health

Department:
Health
REPUBLIC OF SOUTH AFRICA

VOLUNTARY MEDICAL MALE CIRCUMCISION

Project 400K Winter Campaign 19

South Africa

April - September 2019

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ACRONYMS

AE	Adverse Event
APP	Annual Performance Plan
BMGF	Bill and Melinda Gates Foundation
CDC	Centers for Disease Control and Prevention
DATIM	Data for Accountability, Transparency and Impact Monitoring
DCS	Department of Correctional Services
DHIS	District Health Information System
DMPPT	Decision-Makers Programme Planning Toolkit
DOH	Department of Health
DVA	Data Variance Analysis
EC	Eastern Cape
FS	Free State
GP	Gauteng
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
KZN	KwaZulu-Natal
LP	Limpopo
MMC	Medical Male Circumcision
MP	Mpumalanga
NC	Northern Cape
NDoH	National Department of Health
NW	North West
PDoH	Provincial Department of Health
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
RT 35	National Treasury Transversal Contract for MMC services
RTC	Right to Care
SBCC	Social Behaviour Change Communication
SFH	Society for Family Health
STI	Sexually Transmitted Infection
THC	TB HIV Care

TMI	Traditional Male Initiation
URC	University Research Company
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WC	Western Cape

EXECUTIVE SUMMARY

Background

South Africa has the world's largest HIV epidemic with an estimated 7.2 million people living with HIV (UNAIDS, 2017). In recent years, South Africa has seen a decline in HIV incidence. The decline is due to a combination of interventions including the aggressive implementation of the Medical Male Circumcision (MMC) programme.

MMC has been identified as a key HIV prevention intervention for South Africa as it reduces the risk of female to male HIV transmission by approximately 60% ((SANAC, 2017). To date, the National MMC programme has achieved extraordinary scale having circumcised close to 4.1 million men. PEPFAR supports the MMC programme in South Africa. However, PEPFAR has been transitioning out of South Africa since 2016, with its contribution shifting from monetary investment to more technical assistance. PEPFAR continues to support 27 districts, while the 25 districts have RT35 contracts.

In South Africa, the winter season has the highest rate of MMC uptake, contributing approximately 50-60% of the annual MMC target. It is with this background that the NDoH initiated a project management approach in line with the winter high volume season by setting high targets aimed at achieving 400 000 circumcisions (Project 400k) during April to September 2019, using innovative demand generation strategies.

Aim and objectives

The Project 400k campaign aimed to build on the considerable gains made during Project 281K and Project 300k and maximise on the increased uptake of MMC services during the winter period.

Methods

The National Department of Health (NDoH) was responsible for the coordination and guidance of implementing partners, as well as communicating with subnational levels to ensure alignment and establishment of collective management of data. Project 400k monitoring was implemented through weekly submissions of data which was collated, cleaned and analysed. There were also bi-weekly meetings held at NDoH, aimed at discussing partner performance and sharing lessons learnt.

Implementing partners

PEPFAR prime implementing partners, through the Centers of Disease Control (CDC) and United States Agency for International Development (USAID) as well as RT35 partners, were responsible for the provision of MMC services and demand generation activities in their supported districts. While there were initially seven partners; Aurum, JGalt, Jhpiego, Right to Care (RTC), Society for Family Health (SFH), TBHIV Care (THC) and University Research Company (URC), but due to unforeseen circumstances, URC had to exit the programme three months into the campaign, leading to service interruptions in its supported districts. This meant that six partners were left to achieve the campaign target. This negatively impacted the success of the campaign.

Traditional sector collaboration

Negotiating with local stakeholders is essential to promoting MMC activities in traditional male initiation (TMI) predominant areas. During the campaign, the importance of stakeholder engagement and collaboration became more apparent in Provinces such as Eastern Cape and Mpumalanga. There were several successful engagements between partners and the traditional sector which aimed at reinforcing the benefits of MMC and working closely with traditional coordinators to mobilise for MMC services.

Demand generation

Demand generation plays a critical part in reaching men aged between 15 – 34 and it played a pivotal role when it came to the MMC performance during project 400k (April to September 2019). With the knowledge that the campaign took place over the peak season, partners were able to plan and effectively implement demand generation initiatives during this period. Partners' main methods of demand generation were centred on utilising the tools that were already available such as community radio broadcasters as well as print media. However, where necessary, partners changed strategies to ensure that they were able to reach men where they were e.g. male-dominated workplaces, rather than wait for men to present themselves at facilities. Partners collaborated with facilities in creating demand for services, and these collaborations proved to be effective with a notable uptake in MMC services during the campaign.

Results

Implementing partners were required to pledge targets to achieve the NDoH's 400k target. However, due to a lack of clarity regarding target setting, partners shifted targets repeatedly during the campaign. Subsequently, partners' combined target was 399 613 which resulted in a deficit of 387 to reach 400K.

At the end of the campaign, a total of 350 801 MMCs were reported to Project 400K, reaching 88% of the 400 000 target. Almost half of the total MMCs were conducted in June. However, according to the DHIS, a total of 295 075 circumcisions were completed between April and September, indicating that 74% of the campaign target was reached. Performance of the RT35 districts contributed 22% of the MMC's completed during Project 400k while the PEPFAR supported districts contributed 78% of the MMC's completed during Project 400k. While the campaign target was unmet, Project 400k surpassed the previous winter campaign (Project 300k) performance by 39 814 MMC's.

The performance varied across provinces and districts. The provinces which contributed to the highest MMCs were Kwa-Zulu Natal, Eastern Cape and Mpumalanga as seen in Table 1 below.

Table 1: Highest performing provinces

Province	*Target*	*Performance*
KwaZulu-Natal	183 708	96 175
Eastern Cape	45 183	63 385
Mpumalanga	19 836	49 903

The majority of the Provinces were able to meet the campaign targets except for KwaZulu-Natal, Northern Cape and Western Cape.

Districts which contributed the highest MMCs were eThekwini, Nkangala and Buffalo City as seen in Table 2 below:

Table 2: Highest performing districts

District	*Target*	*Performance*
eThekwini	90 290	34 270
Nkangala	15 300	34 108
Buffalo City	9 980	33 186

However, eThekwini did not achieve the district target. In total, 22 districts exceeded their targets while 29 districts were unable to meet their targets. There was no target allocated for Namakwa district in Northern Cape as the District did not have a supporting partner.

Partner performance varied monthly. Overall, one partner was able to meet and surpass their set target. Partner performance ranged from 30% to 115% target achieved as seen in

Table 3 below.

Table 3: Project 400k performance by partner

Partner	*Target*	*Performance*	*Percentage*
AURUM (RT35 and DCS)	42830	46763	93%
J GALT	28200	8574	30%
JHPEIGO	100000	77680	78%
RTC	51384	59126	115%
SFH	60031	59190	99%
THC	6942	6342	91%
URC	110226	93126	84%
Total	399613	350801	88%

MMC partner data reporting fluctuated on a month to month basis, making it difficult to verify the data promptly and identification of challenges was therefore delayed. Final Project 400k data is based on the numbers submitted by partners at the end of the campaign.

In addition to MMC reporting, partners were required to report on adverse events (AE), follow-ups, STI and HIV testing as a means of monitoring referral of MMC clients to other services. These indicators were not well-reported and had various discrepancies each week. Partners mentioned that the inaccuracies were due to the tight weekly reporting cycle which meant not all information was collated and verified at the time of reporting.

Conclusions

Overall Project 400k made great strides toward meeting the National Annual Performance Plan (APP) target of 600 000 MMC's. During the duration of the campaign, there were notable successes and challenges which impacted the outcome of the campaign.

The successes included the;

- Enhancement of MMC programme performance,
- Innovative demand generation initiatives which helped increase demand for services during the campaign; and

- Data variance reports which were provided to partners to help them follow up with districts which had been identified to contribute to the disparities.

The challenges included;

- Inadequate target setting which led to the shortfall of targets,
- Unexpected implementing partner changes which impacted programme performance, and
- Poor coordination at Provincial and district levels which lead to some of the data not being captured onto DHIS and subsequently resulting in the increasing data variance.

Recommendations

Project 400k campaign success is evident. The campaign increased coordination and communication between partners and NDoH and allowed for consistent monitoring of the programme's performance. It is with this in mind that it is important to highlight how programme management of future campaigns can be improved. To ensure the success of future campaigns and of the programme the following recommendations need to be implemented:

- Improved target setting,
- Adequate planning for partner changes,
- Strengthened traditional sector engagements
- Strengthening provincial and district engagements,
- Continued targeted demand generation,
- Consistent data variance monitoring,
- Improved coordination of MMC data flow from facility to provincial and national level, and
- Strengthened management of the campaign.

1. BACKGROUND

South Africa has the world's largest HIV epidemic with an estimated 7.2 million people living with HIV (UNAIDS, 2017). In recent years, South Africa has seen a decline in HIV incidence. The decline is due to a combination of interventions including the aggressive implementation of the Medical Male Circumcision (MMC) programme.

MMC has been identified as a key HIV prevention intervention for South Africa as it reduces the risk of female to male HIV transmission by approximately 60% ((SANAC, 2017). MMC is not only one of the most efficacious biomedical HIV prevention interventions but is also one of the most cost-effective interventions under South Africa's Investment Case (South African Department of Health, 2016). The South African National Department of Health (NDoH) has endorsed MMC as an HIV prevention strategy for men in South Africa focusing on medically circumcising men between the ages 15-49 (South African Department of Health, 2016). To date, the National MMC programme has achieved extraordinary scale having circumcised close to 4.1 million men. The programme continues scale-up services and has set ambitious targets of circumcising another 2.5 million men by 2022 to reach 80% of HIV negative men aged 15-49 years (SANAC, 2017).

PEPFAR supports the MMC programme in South Africa. However, PEPFAR has been transitioning out of South Africa since 2016, with its contribution shifting from monetary investment to more technical assistance. To ensure continuity of MMC services nationally, the NDoH MMC programme introduced and facilitated the contracting of additional service delivery partners via its RT35 National Treasury Transversal Contract for MMC services to support Provincial Department of Health (PDoH) sites to achieve individual facility and district targets (South African Department of Health, 2018). PEPFAR continues to support 27 districts, while 25 districts have RT35 contracts.

