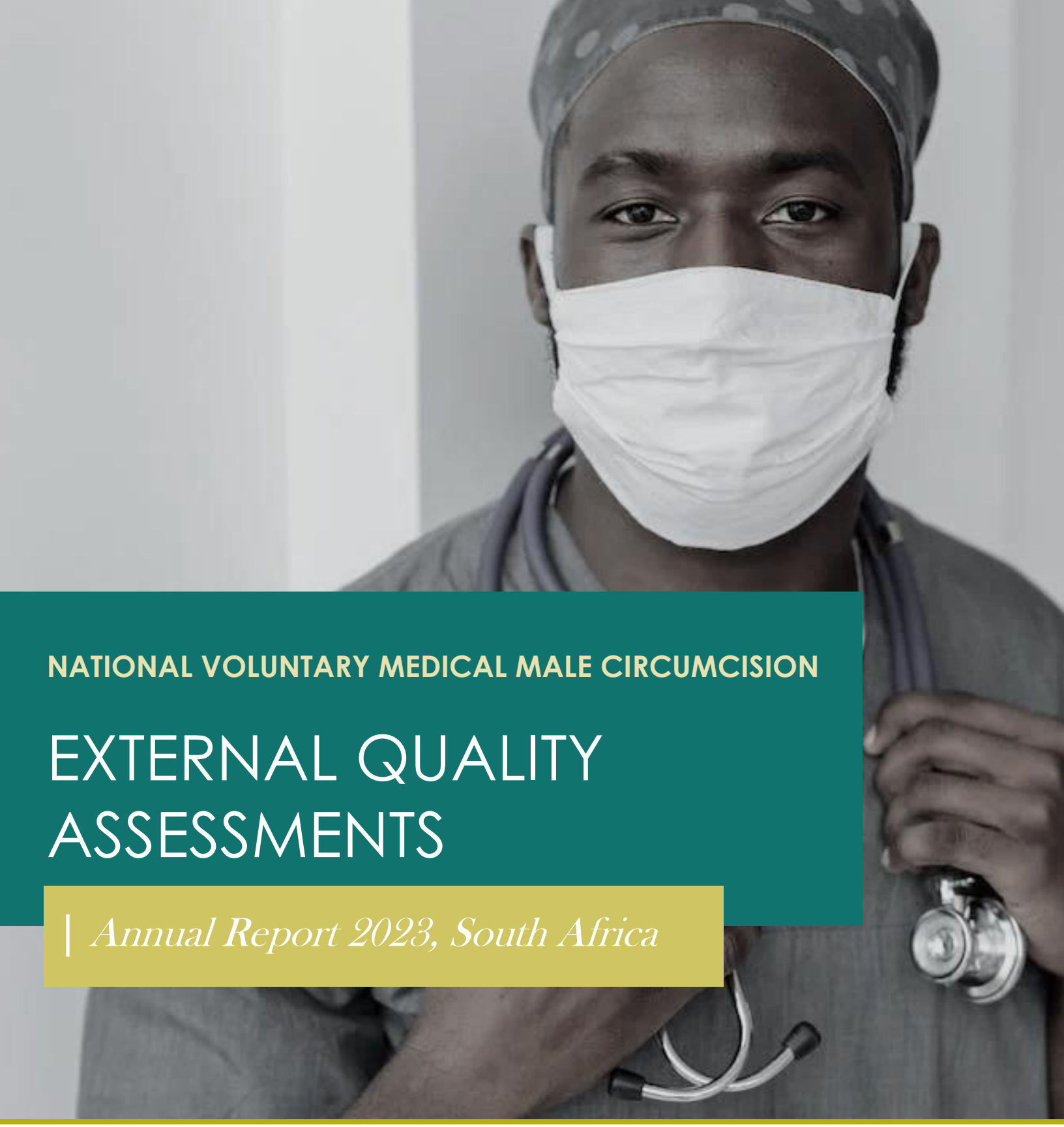

NATIONAL VOLUNTARY MEDICAL MALE CIRCUMCISION

EXTERNAL QUALITY ASSESSMENTS

| *Annual Report 2023, South Africa*

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

World Health Organization

Document reference

National Medical Male Circumcision (MMC) External Quality Assessment | Annual Report 2023 South Africa

Date

August 2023

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Acknowledgements

The External Quality Assessment (EQA) team appreciates the overall leadership of Mr Collen Bonnecwe (NDoH), Mr Dayanand Loykissoonlal (NDoH) for the oversight role, Ms Lisbeth Mathebula (NDoH) for the overall coordination on behalf of the Department of Health (DoH). Special thanks to Mr Daise Sibande (WHO), Dr Malebo Maponyane (WHO) and Dr Busisiwe Msimang (WHO) for providing technical leadership. MMC SUSTAIN team, Dr Lisa Mulenga and Dr Hillary Mukudu, Centers for Disease Control and Prevention (CDC) Mr Matimba Chauke and Mr Peter Vranken for their technical support in successfully executing the 2023 MMC EQA. Lastly, the team acknowledges the facility staff for their participation in making the EQA visits successful.

The following entities are acknowledged for their support of the EQA assessment:

- The Department of Health (DoH) – Provinces and districts
- The World Health Organization (WHO) – South Africa
- Medical Male Circumcision Scale-up and Sustainability to Avert New HIV Infections (MMC SUSTAIN) team – Genesis Analytics and Bill & Melinda Gates Foundation
- MMC implementing partners – Jhpiego, Right to Care, PSI, JGalt, The Aurum Institute (AURUM), Dr N.S Masinga, Insimu, JPS Africa, Southern Health Foundation (SHF), Thathenda Healthcare, TB-HIV Care, Department of Correctional Services

Special thanks to PEPFAR/CDC for funding EQA.

Image 1: Kroonstad DCS

Table of Contents

EXECUTIVE SUMMARY 7

INTRODUCTION 11

1.1. Background and context of MMC in South Africa 11

1.2. South Africa MMC program: situation analysis 11

1.3. Rationale for the EQA 12

1.4. Aim and objectives of EQA 13

METHODOLOGY 14

2.1 Approach 14

2.2. EQA Assessment Tools 16

2.3. Gross Violations and MMC Guideline Issues 18

2.4. Data Collection Processes, Analysis, and Reporting 20

2.5. Sites assessed during the 2023 EQA 21

2.6. Limitations/Challenges 23

EQA 2023 FINDINGS 24

3.1. Summary 24

3.2. Observations 25

KEY RECOMMENDATIONS 45

4.1 Leadership and Planning 45

4.2 Service Delivery Models 46

4.3 Staff Capacity 47

4.4 Training 49

4.5 Quality of Client Records and Documentation 49

4.6 Follow-up and Linkage to Care 50

4.7 Relationship with DoH 51

4.8 Communication and IEC Material 52

4.9 Demand Creation 52

4.10. Continuous Quality Improvement 53

CONCLUSION 55

5.1. Building a Robust Quality Assurance System 55

5.2. Fostering Leadership and Collaboration 55
5.3. Investing in Staff and Service Quality 56
5.4. Prioritising Client Safety and Ethical Practice 56
APPENDICES 57

Table of figures

Image 1: Kroonstad DCS 2
Image 2: IEC material on Wound Care after MMC and Details About the TMI Act of 2016. 8
Image 3: Kutama Sintumule DCS (card Games with MMC messages) 9
Image 4: Levai Mbatha Clinic 14
Image 5: Embhuleni Hospital briefing meeting 20
Image 6: Dr Yako's surgery 23
Image 7: Demand creation and IEC material 42

Table 1: Colour codes interpretation 18
Table 2: Number of Sites in the EQA by partner, by province 21
Table 3: Distribution of assessed sites and MMCs by province 25
Table 4: Distribution of sites with identified gross policy violations per province during the 2023 MMC EQA 26
Table 5: Overall Performance score of 2023 EQA tools by province (%) 28
Table 6: Comparison Performance Scores of the 2021 and 2023 EQA tools by province 31
Table 7: Characteristics of MMC sites assessed in Eastern Cape Province 57
Table 8: Characteristics of MMC sites assessed in Free State Province 58
Table 9: Characteristics of MMC sites assessed in Gauteng Province 59
Table 10: Characteristics of MMC sites assessed in KwaZulu Natal Province 60
Table 11: Characteristics of MMC sites assessed in Limpopo Province 62
Table 12: Characteristics of MMC sites assessed in Mpumalanga Province 63
Table 13: Characteristics of MMC sites assessed in Northern Cape Province 64
Table 14: Characteristics of MMC sites assessed in North West Province 65
Table 15: Characteristics of MMC sites assessed in Western Cape Province 66
Table 16: Tool A performance assessment per province 67
Table 17: Tool B performance assessment per province 68
Table 18: Tool C performance assessment per province 69
Table 19: Tool D performance assessment per province 70
Table 20: Tool E performance assessment per province 71
Table 21: Tool F performance assessment per province 72
Table 22: Tool G performance assessment per province 73
Table 23: Tool H performance assessment per province 74

ACRONYMS & ABBREVIATIONS

AE	Adverse Events
AIDS	Acquired Immuno-Deficiency Syndrome
ART	Anti-retroviral treatment
BMGF	Bill and Melinda Gates Foundation
CDC	Centre for Disease Control and Prevention
CQI	Continuous Quality Improvement
DCS	Department of Correctional Services
DHIS	District Health Information Software
DoH	Department of Health
EQA	External Quality Assessment
GP	General Practitioner
HAST	HIV, AIDS, STI, and TB
HIV	Human Immuno-deficiency virus
HNQIS	Health Network Quality Improvement System
HTS	HIV Testing Services
IEC	Information, Education and Communication
IP	Implementing Partner
IPC	Infection Prevention and Control
IQC	Internal Quality Control
JPSA	JPS-Africa
M&E	Monitoring and Evaluation
MMC	Medical Male Circumcision
MMC SUSTAIN	Medical Male Circumcision Scale-up and Sustainability to Avert New HIV Infections
NDoH	National Department of Health
NDP	National Development Plan
NSP	National Strategic Plan
OTH	Online Training Hub
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PSI 1	Patient Safety Incidence

PSI 2	Population Services International
PT	Proficiency Testing
QA	Quality Assurance
QI	Quality Improvement
QIP	Individualized Quality Improvement Plan
QMS	Quality Management System
RSA	Republic of South Africa
RTC	Right to Care
SOP	Standard Operating Procedure
SHF	Southern Health Foundation
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
US	The United States of America
USAID	United States Agency International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Medical Male Circumcision (MMC) is a highly effective HIV prevention intervention. To deliver high-quality MMC services, it is essential to carefully plan and implement all aspects of the program, from planning to service delivery. This report summarizes the findings of the EQA of MMC services in all nine provinces of the Republic of South Africa (RSA), conducted by a team of WHO-hired experts in collaboration with the NDoH and its technical partners.

The EQA revealed that MMC sites in South Africa have made significant progress in scaling up MMC services while adhering to the WHO standards and guidelines. Sites demonstrated strong leadership and management, adequate infrastructure and equipment, competent and motivated staff, effective infection prevention and control practices, high-quality clinical care and surgical procedures, management of adverse events, data monitoring systems, and innovative demand creation strategies.

The assessments also identified **some areas for improvement** despite the National Department of Health's (NDoH) dedicated efforts to equip all stakeholders with the necessary resources for Implementation of an effective MMC program. The report highlights specific quality issues, including:

- Lack of on-site medical records storage at one facility.
- Circumcision of four clients under 10 at four sites.
- Inadequate pre-operative consenting of three adults at two sites.
- Absence of guardian or parent signatures for 31 clients under 18 from six sites.
- Missing clinician names and signatures for eight files at five sites.
- Use of Forceps Guided method used on eight clients at two General Practitioner sites.
- Lacked of Adverse Events register at 3 sites.

Here are some of the best practices revealed by the EQA, per province:

Eastern Cape

- Cultural Sensitivity: The program adapted to the local culture by incorporating information about traditional initiation practices into post-operative care instructions.

Image 2: IEC material on Wound Care after MMC and Details About the TMI Act of 2016.

Gauteng

- Integrated Services: MMC, men's health, and youth services are offered together, enhancing accessibility and holistic care.
- Quality Assurance: Visual dashboards track progress and demonstrate commitment to improvement.
- Clear Navigation: Signage and footprints guide clients directly to the MMC site.

Free State

- The Free State province demonstrates strong data management practices through dedicated client data capture and record review at the Bizzah Makhate site.
- The province prioritizes CQI by implementing regular supervision with District coordinators supporting sites, fostering team collaboration, and involving the DoH-appointed roving team.

