.5 Assessment Approach

The assessment of facilities took place from the 29th March 2017 until the end of July 2017.

The assessment approach adopted by the AQUITY team was the Assess, Feedback and Coach (AFC) approach to conducting the baseline assessment. This three-pronged developmental approach required the assessment team to utilize the assessment process not only to identify gaps in MMC service delivery but to identify strengths and provide immediate feedback and encouragement to maintain the standards. The team provided immediate feedback on identified gaps and, wherever possible and appropriate, guided the facility staff to address gaps on-site or develop a plan on how to address those gaps post assessment. The assessment team sought "teachable moments" and seized any opportunity that presented itself to offer insight to facility staff and teams on-site. Facility staff were supported and encouraged to be proactive in thinking about service improvement and making suggestions that were realistic for their circumstances. Coaching was provided where the assessment team guided and helped staff to correct errors on the spot, thus offering immediate skills transfer. This was done sensitively with due regard to ensuring staff comfort and respect for clients, in cases where corrective measures had to be implemented during the course of attending to the client.

The team assessed the facility or site adherence to minimum quality standards through various methods:

- Conducting interviews with facility staff.
- Interviews with providers and implementing partner teams.
- Observing providers when performing their duties in relation to MMC services.
- Walking alongside the client as a way to experience what clients go through and sensing what they could be feeling and giving feedback, e.g. walking in the rain with the client as he moved from one MMC point to the other.
- Review of client files and records.
- Review of facility records and policy documents.

At each site assessed, the team requested the participation of the facility manager or, when not available, a senior member of the management team delegated by the facility manager. Staff involved in MMC service delivery were also requested to be part of the process. The purpose of the assessment was introduced at the beginning of the assessment and, at the end of the assessment, the team provided detailed feedback on each of the areas assessed to the facility team, and where possible, implementing partners were invited to attend the feedback sessions.

3.6 Standards Assessed

Using the harmonized assessment tool, the baseline assessments were conducted to determine the quality of services provided at identified sites to assess adherence to the minimum standards as defined by the World Health Organization (WHO), NDoH and PEPFAR guidelines and protocols for reducing MMC-related complications.

Eight broad areas/standards of the services provided were assessed, namely:

i) Leadership and planning
ii) Management systems
iii) Supplies, equipment, environment and emergency
iv) Registration, group education and information, education and communication (IEC) materials
v) Individual counseling and HIV testing for MMC clients
vi) Monitoring and evaluation
vii) Male circumcision surgical procedure and/or device (Tara KLamp)
viii) Infection prevention and control

The assessment sought:

a. To identify strengths and gaps in service provision using the standardized tool.
b. To identify existing opportunities for improved service delivery.
c. To identify possible threats to MMC service delivery.
d. To use the findings to:
   - Make recommendations and support facilities to plan for improved MMC service delivery.
   - Provide on-site guidance, coaching, support and practical interventions with the aim of addressing immediate gaps.
   - Determine the facility's eligibility for the type of CQI support and identify possible/critical areas for CQI support.

4. BASELINE ASSESSMENTS FINDINGS

4.1 Implementing Partners

Throughout the province, facilities were mainly supported by five implementing partners, namely: Right to Care, INSIMU, Southern African Clothing & Textile Workers' Union (SACTWU), New Start and Care Works.

Table 2 : MMC implementing partners, their roles and sites supported

District	Implementing Partner	Type of Support	No. and Names of Sites supported
Amajuba	No NGO implementing partner – Provincial DoH roving teams support facilities	• Surgical procedures • Supplies and commodities • Recruitment and follow-up	4 sites (Madadeni Hospital, Osizweni 2 Clinic, Mndozo Clinic, Madadeni Clinic 1)
	Contracted/sessional doctors	• Surgical Procedures	2 sites (Dannhauser CHC), Osizweni 2 Clinic)
	No NGO – facility staff	• All aspects related to MMC service delivery	1 site (Niemeyer Hospital)
eThekwini	Right to Care	• Mobilize MMC clients • Transport clients to and from MMC sites • Provide admin, counseling and pre, post and surgical staff, as well as equipment to perform MMC • Follow-ups	4 sites (Illovo, Umnini, King Dinuzulu, St Aidens Hospital)
	SACTWU	• Mobilize MMC clients • Transport clients to and from MMC sites • Provide admin, counseling and pre, post and surgical staff, as well as equipment to perform MMC • Follow-ups	8 sites (Prince Cyril Zulu, KwaDabeka, Mpola, Klaarwater, Mpumalanga, Verulam, Halley Stott, Fredville)
	Care Works	• MMC procedure for clients under 15 years	1 site (Umzamo Clinic)
	No NGO implementing partner	• Facility staff	2 sites (Osindisweni Hospital, Prince Mshiyeni)
iLembe	INSIMU	• Mobilize MMC clients • Transport clients to and from MMC sites • Provide admin, counseling and pre, post and surgical staff, as well as equipment to perform MMC • Follow-ups	10 sites (Ndwedwe, Wosiyane, Mwolokohlo, Groutville, Sundumbili, Shakaskraal, Umphumulo Hospital, Thafamasi, Isithebe, KwaDukuza)
	No NGO supporting partner – facilities integrated MMC and conducted their own procedures	• Facility staff – all MMC-related services	3 sites (Stanger, Untunjambili, Montobello)
	Sessional doctor from nearby hospital (Stanger Hospital)	• Surgical procedure	1 site (Darnall)

King Cetshwayo	SACTWU	• Mobilize MMC clients • Transport clients to and from MMC sites • Provide admin, counseling and pre, post and surgical staff, as well as equipment to perform MMC • Follow-ups	5 sites (Mbongolwane, Enseleni, St Mary's KwaMagwaza, Ekhombe, Inkadla)
	Care Works	• Client recruitment	1 site (Nseleni)
	INSIMU	• Mobilize MMC clients • Transport clients to and from MMC sites • Provide admin, counseling and pre, post and surgical staff, as well as equipment to perform MMC • Follow-ups	1 site (Catherine Booth)
Ugu	Right to Care	• Mobilize MMC clients • Transport clients to and from MMC sites • Provide admin, counseling and pre, post and surgical staff, as well as equipment to perform MMC • Follow-ups	1 site (Dududu)
	SACTWU	• Mobilize MMC clients • Transport clients to and from MMC sites • Provide admin, counseling and pre, post and surgical staff, as well as equipment to perform MMC • Follow-ups	1 site (KwaMbendu)
	Provincial DoH roving team	• Surgical procedures • Supplies and commodities • Recruitment and follow-ups	3 sites (Gqayinyanga, KwaMbotho, Turton)
uMgungundlovu	New Start	• Mobilize MMC clients • Transport clients to and from MMC sites • Provide admin, counseling and pre, post and surgical staff, as well as equipment to perform MMC • Follow-ups	4 sites (Balgowan, Gomane, Mpophomeni, Howick)
	SACTWU	• Mobilize MMC clients • Transport clients to and from MMC sites • Provide admin, counseling and pre, post and surgical staff, as well as equipment to perform MMC • Follow-ups	4 sites (Appelsbosch, Bruntville, Embo, Baniyena)
	No NGO implementing partner	• Facilities own MMC services, use own personnel to perform all MMC-related services	3 sites (Northdale, Edendale, Mbalenhle)
uMkhanyakude	SACTWU	• Mobilize MMC clients • Transport clients to and from MMC sites • Provide admin, counseling and pre, post and surgical staff, as well as equipment to perform MMC • Follow-ups	4 sites (Mbazwana, Nkundusi, Madwaleni, Macabuzela)
uMzinyathi	Sessional doctor from nearby hospital	• Surgical procedure	4 sites (Charles Johnson, Kranskop, Rorkesdrift, Qinelani and Pomeroy)
Zululand	Right to Care	• Mobilize MMC clients • Transport clients to and from MMC sites • Provide admin, counseling and pre, post and surgical staff, as well as equipment to perform MMC • Follow-ups	1 site (Itshelejuba Hospital)
	No NGO implementing partner	• Facility staff conducts all MMC-related services	1 site (Ceza Hospital)
	No NGO implementing partner – Provincial DoH roving team	• Surgical procedures • Supplies and commodities • Recruitment and follow-ups	1 site (Ulundi A Clinic)

4.2 Assessment Results

THE PROVINCIAL PICTURE

The baseline assessment covered the facilities in the nine districts of the province. Three districts performed above the provincial average of 75% across all standards assessed. The highest performance being reported under procedure, device, infection control and supplies ranking high with an average of 87% being achieved. Poor results on leadership and planning as well as monitoring and evaluation weighed down the overall performance of the district from a consultative support to the light support grade. Below is the summary table consolidating the facility results to the provincial picture below.

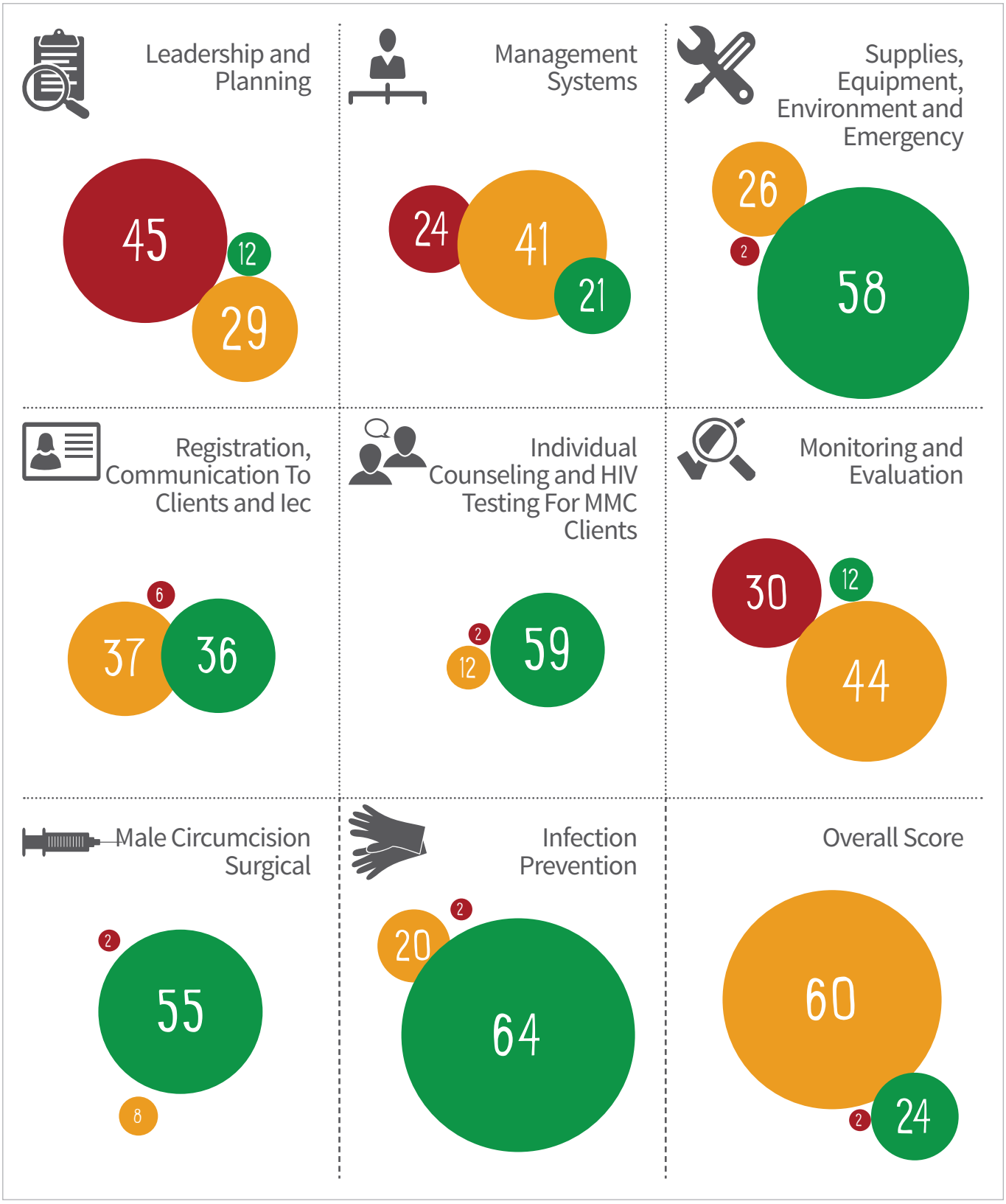
Provincial Dashboard Summary

Assessment Quality Standards Areas (percentage)

DISTRICT	Number of district Sites	Leadership and planning	Management systems	Supplies, equipment, environment and emergency	Registration, communication to clients and IEC	Individual counselling and HIV testing for MMC clients	Monitoring and evaluation	Male circumcision surgical procedure	Device	Infection prevention	Overall performance	Type of support
Amajuba	11	45	62	78	60	67	57	80		82	66	Light
eThekwini	19	42	55	87	71	97	52	98		92	74	Light
iLembe	14	50	74	84	70	87	58	93		88	76	Light
King Cetshwayo	6	60	76	76	86	92	63	94		91	80	Light
Ugu	7	50	53	75	65	87	44	69	86	88	68	Intensive
uMgungundlovu	4	30	60	83	70	82	48	96		79	68	Light
uMzinyathi	11	36	62	88	84	82	60	98	100	86	77	Light
uMkhanyakude	11	47	64	88	73	89	60	92		83	74	Light
Zululand	3	53	80	82	81	88	66	90		89	79	Light
PROVINCIAL SCORE	**86**	**46**	**65**	**82**	**73**	**85**	**56**	**90**	**93**	**86**	**75**	Light

KEY	<50%	50% - 79%	80% - 100%	Not assessed

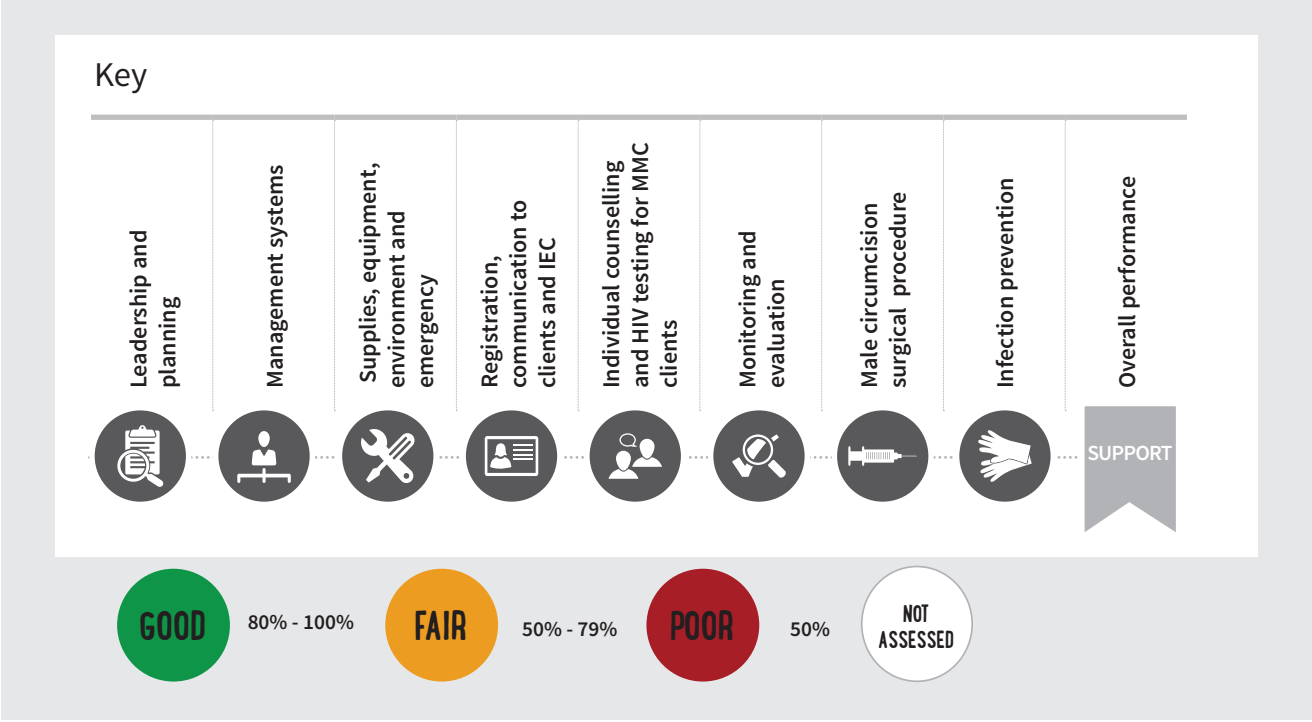
Number of facilities scoring good, fair, poor on each standard