In South Africa, the winter season has the highest rate of MMC uptake, contributing approximately 50-60% of the annual MMC target. The previous FY18/19 winter campaign was named Project 300K with a target of 300 000 MMC's contributing toward a National target of 550 000 MMC's. This target was surpassed, with a total of 310 987 circumcisions conducted at the end of the campaign.

It is with this background that the NDoH initiated a project management approach in line with the winter high volume season by setting high targets aimed at achieving 400 000 circumcisions between April and September 2019, using innovative demand generation strategies. Project 400K necessitated the coordination of key stakeholders, including NDoH, PEPFAR implementing partners, RT35 partners and MMC Sustain (through the Bill and Melinda Gates Foundation), to implement a project capable of increasing National uptake of MMC without compromising the quality of individual procedures or the collection of programme data. To do so, NDoH coordinated communication and implementation processes between the partners by hosting bi-weekly meetings to facilitate collaboration and standardising data analyses processes. Data were submitted and analysed weekly. Based on these analyses, high and low-performance trends were identified and partners were asked to investigate, evaluate or introduce new interventions where needed.

2. AIM AND OBJECTIVES

The Project 400k campaign aimed to build on the considerable gains made during Project 281K and Project 300k. The specific objectives of the campaign were to:

- Maximise on the increased demand and uptake of MMC services during the winter season among the priority target population of HIV negative males aged 15-34 years;
- Scale-up of MMC services in all districts;
- Monitor the reporting and capturing of data on DHIS;
- Ensure effective monitoring of AEs in all districts;
- Effectively monitor men's health screening indicators; and
- Disseminate best practices and lessons learned.

3. METHODS

The NDoH was responsible for coordination and guidance of implementing partners, as well as communicating with subnational levels to ensure alignment and establishment of collective management of data. Project 400k monitoring was implemented through weekly submission of data which was collated, cleaned and analysed. There were also bi-weekly meetings held at the NDoH. The purpose of the bi-weekly meetings was:

- To monitor performance to ensure timely identification of challenges, agree on corrective action and to monitor remedial activities;
- To dissimilate the performance data; and
- To share best practices and lessons learnt.

4. IMPLEMENTING PARTNERS

PEPFAR prime implementing partners, through the Centre of Disease Control (CDC) and United States Agency for International Development (USAID) and RT35 partners, were responsible for the provision of MMC services during the campaign. Partners were responsible for coordinating their sub-partners, including demand generation partners, as well as their activities in the supported districts. Table 4 below depicts the prime partners' and their supported districts.

Table 4: Implementing partners and districts

Implementing Partner (Funder)	Provinces	Districts
Aurum Institute (RT35/DCS)	FS	Fezile Dabi, Mangaung, Xhariep
	GP	Ekhurleni, Sedibeng, Tshwane
	KZN	eThekwini, iLembe, King Cetshwayo Ugu, uMgungundlovu, uMkhanyakude

Implementing Partner (Funder)	Provinces	Districts
	LP	Capricorn, Sekhukhune, Vhembe, Waterberg
	MP	Ehlanzeni, Gert Sibande, Nkangala
	NC	Francis Baard, John Taolo Gaetsewe, Namakwa, Pixley, ZF Mgcawu
	NW	Bojanala, Dr Kenneth Kaunda, Dr Ruth Segomotsi Mompati, Ngaka Modiri Molema
	WC	West Coast
J Galt Express (RT35)	GP	West Rand
	KZN	Amajuba, iLembe, uMzinyathi
	WC	Cape Winelands
JHPIEGO (CDC)	EC	Amathole
	KZN	eThekwini, King Cetshwayo, Ugu, uMgungundlovu, uMkhanyakude, uThukela
	MP	Nkangala
	WC	Cape Town
Right to Care (RTC) (CDC)	EC	Alfred Nzo, Amathole, OR Tambo,
	FS	Thabo Mofutsanyane
	MP	Nkangala
	NW	Dr Kenneth Kaunda, Ngaka Modiri Molema
Society for Family Health (SFH) (CDC)	EC	Buffalo City, Chris Hani
	KZN	eThekwini, Harry Gwala, uMgungundlovu
	WC	Cape Town
TB/HIV Care Association (THC) (RT35)	EC	Joe Gqabi, Nelson Mandela Bay, Sarah Baartman
	WC	Central Karoo, Garden Route, Overberg

Implementing Partner (Funder)	Provinces	Districts
University Research Company (URC) (USAID)	FS	Lejweleputswa
	GP	Ekhurleni, Johannesburg, Sedibeng, Tshwane
	KZN	eThekwini, Zululand
	LP	Capricorn, Mopani
	MP	Ehlanzeni, Gert Sibande
	NW	Bojanala

Initially, seven prime partners participated in the Project 400k campaign. However, during the campaign, there were challenges with University Research Company (URC) and their contract subsequently came to an end, leaving six partners with the task of achieving the Project 400k target. In mid-July, services in the districts which were supported by URC came to a halt as did the data submissions. This negatively impacted on the success of the campaign.

5. COLLABORATION WITH TRADITIONAL SECTOR

One of the historical challenges with the implementation of MMC in South Africa is the continued preference for traditional male circumcision in communities that view traditional circumcision as a rite of passage (Shisana O, 2014). Strengthening the integration of traditional sector and MMC, especially in geographies where traditional circumcision is more common than MMC is essential to a successful programme (Simbayi LC, 2019).

As with the previous campaigns, negotiating with local stakeholders was essential to promoting MMC activities in traditional male initiation (TMI) predominant areas during the implementation of Project 400k. The purpose of these engagements was to ensure that partners were able to provide safe and effective MMC services in a culturally appropriate setting that allows for the promotion of HIV prevention within traditional environments. Partners were responsible for the engagement of traditional sector stakeholders in culturally sensitive provinces such as the Eastern Cape, Mpumalanga and KwaZulu-Natal.

URC engaged with traditional practitioners in Inanda reinforcing the benefits of MMC. Collaborations between MMC service providers and those carrying out traditional circumcision were ongoing and this impacted positively towards project 400k performance between April and June as seen in the performance during this period.

Jhpiego worked very closely with traditional coordinators to mobilise for MMC. Furthermore, they worked closely with Prince Nhlanganiso Zulu of the Zulu Kingdom, under the Isibaya Samadoda campaign.

6. DEMAND GENERATION

Demand generation is the focus on targeted programmes which aims to drive awareness and interest in MMC services among men (National Department of Health, 2018). There is strong evidence to indicate that where men have been exposed to social behaviour change communication (SBCC), through demand generation strategies, there have been higher uptake levels of MMC's (Simbayi LC, 2019).

Demand generation plays a critical part in reaching men aged between 15 – 34 and it played a pivotal role when it came to the MMC performance during project 400k (April to September 2019). Partners transitioned well and managed to plan their implementation of demand generation initiatives during the peak seasonal period. This was particularly true in June, which due to school holidays and the notion that the healing process is much quicker during this period, sees a very high uptake of MMC services.

Partners main methods of demand generation were centred on utilising the tools that were already available such as community radio broadcasters as well as print media. In areas like Dr Kenneth Kaunda, art murals were painted in various communities in Klerksdorp as part of the demand generation strategy. Furthermore, the partner in this district collaborated with one of the national radio channels, SAFM which assisted by using their twitter handle as a form of education and sensitization. This strategy proved that social media is vital in creating demand for MMC services.

The strong collaborations which partners had with facilities in creating demand for services proved to be effective with a notable uptake in service during the campaign. JHPIEGO, for example, opted to strengthen partnerships that focus on male-dominated workplaces in King Cetshwayo District. Furthermore, five other demand generation partners supported with community mobilisation. Jhpiego has also conducted demand generation training, edutainment through soccer tournaments in eThekwini, Ugu, uMkhanyakude and uThukela. Table 5 below highlights some of the partners' demand generation initiatives during the campaign:

Table 5: Demand generation initiatives

Demand generation initiatives	Description	Partner
Celebrity endorsement	Community ambassadors (people that the community can identify with and can tell their story within the community) used to promote MMC. Use of traditional leaders (e.g. Prince in KZN).	RTC JHPIEGO
Edutainment	Edutainment was used to reach young men through providing them with information at social events e.g. soccer tournaments.	JHPIEGO
Incentives	Provision of vouchers for clients to compensate for men's time away from work launched in KZN and WC targeting men 18 and above.	SFH

Demand generation initiatives	Description	Partner
Interpersonal communication	Hosting camps over the weekend which allow parents to accompany children to get MMC. Community dialogues and workshops hosted by outreach coordinators. Use of social mobilisers in the community (spaces where men can be found) e.g. male-dominant workplaces.	THC SFH JHPIEGO
Mass media	Wellness campaigns. Mass distribution of Information, Education and Communication (IEC) materials.	AURUM RT35 JHPIEGO

7. RESULTS

7.1. TARGET SETTING AND ALLOCATIONS

All partners were required to pledge monthly targets for April – September which would be used as a basis to monitor performance during the campaign. While partners were requested to pledge targets to meet the NDoHs 400k target, the targets pledged by implementing partners did not tally up to 400 000. This was due to partners' changing their targets regularly throughout the campaign. This made it difficult to tally the total targets pledged until the campaign came to an end. In total, implementing partners pledged a combined target of 399 613 which resulted in a deficit of 387 to reach the 400 000 target as seen in Table 6 below.