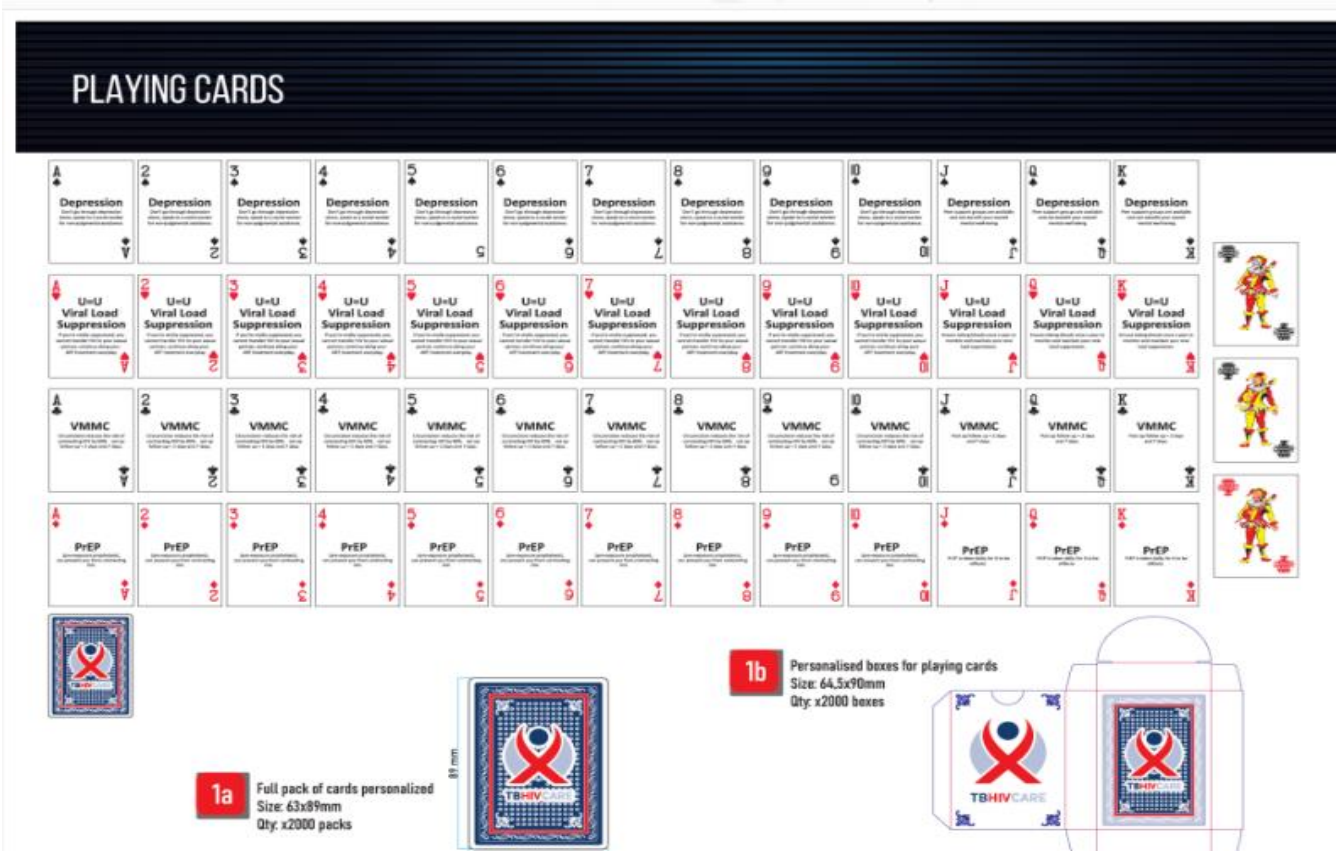
KwaZulu-Natal

- Strong DoH presence and Collaboration: DoH actively support and collaborates with implementing partners across all sites, including GP clinics.
- The pre-operative assessment nurse demonstrates exceptional dedication and patiently informs patients about the MMC procedure and post-operative care.
- Comprehensive service integration: MMC direct service delivery partners collaborate with other Implementing partners for HIV testing, counselling and Antiretroviral therapy services offering a holistic approach to health.

Limpopo

- Referral System: Bi-directional forms ensure client follow-up and prevent loss to care.
- Sustainability: DoH team presence suggests long-term MMC support beyond external funding.
- Prison Outreach: Peer educators and recruiters reach incarcerated men, expanding access.
- Client Feedback: Satisfaction surveys inform service improvement and client needs.
- Education Tool: The mat game educates prisoners about MMC, HIV, TB, and related topics.

Image 3: Kutama Sintumule DCS (card Games with MMC messages)



Mpumalanga

- There is overall leadership by the Implementing partners especially RTC and visible leadership from the provincial department of health in all sites and including GP sites.
- There are strong collaborations and integration of services with the DoH in all sites.

Northern Cape

- Knowledge Sharing: Staff regularly review guidelines and maintain logs, ensuring consistent best practices.
- Inclusive Access: MMC services are extended to inmates, ensuring equal access for all eligible men.
- Quality Improvement: MMC is integrated into the clinic's quality assurance system, showcasing a commitment to continuous improvement.

North West

- The implementing partner provides strong support in operations management, ensuring a steady supply of commodities and consumables to their supported GPs.
- Implementing partners' dedicated QI team actively addresses persistent gaps and monitor quality through site support visits.
- GP practices demonstrated excellent collaboration with DoH facilities, district and provincial health teams.

Western Cape

- TC Newman and Caledon hospitals had very good integration and support with the facility and district HASTmanagers.

The EQA teams **recommended** health facilities and implementing partners conduct continuous quality improvement (CQI) interventions to address quality gaps.

Maintaining high-quality standards in the MMC program is crucial, as rapid scale-up can lead to concerns about service quality decline.

The EQA findings, while concerning, present an opportunity to improve MMC service quality in South Africa. By addressing the identified quality gaps, the NDoH and its collaborators can ensure every MMC client receives the highest quality of care.

INTRODUCTION

1.1. Background and context of MMC in South Africa

The World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS) recommended, in 2007, that medical male circumcision (MMC) be considered as part of an all-inclusive HIV prevention package in countries with high HIV prevalence and low circumcision rates.[1]

MMC is the complete surgical removal of the foreskin as a one-time primary prevention measure that reduces by 60% the risk of heterosexual transmission of HIV from women to men. It provides seronegative males with significant lifelong partial protection against HIV and a variety of other sexually transmitted infections. Male circumcision protects women indirectly by preventing new HIV infections in males. MMC provides a fantastic opportunity to engage men in health care, initiate HIV-positive men to ARV treatment, and improve their access to a full spectrum of clinical services.

In 2010, the South African National Department of Health (NDoH) initiated a plan to medically circumcise men aged 15-49. The program has since achieved remarkable scale, circumcising over Five million males to date. MMC is a key component of the Joint United Nations Program on HIV/AIDS (UNAIDS)'s strategy to eradicate AIDS by 2030.[2]

To safeguard the quality of MMC services in South Africa, the National Department of Health (NDoH) undertook its first DoH-led External Quality Assessment. This assessment, with technical support from the World Health Organization and other partners, spanned from August to September 2019 and involved 113 MMC sites. A second EQA was conducted in August-September 2021, assessing 145 MMC sites. In April-June 2023, two EQA teams, supported by the WHO, visited 52 MMC facilities across 9 provinces to evaluate the quality of services. The EQA involved participation from the national, provincial, and district Departments of Health, as well as several implementing partners, the CDC, and the MMC SUSTAIN team.

1.2. South Africa MMC program: situation analysis

The MMC program in South Africa has secured funding from both domestic and international sources. Domestic funding from the National Treasury covers at least 50% of the program's targets, while the remaining circumcisions are funded by PEPFAR.

An analysis of data from the District Health Information Software (DHIS) reveals a significant increase in the program's performance, particularly in the financial years 2016/17 and 2018/19. This upward trend was temporarily interrupted by the COVID-19 pandemic's and PEPFAR's withdrawal of support

[1] Male circumcision for HIV prevention: research implications for policy and programming. WHO/UNAIDS technical consultation,6-8 March 2007. Conclusions and recommendations (excerpts). Reprod Health Matters. 2007 May; 15(29):11-4

[2] Korenromp EL, Bershteyn A, Mudimu E et al. The impact of the programme for medical male circumcision on HIV in South Africa: analysis using three epidemiological models [version 1; peer review: 2 approved]. Gates Open Res 2021, 5:15

for the 10-14 age group in 2020. However, the program has recovered strongly, demonstrating steady performance improvements in the financial years 2021/22 and 2022/23.

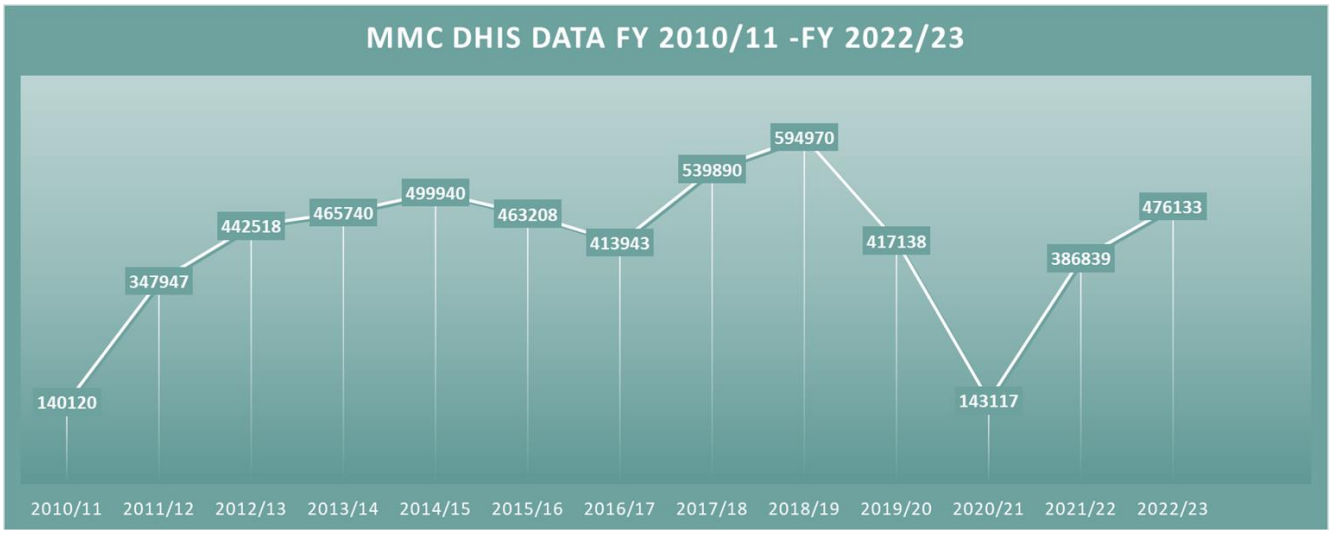


Figure 1: MMC performance data, source: DHIS

1.3. Rationale for the EQA

The increasing number of medical disputes stemming from clinical negligence and non-adherence to safety and quality standards highlights the critical need to uphold the highest level of care in MMC services. As a surgical procedure with inherent risks, maintaining safe and high-quality MMC is essential for the program's success and public acceptance.

To achieve this objective, a comprehensive approach encompassing complianceto WHO and NDoH standards, retraining and refreshers, in-service activities, quality assurance initiatives, continuous quality improvement, and adverse event monitoring. However, regular external quality assurance (EQA) is indispensable for objectively evaluating service quality against established criteria.

Scaling up MMC services without proper quality assurance could jeopardize service delivery, leading to increased operational costs, adverse health outcomes, adverse events, customer dissatisfaction, and negative public perception. Therefore, the South African government has implemented periodic and systematic EQA to monitor the safety and quality of MMC services nationwide.

Findings from previous EQAs revealed ongoing quality gaps at certain MMC sites, which have since developed improvement plans. It is anticipated that these sites will demonstrate significant progress in subsequent EQAs. Additionally, new MMC sites established in the past year and those that were not assessed in 2019 and 2021 were included in the upcoming EQA to ensure comprehensive quality evaluation across all MMC service providers.

In essence, regular EQA is an invaluable instrument for maintaining the highest standards of safety and quality in MMC services in South Africa. By identifying and addressing any shortcomings, the EQA program contributes to the continuous improvement of MMC service delivery, ultimately safeguarding the health and well-being of individuals undergoing this procedure.

1.4. Aim and objectives of EQA

The EQA aims to evaluate the performance of individual MMC sites against the established national MMC guidelines. This assessment is conducted using standardized WHO/UNAIDS tools tailored to the local context.

The objectives of EQA are to:

- Build and strengthen the capacity of DoH staff to conduct and sustain an ongoing MMC continuous quality improvement (CQI) program by identifying specific gaps and appropriate sustainable solutions that are implemented at all program levels.
- Ensuring that all MMC service provision for HIV prevention programs is aligned with National MMC guidelines which are based on WHO/UNAIDS guidance and adhere to best clinical and safety practices.
- Identifying strengths, areas of improvement, and best practices within the MMC program.
- Promote shared learning between MMC clinics, districts, and provinces to share best practices.
- To provide feedback to MMC site staff and the Department of Health regarding the quality of MMC service delivery.
- To provide recommendations to improve service safety and quality.
- To provide a basis for CQI and other applicable interventions.