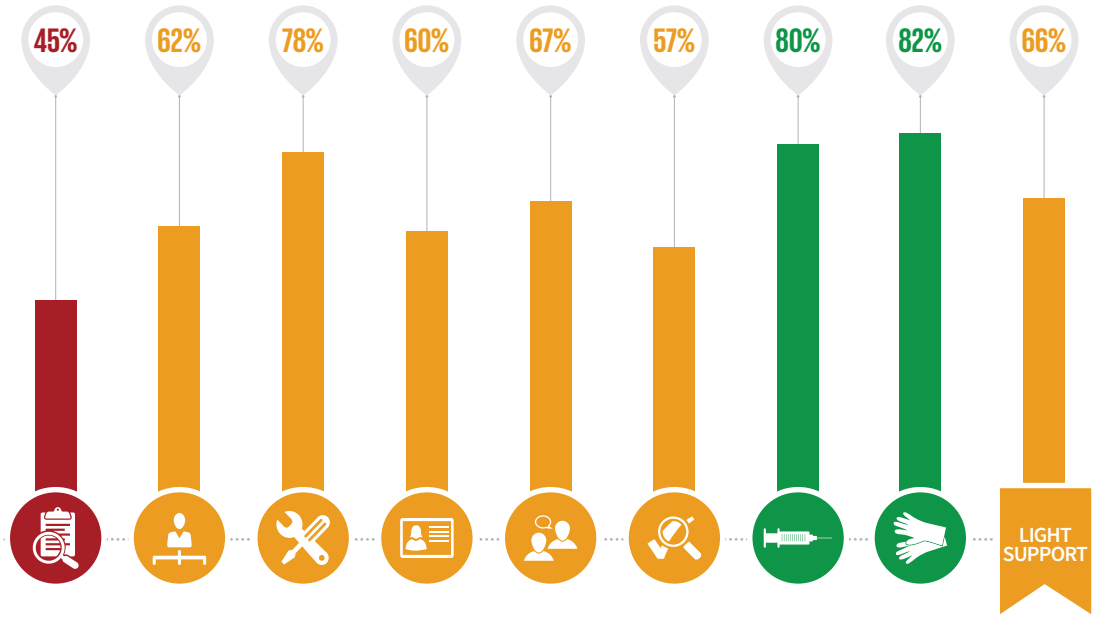
A DISTRICT PROFILE: FACILITIES AT A GLANCE

The assessment was conducted in nine districts of KwaZulu-Natal as indicated in Table 1. The assessment team has taken the approach of not just presenting findings by facility performance only, but also presenting a picture of facility performance by district. This has been done deliberately to allow the province to obtain an analytic picture of the district performance, something AQUITY hopes will assist district MMC coordinators to pick up good practice sites for scaling up interventions as well as to structure their support efforts to facilities at district level.

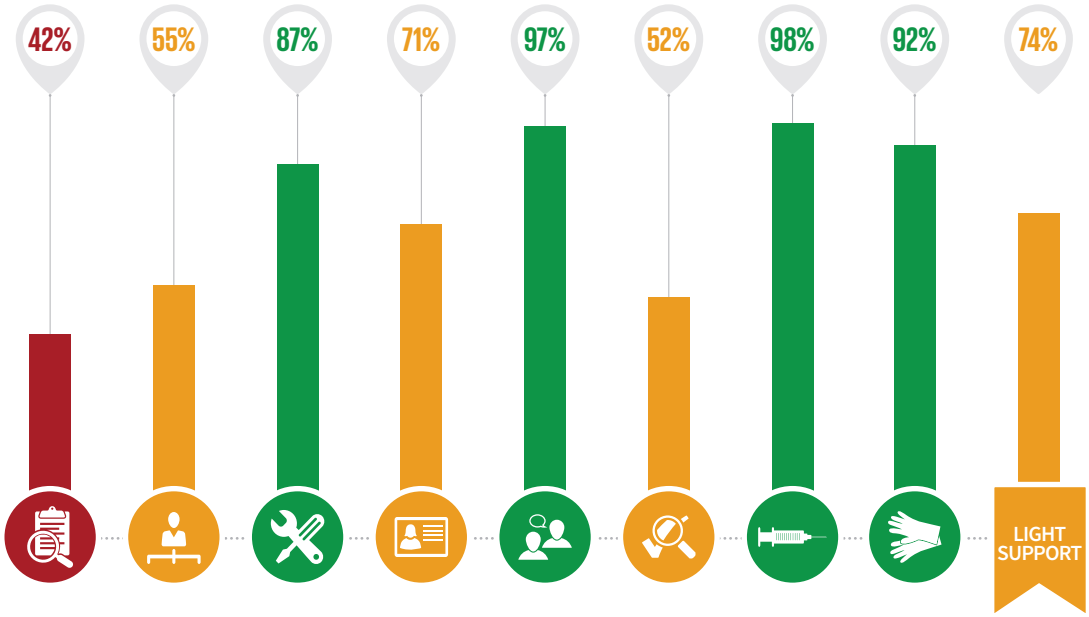
The following diagrams present the total scores on each standard per district. Detailed tables of each facility performance are available in Annexure 2.