Table 6: Partner targets

	April	May	June	July	August	September	Total Targets
AURUM DCS	430	620	1600	490	430	430	**4000**
AURUM RT35	5960	4880	13370	7312	4872	2436	**38830**
J GALT	4700	4700	4700	4700	4700	4700	**28200**
JHPEIGO	15000	15000	25000	20000	15000	10000	**100000**
RTC	2535	5415	24628	15896	1505	1405	**51384**

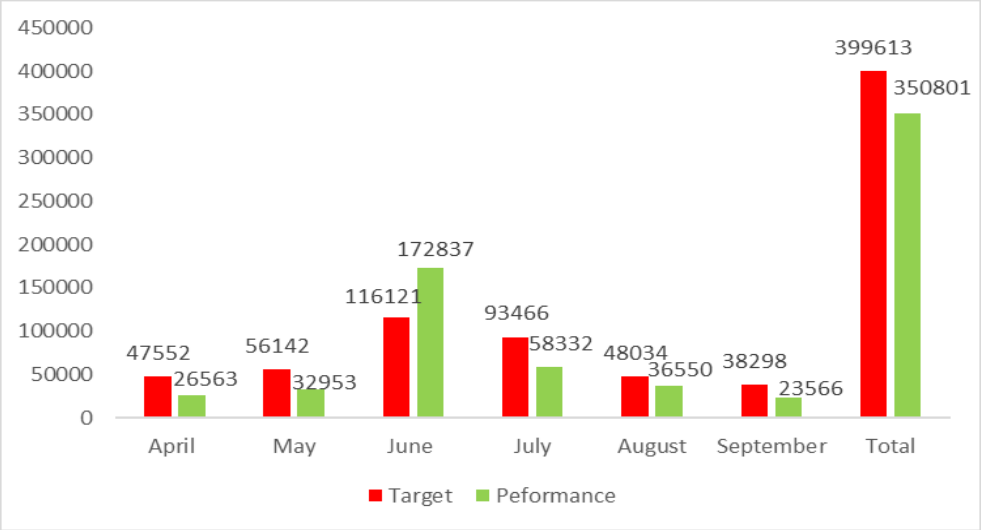
SFH	4200	10800	17693	15938	6800	4600	**60031**
THC	1157	1157	1157	1157	1157	1157	**6942**
URC	13570	13570	27973	27973	13570	13570	**110226**
Total	**47552**	**56142**	**116121**	**93466**	**48034**	**38298**	**399613**

7.2. NATIONAL PERFORMANCE

7.2.1. Project 400k performance

Project 400k concluded with a total of 350 801 MMC's reported between the period of April and September 2019, reaching 88% of the target. Figure 1 below depicts the campaign's monthly performance. Most circumcisions were completed in June and July while April and September had the least reported circumcisions.

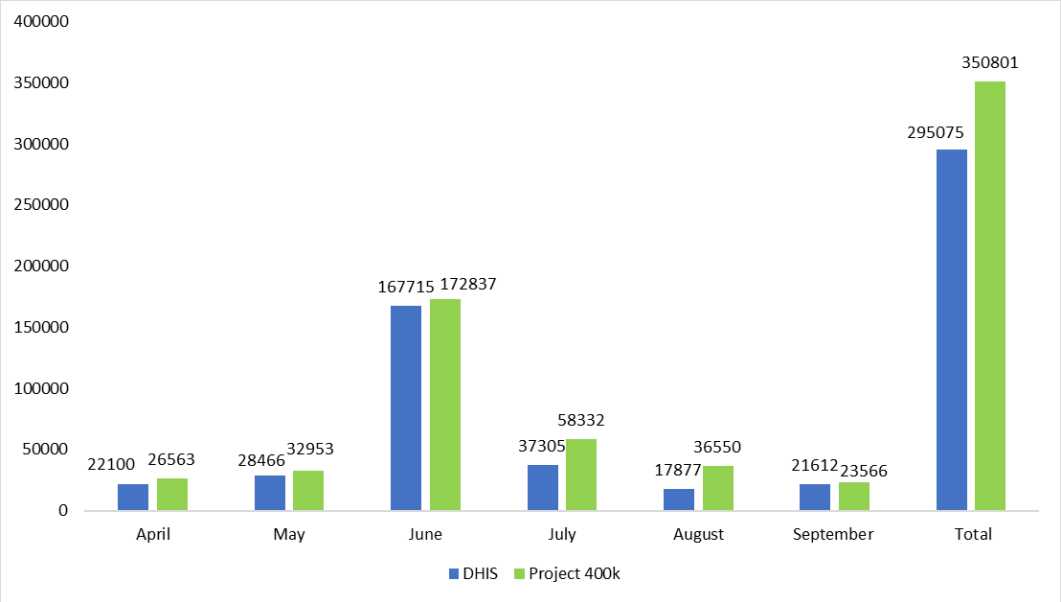
Figure 1: National performance



The total performance is based on partners weekly submissions for the duration of the campaign. Partners reported numbers indicated a much higher performance in comparison to data recorded on the District Health Information System (DHIS). According to DHIS, a total of 295 075 circumcisions were completed between April and September, indicating that 74% of the Project 400k target was reached as seen in

Figure 2 below.

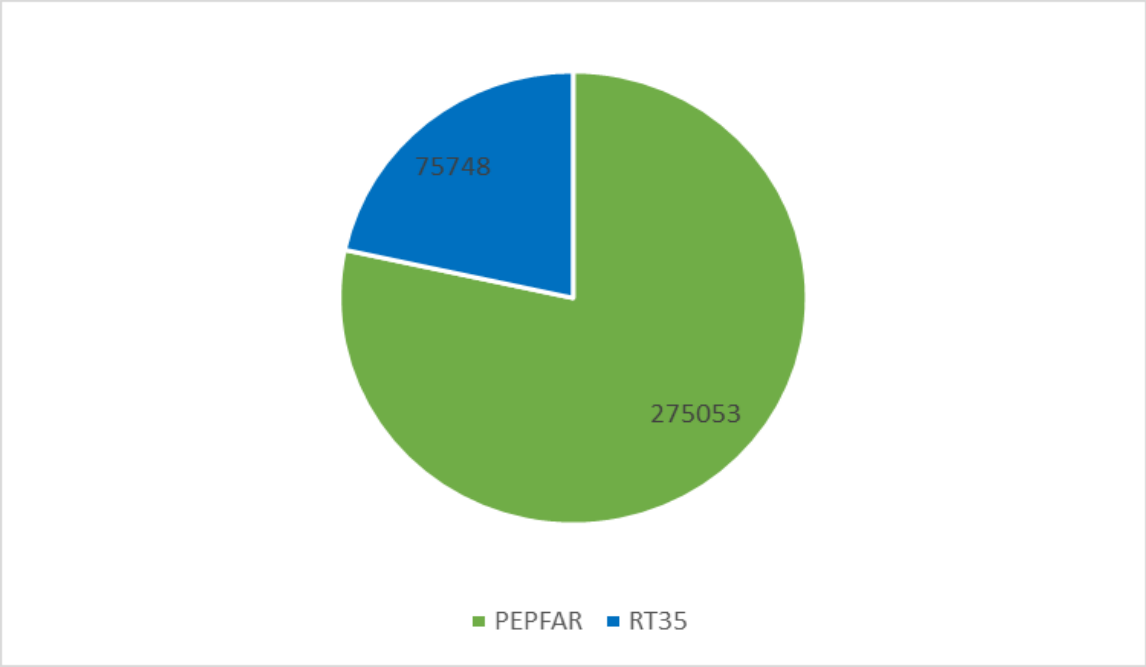
Figure 2: Project 400k vs DHIS



7.2.1. Project 400k performance RT35 vs PEPFAR

Performance of the RT35 districts was much lower during the campaign, contributing 22% of the Project 400k performance while the PEPFAR supported districts contributed 78% of the MMC's completed during Project 400k. This appears to support PEPFARs transition based on exiting saturated districts to focus on less saturated districts for the highest impact. The total numbers are depicted below in Figure 3 below.

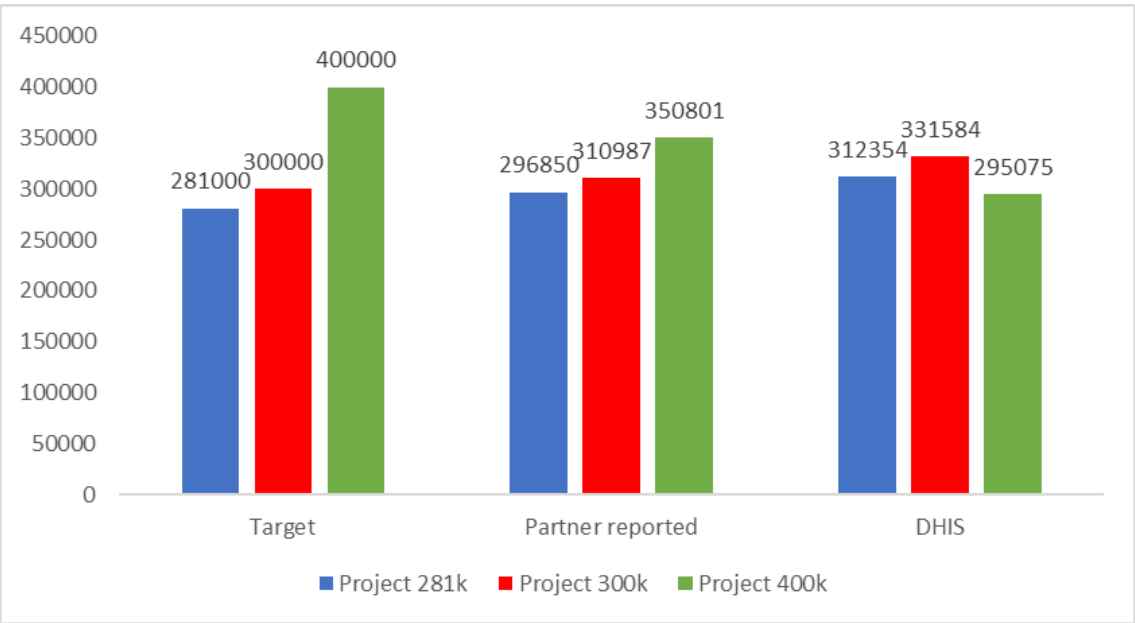
Figure 3: RT 35 districts vs PEPFAR districts