Besides providing an objective verification of the quality and safety of MMC service delivery, EQA helps to get a general overview of the various MMC sites, including their geographical location, service package coverage, and site model of service delivery (roving teams, fixed-site, mobile site, GPs).

It has the potential to provide early warning signs of systemic issues and enables suggestions for areas that need to be improved and guidance for training needs.

METHODOLOGY

2.1 Approach

The EQA assessment employed a multi-pronged approach to comprehensively evaluate the performance of the MMC program. Trained external assessors visited and assessed MMC facilities across various service points to gather objective data on service delivery.

EQA Teams

The EQA teams, each comprised of four to five members. These teams underwent a one-day orientation workshop before the assessment, focusing on EQA assessment techniques and data collection using Google Forms. Team members possessed expertise in clinical care, HIV testing services (HTS), counselling, data management, demand creation, and monitoring and evaluation. Representatives from the Department of Health (national, provincial, and district), implementing partners, WHO personnel, the CDC-SA, and the MMC SUSTAIN also accompanied these teams. The team was guided by a WHO technical team-lead who provided direction and oversight to ensure adirements.

Image 4: Levai Mbatha Clinic

EQA Schedule

The EQA teams conducted assessments in different provinces from April 17 to June 6, 2023. They utilized a standardized set of EQA tools to ensure consistency and objectivity across all assessments.

Assessment Methods

EQA were conducted through a combination of methods:

- Staff interviews: In-depth interviews with facility staff gathered insights into their knowledge, practices, and experiences related to MMC service delivery.
- Checklists: Standardized checklists were used to systematically evaluate the facility's adherence to established MMC standards and guidelines.
- Direct observation: The process of service delivery was directly witnessed in the facility.
- Review of records: Facility-level registers and client files were meticulously reviewed to assess record-keeping practices and the accuracy of documentation.

As mandated by the National Department of Health, MMC facilities are required to provide a minimum package of services, comprising:

- HIV testing and counselling, including comprehensive risk reduction counselling
- Provision of female or male condoms, accompanied by education on their correct and consistent use
- Active exclusion of symptomatic STIs and appropriate syndromic treatment when necessary
- Promotion of safer sexual practices to minimize the risk of HIV and STI transmission
- Male circumcision surgical procedures performed in strict adherence to the MMC national guidelines
- Post-operative wound care management and follow-up
- Screening for Hypertension, TB, Diabetes, and other non-communicable diseases
- Referral to appropriate care and treatment services for identified health conditions.

2.2. EQA Assessment Tools

MMC services were evaluated using standardized assessments to ensure compliance with aligned quality standards set by the World Health Organization (WHO) and the National Department of Health (NDoH). The MMC EQA toolkit comprises modules to assess the following aspects of MMC service delivery:

1. **SOPs, Guidelines, Policies, Registers, and Records:** This module assesses the facility's adherence to established protocols, guidelines, and policies, as well as the accuracy and completeness of registers and records.
2. **Facilities, Supplies, Equipment, and Waste Management:** This module evaluates the adequacy and functionality of the facility's infrastructure, supplies, equipment, and waste management practices.
3. **Client File Review:** This module involves a thorough review of client files to assess the quality and completeness of client records, including documentation of informed consent, counselling, HIV testing results, surgical procedures, post-operative care, and follow-up visits.
4. **Emergency Training and Management:** This module evaluates the facility's preparedness to manage emergencies, including the availability of emergency equipment, staff training, and protocols for managing emergencies.
5. **Adequacy of Staffing:** This module assesses the adequacy of staffing levels and the training and competency of healthcare providers involved in MMC service delivery.
6. **Operating Theatre, Surgical Procedure, Instruments, Equipment, and Supplies:** This module evaluates the cleanliness and safety of the operating theatre, the adherence to surgical procedures as outlined in national guidelines, and the availability and proper use of surgical instruments, equipment, and supplies.
7. **Communication with Clients:** This module assesses the effectiveness of communication with clients throughout the MMC process, including counselling and education, HIV testing, the immediate postoperative period, and follow-up visits.
8. **Continuous Quality Improvement (CQI) Activities:** This module evaluates the facility's engagement in CQI activities, including the identification of areas for improvement, implementation of corrective actions, and monitoring of progress.

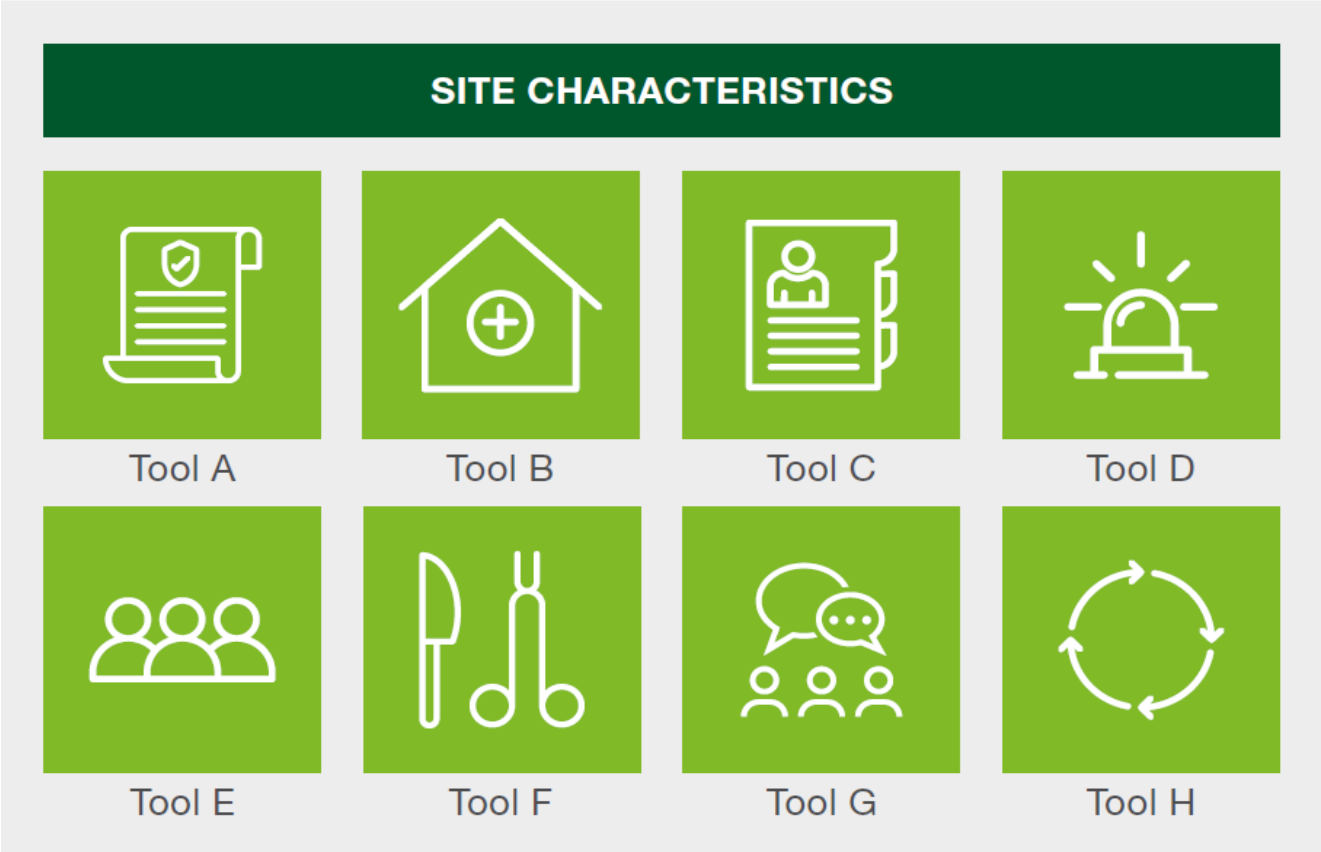


Figure 2: MMC EQA tools

Quality Assessment Scoring

Service quality assessment scores were expressed as percentages and categorized into three levels based on the dashboard colour coding system. A comprehensive quantitative analysis was conducted to assess the performance of each MMC site against the established standards. The assessment included both 'Yes/No' questions and quantitative measurements, each element contributing to a calculated score and percentage. The results of this analysis are presented in color-coded tables of frequencies and percentages, organized by province. To provide a broader overview, the scores were aggregated, and averages were calculated at the national and provincial levels for each EQA tool and for the issues that required immediate attention.

Table 1: Colour codes interpretation

Colour	Percentage score	Comment
Green	85 – 100%	Minimal or no intervention needed
Amber	70 – 84%	Moderate intervention needed
Red	<70%	Extensive intervention needed
Deep red	Issues requiring immediate attention	Requires immediate attention

2.3. Gross Violations and MMC Guideline Issues

The Department of Health identified seven gross policy violations that require immediate action as they render a circumcision extremely unsafe and require that they be urgently attended. These are:

- Performing the Forceps Guided method (FGM) of circumcision on clients
- Circumcision of underage clients (less than 10 years old)
- Incorrect MMC technique – incompetency in doing the MMC surgical procedure
- Lack of MMC training for the site clinicians (or lack of evidence thereof)
- Severe absence of Infection Prevention and Control measures
- Gross absence of clinical records
- Concealing of adverse events (AEs)

The National Department of Health (NDoH) has technical guidelines, called SA National Guidelines for Medical Male circumcision (2016), which provide overall guidance to MMC service provision about the following points:

Target Age Group

The NDoH's target age group for MMC is HIV-negative males aged 15 to 49. MMC is not recommended for boys under the age of 10. Demand creation for MMC is not recommended for boys under the age of 15, but if they voluntarily request MMC and meet the eligibility criteria, they should be circumcised.

Surgical Method

When doing MMC in the 10–14-year-old age group, service providers must exercise caution because the potential of harm is possible. The NDoH recommends that dorsal slit be used for all age groups and the use of forceps guided method is considered a gross violation. To ensure safe circumcision of clients presenting for circumcision, all service providers must be skilled in the dorsal slit surgical procedure. NDoH-accredited trainers must conduct MMC surgical procedure training, and healthcare professionals must have proof of training, including the mandatory refresher programs every two years.

A comprehensive prevention package of services

Male circumcision should be accompanied by the following HIV preventive services package: HIV testing, condom distribution, screening, and treatment of sexually transmitted infections; reparatory diseases e.g., TB and non-communicable disease screening; and HIV risk-reduction counselling.

Consenting for MMC

According to the recommendations, male circumcision is considered an operation and is thus subject to the Act's surgical procedure requirements. Young males aged 18 and up can give written informed permission for circumcision and can be circumcised for any cause (Section 12 of the Children's Act 2005). Circumcision is permitted for boys aged 16 to 18, but they must offer informed agreement and be accompanied by a parent or legal guardian (assent). Circumcision for boys under the age of 16 requires written informed consent from their parents or legal guardians and the boy must also provide assent. On the day of the circumcision, both parents must be present.

Record Keeping

The facility manager must guarantee that all clients' medical records are kept up to date and stored in a lockable unit accessible by assigned staff only. Information on the client's name, the type of service supplied, and any unusual circumstances should be included in the records. If necessary, the implementing partner must create copies but should not remove the originals from the facility.

Feedback and Recommendations

Upon completion of each EQA, the facility was provided with comprehensive feedback and actionable recommendations for improvement. In instances of significant policy violations, targeted suggestions for swift corrective action were offered to address the identified concerns. The EQA process yielded 52 detailed reports, which were disseminated to the implementing partner, district, and provincial health authorities.

Image 5: Embhuleni Hospital briefing meeting

2.4. Data Collection Processes, Analysis, and Reporting

Data collection was done through a combination of observations of facilities, equipment, and client care, discussions with key personnel, document review, and client file review. Evaluators assessed compliance with standards using 'Yes/No' answers, along with qualitative observations to provide additional context. Site visit data was collected through Google Forms and stored in a dedicated database developed with assistance from the Genesis Analytics MMC SUSTAIN and WHO teams. This system allows for generating dashboards which can be used to report findings to the National Department of Health (NDoH).

For tool C, a systematic random sampling of 25 files per site was done. At each site, the total number of MMC files recorded in the MMC register up to 3 weeks before the EQA visit was divided by 25 to get the sampling interval for file numbers to retrieve. If the requested files were missing, a policy violation was noted in the EQA report, and the process was done again to pull out the remaining number of files.

The findings were categorized according to the following headings:

- **Best Practices**: Superior performance that represents a benchmark exceeding relevant quality standards or expectations
- **Strengths**: Areas of performance that meet all standards and demonstrate full compliance with quality standards

- **Areas of Improvement (Weaknesses)**: Areas of performance not meeting minimally acceptable levels
    - Performance Below 70% (where a score is applicable)
    - Require remediation
- **Violations of Policy**: Require immediate remediation.
    - (Gross policy violation) Not appropriate for the site to continue providing MMC services before this is addressed.