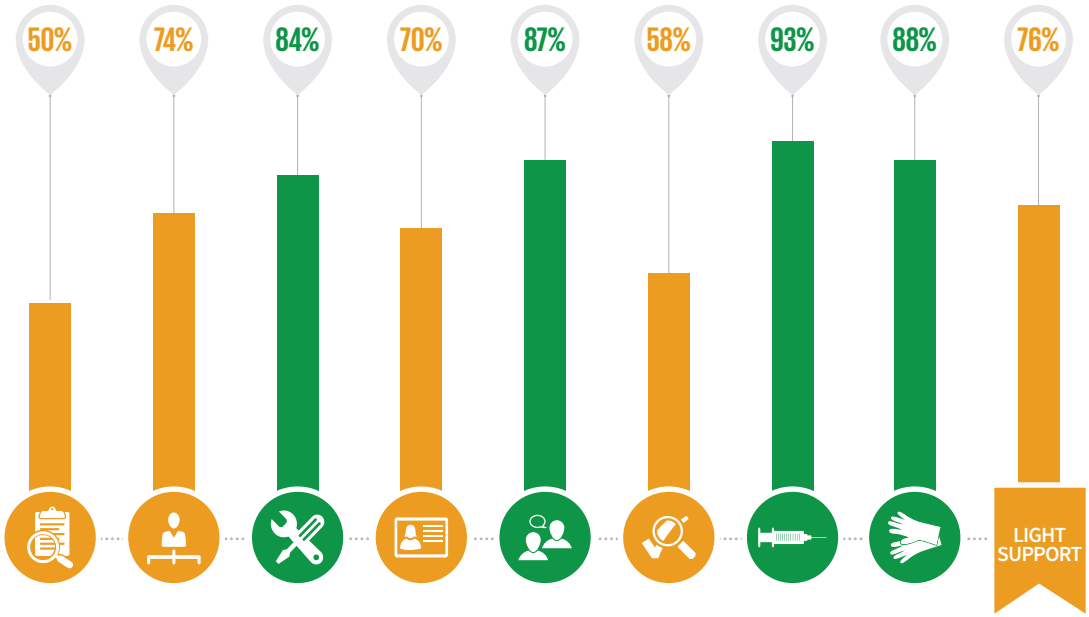
Amajuba District



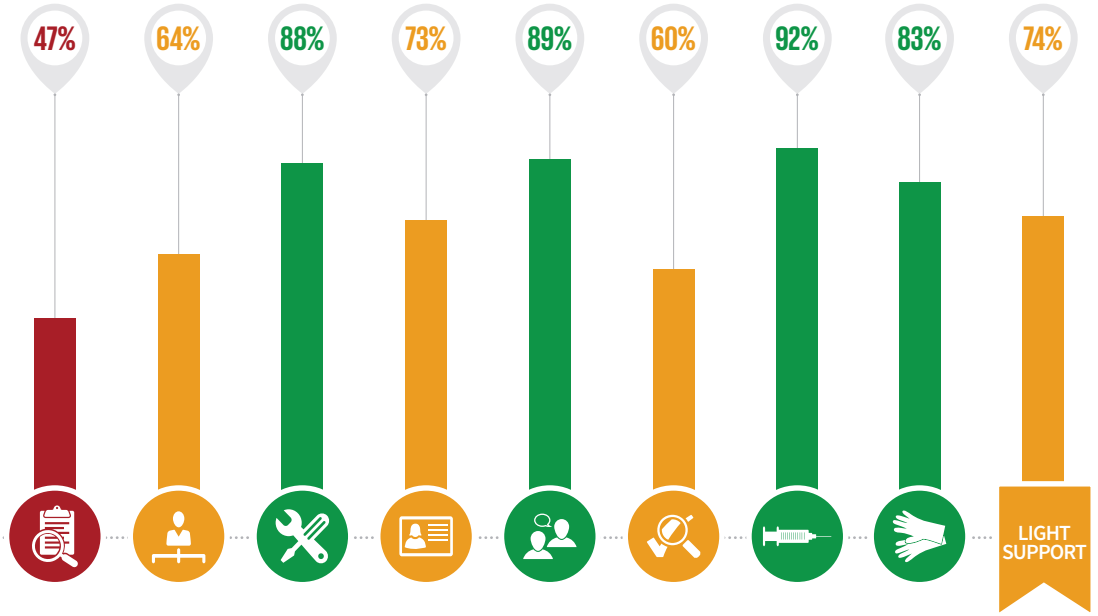
eThekwini District



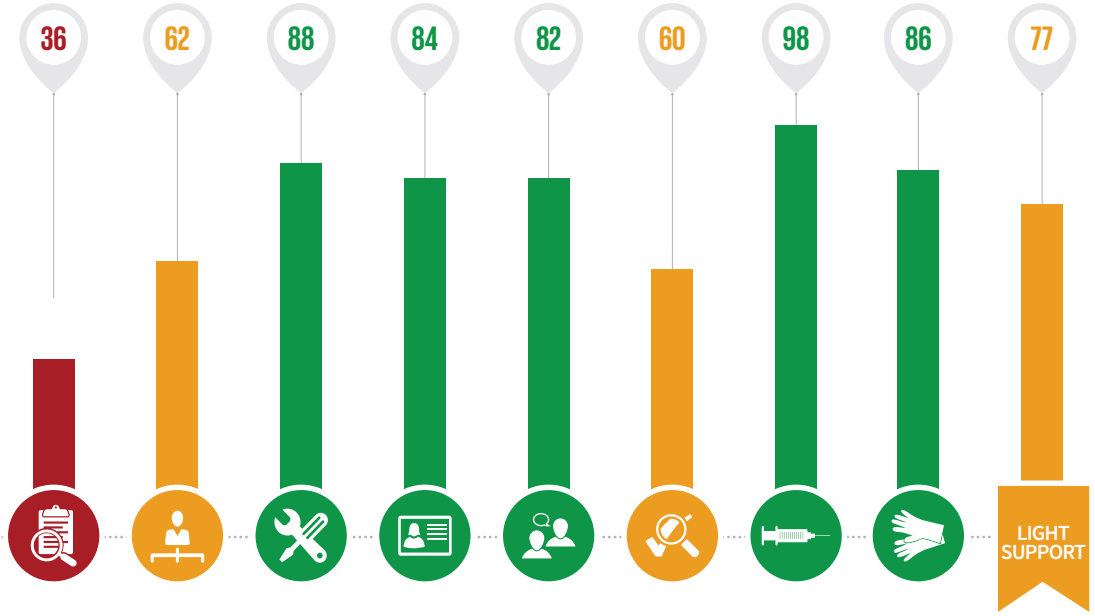
iLembe District



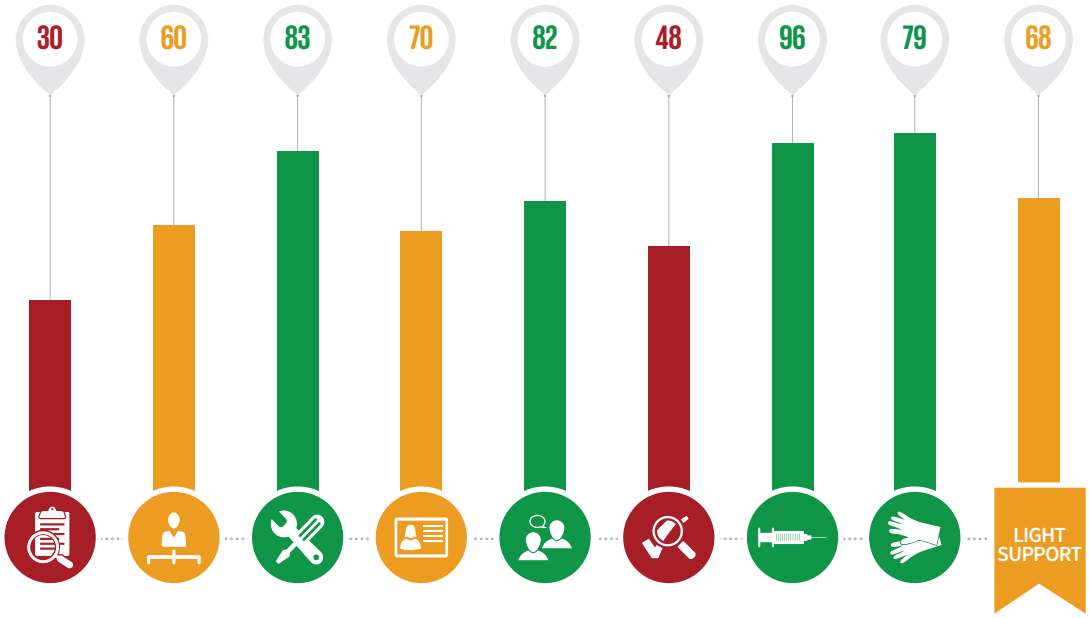
uMzinyathi District



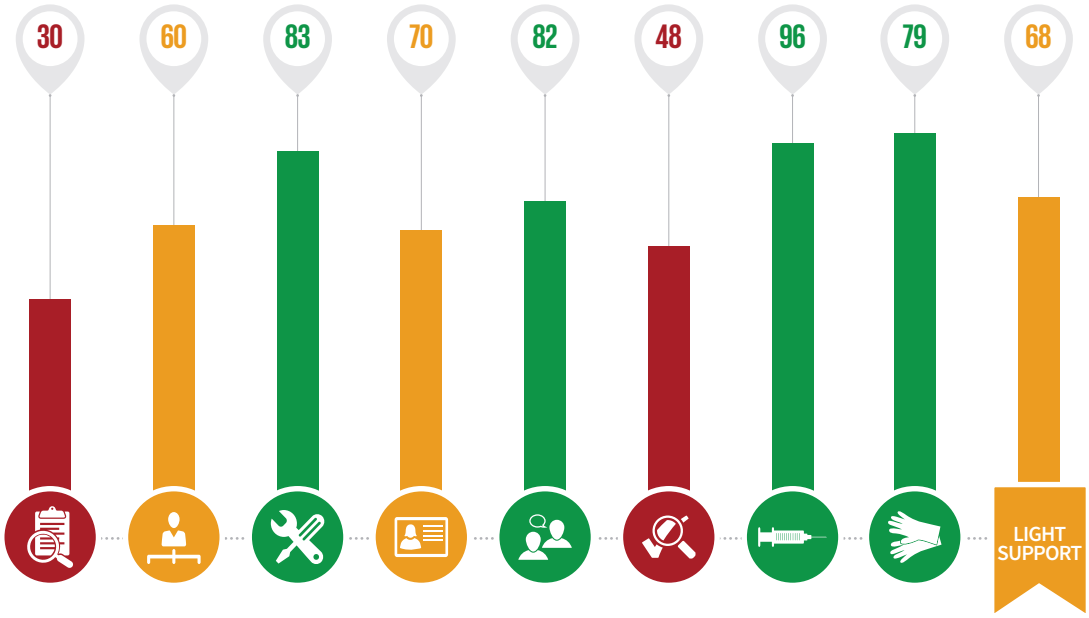
uMgungundlovu District



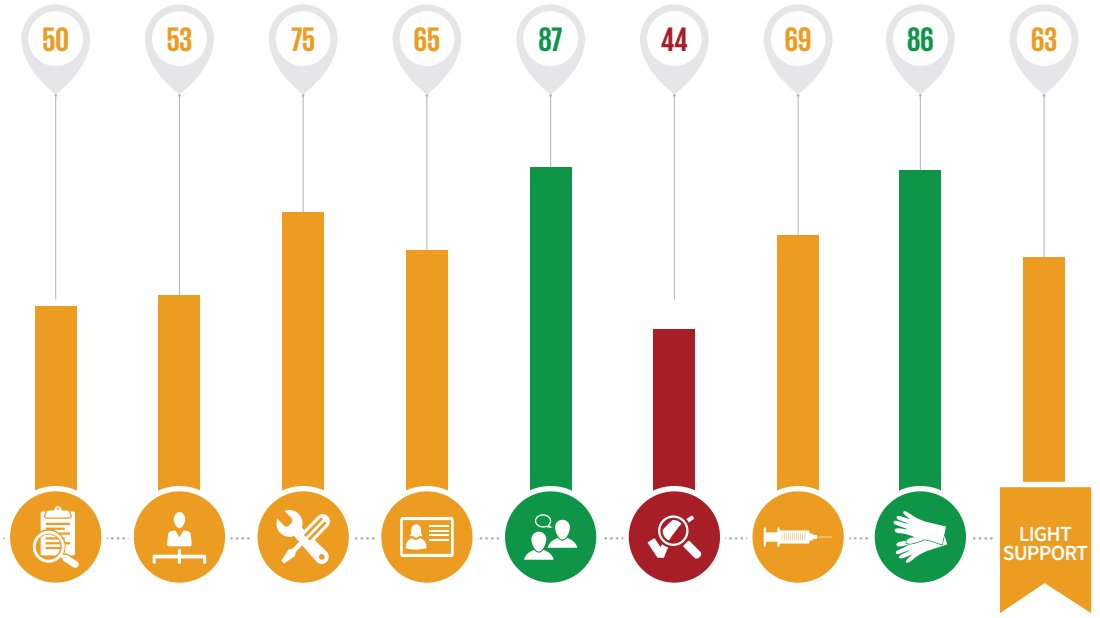
uMkhanyakude District



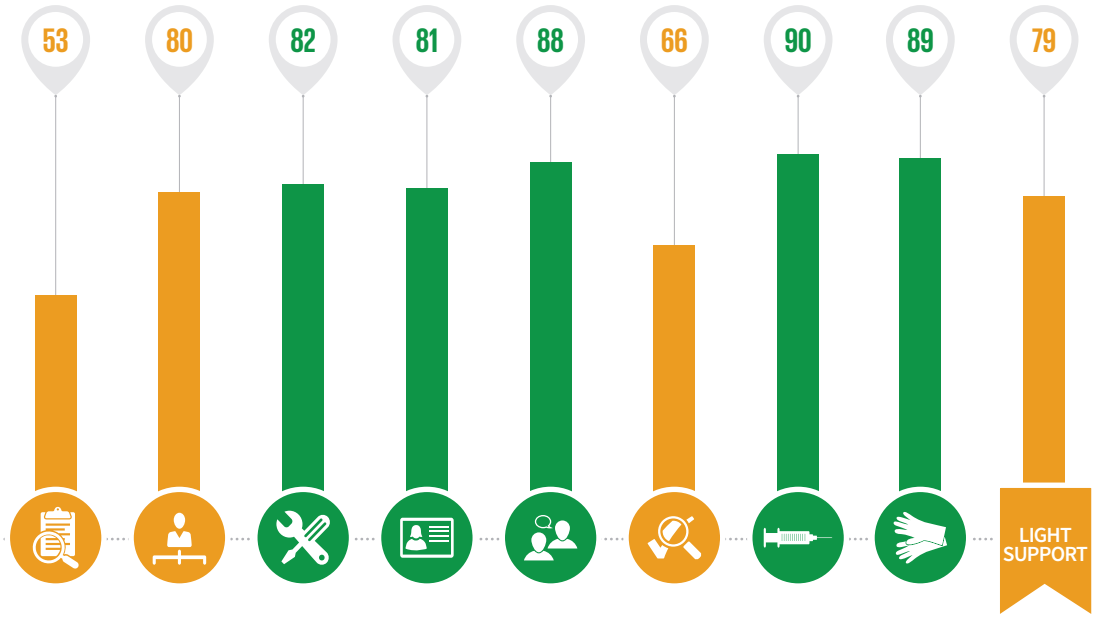
King Cetshwayo District (formerly uThungulu)



Ugu District



Zululand District



DETAILED LOOK AT FINDINGS

A. LEADERSHIP AND PLANNING

In this service standard, facilities were assessed to ascertain the following:

- Involvement of management structures, both from district and facility level, in providing strategic direction through proactive leadership, planning and mentoring.
- Availability of catchment area maps.
- Mapping of areas for social mobilization of clients for MMC.
- Facility knowledge of site budgets.
- Knowledge of population size disaggregated by gender and age, cultural practices and risk behaviors predisposing people to HIV infections.

The overall provincial performance on this standard was a low 46%. Five districts scored between 30% and 47% and these were: Amajuba, eThekwini, uMkhanyakude, uMgungundlovu and uMzinyathi districts. Four districts, namely iLembe, King Cetshwayo, Ugu and Zululand, scored between 50% and 60%.

Critical gaps were found in the following areas:

Catchment area maps and population characteristics

Many of the MMC facilities assessed did not have catchment area maps, and those facilities who did have these maps, did not have mobilization areas reflected on the maps. The facilities also largely did not have population characteristics at hand, such as population sizes disaggregated by age and gender, risky sexual practices, as well as cultural practices. The above gave the assessment team the impression that facilities did not have a clear understanding of the communities they served, nor did they truly understand the population at risk of HIV in their communities. It is the assessment team's recommendation that when facilities (or districts) set MMC targets, these targets get broken down to different age groups. This will assist facilities to set out appropriate mobilization plans, knowing exactly which ages they are targeting. Catchment area maps can be developed for facilities using information obtained from the District Health Information Systems website, as well as from the local Government Communication and Information Systems offices in the respective districts.

Knowledge of budget

The assessment team also found that there is a major gap when it comes to facilities knowing their MMC programme budgets. The major threat in this regard is that facilities who do not know their budget may either overspend or underspend for the program. Additionally, facilities are not able to appropriately plan MMC activities when they do not know the budget, and if they also do not keep track of the programme cash flow. Facility managers should be capacitated and expected to draw up programme budget proposals that are in line with facility MMC micro-plans. Finance managers should work closely with facility managers to track MMC programme expenses.

Support from district and facility management

The level of strategic direction from district was found to be a weak area in many facilities. No minutes of meetings were found. Although some facilities reported to attend Nerve Centre meetings where MMC was discussed, no minutes were found in many instances and there was no evidence of district follow-up and

support to facilities on weaknesses discussed at these meetings. At facility level, it was found that though there were facility management team meetings, most of these did not include MMC discussions. The assessment team observed this when studying facility management team minutes of meetings. Subsequently very little or no support and mentorship was received by MMC staff.

Good practices

Mwolokohlo Clinic was found to have a good mapped out catchment area map. This was shared with other facilities and some district officials.

B. MANAGEMENT SYSTEMS

In this service standard, facilities were assessed to ascertain:

- If the necessary guidelines, standard operating procedures (SOPs), policies, job aids and recording forms related to MMC are available and used. These include: MMC Guidelines, Patient Rights Charter, NDoH Data Working Practice Guidelines, MMC National Strategic Plan, STI Diagnosis and Treatment Policy, Waste Management Practice, Adverse Events Guideline, Referral Guidelines, Site Improvement Framework, Guidelines or Protocols for Medical Emergencies (anaphylaxis), etc.
- The availability of a written plan for MMC services, with expected client flow and service delivery targets, HR requirements, and projected resources such as commodities, supplies and equipment.
- The availability of clearly defined roles and responsibilities for MMC staff.
- Whether supportive supervision and training is offered to staff involved in MMC services.
- The existence of adequate human resources at service points.
- The availability of a client flow system and client flow charts.
- The availability and use of adverse events (AE) protocols in the management of adverse events.
- The existence and use of functional supplies and an equipment ordering system.

The overall provincial performance on this standard was average, ranging between 53% and 80%. Ugu, eThekwini, Amajuba, uMgungundlovu, uMkhanyakude, uMzinyathi, iLembe and King Cetshwayo scored between 53% and 76%. Zululand performed well at 80%. Performance on each of the areas was as follows:

Policies, SOPs and guidelines

For facilities that performed well in this standard, such as Mwolokohlo and Wosiyane in Ilembe and Itshelejuba in Zululand, areas of good performance overall included:

- Availability of most of the guidelines, including the understanding and use of these guidelines.
- MMC plan availability.
- Good supplies and ordering systems.
- Adequate staff available for MMC – including facility and service provider staff.

Lower performing facilities were found mostly in Ugu and eThekwini. Common areas of weakness for most of the facilities included:

Lack of MMC plan

Written MMC plans were missing in the majority of facilities. Exceptions to this were found in facilities such as Charles Johnson Memorial (uMzinyathi) and Mwolokohlo (iLembe), which can be regarded as good practices in this sub-standard.

MMC targets

Meeting of targets was a challenge for many facilities in the province. The assessment team came across facilities which did not even know their allocated targets. In some cases, targets were known but were not met. Another common problem was the understanding of which age group is the primary MMC target. The South African Guidelines for Medical Male Circumcision clearly states that the targeted population for MMC are males who are aged 15 years to 49 years. But looking at the general age group of clients recruited at most facilities, these clients fall out of the targeted range, with most of them being in the 10 to 14 age category. In most cases, facilities were unaware that the under 14 year category is not the primary target group for MMC. Furthermore, where facilities had facility-based MMC targets, the targets were not analyzed based on age groups.

Written roles and responsibilities for MMC staff

The baseline assessment process found that in many cases, facilities did not have dedicated MMC staff. On days or camps for MMC, staff would be drawn from other units or programs to assist. As a result of this practice, facilities did not find it easy to add MMC-related roles and responsibilities to staff members' job descriptions. The assessment team found that even though there were no written roles and responsibilities, staff were still able to relate their responsibilities in relation to MMC services. What was also found to be missing was performance assessment, feedback to staff on their performance, supervision and mentoring of staff involved in MMC.

Existence of adequate human resources at each service point

The assessment found that many facilities across the province seemed to fare well in this sub-standard. This was found to be mainly due to a combination of resources from both the facilities and supporting partner/s. Facilities used their HIV&AIDS, STI and TB (HAST) staff and, for follow-up, most facilities used existing professional staff to attend to clients.

Through the assessments, it was found that the different role-players at service delivery level had varying roles and responsibilities. The major concern is the 'hands-off' attitude portrayed by many facilities with regards to the MMC program. Many facilities did not seem to show a level of ownership of the MMC program, and merely viewed themselves as the 'host' to the roving team or implementing partners. This is a serious concern which needs to be addressed urgently.

Periodic assessments of MMC staff and training

All districts rely on Northdale Hospital for the training of all their clinical staff. Although there were some staff members who have been trained at Northdale, most districts did not have a comprehensive training plan that includes the placement of trained staff members. Most of the trained staff that were reported to the assessment team had never even practiced at any MMC site.

There was also no evidence of a formal mentorship programme for trained MMC staff, and, as a result, staff were not periodically assessed and corrective measures were not in place to further develop staff. With regards to non-clinical staff, all districts had no training plan or mentorship plan in place. This should be urgently reviewed. All counselors should be appropriately trained on HIV Counseling and Testing (HCT) and MMC counseling, and appropriately mentored throughout their tenure. The same applies to cleaners and data management staff.

Adverse events

Adverse events management was found to be a major concern in all districts, with serious under-reporting. The assessment team had a general impression that facilities appear to be reluctant to record and report adverse events, whether mild, moderate or severe. On many occasions, staff reported to have never come across any adverse events. In addition, adverse events seemed to be associated with only severe cases requiring hospitalization or other form of drastic medical intervention. The assessment team observed occasions where a client would present himself at the facility in the presence of the assessment team with a mild adverse event, and such cases would not be properly recorded and recognized as adverse events. It appeared that facility staff thought that reporting these cases was either not necessary because the complaint was mild, or that the reporting of adverse events may negatively impact the image of the facility or staff themselves. These perceptions were immediately addressed by the assessment team.

Another observation made by the assessment team was that due to the fact that roving teams and implementing partner teams conduct follow-ups with clients in the community, they frequently see adverse events. The observation and discussions held revealed that the teams manage these without necessarily recording them appropriately and/or informing the facility or district as required by the Adverse Events Management Protocol. This was also made clear by a number of severe forms of AE found in uMgungundlovu, where clients were admitted to Northdale Hospital as well as with some cases managed by Shakaskraal Clinic. For all these cases, there were no records of AE. The assessment team believes that if such cases had been reported and managed whilst still mild in form, they would have been treated and managed properly before turning into severe forms of adverse events.

Available supply of commodities and medicines and commodities for surgical and non-surgical aspects of MMC service provision (MMC kits, HIV test kits, condoms)

The majority of facilities performed well in this service area. This was largely due to the support of implementing partners or the roving teams who provide disposable MMC kits. It must be mentioned that at the beginning of the assessment process, the team came across a number of expired MMC kits. This improved almost to a 100% as the assessment progressed. With regards to commodities such as HIV test kits and condoms, the assessment found that, overall, facilities provided these to MMC clients. This was one aspect that seemed to be integrated into facility procurement processes. The same applies for medication supplies.

An emergency resuscitation system exists and medications/supplies are available with immediate access

Overall, this was an area of consistent concern for many facilities as it was rare to find a facility that was fully compliant. This is due to the fact that although emergency trolleys were found, some items would be missing or would have expired. It was common to find that even though oxygen cylinders were available, staff did not seem to know how to use them. Another critical concern was that the majority of facilities did not seem to have trained staff for medical emergencies. It appeared that emergency preparedness ranked low for MMC staff. This is a major medico-legal concern. All health care workers are expected to be able to manage any medical or surgical emergency that may occur. It would be prudent for all facilities to ensure that all their emergency management systems are working optimally. It was also noted that most of the high scoring facilities were clinics.

Strengths in this service area were found mainly in eThekwini with Ezimwini meeting all the standards, followed by Mzamo Clinic (99%), Mpola (99%) Emaphephethweni Clinic (97%) and Hlengisizwe Clinic (96%). uMzinyathi District also performed well, with five out of 11 facilities scoring between 90% and 96%. Most of the staff in eThekwini had been trained by the University of KwaZulu-Natal Skills Laboratory and there was evidence of such training in the form of training logs and certificates. Howick Clinic and Edendale (uMgungundlovu) also had training logs for staff who have been trained in basic life support and emergency procedures. Ugu had two sites performing below 50% in this service area, namely Turton, which performed the procedures without an emergency trolley, and Port Shepstone Clinic.

Since this is an area in which most facilities did not perform well, districts should make the necessary arrangements with the relevant emergency medicine departments, or Emergency Medical Services, to provide emergency management training on a periodic basis for all their staff members.

Assessment team intervention

The assessment team provided hard copy and electronic copies of a number of guidelines which facilities were missing.