7.2.2. Project 400k comparison to previous campaigns

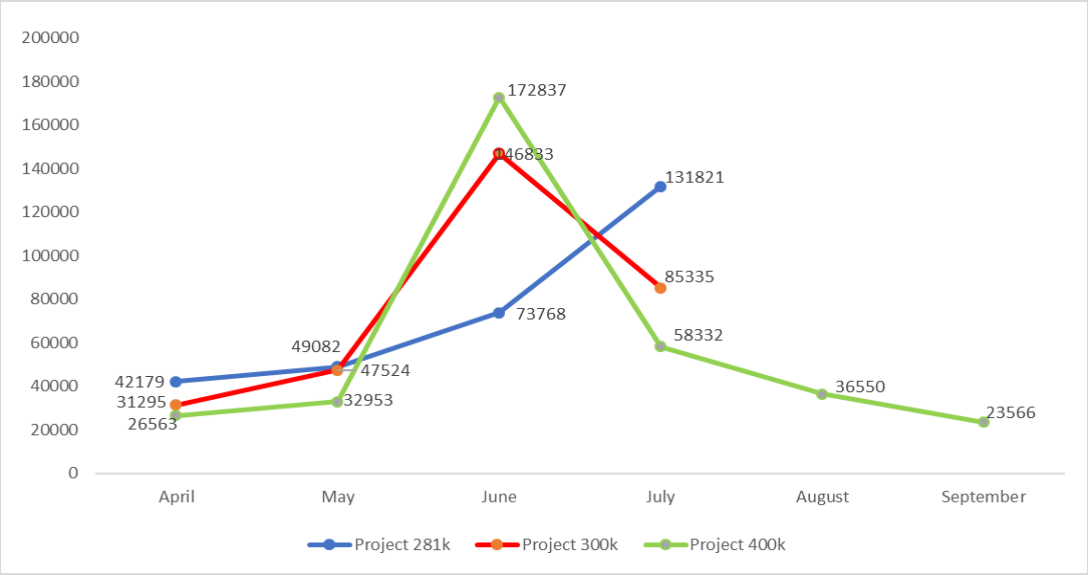
Project 281k and 300k surpassed the set targets. Project 400k target was not met, with a shortfall of 49 199 MMCs. While Project 400k targets were unmet, the campaign completed 39 814 more circumcisions than Project 300k as seen in Figure 4 below. In contrast to the previous campaigns, Project 400k was implemented over six months while the two previous campaigns were concluded in four months. Figure 4 further illustrates that for Project 400k there were discrepancies between partner reported data and DHIS data, which indicates that the Project 400k campaign performance was, in fact, lower than the partner reported performance.

Figure 4: Historical winter campaign performance



In analysing the monthly trends across the campaigns, it is evident that the number of MMC's conducted increased in May and June for all three campaigns. This spike in performance, specifically in June, can be attributed to the school holiday period which increases the availability of school-going boys to undergo MMC. Moreover, the winter season peaks can be attributed to the widespread misconception that the wound heals faster during winter. However, while the increasing trend continues in Project 281k, the increasing trend comes to a halt during Project 300k and 400k, where performance significantly decreases in July as seen in Figure 5 below.

Figure 5: Historical monthly campaign performance

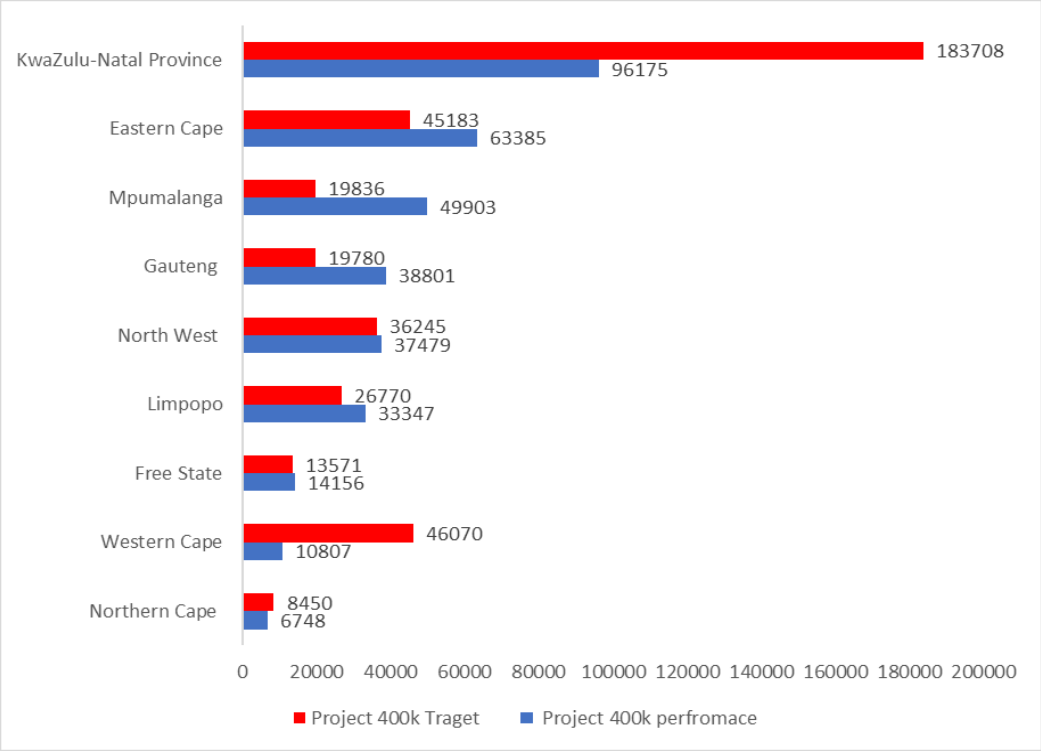


7.3. PROVINCIAL PERFORMANCE

KwaZulu-Natal contributed the highest number of MMC's during the campaign, completing 96 175 MMC's in total. The performance was also high in Eastern Cape and Mpumalanga, with a reported 63 385 and 49 903 MMC's, respectively, as seen in Figure 6 below. Provinces which completed the lowest circumcisions were Western Cape and Northern Cape performing 10 807 and 6 748 MMC's respectively.

In terms of performance against targets, the vast majority of provinces exceeded their target for the campaign period. Overachievement of targets is evident in Mpumalanga, Eastern Cape, Gauteng, Limpopo, Free State and North West as seen in Figure 6 below. Provinces which were unable to meet the set targets were KwaZulu-Natal, Northern Cape and Western Cape.