2.5. Sites assessed during the 2023 EQA

From the planned 50 sites, 52 MMC sites were assessed by two technical teams.

Table 2: Number of Sites in the EQA by partner, b

MMC sites by Province	MMC sites by IP
Eastern Cape (3)	• RTC = 3 sites
Northern Cape (3)	• JGALT = 3 sites
Mpumalanga (6)	• RTC = 3 sites • JPSA = 1 site • SHF = 1 site • Dr Masinga = 1 site
Western Cape (6)	• J Galt = 2 sites • JHPIEGO = 2 sites • SFH = 2 sites
Limpopo (4)	• RTC = 3 sites • TBHIV Care = 1 site
KwaZulu-Natal (13)	• JHPIEGO = 7 sites • PSI = 4 sites • Thathenda = 1 site • TB HIV Care = 1 site
Gauteng (8)	• RTC = 2 sites • PSI = 4 sites

	• SHF = 1 site • Insimu = 1 site
Northwest (5)	• RTC = 2 sites • Aurum = 3 sites
Free State (4)	• RTC = 2 sites • Aurum = 1 site • TBHIV Care = 1 site

A total of 52 MMC sites were assessed, of which:

- 34 were CDC funded: RTC (14), Jhpiego (9), PSI (8), TBHIV (3)
- 18 RT35 contracted: RTC NPC (1), Aurum (4) JGALT (5), Insimu (1), JPSA (1), Thathenda (1), Dr NS Masinga (1), SHF (4)

Image 6: Dr Yako's surgery

2.6. Limitations/Challenges

Two RT35 sites in KwaZulu-Natal (KZN) were initially excluded from the assessment due to contractual complications. These issues resulted in delayed invoice payments, which adversely impacted service delivery in the Amajuba and iLembe districts. Additionally, the review period for PSI sites in Gauteng had to be extended due to a documented decline in performance over the past few years.

EQA 2023 FINDINGS

3.1. Summary

The 2023 MMC EQA exceeded expectations, assessing 52 sites across all nine provinces – surpassing the initial target of 50. Due to a request from the national program director, the assessment expanded its scope by including two additional sites in the North West province. These sites had provided over 37,492 MMCs in the previous financial year (FY 21/22). The assessment encompassed site characteristics, evaluation of guideline documents and MMC procedures, and thorough reviews of up to 25 clinical records at each site. This resulted in a total of 1,094 records assessed using Tool C and captured on the MMC Google forms.

The results of the EQA exercise revealed substantial quality gaps across all provinces, with certain deficiencies being more pronounced in specific regions. Overall, staffing adequacy and compliance with training needs posed challenges in all provinces, as evidenced by only 6 out of 52 sites (<10%) scoring above 85% for tool E. While the inadequacy of staff may reflect broader health system challenges, the low compliance with training needs suggests a necessity to reconsider the approach to providing MMC refresher training.

Similarly, deficiencies in emergency training and trolley management were widespread across provinces, reflected by a significant number of sites scoring below 80% on tool D. The most critical issue was with post-exposure prophylaxis (PEP) procedures. Notably, 50% of sites lacked site-specific standard operating procedures (SOPs) for managing blood pathogen exposure. This lack of clear guidelines left staff uncertain about who would be responsible for covering PEP treatment.

A worrying trend emerged in tool B assessments, with 100% of sites in Eastern Cape and Limpopo, along with 77% in KwaZulu-Natal and 100% in Northern Cape, scoring below 70% for restocking and storage. This indicates significant shortcomings in managing essential supplies. Furthermore, record filing (tool C) posed problems in the Cape provinces, where 33% of sites in the Eastern Cape, 66% in the Northern Cape, and 50% in the Western Cape underperformed.

For tools F and G, certain quality aspects could not be measured for 18 sites (35%) due to the absence of clients on the assessment day. Among the assessed sites, 2 (25%) in GP, 1 (<10%) in KZN, and 2 (25%) in MP scored below 70% for follow-up in tool G. Notably, in WC, 2 (25%) and in NC, 1 (33%) exhibited quality gaps for tool F.

There were too few sites assessed in some provinces (EC – only 3 and NS – 3) resulting in sample representativity constraints in these two provinces.

MMC services are currently predominantly provided by roving teams, and there are no regulations to guide this practice and there are no geographical restrictions for the roving teams, necessitating an

additional discussion of the major capacity issues that this service delivery model has, which poses a high risk of jeopardizing MMC service provision.

The outreach service delivery model with roving teams had some challenges that negatively impacted the quality of service provision. These challenges include:

- Services being cancelled at one site to prioritize other sites
- Ongoing rotation of team members that is not monitored
- Inadequate supportive supervision by Department of Health (DoH)
- Roving teams being inadequate to provide comprehensive MMC services
- Teams being overstretched due to playing multiple roles and covering large distances
- Long distances travelled by teams, leading to poor or low follow-up rates
- Teams being unable to return to sites to conduct follow-ups with clients

3.2. Observations

A total of 1,094 clinical records were examined as part of the tool C assessment. The following table provides a summary of some of thesites assessed, provincial and site MMC performances in the previous financial year (FY 21/22). MMC data was not available for four sites during the assessments.

Table 3: Distribution of the assessed sites and MMCs by province

Province	Number of assessed sites	MMCs performed by province in FY 21/22	MMCs performed by EQA assessed sites in FY 21/22	Number of reviewed records, captured on the MMC Google forms
Eastern Cape	3	15 235	1173	41
Free State	4	9 957	2778	51
Gauteng	8	137 772	7398	171
Kwa-Zulu Natal	13	94 786	8296	286
Limpopo	4	8 073	4828	85
Mpumalanga	6	76 180	2108	136
North West	5	22 915	5075	124
Northern Cape	3	10 444	2402	70
Western Cape	6	11 477	3434	130
National (Total)	**52**	**386 839**	**37492**	**1094**

The following table provides a summary of issues that required immediate attention at the assessed sites in each province. *n = number of sites / % = row percentage of sites with policy violations out of the number of sites assessed per province*

Table 4: Distribution of sites with identified gross policy violations per province during the 2023 MMC EQA

Province	Number of MMC Provider Site assessed (n)	Use of Forceps Guided Methods (FGM) (n, %)	MMC performed in underage boys (<10y old) (n, %)	Violation of Consent Processes (n, %)	Expired drugs or missing items needed on emergency trolley (n, %)	Incorrect performance of MMC technique or anaesthetic dosage (n, %)	Missing or outdated proofs of MMC training among staff (n, %)	Absence of MMC clinical records on site (n, %)	AEs not appearing in the register
Eastern Cape	3	0 (0)	1 (33.3)	2 (66.7)	0 (0)	0 (0)	0 (0)	0 (0)	1 (33.3)
Free State	4	0 (0)	0 (0)	0 (0)	1 (33.3)	0 (0)	1 (33.3)	0 (0)	0 (0)
Gauteng	8	1 (12.5)	1 (12.5)	2 (25.0)	1 (12.5)	1 (12.5)	1 (12.5)	0 (0)	0 (0)
KwaZulu Natal	13	0 (0)	2 (15.4)	1 (7.7)	1 (7.7)	0 (0)	4 (30.8)	0 (0)	0 (0)
Mpumalanga	6	0 (0)	0 (0)	0 (0)	1 (16.07)	0 (0)	5 (83.3)	0 (0)	0 (0)
Limpopo	4	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	1 (25.0)	0 (0)
North West	5	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	2 (40.5)	0 (0)	0 (0)
Northern Cape	3	1 (33.3)	0 (0)	3 (100)	0 (0)	3 (100)	0 (0)	0 (0)	0 (0)
Western Cape	6	0 (0)	0 (0)	0 (0)	2 (40.0)	1 (20.0)	0 (0)	0 (0)	2 (40.0)
National (total)*	**52**	**1 (3.8)**	**4 (7.5)**	**6 (11.3)**	**6 (11.3)**	**5 (9.4)**	**13 (24.5)**	1 (25.0)	**3 (5.7)**

Table 4 shows the distribution of sites with identified gross policy violations per province during the 2023 MMC EQA. The first row is the header row, which lists the province, the number of MMC provider sites assessed, and five types of policy violations. The second to tenth rows show the data for each province, including the number and percentage of sites with each type of policy violation. The last row shows the national total and percentage of sites with policy violations out of the 52 sites assessed.

Some key points from the table are:

- **Use of Forceps Guided Methods (FGM)**: Only one site in Gauteng and one site in the Northern Cape used FGM, which is not recommended by the NDoH and WHO guidelines. The national percentage of sites using FGM was 3.8%.
- **MMC performed in underage boys (<10y old)**: Four sites in Eastern Cape, Gauteng, and KwaZulu Natal performed MMC in boys younger than 10 years old, which is not allowed by the NDoH policy. The national percentage of sites performing MMC in underage boys was 7.5%.
- **Expired drugs or missing items needed on the emergency trolley**: Six sites in Free State, Gauteng, KwaZulu Natal, Mpumalanga, and Western Cape had expired drugs or missing items needed on the emergency trolley, which poses a risk to patient safety. The national percentage of sites with this issue was 11.3%.
- **Absence of MMC clinical records on site**: Only one site in Limpopo did not have MMC clinical records on site, which hampers data quality and monitoring. The national percentage of sites with this issue was 25.0%.
- **AEs not appearing in the register**: Three sites in Eastern Cape and Western Cape did not record adverse events in the register, which affects the reporting and management of AEs. The national percentage of sites with this issue was 5.7%.
- **Violation of Consent**: 6 sites (11.3%) violated the consent policy, which means they performed MMC on clients who did not give informed consent or were coerced. The highest number of violations was in the Northern Cape, where all 3 sites (100%) violated the consent policy.
- **Incorrect performance of MMC technique or anaesthetic dosage**: 5 sites (9.4%) performed MMC incorrectly or used inappropriate anaesthetic dosage, which could lead to adverse events or poor outcomes. The highest number of violations was in the Northern Cape, where 3 sites (100%) performed MMC incorrectly or used inappropriate anaesthetic dosage.
- **Missing or outdated proofs of MMC training among staff**: 13 sites (24.5%) did not have proof of MMC training among staff or had outdated proofs, which means they did not have the required skills or knowledge to perform MMC safely and effectively. The highest number of violations was in Mpumalanga, where 5 sites (83.3%) did not have proof of MMC training among staff or had outdated proofs.

Table 5: Overall Performance score of 2023 EQA tools by province (%)

Province	Tool A	Tool B	Tool C	Tool D	Tool E	Tool F	Tool G (HIV-ve)	Tool G (HIV+ve)	Tool H IP Standard CQI	Tool H DoH overall support
Eastern Cape	76	74	75	77	60		100	100	15	67
Free State	85	89	87	79	56	96	81	96	36	95
Gauteng	84	90	87	89	72	96	53	84	68	90
Kwa-Zulu Natal	79	90	85	83	68	75	73	78	59	74
Limpopo	87	84	86	90	64	97	75	69	39	90
Mpumalanga	79	93	86	80	57	90	66	64	52	75
North West	62	82	72	77	57	96	80	92	31	55
Northern Cape	81	67	74	51	49	87	75	50	8	50
Western Cape	71	78	75	62	46	89	55	95	31	80
National (Total)	78	83	81	76	59	91	73	81	38	78

Table 4 summarises the findings of the 2023 EQA of MMC services in South Africa. The EQA tools evaluate various aspects of MMC programs at the site level, helping to ensure high-quality services for all clients.

Key Findings

- **National Averages**: Scores range from 59% (adequacy of staffing) to 91% (surgical procedure skills), with an overall average of 78%.
- Tool F (surgical procedure) scores highest, while Tool E (staffing) scores lowest.
- **Provincial Variations**: Performance varies significantly across provinces with Gauteng excelling in facilities/supplies (90%), while Northern Cape struggles with staffing (49%).
- **Sub-Score Gaps**: A concerning gap emerges in Tool G scores, indicating that HIV-positive clients consistently receive better services in counselling and testing (95%) than negative clients (55%) in the Western Cape. This disparity highlights the need for more equitable HIV testing and counselling experiences.

Overall performance

- 78% average score indicates moderate intervention is needed across various areas.

Areas for Improvement

- **Staffing**: Extensive interventions are needed nationwide to address the critical issue of inadequate MMC staffing (59%).
- **Continuous Quality Improvement (CQI)**: Both implementing partners and District DoH need significant improvement in conducting and implementing CQI evaluations and plans (38%).
- **Other Priorities**: Moderate interventions are needed for aspects like:
    - Adherence to standards, SOPs, guidelines, and job aids (73%)
    - Emergency management and requisite training (76%)
    - Client counselling and communication (81%)
    - Continuous quality improvement support visits by PDoH (75%)

Province-Specific Performance

- Lowest Performer: Northern Cape had the lowest overall facility compliance (49%).
- Top Performers: Free State and Gauteng achieved the highest overall facility compliance with EQA standards (84%).