With regards to emergency training, in addition to raising awareness with management and staff about the importance of keeping an up-to-date emergency system at the MMC site and having staff trained, resident doctors and implementing partner doctors were urged to provide emergency training to facility staff.

The assessment team also assisted facilities by helping them to draft roles and responsibilities for staff.

C. REGISTRATION, COMMUNICATION WITH CLIENTS AND IEC MATERIAL

Under this service standard, sites were assessed on:

- How they registered their clients.
- The availability and distribution of appropriate education materials on MMC and reproductive health.
- Techniques and skills used in the provision of group education as well as on whether group education was delivered with the correct information.

The overall score of the province under this standard was 73%. The lowest scoring district was Amajuba (60%) and the highest was King Cetshwayo (86%). The rest of the districts averaged from 60% to 73%. It is important to note that this service area could not be observed at four facilities within Amajuba because there were no clients at the facilities on the days of assessment. In addition, facilities where there were no clients to observe were also feeder facilities who conduct recruitment processes and send clients directly to larger facilities for the rest of the MMC services. In such cases, the assessment team was informed that group counseling was conducted at the recruitment stage.

Client registration

Overall, all districts integrated the facility registration processes for the MMC service very well. Most facilities registered MMC clients in the same way as all other patients seen at the facilities. Primary health care registers were used in all MMC facilities. What was also noted was that MMC clients were fast-tracked and did not have to wait in long queues. They were immediately registered and transferred to the MMC service point. Another common practice was for implementing partners to enter client information in their MMC registers.

Provision of appropriate information and educational materials on MMC and other reproductive health issues

The assessment team found most facilities were able to supply clients with MMC-related IEC materials. In many instances, these materials were provided by implementing partners. There were no IEC materials that were supplied by the districts. Where facilities were not supported by NGOs, it was common for clients to not be given any MMC materials. Additionally, no IEC materials concerning sexual reproductive health (SRH) were available in the majority of facilities. The exception was Mbongolwana Hospital where SRH materials were available and distributed to clients. The lack of SRH information and materials is a major missed opportunity to provide comprehensive SRH information to male clients, who generally struggle to access health services.

Group education delivered with correct information

The assessment revealed inconsistencies in the delivery of group education information. Most sites conducted group education sessions without the use of standard counseling aids. These sites did not have such aids in their possession. This was commonly found when facility counselors conducted group education. As a result, critical information would be missed. In many cases where implementing partners conducted group sessions, they used aids and were able to cover all relevant information.

Group education delivered with appropriate techniques

This was an area where most facilities performed well. Counselors displayed good counseling skills and techniques. A gap was with regards to the segregation of clients according to age. There were instances where children under 14 were mixed in the group with adults. On such occasions, the assessment team would confidentially point this out to counselors, to enable the younger ones to be attended to separately. Very few counselors seemed prepared with appropriate child-friendly group information, which is also a gap.

D. INDIVIDUAL COUNSELING AND HIV TESTING FOR MMC CLIENTS

Under this service standard, facilities were assessed on:

- Obtaining informed consent.
- Providing skills, techniques and materials used in the provision of individual counseling and routine HIV testing.
- Providing skills and techniques for giving results (whether positive or negative) and post-test counseling.
- Demonstration and provision of condoms.

The overall provincial score under this standard was a high 85%. Eight districts scored well, with scores ranging from 82% to 92%. Only one district (Amajuba) had a relatively low score of 67%.

Provision of appropriate individual counseling on MMC

The assessment found that facilities performed well in this service area. All clients, prior to having an MMC procedure, do receive HIV counseling and testing. All counselors, both DoH and implementing partners, conducted HCT very well, showing that they were well-trained. However, variations were noticed when counseling was offered by facility staff and implementing partner staff. Whilst some facility counselors performed extremely well, in some cases they were very good on the HIV part of the counseling. They were very good at providing accurate information about HIV, addressing misconceptions, encouraging partner testing

and explaining the HIV test procedure. Gaps could be seen on areas such as emphasizing 6-week abstinence following the MMC procedure and repeating that MMC only partially offers protection against HIV. The gap noted in this regard is that most DoH counselors are not formally trained on the MMC component of counseling. It is strongly recommended that districts implement a training plan for lay counselors in this regard.

Demonstration and provision of condoms

Condom availability was not an issue in almost all facilities. There were a couple of good practices where both male and female condoms were well demonstrated and made available to clients. Umnini had a creative way of packaging condoms and distributing it to clients as a nicely wrapped present, which was highly appreciated by clients. The gap though was observed when it came to condom demonstration. The assessment team observed that in many facilities, condom demonstration was skipped. As mentioned elsewhere in this report, there were also a couple of instances where condom demonstration was done inappropriately, such as in spaces with younger children.

Assessment team intervention

Assessment of individual counseling was normally done by observing two client counseling sessions, although there were facilities where only one client was observed. The assessment team intervened by providing feedback sensitively should critical information be missed. Counselors would be able to correct and give additional information before the client left. This practice accounted for improved performance when counseling was given to the second client. The assessment team also encouraged skills transfer between implementing partner counselors and facility counselors.

E. MONITORING AND EVALUATION

Under this service standard, facilities were assessed on:

- The availability of relevant tools for MMC data management, such as registers and forms.
- The availability of staff for MMC data management.
- The availability of mechanisms for data quality control.
- Whether client records were completed with all relevant MMC tools for data management.
- Whether MMC data was analyzed and used for reporting and planning.
- The availability of a system for referrals of clients found to be HIV positive to HIV care and treatment.

The provincial performance on this standard was an average 56%. District scores ranged between 44% and 66%. The lowest scoring district was Ugu with 44%, followed by uMkhanyakude at 48%. Ugu had four out of seven facilities scoring under 40%. The highest score was Verulam Clinic in eThekwini (97%), compared to the district score of 52%.

Availability of relevant tools for MMC data management

MMC sites should have the following MMC tools on-site – MMC Booking Register, MMC Client Form/File, MMC Register, MMC Follow-up Register, HCT Register, Adverse Events Register with grading scale – and be able to produce a monthly data summary with MMC indicators.

The assessment team found that:

- A number of sites did not have all the required registers, with the exception of the MMC registers.
- Many sites relied on implementing partners' registers, which partners took away with them at the end of the day, leaving no records at facility level.
- Where registers were found, different formats were used, with different important and relevant points emphasized.
- A number of gaps were also assessed with regards to follow-up registers and these include: no track or evidence of clients returning for follow-up visits after 48 hours, 7 days or 21 days; no evidence that such clients were tracked (though the assessment team was informed that many were tracked directly by the implementing partner).
- As a result, it was common to hear of severe AEs whose source could not be tracked.

MMC data management and control systems

The majority of facilities assessed did not have dedicated and trained data management personnel. Data management systems for tracking MMC information and data were not in place. MMC data tools and records were not filed, stored and locked away safely. Many facilities did not have or use MMC data management protocols. MMC data quality assessments were also not routinely conducted.

Completion of client records with all relevant MMC tools for data management

The assessment team found that overall, client records presented a number of challenges. There were facilities that had no client records, in spite of the fact that clients were registered at the facility. When this was explored further, it was established that although registration is done by the facility, the client file is taken away by the implementing partner, leaving the facility with no duplicate copy. This poses a serious medico-legal challenge for the facility. Furthermore, this leads to incomplete files – for example, when a client goes for follow-up, no file is available to refer to their pertinent clinical history. Due to files not being kept at facilities, it was not possible to audit client files at some facilities.

Where client forms were available, facilities used the Provincial DoH MMC Client Form. In most cases, these forms were not fully completed. The form is designed to capture information relating to: informed consent for HIV testing; MMC and client vital signs; anesthetic dosage; client HIV status; client sexual history; allergies; alcohol, intra-operative adverse events and complications; post-operative review; and instructions given as well as treatment given. The assessment found that few facilities were completing client records fully. Some files did not have signed consent forms. Most of the client files studied missed critical information such as vital signs. In some cases, dosage used was not indicated. Intra-operative status was also not recorded. Finally, information on follow-up visits was not recorded on file.

Service referral and linkage system

The assessment found that there was a gap in referrals and linkages of MMC clients found to be HIV-positive to appropriate HIV care services. It was difficult to find records of such referrals even when they had been diagnosed from the MMC service point. No evidence was found that MMC clients who were diagnosed HIV-positive, were referred to an ARV clinic for further management. Common practice is to verbally refer the client. The assessment also found no evidence that a client was supported, given proper counseling and encouraged to go back to an MMC clinic once their CD4 count had reached acceptable levels. The assessment team also

found that no system was in place for dealing with clients who come for MMC with birth defects and how they should be managed.

There were a few instances where the assessment team could track a client from the MMC register and be able to find evidence of care from the HIV Unit. A good example of this was found at Ulundi A Clinic. The team identified three clients who had tested positive. They had been properly recorded in the MMC register. The team went to the ARV clinic and managed to get their files, with written referral and details from the MMC site. Positive feedback and encouragement was immediately given to the facility manager and staff.

Good practices

One example of a MMC register was found at Mwolokohlo where a form showing a breakdown of ages was used. This was encouraged and the assessment team advised that an AE column be created.

Assessment team intervention

During discussions on the importance of the MMC register, it was emphasized that the register should include:

- Clients details – names, traceable address and contact number, specific ages (to assist with M&E)
- Information pertaining to the MMC procedures – e.g. date of the procedure; type of procedure; consent for HST and MMC
- Pre-op done; anesthesia given
- Post-op done (*refer to p135 of MMC Guideline 2016*)
- Any referrals made
- Intra-op adverse events
- Follow-up dates (48hrs, 7 days and 21 days)
- Where will next follow-up be done (if client will go to another facility)
- Signature of operating clinician and assistant (sometimes client files go missing and it becomes difficult to track who performed the procedure if there are no signed client registers)
- Facility can also use the register to check if booked patients came for the procedure as planned.

The MMC register format was discussed with facility staff. Advice was given on important information to be added in columns. These include, among others, information on follow-ups, AE, referral and name and signature of attending clinician.

F. SUPPLIES, EQUIPMENT, ENVIRONMENT AND EMERGENCY

Under this service standard, facilities were assessed on:

- The appropriateness of the physical structures for MMC service delivery.
- The availability of necessary equipment for performing MMC procedures. This included overall cleanliness of the facility, overall layout of surgical suites for effective client flow and availability of emergency exits.
- The availability of commodities including marcaine, chlorine, syringes, suture materials, surgical gloves and other safety wear.
- Adequate supplies of medicines and commodities, such as analgesics, STI medication, HIV testing kits, adequate stocks of condoms for distribution to clients, etc.
- The availability of emergency resuscitation protocols in the operating room.
- Site preparation for dealing with or managing medical emergencies at operating sites.

The overall provincial performance on this service standard was 82%, with facility performance ranging between 75% and 88%. Three districts, namely, Amajuba, King Cetshwayo and Ugu, scored between 75% and 79%.

Facility infrastructure

With regards to infrastructure, assessment took place in fixed facilities, including clinics, community health centers (CHCs) and hospitals all belonging to the Department of Health. Within the facilities themselves, there were variations with regards to the physical spaces used for MMC. The assessment found that there were four types of spaces:

a. Facility with a clearly allocated or dedicated room or space for MMC procedures inside the main building.
b. Facility which converts certain spaces for MMC (e.g. converting a waiting room) on the day of the procedure.
c. Facility which shares space for an existing service (e.g. a maternity ward) with MMC.
d. No dedicated room or space, where the MMC procedure is performed in the truck or tent of the supporting partner.

The assessment found that infrastructure was a challenge that sometimes impacted negatively on the performance of MMC services. The assessment team observed that:

- Some spaces that were allocated to MMC were very small, with no adequate room to provide counseling and conduct pre-assessments or provide proper post-operative care.
- Where certain spaces were converted for MMC on the day of the procedure, cleanliness was often a challenge. Moving couches and the necessary equipment to the space also posed practical challenges, including increased waiting time for clients. Sometimes even moving the emergency trolley from one space to another was a challenge.
- Infrastructure related challenges also affected the layout of surgical suites. It did not allow for the effective flow of patients and clinicians.
- Where space was limited, it affected HIV testing. Client confidentiality and privacy could not be assured. Sometimes counseling rooms were used for other services, resulting in staff moving in and out whilst counseling was in progress.
- There were a couple of instances where group education was not conducted due to the lack of space.
- In some facilities, there was ample space but MMC clients were mixed with antenatal clients or there would be no room for pre- or post-care counseling. The assessment team found that in such situations, there was ample room to be used if earmarked creatively to provide better services to MMC clients. Examples were found at KwaDukuza and Darnall (iLembe District) and Ceza (Zululand District). At KwaDukuza Clinic, the building was big, but MMC clients were mixed with antenatal clients. Similar observations were made where group education, including condom demonstrations, were done at antenatal sites with young children and concerned parents watching with confusion. In such instances, the assessment team intervened immediately and, together with the provider, an appropriate solution was sought. At Darnall Clinic, MMC services were conducted in an unused, old, dirty hall, whereas there was a clean, accessible space within the clinic which was available. Ceza Hospital had earmarked a very large space for MMC but a big part of the space which could have been used for pre-and-post operative care was unused.
- Emergency exits were problematic in many facilities.

- Some sites also lack basic infrastructure such as elbow taps, etc.
- Fire extinguishers were also a general problem. In many instances, they were not serviced and some had expired. Fire extinguishers were not available at MMC service sites in some cases.

Assessment team intervention

The assessment team consistently moved around the facility with the facility manager and came up with ideas such as using a certain side of the building for antenatal clients, and that this could be easily achieved by having certain doors in the facilities opened. This would free up space for MMC clients, without compromising space for antenatal patients.

In facilities without emergency exits and with spaces that limit client flow, the assessment team encouraged creative thinking around moving furniture and changing the position of couches, wherever possible, to enable better client flow and promote safety. It should be noted that infrastructural challenges for MMC services were much more complex and require province to re-evaluate and audit the appropriateness of some of the spaces where MMC is conducted.

G. MALE CIRCUMCISION SURGICAL PROCEDURE

Under this service standard, facilities were assessed on screening of clients, how the procedure was performed by the provider and post-operative care. Areas assessed included:

- The preparation of clients for the surgical procedure.
- The provision of pre-operative examination for the procedure or the device where applicable.
- The performance of the procedure, including achieving homeostasis, wound suturing and the correct application of a dressing.
- The provision of immediate post-operative care.
- The provision of post-operative care instructions.
- Client record completion prior to client discharge.
- Client follow-up where available.

The overall performance for the province under this standard was a high 89%. Seven districts scored extremely well, with scores ranging from 90% to 98%. The other two districts had average scores of 80% (Amajuba) and 69% (Ugu).

The assessment team noted that surgical procedures were performed by different providers. In some districts, the roving team was the backbone of the MMC procedure. In other sites, facilities performed the procedure using their own clinical staff, whilst the majority of facilities were supported by implementing partners in this service area. Table 3 summarizes district performance in this service area.