Figure 6: Project 400k provincial performance



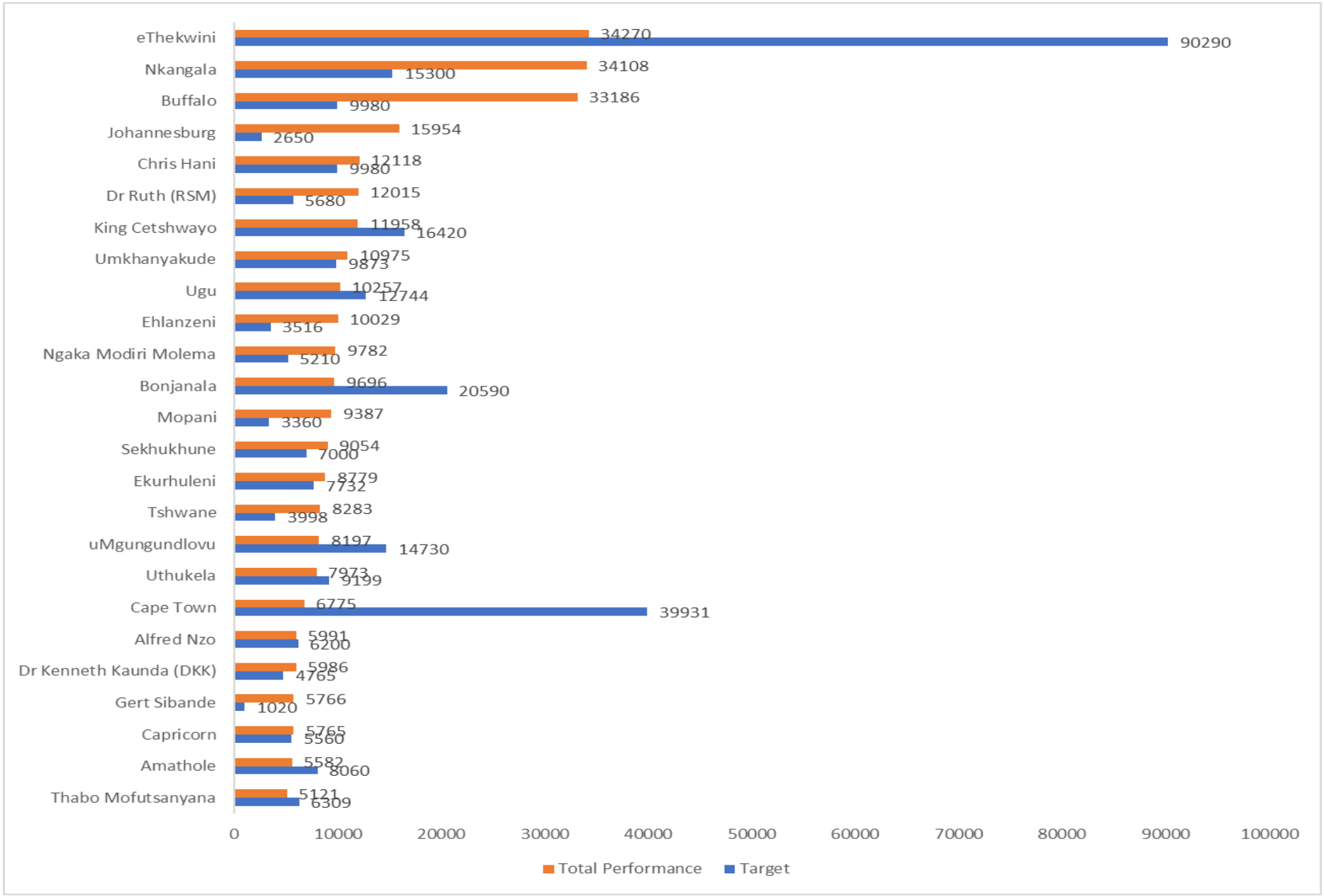
7.4. DISTRICT PERFORMANCE

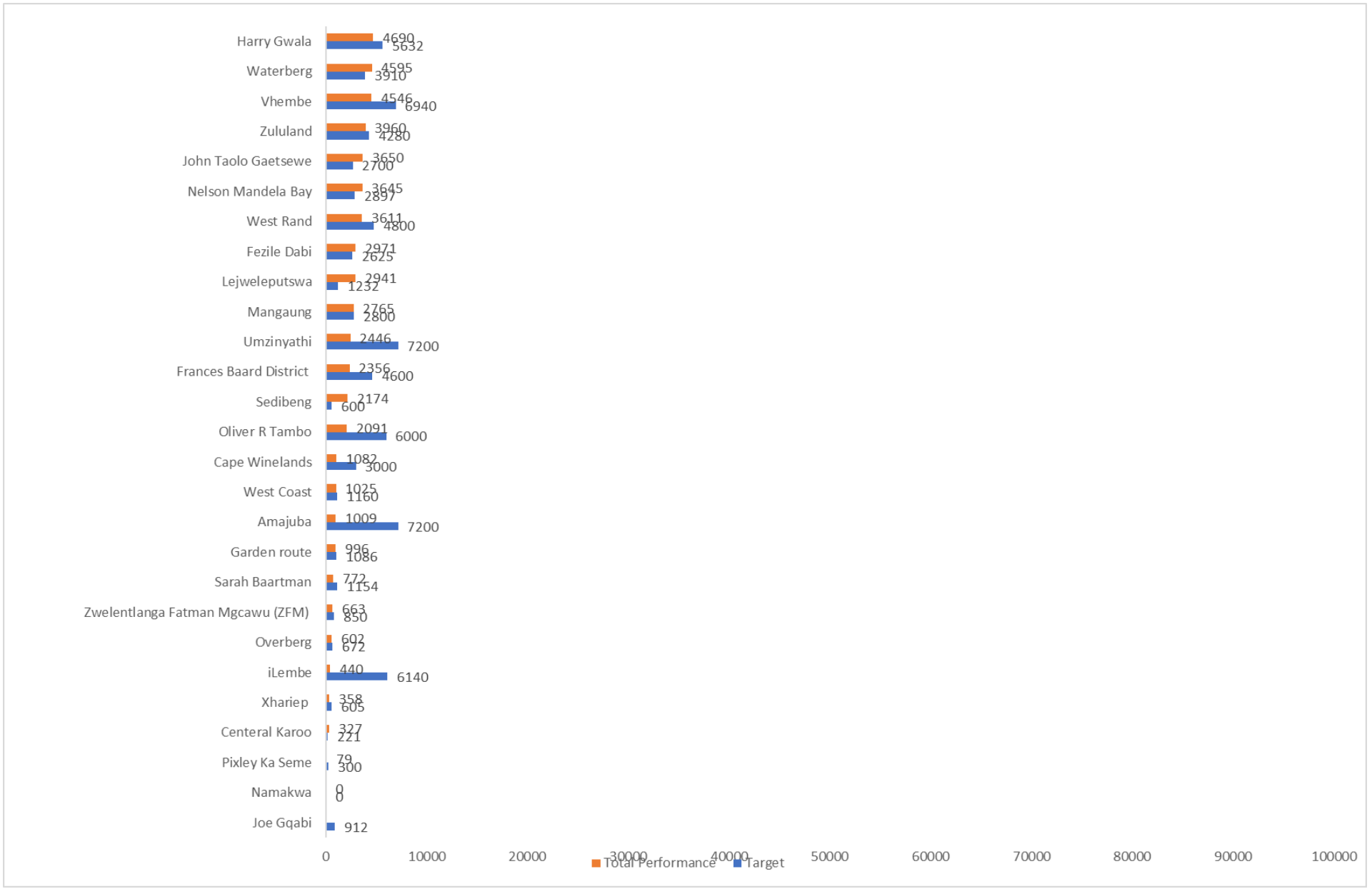
There were three top-performing districts during Project 400k. These districts produced the highest number of circumcisions. eThekwini completed 34 270 MMCs. However, this was 38% of the district target. Nkangala and Buffalo City had a total performance of 34 108 and 33 186 MMC's respectively as seen in Figure 7 below. These two districts exceeded their targets reaching 223% and 333% of the set targets, respectively.

Districts which far surpassed their targets were Johannesburg and Gert Sibande which completed 602% and 565% of their targets, respectively. The targets for these two districts were most likely set too low at the beginning of the campaign thus the significant over performance.

A total of 22 districts exceeded their targets while 29 districts were unable to meet their targets. There was no target allocated for Namakwa district in Northern Cape as the District did not have a supporting partner. There were no circumcisions completed in Namakwa and Joe Gqabi, the implementing partner attributes the poor performance in Joe Gqabi to a letter from the Northern Cape Department of Health restricting demand generation activities. Other low performing districts were iLembe (7%) and Amajuba (14%) and Cape Town (17%).

Figure 7: Project 400k performance by district

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Waterberg
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Zululand
3960
4280
John Taolo Gaetsewe
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2700
Nelson Mandela Bay
3645
2897
West Rand
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Fezile Dabi
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Oliver R Tambo
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Cape Winelands
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West Coast
1025
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Amajuba
1009
7200
Garden route
996
1086
Sarah Baartman
772
1154
Zwelentlanga Fatman Mgcawu (ZFM)
663
850
Overberg
602
672
iLembe
440
6140
Xhariep
358
605
Centeral Karoo
327
221
Pixley Ka Seme
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Namakwa
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70000
80000
90000
100000
Total Performance
Target

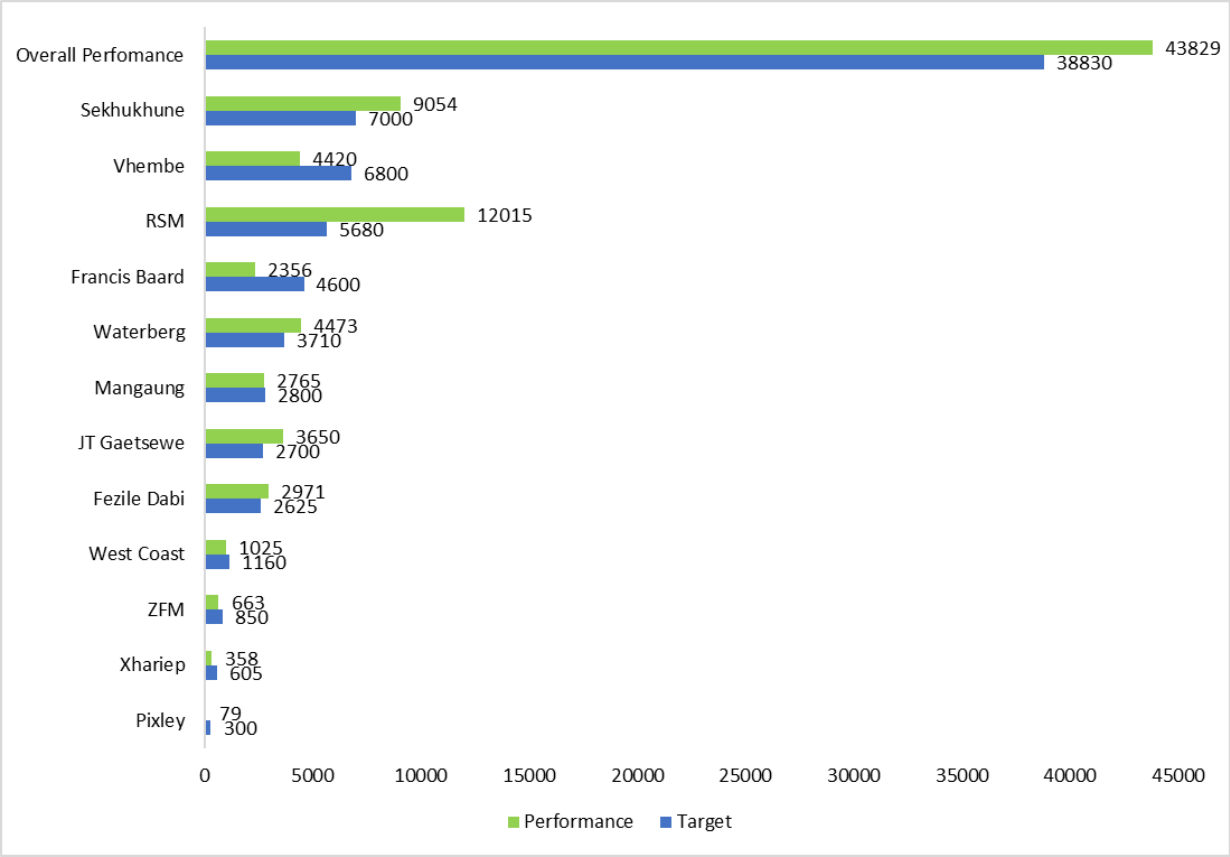
7.5. PARTNER PERFORMANCE

7.5.1. AURUM

Overall, Aurum completed 46 763 MMC's which is 109% achievement of their 42 830 target. This achievement incorporates the performance of both Aurum's RT35 districts and the Department of Correctional Services (DCS) sites.

In total, there were 12 Aurum RT35 districts. Of these districts, five districts surpassed their targets, while some districts struggled to meet the set targets. Aurum RT35 performance far surpassed the overall set targets of 38 830, with a total of 43 829 MMC's completed as seen in Figure 8 below. This reflects a 113% achievement.