Setting the standard: Tools F, B, C, and G Lead the Way

Tools F, B, C, and G have set the gold standard for MMC programs, achieving impressive compliance rates of 91%, 83%, 81%, and 81%, respectively. This exceptional performance shines a light on key areas for success:

- **Consistently high-quality MMC procedures**: Skilled healthcare professionals ensure safe and effective circumcisions, fostering trust in the program.
- **Enough space guarantees smooth MMC services:** Adequate facilities create a comfortable and efficient environment for both clients and providers.

- **Excellent supplies and equipment pave the way for quality care:** Sterile instruments, quality sutures, and necessary medications contribute to optimal wound healing and client well-being.
- **Skilled counsellors offer reliable HIV testing and MMC group sessions, boosting program effectiveness:** Knowledgeable counsellors provide accurate information, address concerns, and encourage MMC participation, leading to a wider program reach.

By focusing on these critical factors, Tools F, B, C, and G demonstrate a model for other programs to emulate, ultimately aiming to improve MMC service delivery and health outcomes for all. *Detailed reports for each province are available in the* ***appendices B***

Table 6: Comparison Performance Scores of the 2021 and 2023 EQA tools by province

2021 Overall Performance score of EQA tools by province (%)										
Province	**Tool A**	**Tool B**	**Tool C**	**Tool D**	**Tool E**	**Tool F**	**Tool G (HIV-ve)**	**Tool G (HIV+ve)**	**Tool H DoH overall support**	**Total**
Eastern Cape	84	88	84	76	67	71	61	57	60	72
Free State	86	85	86	74	84	92	72	70	72	80
Gauteng	84	85	77	80	75	88	63	60	17	70
Kwa-Zulu Natal	82	76	82	80	66	81	75	73	26	71
Limpopo										
Mpumalanga	90	84	82	77	83	91	77	75	38	77
North West	78	76	81	74	68	84	84	82	26	73
Northern Cape	81	78	75	73	60	75	61	57	12	64
Western Cape	61	79	68	68	62	72	62	55	15	60
National	79	80	78	75	69	73	62	59	25	67

2023 Overall Performance score of EQA tools by province (%)										
Province	Tool A	Tool B	Tool C	Tool D	Tool E	Tool F	Tool G (HIV -ve)	Tool G (HIV +ve)	Tool H DoH overall support	Total
Eastern Cape	76	74	75	77	60		100	100	67	80
Free State	85	89	87	79	56	96	81	96	95	84
Gauteng	84	90	87	89	72	96	53	84	90	82
Kwa-Zulu Natal	79	90	85	83	68	75	73	78	74	79
Limpopo	87	84	86	90	64	97	75	69	90	81
Mpumalanga	79	93	86	80	57	90	66	64	75	77
North West	62	82	72	77	57	96	80	92	55	77
Northern Cape	81	67	74	51	49	87	75	50	50	67
Western Cape	71	78	75	62	46	89	55	95	80	71
National (Total)	78	83	81	76	59	91	73	81	75	78

Overall Scores

The implementation of the External Quality Assurance Assessment (EQA) has led to a significant improvement in the overall quality of MMC services across the country. This is evident from the increased national average score for all EQA standards from **67%** in 2021 to **78%** in 2023, indicating an improvement in the quality of MMC services across the country. The **highest** score in 2023 was achieved by the Free State (84%), followed by **Gauteng** (82%) and **Limpopo** (81%). The **lowest** score in 2023 was recorded by the **Northern Cape** (67%), followed by the **Western Cape (71%)**.

Tool A

The national average score for this tool decreased slightly from **79%** in 2021 to **78%** in 2023. The **best-performing** province in 2023 was **Limpopo** (87%), while the **worst-performing** province was **North West** (62%).

Tool B

The national average score for this tool increased significantly from **80%** in 2021 to **83%** in 2023. The **best** performing province in 2023 was **Mpumalanga** (93%), while the **worst** performing province was **Northern Cape** (67%).

Tool C

The national average score for this tool increased slightly from **78%** in 2021 to **81%** in 2023. The **best** performing province in 2023 was **Free State** (87%), while the **worst** performing province was **North West** (72%).

Tool D

The national average score for this tool increased slightly from **75%** in 2021 to **76%** in 2023. The **best** performing province in 2023 was **Limpopo** (90%), while the **worst** performing province was **Northern Cape** (51%).

Tool E

The national average score for this tool decreased slightly from **69%** in 2021 to **59%** in 2023. The **best** performing province in 2023 was **Gauteng** (72%), while the **worst** performing province was **Western Cape** (46%).

Tool F

The national average score for this tool increased significantly from **73%** in 2021 to **91%** in 2023. The **best** performing province in 2023 was **Limpopo** (97%), while the **worst** performing province was **Kwa-Zulu Natal** (75%).

Tool G

The tool was divided into two sub-tools: one for HIV-negative clients and one for HIV-positive clients. The national average score for the sub-tool for HIV-negative clients increased slightly from **62%** in 2021 to **73%** in 2023. The **best-performing** province in 2023 was **North West** (80%), while the **worst** performing province was **Western Cape** (55%). The national average score for the sub-tool for HIV-positive clients increased significantly from **59%** in 2021 to **81%** in 2023. The 2023 **best** performing province was **Western Cape** (95%), while the **worst** performing province was **Northern Cape** (50%).

Tool H

This tool evaluated the **overall support** of the Department of Health (DoH) to the MMC sites, including the supervision, monitoring and evaluation, and quality improvement activities. The national average score for this tool increased significantly from **25%** in 2021 to **75%** in 2023. The **best** performing province in 2023 was **Free State** (95%), while the **worst** performing province was **Northern Cape** (50%).

Overall Trend

Despite remaining performance gaps, a clear upward trend across provinces and standards indicates the EQA's effectiveness in driving quality enhancements.

Provincial Performance 2021 vs 2023

Mpumalanga emerges as the 2023 frontrunner with an impressive 93%, surpassing Gauteng's 2021 high of 80%. Notably, even the Western Cape, at the bottom of the pack, witnessed a remarkable climb from 60% to 71%.

Tool Performance

Tool G (HIV-ve) steals the show in 2023, achieving a top score of 91%, surpassing Tool B's previous high of 80%. Remarkably, even Tool H, lagging at the bottom, boasts a significant rise from 25% to 71%.

3.2.1 Leadership and Planning

This section delves into the leadership, planning, and resource allocation of MMC programs. Tools A and B dissected different aspects of this crucial domain. Tool A: This tool assessed the availability and adherence to vital documents like standard operating procedures (SOPs), guidelines, policies, registers, and records. The national average score was 78%, with Limpopo leading the charge (87%) and North West facing challenges (62%). Tool B: This tool evaluated the adequacy, suitability, and maintenance of MMC facilities, supplies, and equipment. The national average score was 83%, with Gauteng and Mpumalanga boasting top scores (90% and 93%, respectively) while Northern Cape trailed behind (67%).

Overall Results

Across all domains, the national average score of 83% reflects a high level of quality for MMC infrastructure, supplies, and equipment. This bodes well for program effectiveness and client safety.

Waste Management: Exceeding Expectations

Waste management practices exceeded expectations, with a national average of 92%. This highlights its critical role in preventing infections and ensuring a hygienic environment.

Medicines: Room for Improvement

The area of medicines presented the biggest hurdle, with a national average of just 70%. This indicates potential issues with the availability and proper management of essential drugs.

Provincial Standouts

Mpumalanga claimed the top provincial spot with an impressive 93% average across all domains, excelling in areas like HTC/exam rooms, theatres, recovery rooms, medicines, and equipment.

Performance Gaps: Bridging the Divide

Despite overall progress, some common gaps emerged:

- Missing or outdated guidelines, SOPs, job aids, and essential documentation.

- Lack of clear protocols for managing adverse events, needle sticks, and post-exposure prophylaxis.
- Inadequate waste segregation practices and missing performance reports.
- Inconsistent recording of adverse events and referrals.
- Limited evidence of continuous quality improvement efforts.

Areas of Excellence

While gaps exist, several positive aspects were also observed:

- Well-organised policy and guideline files with clear labelling.
- Strategic placement of relevant job aids throughout the facilities.
- Up-to-date WHO and NDoH guidelines provide comprehensive guidance.
- Effective utilisation of policies and guidelines during CQI meetings and in-service training.
- Clear and accessible signage for patient navigation.
- Availability of patient rights charter in multiple languages.

3.2.2 Service Delivery Models

Adapting to Reach: A Diverse Landscape of MMC Services

The EQA evaluation revealed a rich tapestry of MMC service delivery models, reflecting the program's commitment to reaching diverse communities. Key models included:

- DoH and DCS Fixed Facilities: These facilities serve as reliable hubs for MMC services, offering ample space and acting as outreach points for implementing partners.
- General Practitioner (GP) Sites: Leveraging existing healthcare infrastructure, GP offices provide convenient access to MMC for patients within their networks.
- Mobile Units: These roving teams bring MMC directly to remote or underserved communities, offering flexibility but potentially impacting service consistency.

Challenges of the Roving Model: Balancing Reach with Quality

While the mobile model expands MMC access, it also presents challenges that can impact quality:

- Unpredictability: Services at specific sites were cancelled to prioritise others, causing inconvenience and disrupting patient flow.
- Team Fluctuation: Frequent rotation of team members without proper monitoring can affect service continuity and expertise.
- Limited Support: Inadequate supervision from the Department of Health (DoH) can leave teams unsupported and facing challenges.
- Scope Limitations: Mobile teams may struggle to provide comprehensive MMC services due to resource constraints and time limitations.

- Overburdened Teams: Playing multiple roles and covering vast distances can lead to overworked staff and potentially compromised service quality.
- Follow-up Challenges: Long travel distances and limited return visits can hinder effective post-operative follow-up, impacting patient outcomes.

Essential MMC Components (Minimum Package)

The World Health Organization (WHO) and South African National Department of Health (NDoH) outline a minimum package of services for MMC, yet two assessment tools (F and G) revealed concerning gaps in 30% of sites. Let's break down the crucial missing components:

Pre-Surgery

- HIV Testing: Quality assurance gaps include unregistered test kits, missing internal quality control, and lack of thermometer-controlled storage.
- Counselling: Group sessions are interrupted, condom demonstrations and STI/HIV risk reduction education are often omitted. Some counsellors lack knowledge or confidence in these areas.
- Preoperative Assessment: Clinicians frequently skip history taking, keloid inquiry, and physical examination.

Surgery

- **Sterility and Safety**: Providers touched inside sterile packs, used fingers instead of tools, and breached infection control measures.
- **Procedure Documentation**: Start and end times were recorded before surgery, leading to inaccurate procedure durations. Markings weren't done before cutting.
- **Anaesthesia**: Overdose symptoms weren't explained, injection technique was sometimes inadequate, and although a job aid is present dosing wasn't adjusted correctly for patients weighing above 50kg, potentially leading to inadequate pain control.
- **Adverse Events**: Missed identification is a concern. Clinicians often failed to classify pain experienced during the procedure as an intra-operative adverse event.
- **Antiseptics**: Skin preparation often lacked proper layering.
- **Equipment**: Essential supplies are lacking or misused. Strapping for wound dressing was unavailable in some clinics, and varying practices were observed regarding surgical kit placement (between legs vs. cardiac table).

Infrastructure and Resources

- **Reporting Gaps**: A lack of communication exists. Most sites failed to report instrument failures within the MMC surgical kits.

3.2.3 Staff Capacity

Staffing Challenges Hamper MMC Program Effectiveness: A critical barrier to effective MMC service delivery is the widespread issue of inadequate staffing. Breakdown of the key challenges:

- **Overburdened HAST Managers**: Managers juggling responsibilities across multiple programs lack the capacity to provide crucial supportive supervision for MMC teams.
- **Resource Limitations**: Implementing partners, already stretched thin, rely heavily on locums and roving teams to cover multiple sites, further straining resources and impacting consistency.
- **RT35 Funding Gap**: Sites relying on RT35 funding often struggle with insufficient staffing, hindering their ability to meet service demands.
- **Regional Disparities**: Only Mpumalanga, KZN, North West, and Gauteng possess sufficient personnel to effectively manage high-volume seasons.

Despite Challenges, Pockets of Hope Emerge

- **Human Resource Database**: A database exists to facilitate locum support during peak periods in most sites.

Key Findings

- **Highest Staffing Levels**: Mpumalanga (96), KwaZulu-Natal (87)
- **Lowest Staffing Levels**: Northern Cape (64)
- **Reliance on Locums**: Unfamiliarity with sites and processes caused by locum reliance posed a major challenge during EQA, leading to delays, inconsistencies, and potential errors.

Performance by Province

- **Staffing**: Highest in Mpumalanga (96%), lowest in Western Cape (62%)
- **Training**: Highest in Gauteng (62%), lowest in Mpumalanga (18%)
- **Tool E**: Highest in Gauteng (72%), lowest in Western Cape (46%)

Gaps and Strengths

- **Gaps**: Most staff lack training in IPC, BLS, medical emergencies, and AE management.
- **Strengths**: Most job descriptions are available and signed, and some training certificates exist.