Table 3: MMC Surgical Procedure by District

District	Clinical team	• Comments on performance
Amajuba	4 out of 6 facilities were serviced by the roving team.	• The roving team was the backbone of MMC in the sub district. • There were some challenges that contributed to Umndozo Clinic's score being significantly lower than others – for instance, the structure was not conducive for the surgery and the facility staff were not actively participating. • After the assessment at Madadeni Hospital, the roving team's scores on surgical procedure improved through coaching from the assessment team, which encouraged collaboration between facility staff and the roving team. • Scores improved from Madadeni Hospital (76%) to Osizweni Clinic 1 (85%) and Madadeni 1 (99%).
eThekwini	Main supporting partners were Right to Care and SACTWU.	• Lowest performing facility had a score of 79%, while the rest scored highly between 97% and 100%. • Illovo had the lowest score, where the main contributing factor was the poor infrastructure that was not conducive for the surgery. There was also no collaboration/ relationship between the facility and the supporting partner. • King Dinuzulu and Fredville met all performance standards.
iLembe	INSIMU supported 10 out of 15 facilities. Facility staff performed the procedure in three hospitals whilst one had support from a sessional doctor from a neighbouring hospital.	• With the exception of 1 facility which scored 78%, the rest scored well between 80% and 100%, with five facilities scoring 100% (Mwolokohlo, Wosiyane, Montobello, Ndwedwe and Untunjambili). • Whilst scores were generally good, what brought the scores down were the pre- and post-op factors, not the surgery itself. • At Thafamasi, suturing was not done very well by the registered nurse who was performing alongside the doctor, but this was immediately corrected by the doctor without causing pain to the client. • Another factor which contributed to lower scores was that, in some facilities, staff were being mentored for the first time since receiving MMC training. • Challenges posed by limited space and poor infrastructure could also be seen clearly where mentoring of facility staff was taking place. However, this did not compromise the quality of the procedure and the care received by clients. • At Darnall, the operating room was not conducive to perform an operation.
King Cetshwayo	SACTWU performed 5 out of 6 procedures. One was performed by INSIMU.	• Scores ranged between 80% and 100%, with Mbongolwane and St Mary's KwaMagwaza scoring 100%. • The scores indicate an improvement in performance from the first facility done (Ekhombe 80%) to Enseleni Hospital (97%) which was visited last in that particular district. • The doctor from SACTWU was very good and worked very well with the facility staff. This proves that collaboration between partner organizations and facilities is the ideal method to improve MMC services.
Ugu	Right to Care supported Dududu Clinic. The rest of the facilities where the procedure was observed, performed the Tara KLamp	• Procedure was exceptionally performed at 100%.
uMkhanyakude	SACTWU was the supporting partner for all 4 facilities assessed.	• Growing cooperation was observed between the staff from the facility and implementing partner. Minor errors noted were that the suturing and dressing of the wound were not properly done.
uMgungundlovu	New Start supported 4 facilities, SACTWU supported 3 and 3 facilities had procedures performed by their own staff.	• Performance ranged from 88% (Gomane) to 100%, with 5 out of 10 facilities meeting all standards at 100%. These were Edendale, Bruntville, Mpophomeni, Howick and Mbalenhle. • Gomane had the lowest score of 88%, due to the infrastructure not being conducive for the operation. • Furthermore, there were new staff members that still needed to be trained. • It was recommended that the partner organization and facility staff needed to communicate and work together.
Zululand	3 facilities were assessed. One was supported by Right to Care; one by a roving ream; one had the procedure performed by the facility staff.	• Performance ranged between 72% and 100%. Ceza scored lowest at 72%. Ulundi A Clinic scored 98% whilst Itshelejuba scored 100%. • From the observations at Ceza, the challenge was that the pre- and post-operative examinations were not done well – for instance, the vital signs were not taken, no proper cleaning of the genitalia was observed and the dressing was not properly secured.

Pre-and post-operative care inconsistencies

Pre-operative history and examination was a concern at most sites. The clinical staff did not collect and record the relevant medical history from clients prior to the procedure. Although genital examination took place in most facilities and vital signs were taken, the clinical staff did not perform a quick head-to-toe examination, and did not record this information in the patient files. With regards to post-operative care, there was no adequate space to monitor patients appropriately after the procedure. This meant that patients were not appropriately observed after the procedure for some time, dressings weren't checked and vital signs weren't checked before discharge. There was also not enough patient education and re-emphasis of messaging done after the procedure, especially relating to wound care and how to deal with emergencies should they arise while the patient is at home.

Follow-up care

In all the districts, the assessment team could not assess follow-up care being provided because follow-up care was provided by the roving team and implementing partners within the community. The districts are encouraged to periodically follow these teams and assess the quality of follow-up care being provided within the community. This will also assist the district teams to have a better picture of the adverse events seen during follow-up and how they are managed in the field. Follow-up registers should also be implemented, and reporting of follow-ups seen should also be made a reporting requirement to the district and province.

Device

Four facilities were using the device in the form of the Tara KLamp. These were KwaMbotho, Gqayinyanga, Turton (all Ugu) and Mbalenhle (uMgungundlovu).

Under this service standard, facilities were assessed on the screening of clients, how the device procedure was performed by the provider and post-operative care. Areas assessed included:

- The provision of pre-operative examination for the device procedure.
- Whether skilled surgical backup was available within prescribed hours.
- Whether appropriate device kits were used for the circumcision procedure (e.g. MMC consumables, etc.).
- The provision of post-operative care instructions.

The overall performance for the province under this standard was a very good 93%. Only two districts (Ugu and uMgungundlovu) were observed using the Tara KLamp Device for procedure, with uMgungundlovu scoring a perfect 100% and Ugu scoring just 86%. The teams observed that in both the districts, the device procedure was conducted by the roving team.

Provision of pre-operative examination for device procedure

Pre-operative history and examination was generally well done in 3 out of the 4 facilities in the 2 districts that used the device procedure. However, KwaMbotho raised a concern scoring 0% under this sub-standard, signaling a serious and urgent need to train relevant staff on the use of the device procedure.

Skilled surgical backup available within 6 hours

All four facilities did extremely well on this standard as they scored 100%, indicating that surgical back up is readily available at all times should there be an emergency.

Appropriate device kits were used for circumcision procedure

The general observation in this sub-standard was satisfactory, with the exception of one facility that was found with an expired device kit.

Provision of post-operative care instructions

This proved to be an area of concern for most of the facilities, as clients were not given proper instructions on post-operative care.

Recommendations

Three out of four facilities were encouraged by the assessment team to train staff on MMC device procedure, as well as to develop a written post-operative set of instructions for clients.

Assessment team intervention

The assessment team encouraged the coaching and mentoring of facility staff by the supporting partner's clinicians. This was particularly in the area of performing the MMC procedure. The acting operations manager at Shakaskraal Clinic was encouraged to join the clinical team as there was a huge client demand and more hands were needed. Similarly in Groutville, the MMC-trained Professional Nurse (P/N), who had not done anything since undergoing training at Northdale, was encouraged to perform the procedure under the mentorship of the clinician and afterwards expressed his appreciation at the opportunity. He was encouraged to always join the operating team and learn as much as he can so that the facility will develop skills and capacity (and confidence) in the MMC area.

H. INFECTION PREVENTION

Under this service standard, the sites were assessed on:

- Whether antiseptics were prepared according to standards.
- The cleaning of rooms between and after procedures.
- The cleaning of instruments, decontamination and high level disinfection.
- Waste management practices.

For this standard, 8 districts performed well, scoring between 82% and 92%. The other district (uMkhanyakude) had an average score of 79%.

All districts had dedicated housekeeping staff, either hired through the facility directly or provided by a contracted entity. Performance of housekeeping staff on infection prevention measures ranged from those who knew and were able to demonstrate their knowledge of this service area very well, to those facilities where cleaning staff had very little knowledge, experience or supervision. However, some facilities struggled to perform in this area due to a shortage of facility staff. One example of this was Shakaskraal, which had only two cleaning staff, one for external areas and another for internal areas. Adherence to standards in such instances requires all staff, including professional staff, to pull together and share some of the cleaning and housekeeping responsibilities during MMC procedures.

The process of cleaning rooms between and after procedures was performed according to the standards

It was very rare to find rooms being cleaned between and after procedures. This was found in about 12% of facilities, which scored 100%. Outside of this group of facilities, this practice was rare. Sometimes space and infrastructure was a problem. At other times, it appeared housekeeping staff were not aware that this was an important standard.

The preparation of a disinfectant cleaning solution was performed according to the standards

Many facilities were able to prepare disinfectant cleaning solutions properly. However, some facilities were found to be using soap and water instead of disinfectant solutions. In other facilities, facility management or infection control managers had no idea what type of disinfectants were used since these came with outsourced service providers. It was only when the assessment team asked, that they became aware, for instance, that only soap and water were used. This is an area that requires urgent attention and consistent supervision and monitoring. In all districts, there were no formal plans for the training of housekeeping staff on their duties and infection control standards. Facilities also did not have standard operating procedures for housekeeping staff. For instance, in most of the sites, cleaning staff prepared large quantities of disinfectant solution and this solution was used until finished. There was no daily preparation of small amounts of solution. Additionally, containers of solution were not appropriately labelled with the date of preparation and the contents. The cleaning staff were, in most cases, found to be unfamiliar with how to clean body fluid spills appropriately.

All facilities had dedicated housekeeping staff, although the ratio of the housekeeping staff to the size of the facility could be improved in most cases. Furthermore, in some facilities, cleaning services were outsourced, and cleaning staff did not belong to the facility. In cases where cleaning services was outsourced, facility managers often did not seem to play an active role in supervising their work. However, many gaps were identified during this process, with cleaners not fully knowing how to properly clean facilities and/or equipment relating to the MMC service.

It is strongly recommended that cleaners must be trained on infection control and proper cleaning, according to guidelines. This includes the appropriate mixing of disinfectant solutions, the cleaning of body fluid spills and the proper use of housekeeping equipment, such as mops. Additionally, job aids should be created and pasted on the walls in the sluice rooms, for everyday reference for the cleaners. Catherine Booth Hospital had a good example of these aids.

The process of cleaning instruments and other items was performed according to the standards

Facilities used disposable kits. The assessment found that disposable instruments were properly discarded using prescribed procedures. Cleaning of items such as utility gloves was not observed in the majority of facilities assessed, due to the fact that waste disposal staff did not have or utilize such items.

Waste management and disposal

The assessment found that waste management was outsourced in many facilities. It was found that waste was properly segregated into hazardous and non-hazardous waste at the point of origin. Medical waste was also properly disposed of. However, a consistent gap in many facilities was that housekeeping and waste management staff did not have or use utility gloves, plastic aprons or covered shoes. Therefore, this area was not observed. In some facilities, it was observed that whilst medical waste was generally disposed of according to standards, waste areas (where waste was kept) were not clean, bins were left unclosed and, in a few facilities, general waste was not kept away from public areas (e.g. lots of filled cardboard boxes at different points around the facility).

Assessment team interventions

The assessment team went to great lengths to teach the cleaning staff how to mix the disinfectant solution and how to clean body fluid spills. Facility managers and infection control managers were encouraged to provide regular supervision to housekeeping staff. They were also advised to develop SOPs for cleaning MMC units and ensure that housekeeping staff and facility managers were appropriately capacitated and trained on the SOPs.

The assessment team also noted that since cleaning and waste management services were outsourced in many facilities, facility managers tended to not actively supervise the cleaning staff. Facility managers were encouraged to supervise all staff on their premises, regardless of who employs which particular staff member. In some facilities, the team, together with facility staff, sought out service provider staff and gave them feedback on the state of waste management and housekeeping activities. The district and facilities should review their agreements with cleaning companies, with regards to servicing MMC units, and ensure that contractors are familiar with the requirements of cleaning MMC units according to standards. The supervision of cleaning services should be actively managed by the facility managers.

4.3 Challenges

The baseline assessment was conducted in 86 facilities. Efforts were made to undertake the full assessment on all eight service standards. In certain instances, this was not possible for standards such as Registration, Communication to Clients and IEC Materials, Individual Counselling and HIV Testing, and Male Circumcision Surgical Procedure. The following reasons contributed to this:

- Finding no clients on the date of the assessment. On some occasions, clients that had been booked for the MMC procedure did not turn up. The Assessment Team made efforts to return to some facilities wherever possible in order to complete the assessment. This depended on the distances that had to be covered to for a return visit. Where facilities were in very remote and far flung areas, it was not possible to return. In other cases, the Assessment Team could not obtain dates from facilities confirming the availability of clients.
- Clients testing HIV positive and therefore not undergoing the procedure on the day. In such cases the Assessment Team would observe other standards such as counselling and referral to other treatment and care services
- Only one client turning up, thus leaving the Assessment Team with no opportunity to observe performance on Registration standards
- District arrangements where a number of “feeder” facilities only recruit and refer to bigger facilities for the MMC procedures. Where such arrangements are in place, it was not possible to assess three standards, i.e. Registration, Communication to Clients and IEC Materials, Individual Counselling and HIV Testing, and Male Circumcision Surgical. The Assessment Team learned that in such cases, arrangements differed. Sometimes, Group Education was conducted in the community as part of the recruitment. These arrangements were encountered mostly at Amajuba and uMzinyathi Districts.
- There were no doctors to perform the MMC procedure in some facilities at uMzinyathi District where MMC camps had been arranged.

Facility performance was based on dashboard scores which rates performance under three categories:

Category 1	Category 2	Category 3
• Facilities found to have significant gaps with an average score of less than 50%	• Facilities found to have moderate gaps with an average score of between 50% and 79%	• Facilities found to have minimal gaps with an average score of 80% or more

5. FOLLOW-ON CQI ASSESSMENT VISITS

This section seeks to present summarized findings of baseline assessments and follow-on assessment visits conducted by AQUITY in 6 facilities. Table 4 shows facilities that received follow-on visits and their location by district.

Table 4 : Facilities that received follow-on CQI assessment visits

No.	Name of Facility and District	District	Date of Baseline Visit	Date of CQI Visit
1	Dannhauser CHC	Amajuba	5 April 2017	13 July 2017
2	Dinuzulu Hospital	eThekwini	12 June 2017	27 July 2017
3	Dundee Hospital	uMzinyathi	30 March 2017	28 July 2017
4	Edendale Hospital	uMgungundlovu	20 June 2017	27 July 2017
5	Madadeni Hospital	Amajuba	4 April 2017	19 July 2017
6	Niemeyer Hospital	Amajuba	6 April 2017	14 July 2017

A total of 6 sites were selected from the facilities where the baseline assessments had been conducted by the AQUITY assessment team. Facilities were purposefully selected based on their availability for the follow-on assessment visit, in view of the limited time frame that the project had. The aim of the follow-on visit was to establish if the selected facilities had implemented any measures to improve on the gaps that were identified during the baseline assessment process. Specifically, the follow-on assessment sought to:

- Determine if facilities had implemented any of the improvements discussed and recommended during the baseline assessment visit.
- Identify specific service areas where improvements had been implemented.
- Identify service areas where performance had regressed or declined and, where possible, establish reasons thereof.
- Identify areas where service gaps exist.
- Provide any support and on-site guidance appropriate to facility teams, aimed at improving service areas with significant gaps.

CQI Assessment Summary										
District	Leadership and planning	Management systems	Supplies, equipment, environment and emergency	Registration, communication to clients and IEC	Individual counseling and HIV testing for MMC clients	Monitoring and evaluation	Male circumcision surgical procedure	Device	Infection prevention	Overall Score
Danhausser CHC										
Baseline	60	60	79	77	75	70	77		97	74
CQI	80	84	86	85	90	81	95		98	88
% Change	**33**	**40**	**10**	**11**	**20**	**16**	**24**		**2**	**18**
Dinuzulu Hospital										
Baseline	25	46	92	50	99	46	100		98	69
CQI	40	68	100			63			99	74
% Change	**60**	**49**	**9**	**n/a**	**n/a**	**38**	**n/a**		**1**	**7**
Dundee Hospital										
Baseline	40	75	92			39			96	68
CQI	40	98	86	67	96	45	100		73	76
% Change	**0**	**29**	**-6**	**67**	**96**	**16**	**100**		**-24**	**11**
Edendale Hospital										
Baseline	0	80	83	75	98	65	100		100	75
CQI	60	81	97	100	100	53			100	84
% Change	**60**	**1**	**17**	**33**	**2**	**-18**	**n/a**		**0**	**12**
Madadeni Hospital										
Baseline	60	82	66	73		64	76		92	73
CQI	80	89	72	85	83	64	87		89	81
% Change	**33**	**9**	**8**	**17**	**83**	**0**	**15**		**-3**	**11**
Niemeyer Hospital										
Baseline	60	76	86	64	94	68	93		81	77
CQI	60	76	87	71	90	68	100		94	81
% Change	**0**	**0**	**1**	**12**	**-4**	**0**	**8**		**16**	**4**

Leadership and planning

During the baseline assessment phase, it was found that the overall provincial performance on this service area was below 50%. Three out of six facilities that received a follow-on visit had performed much better on this standard. These were Dannhauser, Madadeni Hospital and Niemeyer CHC (all in Amajuba) which had scored 60%. The rest had scored under 50%, with Dundee Hospital scoring 40%, followed by King Dinuzulu at 25% and Edendale Hospital at 0%. Under this standard, the most critical gaps that facilities experienced were in relation to the availability of good localized catchment area maps, with areas clearly mapped out for mobilization of MMC clients. Another gap was the lack of knowledge of site budget and the availability of minutes indicating support received from district and facility management.