Figure 8: AURUM RT35 performance

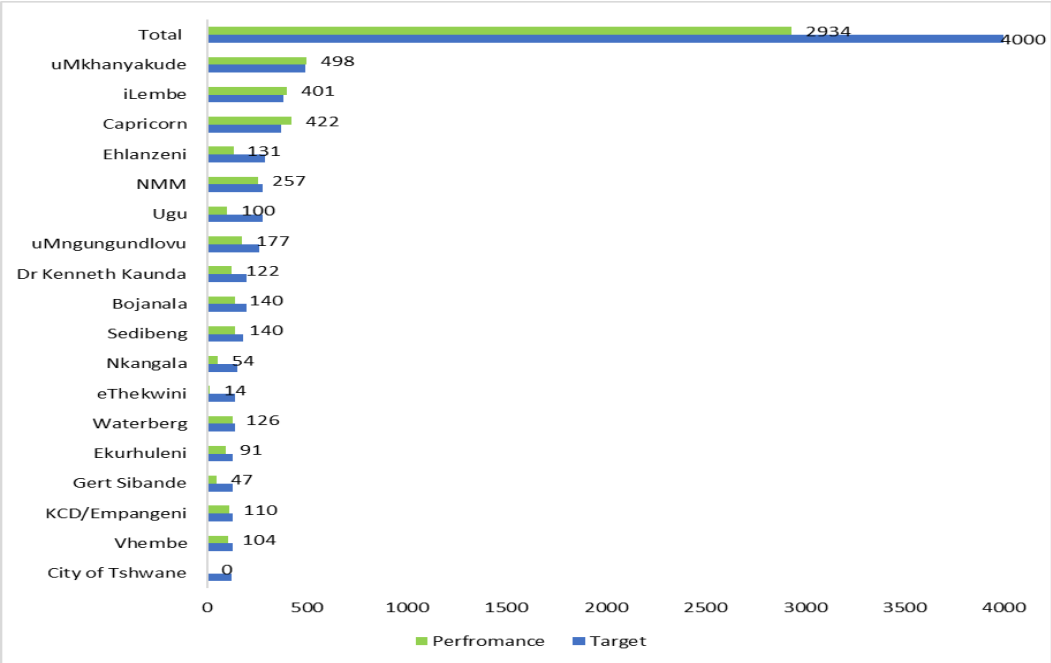


Also, Aurum performed circumcisions at the department of correctional services (DCS), in 18 districts. Of the 18 Districts, targets were met in eThekwini, Ekurhuleni and Tshwane, while the rest of the district targets were not met. The overall target for DCS was 4 000 MMCs. In total 2 934 MMC's were completed in correctional services during the campaign as seen in

Figure 9. This equates to 73% achievement. Aurum reported that the low performance in DCS sites was due to difficulty in gaining access to correctional services. The Aurum DCS grant came to an

end at the end of the campaign and has since been awarded to TBHIVCare to continue providing services.

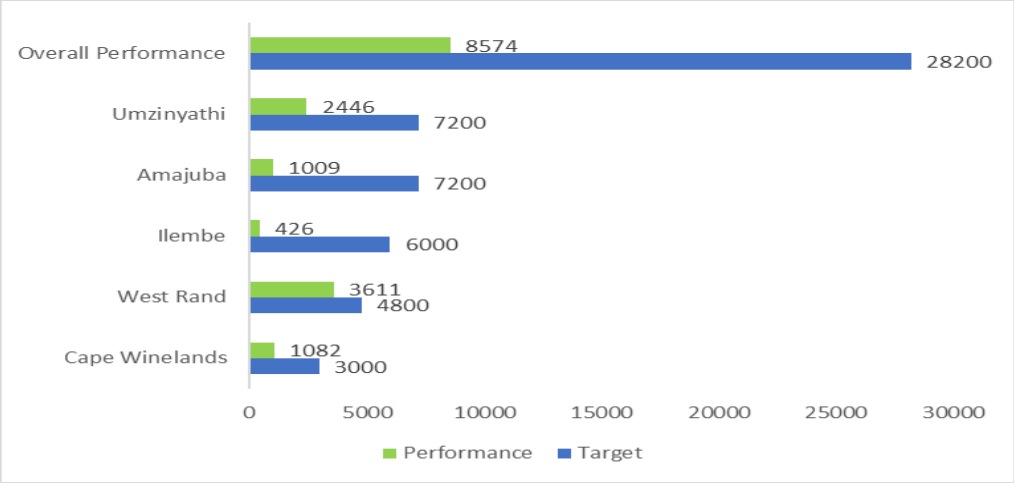
Figure 9: AURUM DCS performance



7.5.2. JGALT

JGALT was responsible for providing MMC services in five districts, three of which were in KwaZulu-Natal, one in Gauteng and one in Western Cape. JGALT's performance was low throughout the campaign. Of the 28 200 target, only 8 574 MMCs were completed at the end of the campaign as seen in Figure 10 below. This equates to 30% of the target. The challenges noted by the partner with regards to low performance was that other unknown services providers were providing MMC services at the partner's allocated sites in KwaZulu-Natal making it difficult for JGALT to gain access to these sites. Furthermore, there was a significant delay in the payment of invoices by KwaZulu-Natal DoH therefore JGALT's subcontractors were not willing to continue to provide services or provide data of MMC's completed due to the non-payment.

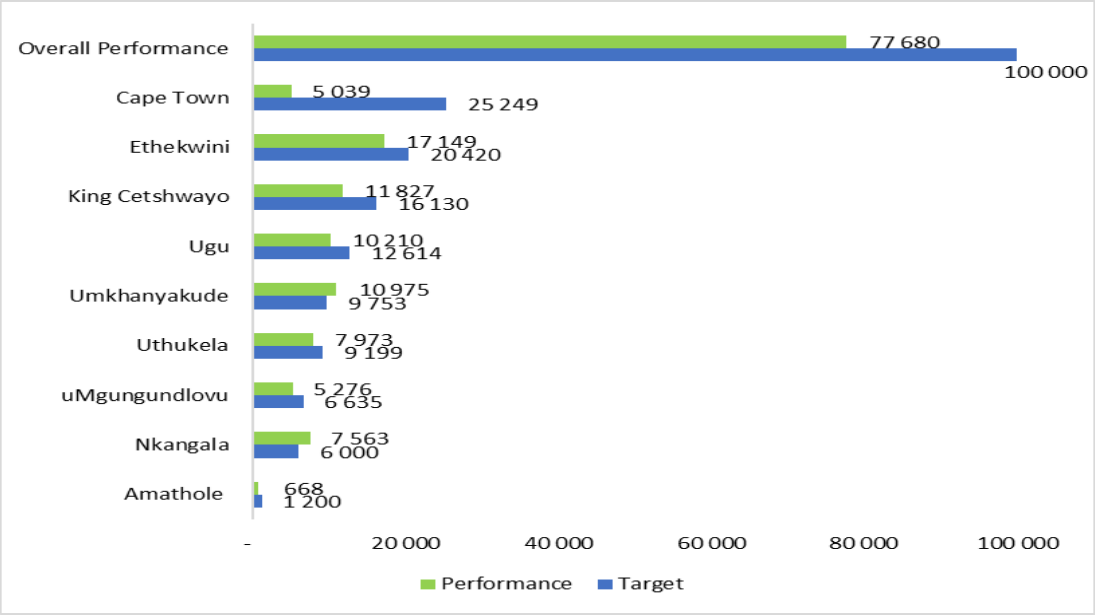
Figure 10: JGALT performance



7.5.3. JHPIEGO

Jhpiego pledged to conduct 100 000 MMC's during the Project 400k campaign. They performed MMC's in nine districts across Eastern Cape, KwaZulu-Natal, Mpumalanga and Western Cape. Jhpiego surpassed the set targets in Nkangala and uMkhanyakude districts. Most of the KwaZulu-Natal districts performed well, with notably low performance in Cape Town, Western Cape. A total of 77 680 MMC's were completed by the end of the campaign as seen in Figure 11 below, which is 78% of the target.

Figure 11: JHPIEGO performance



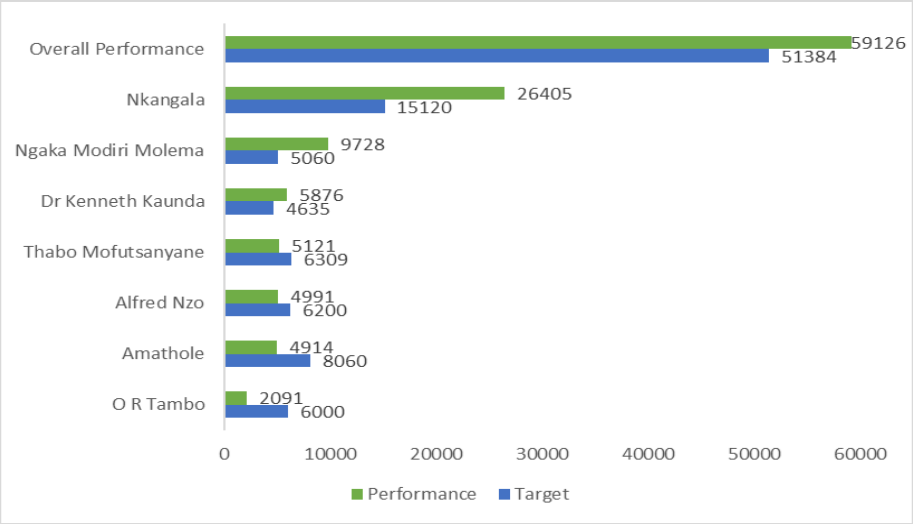
7.5.4. RTC

RTC pledged 51 384 MMCs over the project 400k campaign period. RTC supported seven districts across Eastern Cape, Free State, Mpumalanga and North West. Districts which exceeded targets were Nkangala, Ngaka Modiri Molema and Dr Kenneth Kaunda. Nkangala district exceeded targets by 11 285 MMCs, the over performance can be attributed to the fact that Nkangala is a historically

traditionally circumcising district. Most of the MMC's reported were completed in June, during the winter period, which is traditionally believed to be the best season to undertake circumcision. RTC's total performance was 59 126 MMC as seen in

Figure **12** ,which was 115% achievement.