3.2.4 Training

Training Needs Hamper MMC Program Effectiveness:

Despite efforts, MMC training across provinces remains a critical challenge, evident in the low average score of 39%. The gaps are particularly stark in essential areas like infection prevention, waste management, emergency response, and data management.

Provincial Disparities

- **Highest Training Scores**: Gauteng (62%), Eastern Cape (44%), KwaZulu-Natal (50%)
- **Lowest Training Scores**: Mpumalanga (18%), North West (27%), Western Cape (31%)

Key Issues

- **Low Online Completion Rates**: Many clinicians don't complete online courses, and those who finish theory struggle to access practical training.
- **Lack of Advocacy and Promotion**: Online training initiatives lack sufficient promotion and engagement strategies.
- **Outdated Certificates and Missing Training Plans**: File reviews revealed outdated certificates and a lack of corresponding training plans, raising concerns about documentation and program adherence.
- **Certificate Delays**: Staff experience delays in receiving certificates from training partners, relying solely on attendance registers as proof of training.

Provincial Bright Spots

- **Limpopo**: Leads in emergency management training for clinicians.
- **Mpumalanga**: Employs technical specialists to conduct in-service training on key MMC topics, offers refresher courses, and implements continuous monitoring and supervision.

3.2.5 Quality of client records and documentation

The EQA evaluation revealed a mixed picture regarding client record management in MMC services. While most sites (98%) securely stored records on-site, concerns emerged about the practices of mobile teams in North West, where records were not available onsite and reported to have been transported or kept off-site to CHAPS offices, raising potential security and accessibility issues.

Provincial Filing Rates: Disparities and Opportunities

Filing rates for client records varied significantly across provinces. While the average filing rate reached 96%, with four provinces achieving a perfect score (100%), the Western Cape lagged with only 78% of records properly filed. A similar disparity was observed in record rates, ranging from 82% in the Northern Cape to 99% in Free State and Mpumalanga.

Limpopo Leads in Record Management Innovation

Limpopo stands out for its proactive approach to record management. They implemented a lockable cabinet system to safeguard client confidentiality and employed a monthly data sheet to monitor program progress and identify areas for improvement. Additionally, Free State MMC coordinators actively review client records, ensuring data accuracy and completeness.

Significant Challenges in Document Management

Despite these positive examples, numerous challenges were identified in MMC documentation practices:

- **Outdated Documents**: The use of obsolete forms raises concerns about inaccurate data collection and program compliance.
- **Version Inconsistency**: Confusion and inconsistencies arising from the simultaneous use of different versions of the same document.
- **Data Alteration**: The use of Tippex to erase and modify information compromises data integrity and raises transparency concerns.
- **Duplicate Records and Cancellations**: Inadequate systems for handling duplicate records and cancellations lead to confusion and inaccurate data.
- **Incomplete and Inaccurate Records**: Many records were found incomplete, empty, inaccurate, or illegible, jeopardising data quality and program evaluation.
- **Frequent System Changes**: Disruptions in data continuity and accessibility were observed due to frequent changes in filing systems.
- **Data Verification Issues**: Concerns regarding data accuracy arose from the lack of consistent verification measures.
- **Missing Documentation**: Essential documents like ID proofs, consent forms, and signed affidavits were missing from many records.
- **Photocopy Degradation**: Repeated photocopying of records significantly reduced their quality and legibility, hindering future reference.

Missing Records: A Serious Concern

The most alarming finding was the reported absence of client records at three MMC sites (two in North West and one in Limpopo). This raises critical questions about data security, recordkeeping practices, and potential service gaps.

3.2.6 Follow-up and Linkage to Care

Follow-up and linkage to care remain crucial gaps in MMC services across the country. While the national average of 73% suggests progress, significant disparities exist between provinces, highlighting areas for improvement.

Provincial Performance: A Mixed Picture

- **Top Performers**: Northern Cape leads the way with an impressive 94%, followed by Limpopo (80%) and Mpumalanga (78%). These provinces showcase effective systems for ensuring clients receive post-operative care and support.
- **Areas for Improvement**: North West (59%), KwaZulu-Natal (66%), and Western Cape (67%) reveal concerning gaps in follow-up practices, indicating a need for targeted intervention.

Linkage to Care: Promising Efforts, Incomplete Data

While commendable efforts are made to link HIV-positive clients to care, data limitations hinder a clear understanding of outcomes. This issue manifests across several provinces:

- **Underutilised Registers**: Linkage to care registers are often unavailable, empty, or lacking vital information, making it difficult to track client progress and assess the effectiveness of referral systems.
- **Data Incomplete or Unavailable**: Despite connecting clients to care, recording their outcomes remains inconsistent, leaving crucial gaps in data and hindering program evaluation.

Exceptions to the Trend: Gauteng and Limpopo Lead the Way

Gauteng and Limpopo stand out for their integrated approach to HIV care. In these provinces, HIV-positive clients receive treatment within the same facilities where they undergo MMC, simplifying linkage to care and ensuring continuity of service.

3.2.7 Relationship with DoH

The success of MMC services hinges on a robust and dynamic relationship between Implementing Partners (IPs) and the Department of Health (DoH). While the findings reveal both positive and negative aspects of this partnership, the potential for collaboration and improvement remains immense.

Positive Aspects

- **Collaborative Support**: DoH actively champions MMC through various means, including:
    - **Direct Service Delivery**: Contributing healthcare personnel to MMC sites.
    - **Commodity Supply**: Ensuring availability of essential medical supplies and equipment.
    - **Data Collection and Analysis**: Receiving and analysing MMC statistics to inform program decisions.
- **Integration into DoH Facilities**: MMC services are largely integrated into DoH facilities, fostering smoother workflow and resource sharing. However, full integration requires deeper engagement beyond the dedicated MMC champions, involving broader staff buy-in and ownership.
- **Commitment to Quality**: The IP demonstrates a strong commitment to continuous quality improvement (CQI) through its active program. Notably, TC Newman and Caledon Hospital showcase exemplary integration and support with facility and district HAST managers, setting a high standard for quality assurance.
- **Shared Commitment to High-Quality Services**: Knysna Hospital exemplifies a successful partnership with both district and sub-district DoH, evident in the dedication of DCS and partner staff to collaborate and serve clients effectively.

Negative Aspects

- **Limited Support for RTC Site**: The RTC site in Phuthaditjhaba faces challenges due to its location in a private facility. This limits DoH facility staff support, particularly in crucial follow-up activities.
- **Poor Integration into Facility Systems**: MMC records remain largely siloed from facility systems at most sites, creating a barrier to patient care continuity and hindering comprehensive medical history access.
- **Limited Integration with HTS Activities**: MMC sites generally lack seamless integration with district HTS activities, including refresher training, proficiency assessments, and supportive site visits. This hinders potential synergies and knowledge sharing between the two programs.
- **Hospital Management Involvement**: While Knysna Hospital enjoys strong district and sub-district support, hospital management's involvement in MMC activities remains limited. This presents an opportunity for further engagement and leadership from the hospital administration.

3.2.8 Communication and IEC Material

Limited Accessibility and Targeting: Wound care pamphlets, though available in English and one local language, lack tailoring to diverse demographics and cultural needs. This could lead to decreased understanding and adherence among specific audiences.

- **Branding Disconnect**: Job aids and SOPs solely feature Implementing Partner logos, neglecting the Department of Health's (DoH) branding and potentially undermining a unified program identity.
- **Absence of Visual Information**: The complete lack of posters across crucial areas like counselling, registration, and surgical rooms hinders client awareness and engagement with MMC services.

Image 7: Demand creation and IEC material

- **Inadequate Individual Counselling Resources**: Individual counselling sessions often lack essential resources like job aids, IEC materials, and flip charts, limiting counsellors' ability to provide comprehensive and engaging information.

Communication Gaps and Inconsistencies

- **Privacy Concerns and Shared Spaces**: Limited space for group counselling at some sites raises privacy concerns and compromises client confidentiality. Shared spaces further exacerbate these issues and require immediate attention.
- **Shallow Counselling and Missed Topics**: Observations indicate shallow and inadequate counselling at some sites, neglecting crucial topics like infection prevention, STIs, PrEP, wound care, abstinence periods, and referral pathways to DoH services. This incomplete information could negatively impact client health outcomes and program effectiveness.
- **Mixed Messages and Confusion**: Inconsistent messaging between provider instructions and IEC materials creates confusion for clients, particularly regarding wound dressing removal. This lack of clarity undermines trust and adherence to essential post-operative care practices.
- **Incomplete Information and Missing Slides**: Incomplete group counselling sessions due to missing slides leave crucial information gaps and limit clients' understanding of the MMC process and post-operative care.
- **Counsellor Performance Disparities**: While some counsellors receive high ratings for their comprehensive and client-centred communication, others require improvement to ensure consistent quality across all sites.

3.2.9 Demand creation

Navigating Cultural Sensitivities

While openly recruiting for MMC in certain areas can present challenges due to cultural sensitivities, Implementing Partners (IPs) demonstrate remarkable resilience and resourcefulness. They employ creative strategies to reach potential clients, ensuring services are accessible and inclusive for all. This includes:

- **Community Engagement**: Building relationships with local leaders, traditional healers, and community-based organisations to foster trust and understanding about MMC.
- **Targeted Messaging**: Developing culturally sensitive IEC materials and communication strategies tailored to specific demographics and beliefs.
- **Leveraging Existing Networks**: Collaborating with healthcare providers and other relevant professionals to raise awareness and promote MMC within their communities.
- **Utilising Alternative Outreach Methods**: Employing mobile outreach teams, radio announcements, and community events to reach individuals in remote or culturally conservative settings.

Varying Demand Across Sites

Demand generation for MMC services varies across sites. Some facilities, like Bizzah Makhate, showcase exemplary efforts by Dedicated Circumcision Supervisors (DCS) personnel, actively engaging with and informing potential clients. However, other sites may require further support and strategies to increase awareness and interest.

IEC Material: Updates and Expansion Needed

While IEC materials are generally available, they require updates to ensure their accuracy and cultural relevance. Expansion to include additional local languages is crucial to reach a wider audience and overcome language barriers. The materials should also be regularly evaluated and refreshed to address evolving community needs and information requirements.

Limited Visibility: A Hindrance to Demand Creation

Limited visibility of MMC services at some sites significantly hinders effective demand creation. This could involve factors such as:

- Lack of signage or information materials in waiting areas and community spaces.
- Limited awareness among healthcare providers and staff about MMC services.
- Inadequate integration of MMC into existing community health initiatives.

3.2.10 Continuous Quality Improvement

CQI Implementation and Performance Disparities

While the overall improvement in CQI activities from 25% to 38% shows some progress, it remains concerning that the program's quality hasn't seen a more significant boost. This raises questions about the effectiveness of CQI implementation, particularly given the substantial performance disparities between provinces.

Uneven Progress and Provincial Disparities

- **High Performers**: Only three provinces, KwaZulu-Natal (59%), Gauteng (68%), and Mpumalanga (52%), achieved above 50% in CQI activities. This indicates pockets of success where CQI is effectively driving improvements.
- **Low Performers**: The remaining provinces, particularly Northern Cape (8%), Limpopo (39%), and North West (31%), lag far behind, highlighting significant challenges in implementing CQI and achieving quality improvements.

Provincial Performance Highlights

- **Free State**: Had the highest overall Tool H performance (36%) and excelled in standard CQI, pre-operation, post-operation, and follow-up indicators. This suggests their CQI efforts are focused on core program aspects.
- **Gauteng**: Led in education, HTS, screening, procedure, and adverse events indicators. This demonstrates their focus on client education, prevention, and service delivery.
- **Eastern Cape**: Achieved the highest records indicator (67%), indicating strong data management practices.
- **Western Cape**: Performed best in mobilisation (13%), suggesting effective client outreach and awareness strategies.
- **Northern Cape**: Unfortunately, showed the lowest performance in all indicators except mobilisation, raising serious concerns about program quality and CQI effectiveness in this province.

Underlying Issues and Opportunities

These disparities point to potential underlying issues, such as:

- Lack of standardised CQI processes and tools across provinces.
- Inadequate training and support for CQI implementation and data collection.
- Variations in resource allocation and infrastructure affect CQI activities.
- Limited DoH involvement in partner-led CQI efforts.

KEY RECOMMENDATIONS

The following important recommendations are given for each area evaluated:

4.1 Leadership and Planning

Building a Collaborative and Effective Foundation:

Recognising both strengths and areas for improvement, these recommendations aim to strengthen MMC's leadership and planning, paving the way for continuous growth and impact:

4.1.1 Empowering DoH Leadership and Collaboration

- **Clear Roles and Responsibilities**: Establish well-defined roles and responsibilities for MMC within the DoH structure, including dedicated MMC coordinators at provincial and district levels to ensure strong oversight and guidance.
- **Fostering DoH-IP Partnerships**: Enhance collaboration between DoH and Implementing Partners through regular communication, joint planning, and shared decision-making for all aspects of program implementation, maximising resource allocation and effectiveness.