The follow-on assessment showed a significant improvement of 60% at Edendale Hospital. This shows that the facility took note of the gaps identified during the baseline assessment and instituted improvements in just over a month. This facility had also obtained a localized catchment area map and there was evidence of improved support from management. It was found that previously low-scoring facilities were more aware of MMC budgetary issues and were engaging the necessary departments in trying to improve in this area. The AQUITY assessment team provided support by inviting the finance manager to be part of the MMC meeting at Madadeni. This enabled staff to discuss budgetary issues and to obtain knowledge of what was allocated to the MMC programme. Two facilities retained their initial performance.

Management Systems

During the CQI follow-on assessment, facilities were assessed on the availability of relevant MMC Guidelines, availability of written MMC plans, clearly defined and written roles and responsibilities of staff, availability of adequate human resources, effective use of data for MMC service improvements and, most importantly, on the availability of systems to manage adverse events. These were found to be serious gaps for many low-performing facilities during the baseline assessment process. During the baseline assessments, these six facilities had varying degrees of performance, ranging from 46% (Dinuzulu) to 82% (Madadeni). Only one had scored below 50% and two, Edendale and Madadeni Hospitals, had scores of 80% and 82% respectively. With the exception of Niemeyer Hospital, which retained its initial performance of 76%, the rest of the facilities improved their scores during the follow-on assessment. Dannhauser showed a 40% improvement, scoring just above 80%. Dundee also improved its performance by 29% to score an impressive 98%. Dinuzulu Hospital, which had an initial assessment score of below 50%, also improved its performance to 68%.

Contributing factors to the improved scores on management systems included:

- Facilities had obtained most of the guidelines that were missing during the assessment process. During the follow-on visit, the assessment team also assisted facilities with missing guidelines and policies. Most facilities significantly improved on the availability of guidelines. However, no change was noted at Madadeni. This is an area the facility needs to look at, as well as being an area for district support.
- All facilities which previously did not have written MMC plans with projected resource needs, had made an effort to develop these. Some had moved beyond just a written MMC plan to allocating at least a dedicated staff member to MMC. Edendale, Dinuzulu and Dundee were examples of facilities that allocated dedicated staff members to the MMC programme.
- Most facilities had developed written job descriptions for staff. For instance, Dundee and Madadeni had scored 50% in this area during the baseline assessment and, at the follow-on visit, they scored 100%.

The availability of a system to manage adverse events is an area that still needs more attention. However, it is important to note that the assessment team found that there was a different level of awareness on the management of adverse events compared to the team's initial experience. It bears mentioning that there was some attempt at addressing this gap in some facilities. Some facilities had had discussions and meetings to develop such a system. Others had secured or designed adverse events graded forms and created AE registers. One facility had even managed one adverse event since the last visit of the team. This was found in Dundee where the adverse event was recorded in a graded form designed by the facility. There were minutes of a MMC team meeting where the adverse event was discussed and the assessment team was satisfied that the event was managed according to protocol.

Common gaps were still identified in the following areas:

- Lack of supportive supervision to staff.
- Facilities still need some training on the management of adverse events. The team found that though the AE protocol provides clear guidelines about forms, procedures and other management tools and requirements, facilities have yet to fully understand how to implement the protocol.

Supplies, Equipment and Environment

This is one of the standards where the average provincial baseline assessments score was 82%. The baseline assessments found that this was an area where facilities showed the most integration of MMC into facility procurement processes. Three out of the six facilities scored above 80%, with King Dinuzulu scoring 92%. This facility increased its performance to 100% thus becoming the second facility to fully meet this standard after Ezimwini Clinic, which is also located in eThekwini. Edendale also showed a marked improvement of 17% to score 97%. One facility (Niemeyer) had a marginal increase whilst it was noted that Dundee and Madadeni had a slight decrease in their scores. At Dundee it was noted that since the baseline assessment, the facility management had taken a decision to improve on space and infrastructure for MMC services by identifying premises which were being renovated at the time of the follow-on visit. As a result, there were practical impediments of having to move supplies all the time from the main hospital to the new premises, thus affecting the availability of some supplies on the day. However, it should be noted that once renovations are completed and commodities stored at the new premises, the facility should see an improvement on the performance.

During the baseline assessments, most facilities had performance gaps when it came to emergency procedures. Common and consistent challenges included:

- Emergency trolleys not complete.
- Protocols for medical emergencies not available.
- Staff not having knowledge of emergency procedures.
- Staff not trained in basic life support.

During the follow-on assessments, some changes were noted on the adequate supplies of medicines. Dundee was found to have procured STI medication. All medication was stored according to temperature and light standards. Two sites (Edendale Hospital and Dannhauser CHC) also improved their performance to over 86%. The follow-on assessment identified that there were still gaps in performance on emergency procedures. Madadeni Hospital, for instance, had still not trained its staff on emergency procedures. Edendale was one of the facilities which improved its performance in this area, and was able to provide training log sheets for staff.

A further common outstanding gap remained in the area of the availability of pediatric and adult dosing charts.

Registration of Clients, Group Education and IEC Materials

For this service standard, It is not possible to rate whether performance had improved or declined in two facilities, namely Dundee Hospital and King Dinuzulu Hospital. This was because this standard could not be assessed at Dundee due to the unavailability of clients on the day of the baseline assessment visit. For King Dinuzulu, there were no clients to observe on the day of the follow-on visit. This service area requires the assessor to “walk” with the client from the point of registration to other MMC service stations, as well as to observe the delivery and content of group education sessions. Facilities were also assessed on the availability

and distribution of IEC materials for MMC and other SRH materials, an area which was found to be a consistent gap during the baseline assessment process. In the four sites which went through both the baseline and follow-on assessments, there was an improvement in scores, ranging from 71% to 100%. Edendale hospital had a 33% increase, from 75% at baseline assessment to 100%.

Availability of IEC materials for both MMC and SRH was a challenge in most of the facilities during the baseline assessments. Edendale Hospital again had a 100% improvement in this area. Availability of IEC materials was still a gap, especially SRH materials. This is an area that requires provincial support and intervention. For the two facilities which only had one of the two types of assessment, it is noted that their scores in this service were average, one scoring 50% at baseline assessment (Dinuzulu) and the other (Dundee) scoring 67% when the facility was visited for the follow-on assessment. Both these scores signify a need for these facilities to make plans for service improvement in this area.

Individual Counseling and HIV Testing for MMC clients

Three facilities, i.e. Dundee, Dinuzulu and Madadeni Hospitals did not have comparative scores. It should be noted that their respective assessment scores were generally high. Dundee had scored 95% at follow-on visit, Dinuzulu scored 99% at baseline assessment and Madadeni scored 83.3 % during the follow-on assessment visit. Only Dannhauser had a lower baseline assessment score of 75%. This score increased by 14.4% at follow-on visit to an impressive 90%. Edendale Hospital improved its performance to 100% on the following areas:

Areas of improvement were noted in the provision of counseling and routine HIV testing. Another area where good practices were observed was in giving results to HIV positive young boys. Common gaps included not addressing misconceptions about HIV sufficiently and giving of results and post counseling. This shows that there is a need for counselors to receive regular in-service training and supervision. They also need a job aid to keep on their side to improve their skills and ensure that all key are delivered to clients.

Monitoring and Evaluation

With regards to provincial performance, monitoring and evaluation revealed a lot of gaps, second only to the leadership and planning standard. Two out of the six facilities which received a follow-on assessment, scored below 50% in this service area. Performance scores after the follow-on visit revealed clearly that this is an area that requires more attention if MMC services generally are to improve. The lowest scoring facility at baseline assessment was Dundee Hospital, with a score of 39%. The facility's performance did not sufficiently improve after baseline, as it still remained below 50%. Out of the six facilities, Dannhauser had an increase of 16% reaching 81%. This makes Dannhauser the second facility to obtain a score of over 80% at Amajuba district, after Madadeni Clinic 1 which scored 88% at baseline assessment. Another facility which improved its performance by 38% was King Dinuzulu Hospital. Its performance at baseline assessment was under 50% and this increased to 63%.

An area that was picked up as improved in Dannhauser was the referral and linkage to care system. At follow-on visit, the facility was found to have put in place a system with standard tools for referrals of clients or patients found to be HIV-positive to HIV care and treatment.

Common areas of improvement also included:

- Availability of most MMC registers, including a graded AE register (Edendale) and an MMC follow-up register (Dundee).
- Availability of client forms, with client files properly stored and secured (Edendale).
- General improvement in the recording of client files.

Whilst some improvements are noted at different facilities assessed, it must be mentioned that monitoring and evaluation still remains an area with many gaps. As long as facilities do not have dedicated personnel for MMC data management, and structured MMC quality improvement teams, it will be difficult to improve in this area. It is also important for facilities to have, and make use of, available data management protocols. This is an area that the district and the province need to pay attention to through capacity development and close monitoring.

MMC Surgical Procedure

Three facilities, namely Dundee, King Dinuzulu and Edendale Hospitals, had received only one form of assessment due to the unavailability of clients on the days of assessments. For all three of them, this was an area where they performed very well, scoring 100%. The rest of the facilities showed an improved performance in this service area. Niemeyer improved its score by 8% to achieve a 100% performance. Dannhauser also increased its score from 77% at baseline assessment to 95%.

There were varying degrees of improvements across facilities that did not score 100% at follow-on assessment. Some facilities had improved on the preparation of clients for surgery, whilst others had done well on post-operative care and giving clients instructions on post-operative care. The reinforcement of HIV-prevention messages was also found to be missing in many interactions with clients.

The assessment team noted that these are still areas that need attention for many clinicians and MMC teams. More training should be given to clinicians assisting doctors with surgery.

Infection Prevention

All six facilities had generally good infection prevention scores at baseline assessment. Edendale had the highest score of 100%, showing complete adherence to infection prevention standards. Dinuzulu, Dannhauser and Madadeni Hospitals scored 98%, 97% and 92% respectively. Whilst Dannhauser and Dinuzulu improved their scores slightly, the follow-on assessment showed a 3% decline in Madadeni from 92% at baseline assessment to 89% at follow-on visit. Dundee also recorded a 24% decline in performance from 96% to 73%. The highest percentage increase on this score was achieved by Niemeyer which rose by 16% from 81% to 94%.

The decline in performance is cause for concern as it signals poor quality improvement practices at facility level. Whilst Dundee had a positive intervention aimed at improving service delivery through MMC infrastructural renovations, it appears that other aspects of delivery were neglected or not monitored sufficiently.

6. DISCUSSION

The baseline assessments have highlighted a number of issues, strengths and gaps in the delivery of MMC services.

Leadership and planning: Leadership and planning is one of the service standards where 52% of facilities assessed performed poorly, scoring under 50%. Other than establishing low levels of knowledge of the catchment area, the population characteristics and MMC budgets, the assessment of this standard sought to ascertain the level of strategic direction from district and facility management teams and their involvement in the support and mentorship of those providing the MMC services.

Through the baseline assessment process, a significant commitment was shown by the different role-players at provincial, district and facility levels, with a deep desire for a successful MMC program, as part of a comprehensive HIV prevention strategy in the province. However, when attempting to establish the kind of provincial and district support to facilities, there was no evidence of structured support and mentoring meetings with higher level officials. District-led meetings and Nerve Centre meetings did not seem to provide structured and strategic support to facilities by addressing their unique needs and plans in relation to MMC. This is a potential threat to the sustainability and improvement of MMC service delivery as it results in a lack of ownership of the MMC programme by facility staff.

Management systems: 28 facilities (32%) had an average score in this standard, whilst 24 (27%) performed poorly under 50%. One of the areas assessed was the availability of guidelines and policies. The assessment team observed that in many facilities MMC and other critical guidelines were missing. There were also instances where the assessment team discovered that these guidelines were available but unknown and unused by facility staff. It was for this reason that the assessment team undertook to carry copies, both hard and electronic copies, of these guidelines and shared them with staff as part of the support and intervention. Not only did the assessment team share the guidelines but also used them as a reference to guide and coach on-site.

Another critical area under management systems was the availability of MMC plans at facility level. It is estimated that written up MMC plans were not available in more than 90% of sites assessed. Many facilities had no idea of district MMC operational plans, which are largely based on the provincial MMC operational plan. It was common to find facility managers and staff involved in MMC not being aware of their allocated MMC targets. Facilities require assistance in developing their micro MMC plans with the necessary resource projections. Once such plans are in place, facilities require support with implementation and site quality improvement plans.

The district should also take ownership of the MMC quality assurance and CQI activities for the district, with formal plans of implementation and monitoring of activities. This will ensure that the district, as a whole, provides services which are of high quality at all times, and services that are consistent throughout the district. These quality assurance programmes will ensure that no component of MMC services is neglected; from demand generation and mobilization activities to follow-ups and adverse event management. These activities will range from training to the provision of standard IEC materials.

Relationships between facilities, roving teams and implementing partners: One of the issues that seemed to consistently pose a challenge to the delivery of MMC services was the lack of role clarity between facilities, roving teams and implementing partners. Whilst the value added by supporting and implementing partners cannot be disputed, the baseline assessments also noted with concern the "hands-off" attitude portrayed by many facilities with regards to the MMC program. Many facilities did not seem to have any ownership of the MMC program, and merely view themselves as 'host' to the roving team or implementing partners, though this attitude is worse with NGO implementing partners. An extreme example of this 'hand-off' approach was seen at Mpumalanga clinic, where the implementing partner was only provided with space at the facility to conduct MMC procedures. The facility did not even provide any consumables for the services. Worse, it was reported that facility staff do not even see any MMC clients who may be presenting with any problem relating to the MMC procedure. The staff merely calls the implementing partner to come and 'sort out' their clients. This is a serious concern which needs to be addressed urgently.

There are also many missed opportunities to improve MMC service delivery if the role-players do not work hand in hand and collaboratively. The threat is that if the programme structure changes in the future, and implementing partners leave, then the facility is left without the capacity, skills and ability to appropriately run the programme efficiently. The assessments have highlighted the urgent need for the district and province to facilitate joint collaborative meetings between facilities and implementing partners, where the roles and responsibilities of all stakeholders in a number of MMC service delivery areas can be clarified, including client recruitment and mobilization, group education, individual counseling, pre-operative and post-operative care, client follow-up care and support, record keeping, monitoring and evaluation as well as managing and preventing adverse events. It would be good practice for the implementing partner's roles and resources for MMC to be integrated in MMC plans.

Human resources and training: With regards to clinical staff, many of the facilities assessed through this process did not have permanent staff available on-site to provide a full MMC service to clients who walk in on a daily basis. Services were provided on days when either the roving team or implementing partner were available to provide the MMC services. The facility would then try and provide additional staff members, who were usually removed from other services on the day, to support the services. The assessment team came across staff that had been selected to be MMC "Champions" and who had been sent for training at the School of Excellence. However, in many instances, such trained staff were not involved with MMC and did not seize the opportunity to work alongside the doctors during MMC procedures to learn, be mentored and develop confidence. In some facilities, staff that were trained at Northdale Hospital reported that they only completed the theoretical training at Northdale and had never conducted any practical training. The training requires that all clinical staff perform practical sessions at their own facilities or in their districts, under supervision of an experienced clinician. However, without a clear training plan from the facilities and districts, there is no monitoring plan in place to ensure that all clinical staff proceed with, and complete, practical training. It is

recommended that districts, together with facilities, draw up training plans as part of their MMC micro-plan, and include a placement plan for all trainees. It would be good practice that all trained staff be either placed at an MMC site on a rotational basis, or at least work at three camps in a quarter. This should be added to their performance management agreements.