Figure 12: RTC performance

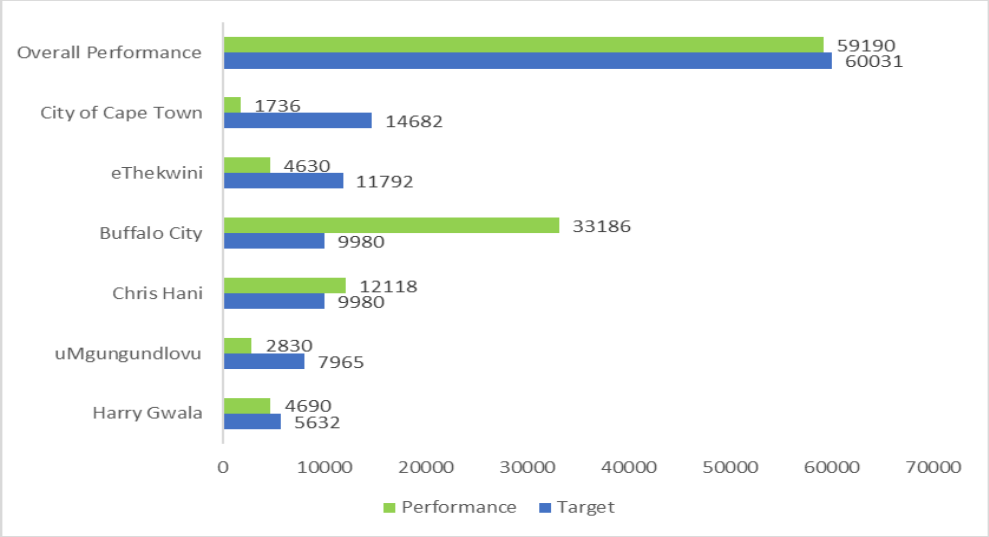


7.5.5. SFH

SFH pledged to perform 60 031 circumcisions during the 400k campaign. They provided services in six districts across Eastern Cape, KwaZulu-Natal and Western Cape. The two districts in Eastern Cape; Buffalo City and Chris Hani exceeded the set targets contributing the highest numbers of MMC's to SFH's overall performance. There were notable challenges in Eastern Cape throughout the campaign, these challenges were specific to aligning partner reported numbers with the numbers captured onto DHIS. DHIS reflected much lower MMC performance. The under-reporting on DHIS contributed to the ongoing data variance challenges. The challenges during the campaign highlighted the need for NDoH to have further discussions with the Eastern Cape to discuss data reporting challenges. SFH completed 59 190 MMC's at the end of the campaign as seen in Figure 13 below. This performance is a

Figure 13 99% achievement.

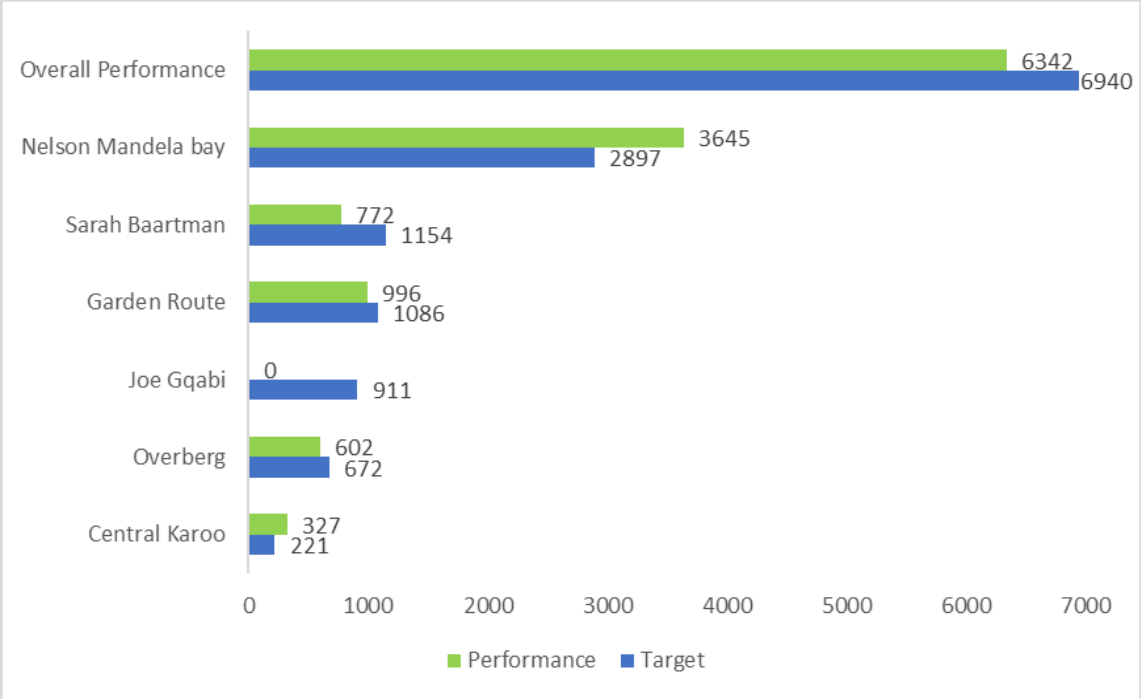
Figure 13: SFH performance



7.5.6. THC

THC pledged 6 940 MMCs during the Project 400k period and completed 6 342 of those MMC's which is 91% achievement as seen in Figure 14 below. THC's highest performing district was Nelson Mandela Bay which achieved 126% of the set target. Notably, there were no MMCs conducted in Joe Gqabi for the duration of the campaign. THC highlighted challenges related to an inability to get access to Joe Gqabi district, as a result, no services were provided. After discussions with the NDoH, it was agreed upon that the targets for this district would be re-allocated to Sarah Baartman district where access had already been obtained.

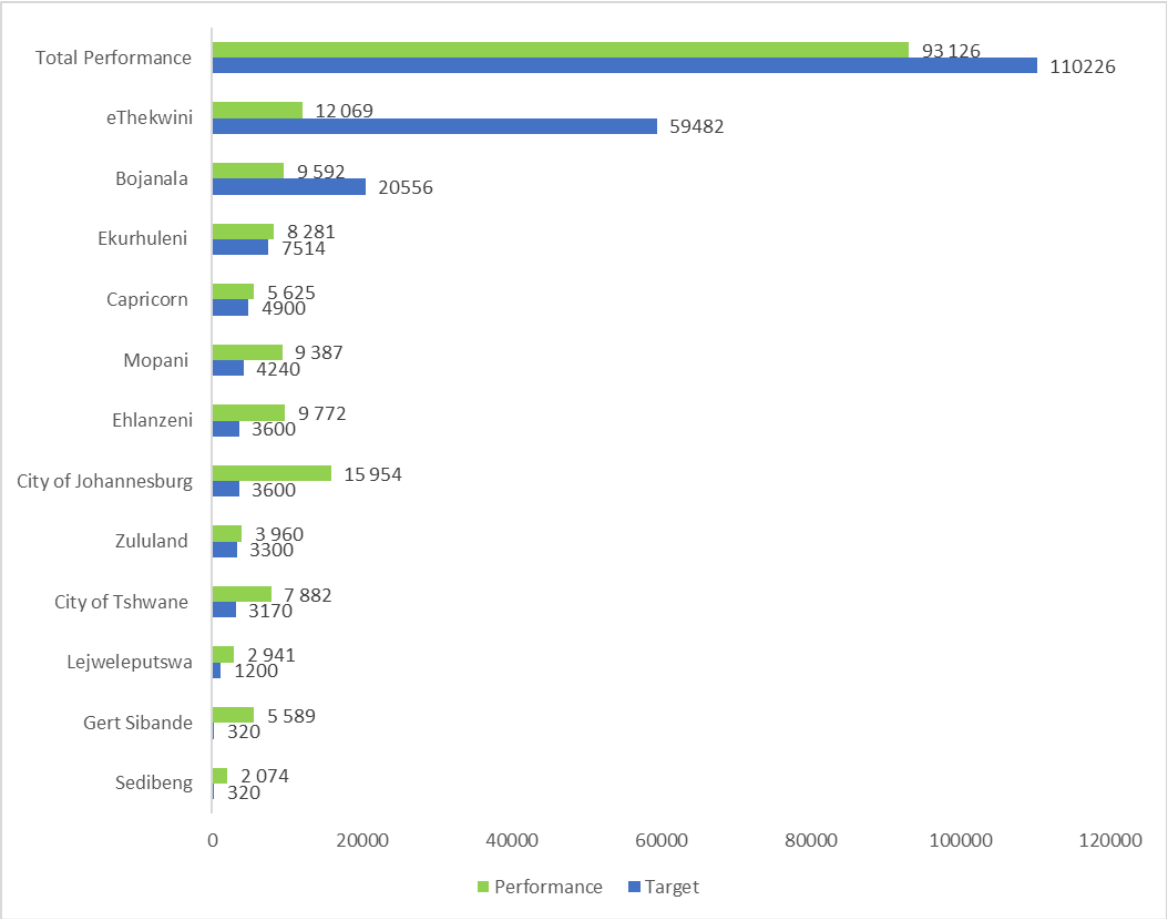
Figure 14: THC performance



7.5.7. URC

URC pledged 110 226 MMC's for the Project 400k campaign. URC exceeded the expected target in eight of the 12 districts which they were supporting. Most notably, was the 271% achievement in the City of Johannesburg. Challenges with this partner resulted in an unexpected stop in the provision of MMC services in July, as a result, the URC target was unmet. As of mid-July, URC had achieved 84% of their target which was a total of 93 126 MMC's as seen in Figure 15 below.

Figure 15: URC performance



7.6. DATA MONITORING

7.6.1. MMC performance reporting

As per the previous campaigns, there were challenges in monitoring data reported by partners during the 400k campaign. The overall number of MMCs reported fluctuated monthly, making it difficult to verify the data monthly and to promptly identify where support was needed.

7.6.1. Men's health screening reporting

MMC implementing partners were requested to report on men's health screening indicators including AEs. Project 400k highlighted the need for improved reporting and analysing AEs by all partners as most districts' AE data was either incomplete or incorrectly captured. Partners were all requested to document AE trends and conduct AE cause analysis, to improve MMC monitoring and review responses to AE by contracted MMC providers. MMC providers were required to review AE trends and develop remedial action plans for AE patterns e.g. identify if there is a need for further training; is it a question of misconduct by the provider; is it due to poor wound care; can communication to clients be improved, and steps to avoid AEs in future.