4.1.2 Developing and Utilising Evidence-based Plans

- **Contextualised Plans**: Create comprehensive MMC plans that are grounded in evidence and tailored to specific contexts, addressing all program components and ensuring efficient resource utilisation.
- **Regular Review and Update**: Regularly review and update guidelines and SOPs to reflect current best practices and ensure they are readily accessible to all staff, promoting consistent adherence to high-quality standards.

4.1.3 Optimising Internal Systems and Practices

- **Standardisation and Streamlining**: Develop comprehensive, readily accessible SOPs, guidelines, and job aids for all provinces, creating a unified foundation for quality program implementation.
- **Enhanced Client Safety**: Strengthen adverse event management with clear protocols for handling needle sticks, post-exposure prophylaxis, and other incidents, ensuring client safety and accurate data collection.
- **Elevating Waste Management**: Implement proper waste segregation procedures, regular performance reporting, and address any gaps in disposal systems to maintain a hygienic environment.
- **Boosting Data Accuracy**: Standardise processes for recording adverse events and referrals, facilitating precise monitoring and improved program feedback loops.

- **Championing CQI**: Foster a culture of continuous quality improvement by providing resources, training, and support for CQI implementation across all levels, empowering staff to actively participate in program optimisation.
- **Learning from Leaders**: Leverage best practices observed in leading provinces like Mpumalanga, focusing on aspects like document organisation, job aid distribution, and patient-friendly information materials to accelerate program advancement.

4.2 Service Delivery Models

To ensure high-quality MMC services reach all communities, these recommendations address key aspects of service delivery models:

4.2.1 Building Stable Ground

- **Shifting towards Fixed Sites**: Prioritise fixed-site service delivery models whenever possible. This fosters a stable environment for consistent quality and accessibility, improving client experience and staff performance.
- **Investing in Workforce Capacity**: Recruit and retain sufficient dedicated MMC personnel, including nurses, counsellors, and data clerks. A well-staffed program enables efficient service delivery and personalised care.

4.2.2 Empowering Effective Staff

- **Comprehensive Training**: Provide thorough training in key areas like infection prevention, waste management, emergency response, data management, and client communication. Equipped staff to deliver safe, efficient, and client-centred services.
- **Supportive Supervision**: Develop and implement robust supportive supervision plans. Regular monitoring, mentoring, and feedback ensure adherence to best practices, address challenges proactively, and promote continuous improvement.

4.2.3 Leveraging Technology for Enhanced Impact

- **Streamlining Data Management**: Implement electronic data capture systems for accurate and timely data reporting. This enables efficient program monitoring and evaluation, informing data-driven decision-making for continuous improvement.

Based on the identified gaps in the MMC Minimum Package of Service, the team recommended the following remedial actions for each area:

4.2.4 Pre-surgery

- **Sharpen HIV Testing Practices**: Register kits, implement quality control, and use proper storage.
- **Boost Counselling**: Train counsellors, standardise education on condoms and STI/HIV, and offer support.

- **Thorough Pre-operative Assessment**: Use checklists, and emphasise importance to clinicians.

4.2.5 Surgery

- **Prioritise Sterility and Safety**: Train on infection control, monitor procedures, and provide sterile supplies.
- **Accurate Documentation**: Standardise start/end time recording, and mark before cutting.
- **Effective Anaesthesia**: Educate on overdose, adjust dosage for heavier patients, and document pain as adverse events.
- **Proper Antiseptics and Equipment**: Train on layering, enforce protocols, and ensure necessary supplies.

4.2.6 Reporting and Infrastructure

- **Bridge Communication Gaps**: Improve reporting channels, and provide clear instructions for instrument failure reports.

4.3 Staff Capacity

Addressing staff capacity is crucial for the MMC program's success. This may involve:

4.3.1 Building a Skilled and Stable Workforce

- **Expand Dedicated MMC Staff**: Reduce reliance on locums by increasing the number of permanent MMC personnel. This fosters familiarity with site-specific procedures, ensuring consistent quality and continuity of care.
- **Comprehensive Training Investment**: Provide staff with thorough training that encompasses all aspects of MMC service delivery, including theoretical knowledge and practical skills development. This empowers them to handle diverse situations confidently.
- **Mentorship and Coaching for Growth**: Implement robust mentorship and coaching programs to support staff development. This cultivates competence, builds confidence, and promotes continuous improvement in MMC service delivery.
- **Performance Management for Excellence**: Establish effective performance management systems with regular monitoring, constructive feedback, and targeted support. This enables staff to excel and consistently deliver high-quality services.

4.3.2 Fostering Confidence and Continuity

- **Reduce Locum Reliance**: Increase the number of dedicated MMC staff to minimise reliance on locums. This builds familiarity with site-specific procedures, fosters continuity of care, and enhances client trust.

- **Investing in Skills and Knowledge**: Equip staff with comprehensive training covering all aspects of MMC service delivery, both theoretical and practical. This empowers them to handle diverse situations effectively and confidently.
- **Mentorship and Coaching for Mastery**: Implement mentorship and coaching programs to nurture staff development, refine their skills, and boost confidence in delivering MMC services.
- **Performance Management for Continuous Improvement**: Establish effective performance management systems with regular monitoring, constructive feedback, and proactive support. This drives continuous improvement and ensures consistently high-quality MMC services.

4.3.3 Building a Strong and Empowered Team

- **Expand the MMC Core Team**: Recruit and retain dedicated MMC staff to reduce reliance on locums and foster a stable, experienced team. This strengthens program continuity and client relationships.
- **Invest in Comprehensive Training**: Provide all staff with thorough training in MMC service delivery, encompassing theoretical knowledge and practical skills development. This empowers them to handle diverse situations confidently and competently.
- **Mentorship and Coaching for Development**: Implement mentorship and coaching programs to support staff growth, enhance their expertise, and boost confidence in providing high-quality MMC services.
- **Performance Management for Excellence**: Establish robust performance management systems with regular monitoring, constructive feedback, and targeted support. This drives continuous improvement and ensures all staff excel in delivering quality MMC services.

4.4 Training

To improve MMC training, addressing the following is crucial:

- **Enhance Online Training Engagement**: Develop targeted strategies to encourage completion and address access barriers for practical training.
- **Strengthen Advocacy and Promotion**: Increase awareness and highlight the benefits of online training for MMC providers.
- **Streamline Certificate Issuance**: Ensure timely delivery of certificates to avoid relying solely on attendance records.
- **Standardise Training Plans**: Implement consistent training plans across provinces and ensure their alignment with online modules.
- **Focus on Critical Skills**: Prioritise training in key areas like infection prevention, waste management, emergency response, and data management.
- **Invest in Practical Training**: Expand access to practical training opportunities to complement online learning.
- **Increase Online Training Completion Rates**: Implement strategies to encourage participation and address barriers to online learning.
- **Organise Regular Practical Training Sessions**: Supplement theoretical knowledge with hands-on training to improve skills and confidence.
- **Training**: Advocate for MMC training within the healthcare system.
- **Conduct Regular Needs Assessments**: Identify and address evolving training needs to ensure staff remain up-to-date on best practices.

4.5 Quality of Client Records and Documentation

To address these challenges and ensure optimal client record management, several actions are recommended:

4.5.1 Building a Foundation of Trust and Accuracy

- **Streamlining Data Collection**: Implement standardised and up-to-date client record forms across all sites to ensure consistent data collection, compliance, and ease of access.
- **Organised and Accessible Records**: Develop clear and user-friendly filing systems for both physical and electronic records, empowering staff and facilitating efficient data retrieval.
- **Ensuring Data Integrity**: Implement robust data verification processes to identify and correct inconsistencies, guaranteeing data accuracy and reliability.
- **Empowered Staff**: Provide comprehensive training on recordkeeping practices, data security, and document integrity, equipping staff to manage client information effectively.
- **Secure and Accessible Storage**: Invest in secure storage solutions for both physical and electronic records to prevent unauthorised access or loss while ensuring accessibility for authorised personnel.

- **Continuous Improvement**: Implement regular audits to monitor adherence to recordkeeping protocols, identify areas for improvement, and promote ongoing optimisation of the system.

4.5.2 Prioritising Client Data Security and Privacy

- **Standardised Forms and Systems**: Ensure consistency and ease of use for client record forms and filing systems across all sites to minimise errors and facilitate efficient data management.
- **Compliance with DoH Guidelines**: Standardise the use of DoH-recommended source documents for client records, fostering consistency and adherence to regulations.
- **Data Accuracy and Accessibility**: Implement procedures for regular review and update of client records to ensure information is accurate, complete, and accessible for authorised personnel while safeguarding client confidentiality.
- **Robust Verification and Integrity Checks**: Implement robust data verification processes and mechanisms to guarantee data accuracy, integrity, and consistency across the system.

4.5.3 Streamlining Data Management for Enhanced Service Delivery

- **Standardise Data Collection Across All Sites**: Ensure consistency in client record forms and data entry practices to facilitate accurate data analysis and reporting.
- **Clear Filing Systems**: Implement user-friendly filing systems for both physical and electronic records, enabling efficient retrieval and utilisation of client information.
- **Data Accuracy at the Core**: Prioritise data integrity through robust verification processes and mechanisms, ensuring data consistency and reliability for informed decision-making.
- **Empowering Staff through Training**: Provide comprehensive training to MMC staff on data management best practices, data security protocols, and document handling procedures.
- **Address Missing Documentation**: Develop protocols for retrieving missing documents and resolving discrepancies.
- **Secure Storage and Accessibility**: Invest in secure storage solutions for both physical and electronic records, ensuring data protection while maintaining accessibility for authorised personnel.

4.6 Follow-up and Linkage to Care

Recommendations for Strengthening Follow-up and Linkage to Care:

Building a Supportive Bridge to Long-Term Care:

Recognising the importance of comprehensive care beyond MMC, these recommendations focus on strengthening follow-up and linkage to other services:

4.6.1 Ensuring Seamless Transitions

- **Standardise Follow-up Protocols**: Develop and implement clear and consistent protocols for follow-up, ensuring clients receive timely checkups and address any potential complications.
- **Accurate and Timely Reporting**: Improve data collection and reporting processes to track clients successfully linked to other services, informing program evaluation and resource allocation.

4.6.2 Strengthening Collaborations for Comprehensive Care

- **Prioritise HIV Linkage**: Enhance collaboration with HIV services to ensure efficient linkage and ongoing care for HIV-positive clients, promoting holistic health outcomes.

4.6.3 Supporting Clients on the MMC Journey

- **Beyond the Procedure**: Provide ongoing support and resources to address clients' needs and concerns throughout their MMC journey, from pre-operative preparation to post-operative follow-up. This could include access to mental health services, social support groups, and educational materials.

4.7 Relationship with DoH

Building a Bridge of Collaboration and Shared Success:

These recommendations aim to strengthen the partnership between IPs and the DoH, fostering a collaborative environment for MMC program excellence:

- **Open and Inclusive Communication**: Establish clear and regular communication channels at all levels, ensuring transparency, timely information flow, and open dialogue between IPs and the DoH. This can include regular meetings, designated points of contact, and effective feedback mechanisms.
- **Joint Monitoring and Evaluation**: Collaboratively develop and implement comprehensive monitoring and evaluation frameworks. This allows for shared tracking of progress, identification of areas for improvement, and data-driven decision-making to optimise the program's impact.
- **Investing in Workforce Development**: Strengthen collaboration on training and capacity building for MMC staff. This could involve joint needs assessments, co-creation of training programs, and knowledge-sharing workshops, empowering staff and ensuring consistent service delivery across all levels.
- **Sharing Wisdom and Growth**: Foster a culture of learning and continuous improvement within the program. Encourage the regular sharing of best practices, lessons learned, and innovative ideas between IPs and the DoH, promoting program adaptability and growth.

4.8 Communication and IEC Material

Creating a Unified Voice for MMC Success:

These recommendations focus on optimising communication and IEC materials to ensure clarity, accessibility, and consistency across the MMC program:

4.8.1 Branded for Impact

- **Align with DoH Guidelines**: All MMC sites and Implementing Partners (IPs) should ensure their branding and information, education, and communication (IEC) materials adhere to the Department of Health's (DoH) corporate communication guidelines. This fosters a unified identity and strengthens the program's impact.

4.8.2 Reaching Each Client

- **Culturally Competent and Accessible**: Develop IEC materials that are culturally appropriate, translated into relevant languages, and accessible to diverse audiences. Consider formats like posters, brochures, videos, and audio recordings to cater to different learning styles and needs.
- **A Journey of Information**: Integrate IEC materials seamlessly into all stages of the client journey. Provide clear and relevant information in counselling sessions, waiting areas, printed materials, and digital platforms.