When it comes to non-clinical staff, during the assessments it was established that most facility-based lay counselors were only trained on HIV counseling and testing and had not undergone any MMC-related training. Furthermore, facilities do not have refresher training plans for counselors. The assessment team also noted that implementing partners' counselors were much more competent and experienced in MMC counseling. A transfer of skills needs to be encouraged. Facilities were advised to take advantage of working with implementing partners, by having systems in place where facility lay counselors receive regular in-service training from the partners.

Monitoring and Evaluation: The assessment revealed this to be a serious challenge, with 36% of facilities performing below 50% and only 13% performing over 80%. At many of the sites assessed, there was no designated data management staff member. This function mostly fell on a data capturer, who only collected statistics. All facilities should have a team of dedicated staff members delegated this function, and the district should develop and implement a data management training and mentorship programme to ensure that all staff are appropriately trained and supported. This will ensure that facility monitoring and evaluation systems are strengthened, since this was an area of concern for most facilities in many of the districts. The Data Working Practice Guideline is a useful reference and guide that facilities must be trained in and supported to use.

Another area that was found to be a challenge consistently was on MMC registers and client records. There was generally a confusion as to what records to use for MMC. Some sites had to improvise to develop their own MMC registers, although these improvised registers missed key information that is needed, as per the national MMC guidelines. Many facilities did not have other registers, such as follow-up registers to record all follow-ups seen, adverse event registers and referral registers. In other facilities, such as Amajuba, the assessment team was made aware that the KwaZulu-Natal Department of Health has developed client files that are to be used for all male clients. These files were reported to have been introduced in this year. The glaring challenge with these client files is that they do not have any section which talks to clients presenting for MMC services. As a result, facilities have to use a separate MMC client file and try and attach this separate file to the standard client file, for these files to be filed together.

Facilities struggled with various records they have to keep and the issue was further compounded by implementing partners also keeping their own separate records. Confusion was also found when it comes to the "ownership" of client records as implementing partners tend to take away client records without leaving copies at facilities, as prescribed by the Data Practice Working Guideline. This guideline states clearly that MMC client files should be opened and kept safe at the site at which the MMC is conducted, regardless of whether it is performed by the facility or private sector partners. A copy of the client file must be left at the site. The Guideline also states that the implementing partner should leave a copy of the register at the MMC site. It is recommended that the provincial team should consider developing a standard MMC register, which will record all relevant information, including follow-up visits and adverse events. Until such a comprehensive register is developed, districts should provide guidance and monitoring to facilities to ensure that they comply with the standard of keeping registers from the booking register to the follow-up register.

Adverse events: Adverse events management was found to be a major concern in all districts, with a serious under-reporting of adverse events at all facilities. The Adverse Events Management Protocol provides detailed procedures that need to be followed if an adverse event is reported or picked up. It guides on the tools, such as forms, that should be used. It also provides a very good definition of what constitute adverse events and how these should be graded. The assessments have picked up that this is an area for urgent action and support, through staff training and by establishing adverse events surveillance teams to identify, appropriately grade, manage and report adverse events. A system should be found to improve the reporting of adverse events.

Client follow-up: As mentioned elsewhere in this report, there are many role-players that conduct community-based follow-up activities with clients. Some clients do not return to the site where the procedure was performed but rather go to another facility that is convenient, such as a facility closer to their home. In one of the facilities, the assessment team encountered a client who had missed his 7-day follow-up appointment due to not getting time off work. Afraid to go to the clinic where he was operated on, he went to a clinic further away. Luckily he had healed well. This shows how difficult and complex the issue of tracking clients for follow-up visits is and that many are missed. The district needs to pay more attention to MMC follow-up registers and work with partners to put a system in place to trace those clients not reached during community follow-up visits. It may be valuable practice to have facility staff trained on conducting follow-up care.

The results and observations from the baseline assessments highlight a number of challenges that impact on facilities' ability to adhere to MMC standards. They have also highlighted that, in spite of challenges faced by facility staff, there are a number of committed individuals who seek solutions and perform to the best of their ability for the benefit of MMC clients.

CQI visits: The findings from the six CQI follow-on visits indicate that continuous quality assessments are necessary to ensure quality service delivery. The findings show that facilities have improved on adherence to certain standards. It was clear that most facilities had listened and taken on the recommendations given during the assessment. However, it also showed that some facilities need more ongoing support to implement improvements, seeing that some sites had had almost 3 months to implement quality improvement activities, yet their standards declined. It is recommended that district officials conduct regular CQI visits to ensure improved performance and sustain it. The following recommendations are made with regards to facilities that require CQI support and the level of intensity at which this should be provided. Annexure 2 at the end of this report indicates that whilst overall scores may imply that the facility needs moderate support, district officials need to intensify their support to improve performance on standards where performance is poor.

KEY RECOMMENDATIONS

Based on the findings from the baseline assessments, the following recommendations are critical for the improvement of the quality of MMC services in facilities where the assessment was conducted:

- *MMC Infrastructural improvements:* The KZN MMC Provincial Team, in consultation with facility management, must conduct a comprehensive infrastructural audit of all facilities assessed in order to develop an infrastructure improvement plan aimed at improving MMC services and adherence to standards with regards to space, surgical operations and related services as well as infection prevention. Each facility must be individually reviewed, looking at infrastructure and how this impacts on client flow; from waiting area to post-operative assessment and discharge. Based on this audit, a plan with corrective measures for each station should be drawn up with milestones and timeframes. Improvements can be done progressively.
- *Training and facility capacity building:* NDoH should develop a comprehensive training package for facility managers and staff involved in MMC service delivery. The KZN MMC Provincial Team, together with each district, must develop a facility training plan and conduct training in order to improve performance on service areas assessed. This training should also cover critical guidelines and policies for MMC. Cross-pollination of ideas and working methods may be achieved during district training workshops.
- *Training for facility clinical staff on basic and advanced life support:* There is an urgent need to provide training on basic and advanced life support, including appropriate use of emergency trolley equipment and drugs. All facilities should have training log sheets for all staff. The district must oversee this aspect to ensure that medical emergency protocols are appropriately displayed in all MMC facilities.
- *MMC registers:* NDoH should develop a comprehensive MMC Register covering booking information, follow-up and AEs. The registers need to be standardized across all facilities. This will also ensure uniformity in data collection and reporting.
- *Client follow-up and AE surveillance systems:* The KZN MMC Provincial Team should develop a comprehensive client follow-up, tracing and tracking system to ensure that there is a comprehensive record of all clients who have undergone the procedure at different facilities. Such a system would assist in mitigating AEs.

- *MMC IEC materials, SOPs and job aids:* There is an urgent need for the development of IEC material both for MMC and SRH. MMC job aids should be developed for counseling staff at all facilities. An SOP on MMC infection control and for housekeeping staff on their roles in MMC should also be developed.
- *Protocol for managing MMC stakeholder relations and cooperation:* In view of the different role-players involved in MMC service delivery, including implementing partners, as well as the lack of ownership of MMC services by facilities as observed during the baseline assessments, it is critical that the National and Provincial MMC Teams develop a protocol for managing stakeholder relationships. This protocol will help to clarify roles of facility managers and facility MMC coordinators in relation to implementing partners, the roles and responsibilities of these partners, record keeping, client follow-up, management of AEs, M&E, reporting and accountability mechanisms.
- *Provincial MMC CQI*: Provincial CQI teams should be established, comprising national, provincial and district officials and an NGO representative. These teams should be made up of persons with clinical and non-clinical expertise and should be responsible for developing a CQI plan to provide structured feedback and support facilities with the required level of support as indicated in Annexure 2. These teams must receive training on MMC CQI processes and activities.
- *Facility-based QI Teams*: Each district office should set up facility-based QI teams or facilitate the integration of MMC into facility QI and provide structured support and mentoring to facilities in order to address gaps identified during the baseline assessment process. Each site should also have an internal quality assurance team, consisting of different cadres of staff, to work on an internal quality improvement plan, based on the baseline assessment results. These activities should be recorded and documented, and be monitored by the district.

OVERALL RECOMMENDATIONS

46%

LEADERSHIP AND PLANNING

Recommendations

- Consider a separate MMC coordination post separate from HAST coordination.
- Ensure the district MMC coordinator holds regular MMC update meetings with MMC facility management, including other stakeholders such as partners and community leadership.
- Facility managers to be capacitated on managing and tracking the facility MMC budget.
- Regular budget meetings should be scheduled between MMC facility management and relevant finance managers.
- Review scope of work and available resources for traditional mobilizers to include documented mapping of mobilization areas.
- All mobilizers to be actively managed and allocated monthly or quarterly targets.
- Increase service capacity of referral clinics in the district to provide a more comprehensive preparatory MMC service and follow-up care.
- Develop facility catchment area maps using information from local authorities and local GCIS office, and mount these on walls.
- Document area population sizes, disaggregated by age and gender, risky behaviors and cultural practices. This information can be obtained at Local Authorities offices.

RECOMMENDATIONS

65%

MANAGEMENT SYSTEMS

Recommendations

- District to assist facilities with drawing up and implementing a plan to discuss the various guidelines with all staff involved in MMC at facility level. These can be done in the form of Continuous Medical Education (CME) sessions or in-service trainings. Log sheets for these activities should be kept for all staff.
- District to facilitate the drawing up of individual facility MMC plans, which include service targets (by targeted ages according to guidelines), human resource needs, and other resource needs.
- Districts should implement adverse events training for all clinicians.
- District should follow up their adverse events management training by implementing an intensive adverse events monitoring at all sites.
- District and facilities together should come up with a training plan for all staff members including clinical, data staff and cleaning staff. These plans should also include a practice plan for all those who have been trained. These plans should be reviewed and updated yearly together with each staff member.
- Implement a standard periodic assessment system for all MMC staff, such as Performance Management Development System, and monitor implementation.
- Develop and implement a client satisfaction survey system, including a client complaints management system for each facility. This is to be monitored regularly.
- Consider linking all MMC sites to facility quality assurance (QA) teams, where all sites are to be supported by the larger facility QA team. Each site should also have an internal QA team, consisting of different cadres of staff, to work on an internal quality improvement plan. These activities should be recorded and documented, and be monitored by the district.

RECOMMENDATIONS

56%

MONITORING AND EVALUATION

Recommendations

- Have designated data management staff at all sites, and provide them with training and support from district, with regular data review meetings.
- Develop and implement an MMC booking register. This will help trace recruitment vs actual procedures performed, and will indicate any loss of clients.
- Develop a standard provincial MMC register to be used by all MMC sites. This will facilitate data collection and management.
- Develop a standard MMC follow-up register and a referrals register to be used by all sites seeing follow-up clients, including roving team and partners. These could be additional columns in the MMC register itself to track patients better.
- Develop a template for monthly data summary with MMC indicators, and make this a reporting requirement for sites.
- Include compulsory client file audit reports in monthly reporting requirements.
- All facilities to have copies of patient files on-site, which should be stored and filed in an orderly manner, in a safe space.

RECOMMENDATIONS

73%

REGISTRATION, GROUP EDUCATION AND IEC MATERIALS

Recommendations

- Urgent need for consistent supply of IEC materials (both for MMC and SRH) and counseling aids for all facilities.
- District to ensure that all MMC sites have a 24-hour emergency number, where clients can have access for any MMC-related emergencies.
- Supervisory visits and support during group counseling sessions to be conducted regularly to ensure consistency of sessions.

85%

INDIVIDUAL COUNSELING AND HIV TESTING FOR MMC CLIENTS

Recommendations

- Ensure consistent supply of male condoms.
- Ensure HCT quality assurance programme reaches MMC sites.
- Develop and implement formal MMC training plan for all DoH lay counselors.
- Develop and implement a refresher training programme for all lay counselors.
- Develop and implement a regular in-service training and mentorship plan for all DoH lay counselors.
- Ensure testing equipment is available at all sites, including time keeping devices.

RECOMMENDATIONS

82%

SUPPLIES, EQUIPMENT, ENVIRONMENT AND EMERGENCY

Recommendations

- Have designated data management staff at all sites, and provide them with training and support from district, with regular data review meetings.
- Develop and implement an MMC booking register. This will help trace recruitment vs actual procedures performed, and will indicate any loss of clients.
- Develop a standard provincial MMC register to be used by all MMC sites. This will facilitate data collection and management.
- Develop a standard MMC follow-up register and a referrals register to be used by all sites seeing follow-up clients, including roving team and partners. These could be additional columns in the MMC register itself to track patients better.
- Develop a template for monthly data summary with MMC indicators, and make this a reporting requirement for sites.
- Include compulsory client file audit reports in monthly reporting requirements.
- All facilities to have copies of patient files on-site, which should be stored and filed in an orderly manner, in a safe space.

RECOMMENDATIONS

90%

MALE CIRCUMCISION SURGICAL PROCEDURE

Recommendations

- District and facility to draw up an infrastructure improvement plan to improve facilities with regards to space and scrubbing areas and post-operative area.
- Provide appropriate training for outreach clinic staff to conduct thorough pre-and post-operative care, including follow-up care.
- Provide patient files to outreach clinics for them to complete pre-operative section during screening at booking.
- Regular supervisory and support visits during procedures to ensure clinicians continue providing high quality services, and checking consent forms, diathermies, etc.
- Re-train clinical staff on weight-based anesthesia for MMC procedures, and record trainings through training logs.
- Develop a facility based post-operative SOP and train all staff on the SOP. Monitor implementation of post-op SOP.

86%

INFECTION PREVENTION AND CONTROL

Recommendations

- Develop working aids for cleaning staff and mount these on walls.
- Develop a cleaning log for cleaners to record the time that various key spaces are cleaned.
- Ensure utility gloves are available.
- Need SOP on MMC infection control and train all staff on the SOP, recording the training on a training log sheet.
- Develop guidelines on how to prepare cleaning solutions, quantities, and labeling of containers.
- Ensure gloves, aprons, boots, masks, etc. are available.
- Develop guidelines on how to properly clean surgical areas and body fluid stains.
- Different mops to be used in different facility areas: kitchen, passages, and operating room.

ANNEXURE 1.