Follow up visits, HIV testing and referrals were also part of the reporting template. Partners reported difficulty in reporting some of these indicators weekly due to the delay in the submission of data from sub-contractors. An example of this was the seven-day follow-up visit data, in which Partners highlighted the inaccuracy of the data as it would reflect the follow up of the previous week's MMC's rather than those conducted in the reported week.

8. CONCLUSIONS

Overall Project 400k made great strides toward meeting the National Annual Performance Plan (APP) target of 600 000 MMC's. There were notable successes and challenges which impacted the outcome of the campaign and these are detailed below.

8.1. SUCCESSES

8.1.1. Enhancement of MMC programme performance

While Project 400k targets were not met during the campaign, the reported performance was higher than the previous campaign (Project 300k). At the end of the campaign, there were 39 814 more MMCs conducted compared to Project 300k. This will make a significant contribution to the 600k APP target.

8.1.2. Innovative demand generation initiatives

Partners highlighted several successes with regards to demand generation. Partners mentioned that they used existing platforms such as mass media and social media. However, where necessary, partners moved away from old demand generation activities which were bearing no yield. The most notable successes were initiatives which targeted male-dominant workplaces, coming up with male-targeted activations such as soccer tournaments to reach men and providing men with small incentives such as vouchers to compensate men for time spent away from work while up taking MMC services. Partners also worked in collaboration with additional demand generation partners and this assisted in the provision of MMC initiatives across the districts. Active demand generation is essential for the success of the MMC programme.

8.1.3. Development of data variance reports

Partners also identified that lack of access to DHIS limits regular monitoring of data which had been uploaded on DHIS. This was mentioned as one of the causes of the ongoing discrepancy in the data reported by partners versus data reflected on DHIS monthly. A data variance report was developed monthly to allow partners to have oversight of the variance at a district level. Since the development of the reports, the most notable decrease in variance was seen in Nkangala which had a variance over 20 710 in July. This subsequently decreased to 2 560 at the end of the campaign.

8.2. CHALLENGES

8.2.1. Inadequate target setting

The total MMC targets pledged by partners did not reach the required 400k target. This meant that even if all partners had met their targets, 400 000 MMCs would still have not been met. This was not recognised until the last month of the campaign because partners changed the pledged targets throughout the campaign making it difficult to monitor the total number pledged until the final month.

8.2.2. Unexpected Implementing partner changes

URC had the largest portion of the Project 400k target, as they had committed 110 026 MMC to be conducted between April and September. Moreover, of the 12 districts which URC supported, they were the only partner in four of these districts; Mopani, Lejweleputswa, Johannesburg, and Zululand. Due to unforeseen challenges, URC's contract came to an abrupt end before the end of the campaign and their participation in the campaign ended during the second week of July. As a result, four districts were left with no partner support and the remaining districts were left with reduced partner support. It is understood that URC performed circumcisions until the end of July and met their COP 18 target. This would mean that URC met their Project 400k target. However, data submissions to the NDoH were last received during the second week of July thus impacting their overall performance for the campaign.

Additionally, there was a notable decline in performance during the transition from one partner to the next, especially in DCS (Aurum- North West). This was as a result of operational arrangements with MMC partners, this highlighted the need for a dedicated DCS health team to support MMC providers.

8.2.3. Poor coordination at provincial and district levels

Eastern Cape has always been a traditionally circumcising community. The introduction of MMC requires strong coordination and integration between the two sectors. While Implementing Partners made progress by accessing TMI sites, engagements proved inadequate as partners working in the Eastern Cape reported that the Province did not allow for active demand generation. The PDoH instructed partners to perform MMC on walk-in clients only thus reducing demand and overall circumcision achievement.

Additionally, while partners were able to perform MMC, they were unable to ensure that all the data was reported into the DHIS. Eastern Cape leaders insisted that MMC data cannot be uploaded without the provision of supporting documents which were different from the documents that the partners were using. This resulted in the data not reaching the DHIS causing a large variance between partner reported numbers and DHIS data. Inadequate engagement of these leaders impacted on the success of Project 400k and ultimately the success of the whole MMC programme as vast numbers of MMC's are conducted in the Eastern Cape. During the campaign, partners reported 63 385 MMC completed, however, only 5795 were recorded onto DHIS.

Furthermore, there were also notable challenges in Joe Gqabi and Namakwa where no circumcisions were completed within the six-month campaign period, due to challenges in accessing the districts. This highlighted the need for future intensified engagement with these districts.

8.2.4. Increasing data variance

There was an increasing data variance between partner reported data and data reflecting on DHIS. The data variance increased every month. Partners reported that they were unable to follow up on data issues unless they had access to the data variance at a district level. In June a data variance report was shared will all partners as an intervention to identify which districts needed to be followed up. While every effort was made by partners to continue to follow up with their supported districts at the end of the campaign there was still a notable variance in the total number of MMC conducted. The province with the highest variance was Eastern Cape as seen in Table 7 below. This issue impacted the overall success of the project.

Table 7: Data variance per province

Province	Variance
Eastern Cape	57590
Free State	-1676
Gauteng	-20766
KwaZulu-Natal Province	12871
Limpopo	-4544
Mpumalanga	2225
Northern Cape	1210
North West	8561
Western Cape	830

9. RECOMMENDATIONS

Overall NDoH's approach of transitioning the MMC programme into a project during the winter period is one of great value, particularly concerning oversight and monitoring of the programme performance. Project 400k campaign allowed for knowledge sharing with partners and also quick identification of bottlenecks which needed to be addressed to ensure that the programme achieves the APP targets. However, partner reported data should only be used as a proxy to monitor programme performance rather than for reporting purposes as partner reported data is subject to PEPFAR verification, furthermore this data does not reflect on DHIS.

9.1.1. Improved target setting

Target setting is an important part of the programme. Partners should be capacitated to pledge targets for the winter campaign that are well aligned to the APP targets. Also, partners should not be allowed to change set targets during the campaign based on performance. This will ensure consistency and better monitoring of progress toward set targets and efficient identification of challenges, some of which can be course-corrected during the campaign. Tools such as the DMPPT 2 tool should be prioritised as a mechanism for adequate target setting in future.

9.1.2. Adequate planning for partner changes

Partners need to be viewed as a support structure, not owners of the programme, to ensure a DoH led MMC programme. This will ensure that, should partners exit the programme, planned or unplanned, MMC services will still run smoothly and uninterrupted in all DOH facilities. Partners should be required to submit a transition plan to DOH in advance, which clearly outlines the handover processes which will be undertaken should they need to transition out of a district.

9.1.3. Strengthening of traditional sector engagements

There is still the need to strengthen relationships between the DoH and the traditional sector, particularly where TMI is still more prominent than MMC. This finding is further substantiated by the findings in the HRSC 2017 report (Simbayi LC, 2019) which mentioned that in districts where traditional MMC is more prevalent, there needs to be strengthened integration to meet the goal of saturating the targeted age group.

Specifically, in the Eastern Cape, the engagement strategy needs to be adapted to ensure that leaders in the Province understand the need to be able to separate the reporting of TMI and MMC data. This will subsequently allow for the capturing of MMC data onto the DHIS and address the data variance issues observed specifically in Buffalo City.

9.1.4. Strengthening of provincial and district engagements

Partners are encouraged to raise challenges with NDoH when they arise to ensure that strategies can be put in place to ensure there is constant access to MMC services. If engagements are not

successful then partners should be encouraged to shift the allocated targets to other districts where access has been granted, in order not to impact the overall programme performance.

9.1.5. Continued and targeted demand generation

Partners mentioned that there was a visible improvement in implementing changes in some of the demand generation strategies such as going to find men where they were e.g. male-dominated workplaces rather than waiting for them to come to facilities. One of the identified barriers to seeking services reported by men is fear of losing out on compensation if time is taken off work. Therefore, partners are encouraged to provide compensation to those men for their travel and loss of wages.

9.1.6. Consistent data variance analysis (DVA) monitoring

Partners mentioned throughout the campaign that they struggled to adequately address challenges concerning the data variance because they had no sight of the DHIS data. In response to this, monthly data variance reports were developed which presented the partner data against DHIS so that partners could see the variance breakdown at the district level. This allowed partners to identify whether the districts they were supporting needed any intervention to ensure all the data was captured onto DHIS. Partners need to be able to see where the data variance issues are to be able to follow up accordingly with districts. A true success story has been Nkangala district. DVA reports should be developed for all partners monthly as a programme monitoring mechanism to assist with speedy identification of challenges in data submission and uploading.

9.1.7. Improved coordination of MMC data flow from facility to provincial and national level

During Project 400k it became evident that there were discrepancies between data submitted to the facility, data recorded at the provincial level and the final data reflected at the National level. The data leakage at each level has a major impact on the programmes overall performance. Improved coordination of data flow will ensure that these discrepancies are minimised. Moreover, this will increase the reliability of the MMC programme data. Facilities and districts need to have constant in-service training or orientation on the National data flow guidelines with specific emphasis on the submission deadlines at each level of service. This will ensure that data is submitted on time and there is an allowance for data verification to be conducted without DHIS closing deadline pressure.

9.1.8. Strengthening the management of the campaign

During the campaign, partners were expected to submit data weekly and attend bi-weekly meetings to discuss performance and challenges experienced. While these bi-weekly meetings had value in that there were regular discussions about performance it came apparent during the campaign that data which partners needed to discuss on a bi-weekly basis was not verified and often not a true reflection of MMC's conducted in that period. This meant that at the next bi-weekly meeting that data for previous weeks had changed in the interim and there was no time to go back and reflect on the previous performance whether it improved or decreased. As such, it is recommended that

partners should continue to submit monthly to ensure constant monitoring of the data reporting challenges which are contributing to high data variance. Furthermore, data reported during campaigns should only be used as a proxy to measure performance to date while verification processes are completed. Only verified programme data should be reported on.

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