Date	Facility	Area	District
2017/04/04	Madadeni Hospital (CQI- 19/6/2017)	Newcastle	Amajuba District
5/4/& 30/6/2017	Dannhauser CHC (CQI- 20/6/2017)	Newcastle	Amajuba District
6/4/ &6/6/2017	Niemeyer Hospital (CQI- 20/6/2017)	Newcastle	Amajuba District
2017/07/07	Osizweni Clinic 2	Newcastle	Amajuba District
2017/12/04	Mndozo Clinic	Newcastle	Amajuba District
13/4/2017	Madadeni Clinic 1	Newcastle	Amajuba District
20/4/2017	Nellies Farm Clinic	Newcastle	Amajuba District
21/4/2017	Stafford Clinic	Newcastle	Amajuba District
16/5/2017	Madadeni Clinic 7	Newcastle	Amajuba District
17/5/2017	Rosary Clinic	Newcastle	Amajuba District
18/5/2017	Osizweni Clinic 3	Newcastle	Amajuba District
2017/08/05	Umnini Clinic	Umgababa	Ethekwini Metro District
8&20/5/2017	Fredville Clinic	Inchanga	Ethekwini Metro District
2017/08/05	Illovo Clinic	Mid Illovo	Ethekwini Metro District
2017/09/05	Hlengisizwe CHC	Hammersdale	Ethekwini Metro District
9/5/& 30/7/2017	Klaarwater Clinic	Pinetown	Ethekwini Metro District
10/5/& 4/7/2017	Kwa-Dabeka Clinic	Clermont	Ethekwini Metro District
2017/11/05	Prince Cyril Zulu CDC Clinic	Durban	Ethekwini Metro District
2017/12/05	Osindisweni Hospital	Verulam	Ethekwini Metro District

12&14/6/2017	Halley Stott Clinic	Botha's Hill	Ethekwini Metro District
2017/12/06	King Dinizulu Hospital (CQI- 27/7/2017)	Sydenhem	Ethekwini Metro District
13&22/6/2017	Mpumalanga Clinic	Hammersdale	Ethekwini Metro District
13/6/2017	Prince Mshiyeni Gateway Hospital	Umlazi	Ethekwini Metro District
27/6/2017	St Aidens Hospital	Durban	Ethekwini Metro District
2017/11/07	Shallcross Hospital	Chartsworth	Ethekwini Metro District
13/7/2017	Ezimwini (KwaMahleka) Clinic	Mid Illovo	Ethekwini Metro District
14/7/2017	Mpola Clinic	Pinetown	Ethekwini Metro District
17/7/2017	Maphephethweni Clinic	Kwa-Mashu	Ethekwini Metro District
18/7/2017	Mzamo Clinic	Pinetown	Ethekwini Metro District
21/7/2017	Verulam Clinic	Verulam	Ethekwini Metro District
2017/08/05	Isithebe Clinic	Mandeni	Ilembe District
9&24/5/2017	Montobello Hospital	Stanger	Ilembe District
2017/10/05	Kwa-Dukuza CHC	Stanger	Ilembe District
2017/10/05	Ndwedwe CHC	Ndwedwe	Ilembe District
11&25/5/2017	Ntunjambili Hospital	Ntunjambili	Ilembe District
2017/11/05	Sundumbili CHC	Stanger	Ilembe District
2017/12/05	Stanger Hospital	Stanger	Ilembe District
2017/12/05	Umphumulo Hospital	Kwa-Maphumulo	Ilembe District
8/5/ & 13/6/2017	Groutville Clinic	Groutville	Ilembe District
9/5 & 13/7/2017	Darnall Clinic	Stanger	Ilembe District
14/6/2017	Thafamasi Clinic	Ndwedwe	Ilembe District
14&30/6/2017	Shakaskraal Clinic	Stanger	Ilembe District
15/6/2017	Mwolokohlo Clinic	Tongaat	Ilembe District
15/6/2017	Wosiyane Clinic	Ndwedwe	Ilembe District
2017/06/05	Ekhombe Hospital	Nkandla	King Cetshwayo District
19/5/2017	St Marys (KwaMagwaza) Hospital	Melmoth	King Cetshwayo District
20/5/2017	Nkandla Hospital	Nkandla	King Cetshwayo District
20/5/2017	Mbongolwane Hospital	Eshowe	King Cetshwayo District

26/5/2017	Nseleni Hospital	Nseleni	King Cetshwayo District
26/5/2017	Catherine Booth Hospital	Amatikulu	King Cetshwayo District
29/3/2017	Turton CHC	Port Shepstone	Ugu District
30/3/& 25/5/2017	G.J Crookes Hospital	Scottburgh	Ugu District
13/5/2017	KwaMbendu Clinic	Kwambedu	Ugu District
15/5/2017	Port Shepstone Clinic	Port Shepstone	Ugu District
15&16/5/2017	Dududu Clinic	Dududu	Ugu District
17/5/2017	KwaMbotho Clinic	KwaMbotho	Ugu District
18/5/2017	Gqayinyanga Clinic	Mzumbe	Ugu District
2017/02/06	Madwaleni Clinic	Mbazwana	Umkhanyakude District
2017/07/06	Mbazwana Clinic	Mbazwana	Umkhanyakude District
2017/08/06	Macabuzela Clinic	Hlabisa	Umkhanyakude District
2017/09/06	Nkundusi Clinic	Qakwini	Umkhanyakude District
19/6/2017	Appelsbosch Hospital	Ozwatini	Umgungundlovu District
19/6/2017	Northdale Hospital	Northdale	Umgungundlovu District
19/6/2017	Balgowan Hospital	Balgowan	Umgungundlovu District
20/6/2017	Bruntville CHC	Mooi River	Umgungundlovu District
20/6/2017	Baniyena Clinic	Mobeni	Umgungundlovu District
20/6/2017	Edendale Hospital (CQI -27/7/2017)	Plessislear	Umgungundlovu District
21/6/2017	Embo Clinic	Eston	Umgungundlovu District
21/6/2017	Gomane Clinic	Impendle	Umgungundlovu District
21/6/2017	Mpophomeni Clinic	Mpophomeni	Umgungundlovu District
22/6/2017	Howick Clinic	Howick	Umgungundlovu District
22/6/2017	Mbalenhle Clinic	Imbali	Umgungundlovu District
30/3/2017	Dundee Hospital (CQI- 28/7/2017)	Dundee	Umzinyathi District
31/3/2017	Charles Johnson Memorial Hospital	Nquthu	Umzinyathi District
29/6/2017 & 3/7/17	Rorke's Drift Clinic	Rorke's Drift	Umzinyathi District
29/6/2017	Elandskraal Clinic	Elandskraal	Umzinyathi District
30/6/2017	Sakhimpilo Clinic	Sakhimpilo	Umzinyathi District

2017/03/07	Pomeroy CHC	Pomeroy	Umzinyathi District
2017/03/07	Qinelani Clinic	Qinelani	Umzinyathi District
2017/07/07	Douglas Clinic	Douglas	Umzinyathi District
20/7/2017	Collessie Clinic	Collessie	Umzinyathi District
20/7/2017	Nocomboshe Clinic	Tugela Ferry	Umzinyathi District
21/7/2017	Kranskop Clinic	Tugela Ferry	Umzinyathi District
2017/03/05	Ulundi A Clinic	Ulundi	Zululand District
2017/04/05	Ceza Hospital	Ceza	Zululand District
2017/05/05	Itshelejuba Hospital	Pongola	Zululand District

ANNEXURE 2.

Amajuba District

Assessment Quality Standards Areas (percentage)

District clinics	Leadership and planning	Management systems	Supplies, equipment, environment and emergency	Registration, communication to clients and IEC	Individual counselling and HIV testing for MMC clients	Monitoring and evaluation	Male circumcision surgical procedure	Device	Infection prevention	Overall performance	Type of support
Madadeni 7 Clinic	40	65	84			43			69	60	Intensive
Osizweni No. 3 Clinic	20	68	83	50	71	46			90	61	Light
Rosary Clinic	0	43	80			57			72	50	Light
Dannhouser Chc	60	60	79	77	75	70	77		97	74	Light
Madadeni Hospital	60	82	66	73		64	76		92	73	Light
Osizweni No. 2 Clinic	20	53	67	73	84	40	85		88	64	Light
Niemeyer Memorial Hospital	60	76	86	64	94	68	93		81	77	Light
Mndozo Clinic	20	48	72	64	50	31	49		86	52	Intensive
Madadeni Clinic 1	60	52	87	82	92	88	99		82	80	Light
Nellies Farm Clinic	80	89	77	0		67			84	66	Light
Stafford Clinic	80	50	78		0	50			63	53	Intensive
DISTRICT SCORE	**45**	**62**	**78**	60	**67**	**57**	**80**		**82**	**66**	Light

eThekwini District

Assessment Quality Standards Areas (percentage)

District clinics	Leadership and planning	Management systems	Supplies, equipment, environment and emergency	Registration, communication to clients and IEC	Individual counselling and HIV testing for MMC clients	Monitoring and evaluation	Male circumcision surgical procedure	Device	Infection prevention	Overall performance	Type of support
Mnini Clinic	0	47	95	93	98	57	99		93	73	Light
Osindisweni Hospital	50	46	90	75	99	36	100		98	74	Light
Hlengisizwe	20	47	96	88	98	26	100		93	71	Light
Ezimwini (Kwamahleka Clinic)	60	66	100	0	100	71			100	71	Light
Fredville	60	68	94	88	88	82	100		96	85	Collaborative
Haley Scott	40	44	76	88	97	68	99		97	76	Light
Klaarwater Clinic	40	65	87	85	97	45	99		96	77	Light
Prince Mshiyeni - Umlazi	83	0	74		100	21	100		100	68	Light
King Dinuzulu Hospital	25	46	92	50	99	46	100		98	69	Light
Mzamo Pinetown	80	99	99	88	100	87	100		100	94	Collaborative
Illovo	40	42	75	38	92	68	78		62	62	Intensive
Kwa Dabeka	40	55	86	81	87	53	99		97	75	Light
Prince Cyril Zulu	0	73	64	75	100	52	96		57	65	Intensive
Mpola Clinic	60	61	79	88	98	74	99		100	82	Collaborative
Mpumalanga-Hammarsdale	0	33	83	44	89	16	97		78	55	Light
Emaphephetheni Clinic	100	85	97	50	100	30			96	80	Light
Shallcross	40	78	91			62			98	74	Light
St Aidans Hospital	20	39	92	100	100	44	100		100	74	Light
Verulam Clinic	60	81	96	88	100	97	99		98	90	Collaborative
DISTRICT SCORE	42	55	87	71	97	52	98		92	74	Light

iLembe District

Assessment Quality Standards Areas (percentage)

District clinics	Leadership and planning	Management systems	Supplies, equipment, environment and emergency	Registration, communication to clients and IEC	Individual counselling and HIV testing for MMC clients	Monitoring and evaluation	Male circumcision surgical procedure	Device	Infection prevention	Overall performance	Type of support
Untunjambili	60	82	90	75	87	63	100		98	82	Collaborative
Umphumulo Hospital	40	85	73	25	81	59	81		78	65	Light
Kwa-Dukuza Chc	40	73	79	65	88	47	90		83	71	Light
Groutville	40	46	75	75	79	59	94		82	69	Light
Montobelo	60	90	91	61	87	70	100		98	82	Collaborative
Shakaskraal Clinic	0	52	95	60	100	40	99		79	66	Light
Ndwendwe	60	75	94	88	88	92	100		96	87	Collaborative
Darnal Clinic	0	40	64	60	50	9	80		74	47	Intensive
Thafamasi	60	64	88	80	90	50	78		84	74	Light
Isithebe Clinic	40	84	79	65	88	47	95		84	73	Light
W0SIYANE CLINIC	100	91	98	83	100	53	100		93	90	Collaborative
Mwolokohlo	80	90	92	88	93	86	100		100	91	Collaborative
Stanger	60	86	88	66	92	81	94		98	83	Collaborative
Sundumbili Chc.	60	84	76	94	97	59	91		76	80	Light
DISTRICT SCORE	50	74	84	70	87	58	93		88	76	Light

uMzinyathi District

Assessment Quality Standards Areas (percentage)

District clinics	Leadership and planning	Management systems	Supplies, equipment, environment and emergency	Registration, communication to clients and IEC	Individual counselling and HIV testing for MMC clients	Monitoring and evaluation	Male circumcision surgical procedure	Device	Infection prevention	Overall performance	Type of support
Charles Johnson Memorial Hospital	100	81	79	84	60	82	76		77	80	Light
Dundee Hospital	40	75	92			39			96	68	Light
Collissie	0	60	78	59	93	26			57	53	Intensive
Ncomboshe	60	67	89	50		46			80	66	Light
Pomeroy	60	49	87	83	95	64			82	74	Light
Qinelani	40	33	84	71	100	57	100		70	69	Intensive
Sakhimpilo	20	40	86	75		52			69	57	Intensive
Douglas	60	78	96	75		78			100	81	Collaborative
Elandskraal	60	84	94	67		81			100	81	Collaborative
Kranskop Clinic	20	47	90	85	95	52	98		79	71	Light
Rokersdrift	60	87	94	75		78			100	82	Collaborative
DISTRICT SCORE	47%	64%	88%	73%	89%	60%	92%		83%	74%	Light

uMgungundlovu District

Assessment Quality Standards Areas (percentage)

District clinics	Leadership and planning	Management systems	Supplies, equipment, environment and emergency	Registration, communication to clients and IEC	Individual counselling and HIV testing for MMC clients	Monitoring and evaluation	Male circumcision surgical procedure	Device	Infection prevention	Overall performance	Type of support
Balgowan	80	74	89	88	88	82	97		97	87	Collaborative
Baniyena Clinic	20	45	74			28			66	46	Intensive
Bruntville	60	63	94	85	98	69	100		100	84	Collaborative
Edandale Gateway Clinic	0	80	83	75	98	65	100		100	75	Light
Northdale Hospital	0	63	89	55	0	70	98		94	59	Light
Embo	0	58	87	85	78	16	100		49	59	Intensive
Gomane	40	53	92	88	93	72	88		98	78	Light
Howick Clinic	60	41	89	85	95	56	100		95	78	Light
Mbalenhle	40	64	96	100	77	74		100	97	81	Collaborative
Appelsbosch Hospital	60	57	75	80	89	76	97		59	74	Intensive
Mpophomeni Clinic	40	80	95	96	98	54	100		87	81	Collaborative
DISTRICT SCORE	36	62	88	84	82	60	98	100	86	77	Light

uMkhanyakude District

Assessment Quality Standards Areas (percentage)

District clinics	Leadership and planning	Management systems	Supplies, equipment, environment and emergency	Registration, communication to clients and IEC	Individual counselling and HIV testing for MMC clients	Monitoring and evaluation	Male circumcision surgical procedure	Device	Infection prevention	Overall performance	Type of support
Mbazwana	20	73	89	80	90	47	98		87	73	Light
Madwaleni Clinic	40	52	85	57	78	42	95		77	66	Light
Nkundusi Clinic	40	54	73	72	77	45	96		63	65	Intensive
Macabuzela Clinic	20	61	84	71	84	58	95		88	70	Light
DISTRICT SCORE	30	60	83	70	82	48	96		79	68	Light

King Cetshwayo District (formerly uThungulu)

Assessment Quality Standards Areas (percentage)

District clinics	Leadership and planning	Management systems	Supplies, equipment, environment and emergency	Registration, communication to clients and IEC	Individual counselling and HIV testing for MMC clients	Monitoring and evaluation	Male circumcision surgical procedure	Device	Infection prevention	Overall performance	Type of support
Mbongolwane Hospital - Eshowe	80	70	68	88	100	43	100		97	81	Collaborative
Ekombe Hospital	40	79	75	86	92	63	80		96	76	Light
Catherine Booth	100	82	87	82	86	77	86		95	87	Collaborative
Nseleni CHC	60	72	83	88	80	80	97		78	80	Light
Nkandla Hospital	40	86	85	88	95	80	99		83	82	Light
St Mary KwaMagwaza Hospital	40	66	56	88	100	36	100		98	73	Light
DISTRICT SCORE	60	76	76	86	92	63	94		91	80	Light

Ugu District

Assessment Quality Standards Areas (percentage)

District clinics	Leadership and planning	Management systems	Supplies, equipment, environment and emergency	Registration, communication to clients and IEC	Individual counselling and HIV testing for MMC clients	Monitoring and evaluation	Male circumcision surgical procedure	Device	Infection prevention	Overall performance	Type of support
Dududu	80	77	88	98	93	54	100		97	86	Collaborative
Kwa Mbendu	40	31	81	70	85	55	100		92	69	Light
Kwambotho	60	70	87	27	98	40		65	97	68	Intensive
Gqayinyanga	60	62	89	69	92	64	0	100	99	70	Intensive
Turton Chc	20	46	49	70	63	36	75	94	42	55	Intensive
G.J.Crookes Hospital	50	49	88	58		39			94	63	Light
Port Shepstone Clinic	40	34	45	63	88	20			94	55	Light
DISTRICT SCORE	50	53	75	65	87	44	69	86	88	68	Intensive

Zululand District

Assessment Quality Standards Areas (percentage)

District clinics	Leadership and planning	Management systems	Supplies, equipment, environment and emergency	Registration, communication to clients and IEC	Individual counselling and HIV testing for MMC clients	Monitoring and evaluation	Male circumcision surgical procedure	Device	Infection prevention	Overall performance	Type of support
Ceza Hospital	40	77	88	58	75	52	72		92	69	Light
Ulundi "A" Clinic - For Enkonjeni Hospital	60	74	98	98	100	77	98		91	87	Collaborative
Itshelejuba Hospital	60	88	60	88	88	69	100		84	80	Light
DISTRICT SCORE	53	80	82	81	88	66	90		89	79	Light

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

CLINTON
HEALTH ACCESS
INITIATIVE

AQUITY
INNOVATIONS
Access and Quality through Innovations and Technology