4.8.3 Empowering Communication

- **Train for Client-Cantered Care**: Train counsellors on effective communication skills, including active listening, clear explanations of procedures, and addressing client concerns openly and respectfully.
- **Protecting Privacy**: Ensure that clients have access to adequate space and resources for confidential counselling sessions, safeguarding their privacy and fostering trust.

4.8.4 A Consistent Message

- **Standardise Key Messages**: Develop standardised messages for communicating key information about MMC across all communication channels and materials. This ensures consistent, accurate, and easily understandable information for all clients.

4.9 Demand Creation

Sparkling Interest and Inspiring Action:

These recommendations aim to ignite and sustain interest in MMC services, reaching individuals where they are and prompting informed decisions:

4.9.1 Broadcasting the Value

- **Amplify MMC Visibility**: Increase MMC's visibility through diverse communication channels like radio, social media, community events, and mobile outreach campaigns. Make MMC a familiar and accessible concept in everyday life.
- **Culturally Attuned Strategies**: Develop and implement demand creation strategies that are culturally sensitive, resonate with specific communities, and address their unique needs and concerns. Foster trust and understanding through culturally relevant messages and outreach methods.

4.9.2 Targeted Engagement

- **Spotlight MMC Services**: Increase the visibility of MMC services through targeted outreach and campaigns. Partner with local media, health facilities, and schools to promote awareness and accessibility.
- **Leveraging Community Connections**: Utilise partnerships with community leaders, organisations, and influencers to spread the word about MMC. These trusted voices can bridge the gap between communities and healthcare services.

4.9.3 Empowering Local Champions

- **Equipping Community Health Workers**: Train community health workers and peer educators to become MMC ambassadors. Provide them with knowledge, communication skills, and resources to raise awareness and address questions within their communities.

4.10. Continuous Quality Improvement

These recommendations focus on fostering a collaborative and data-driven approach to CQI, ensuring ongoing program improvement and impact:

4.10.1 Equipping for Excellence

- **Invest in CQI Skills**: Organise training workshops for DoH and IP staff on CQI methodologies and tools, empowering them to actively participate in program optimisation. This can cover topics like data analysis, problem-solving techniques, and best practices in implementing CQI initiatives.

4.10.2 Closing the Quality Gap

- **Track and Address Issues**: Implement a robust system for tracking and closing identified gaps in service delivery or program implementation. This could involve utilising standardised reporting tools, regular audits, and feedback mechanisms to ensure timely identification and resolution of challenges.

4.10.3 Collaborative CQI

- **DoH-IP Partnership**: Strengthen collaboration between DoH and IPs to conduct ongoing CQI initiatives for the MMC program. This fosters shared ownership, leverages diverse expertise, and ensures alignment with broader program goals.
- **Regular CQI Dialogue**: Establish regular meetings between DoH representatives and key stakeholders, including IPs, community leaders, and healthcare providers. This facilitates open communication, sharing of best practices, and identification of areas for improvement.
- **Shared CQI Plans**: Collaboratively develop and implement CQI plans and activities, ensuring all stakeholders are involved in setting priorities, defining interventions, and monitoring progress. This promotes transparency and accountability for achieving desired outcomes.

4.10.4 Data-Driven Improvement

- **Open Information Sharing**: Share CQI data, reports, and findings with DoH and IPs to inform decision-making and resource allocation. This ensures transparency, data-driven program optimisation, and efficient utilisation of resources.
- **Joint Monitoring and Evaluation**: Conduct joint monitoring and evaluation of CQI activities to assess progress, track impact, and identify areas for further improvement. This enables continuous adaptation and refinement of CQI strategies for sustained program excellence.

CONCLUSION

Empowering MMC: A Roadmap for Quality, Sustainability, and Impact:

The 2023 national MMC EQA sheds light on crucial areas for improvement to propel the program towards greater impact, ethical adherence, and lasting success. Here's a roadmap focusing on key recommendations across critical domains:

5.1. Building a Robust Quality Assurance System

- **Empowering Districts**: Establish dedicated QA teams at the district level, led by DoH personnel, to champion CQI activities at all MMC sites, including those under RT35 and GP contracts. This fosters local ownership and ensures quality standards reach every corner of the program.
- **Expanding DoH-led CQI**: Broaden the reach of DoH-led CQI teams to encompass additional facilities beyond the current scope. This collaborative approach strengthens quality throughout the program and fosters a culture of shared responsibility.
- **Modernising Guidelines**: Revise and update existing MMC guidelines and SOPs to reflect best practices, address identified gaps, and ensure clarity for all staff. Modernised standards drive consistent quality and ethical service delivery.
- **Standardising Documentation**: Develop and implement standardised, readily accessible SOPs, job aids, and policy documents across all provinces and facilities. This fosters consistent practice and eliminates confusion, ensuring everyone operates on the same page.

5.2. Fostering Leadership and Collaboration

- **Strengthening DoH Guidance**: Establish clear roles and responsibilities for MMC within the DoH structure, including dedicated MMC coordinators at provincial and district levels. This provides strong leadership and direction for the program.
- **Building DoH-IP Partnerships**: Facilitate regular communication, joint planning, and shared decision-making between DoH and Implementing Partners. Collaborative endeavours lead to effective program implementation and resource allocation.
- **Evidence-based Planning**: Develop comprehensive MMC plans at provincial and district levels, grounded in evidence and tailored to local contexts. This ensures strategic implementation that addresses specific needs and priorities.
- **Continuous Improvement**: Foster a culture of continuous improvement by regularly reviewing and updating MMC guidelines and SOPs, and ensuring their accessibility for all staff. Staying current with best practices leads to optimal service delivery.

5.3. Investing in Staff and Service Quality

- **Enhancing Skills**: Continue to provide regular training and supportive supervision to MMC providers, equipping them with the latest knowledge, skills, and best practices. Skilled staff provide high-quality services and ensure client safety.
- **Empowering General Practitioners**: Encourage and support the involvement of general practitioners in MMC services. This expands program capacity, reaches wider communities, and leverages existing healthcare infrastructure.
- **CQI for All**: Foster a culture of CQI at all levels by providing resources, training, and support for staff to actively participate in quality improvement initiatives. Empowering everyone to contribute leads to sustainable excellence.

5.4. Prioritising Client Safety and Ethical Practice

- **Safeguarding Clients**: Implement clear protocols for handling adverse events, needle sticks, and post-exposure prophylaxis to prioritise client safety and ensure accurate data reporting. Robust procedures minimise risks and promote responsible practice.
- **Enhancing Data Quality**: Standardise processes for recording and reporting adverse events and referrals to improve program monitoring and feedback loops. Accurate data drives evidence-based decision-making and program optimisation.
- **Optimising Waste Management**: Implement proper waste segregation procedures, ensure regular performance reporting, and address any gaps in waste disposal systems to maintain a hygienic environment and protect health.
- **Respecting Rights**: Ensure clear and accessible information materials are available in multiple languages, and informed consent procedures are consistently followed, respecting client autonomy and upholding ethical principles.

By acting on these comprehensive recommendations, the MMC program can navigate towards a future of enhanced quality, sustainability, and impact. Empowering a robust quality assurance system, fostering strong leadership and collaboration, investing in skilled staff and service quality, and prioritising client safety and ethical practice. This ambitious yet achievable roadmap paves the way for a MMC program that truly delivers on its promise of improved public health and HIV prevention for all.

APPENDICES

Table 7: Characteristics of the MMC sites assessed in the Eastern Cape Province

Date of EQA	Site	District	Imple-menting Partner (IP)	Type of Site	Service type	EQA period assessed (months)	Total MMCs	MMC Age groups		HIV positive	Follow up	
								10-14 y	15+ y		48hrs	7 days
11-May-23	Humans-dorp	Sarah Bartman	Right to Care	Fixed Site	Outreach	12	623	249	374	0	592 (95%)	517 (83%)
24-Apr-23	Palmer-ton	OR Tambo	Right to Care	Fixed Site	Outreach	12	177	-	177	2 (1%)	177 (100%)	177 (100%)
26-Apr-23	St Patrick	Alfred Nzo	Right to Care (NPC)	Fixed Site	Outreach	12	373	68 (DoH)	305	3 (0.8%)	373 (100%)	373 (100%)
Eastern Cape total							**1173**	**317**	**865**	**5(0.4%)**	**1142 (97%)**	**1067 (90%)**

Table 8: Characteristics of the MMC sites assessed in the Free State Province

Date of EQA	Site	District	Imple-menting Partner (IP)	Type of Site	Service type	EQA period assessed (months)	Total MMCs	MMC Age groups		HIV positive	Follow up	
								10-14 y	15+ y		48hrs	7 days
19-Apr-23	Phuthaditjaba	Thabo Mofutsanyane	Right to Care	Fixed, private site	Routine	12	932	0	932	11	876	839
20-Apr-23	JD New-berry	Thabo Mofutsanyane	Right to Care	Mobile	Outreach	12	128	0	128	4	95	74
19-Apr-23	Pelonomi	Mangaung	Right to Care	Fixed	Outreach	12	1690	554	1136	7	1640	1607
02-Jun-23	Kroon-stad Med. A	Fezile Dabi	TB HIV Care	DCS	Outreach	6	28	-	28	8	28	28
Free State total							**2778**	**536**	**2224**	30	**2639**	**2548**

Table 9: Characteristics of the MMC sites assessed in the Gauteng Province

Date of EQA	Site	District	Imple-menting Partner (IP)	Type of Site	Service type	EQA period assessed (months)	Total MMCs	MMC Age groups		HIV positive	Follow up	
								10-14 y	15+ y		48hrs	7 days
20-Apr-23	KT Motubatse	Tshwane	Right to Care	Fixed	Campaign	29	2038	-	2038	47 (2%)	1936 (95%)	1936 (95%)
02-May-23	Odi Hospital	Tshwane	Right to Care	Fixed	Outreach	12	65	-	65	1 (1.5%)	65 (100%)	65 (100%)
03-May-23	Mogale Clinic	West Rand	SHF	Fixed	Routine	12	68	33	35	0	47 (69%)	14 (21%)
19-Apr-23	Hilbrow	JHB Health	PSI	Fixed	Campaign	27	2190	-	2190	66 (3%)	2080 (95%)	2080 (95%)
18-Apr-23	Chiawelo	JHB Health	PSI	Fixed	Campaign	23	722	-	722	20 (2.9%)	626 (87%)	626 (87%)
17-Apr-23	Itireleng	JHB Health	PSI	Fixed	Campaign	38	878	-	878	26 (3%)	798 (91%)	798 (91%)
05-May-23	Levai Mbatha	Sedibeng	PSI	Fixed	Routine	12	717	77 (DoH)	640	7 (1%)	361 (50%)	284 (40%)
04-May-23	Dr Yako	West Rand	Insimu	Fixed, Private	Routine	12	740	535	205	3 (0.4%)	666 (90%)	628 (85%)
Gauteng total							**7398**	**635**	**6763**	**170 (2%)**	**6579 (88%)**	**6431 (86%)**

Table 10: Characteristics of the MMC sites assessed in the KwaZulu-Natal Province

Date of EQA	Site (13)	District	Imple-menting Partner (IP)	Type of Site	Service type	EQA period assessed (months)	Total	MMC Age groups		HIV positive	Follow up	
								10-14 y	15+ y		48hrs	7 days
19-May-23	Bluff	Ethekwini	JHPIEGO	Fixed	Outreach	21	15	-	15	0	12 (80%)	14 (93%)
15-May-23	Injisuthi	Uthukela	JHPIEGO	Fixed	Routine	12	162	-	162	27 (17%)	127 (78%)	130 (80%)
18-May-23	LCJ	Ethekwini	JHPIEGO	Fixed, Private	Routine	12	554	-	554	16 (3%)	554 (100%)	520 (94%)
17-May-23	Dr Mlungwana	Ugu	JHPIEGO	Fixed, Private	Routine	12	622	-	622	3 (0.4%)	598 (92%)	510 (83%)
05-May-23	Dr Khumalo	King Cetshwayo	JHPIEGO	Fixed, Private	Routine	12	889	-	889	0	889 (100%)	889 (100%)
04-May-23	Dr Ntombela	Zululand	JHPIEGO	Fixed, Private	Routine	12	878	-	878	1 (0.1%)	632 (100%)	632 (100%)
24-May-23	KwaMashu clinic	Ethekwini	JHPIEGO	Fixed	Outreach	12	776	-	776	7 (1.3%)	405 (54%)	248 (31%)
17-May-23	Umlazi K	Ethekwini	PSI	Fixed, Mobile	Mobile	12	372	-	372	8 (2.2%)	350 (94%)	352 (95%)

15-May-23	Kwamakhutha	Ethekwini	PSI	Mobile	Campaign, Mobile	12	123	-	123	1 (0.9%)	84 (68%)	103 (83%)
19-May-23	Eastboom clinic	Umgungundlovu	PSI	Fixed	Routine	12	2389	-	2389	32 (1.3%)	1786(74%)	1878(78%)
18-May-23	Ixopo	Harry Gwala	PSI	Fixed	Routine	12	1360	-	1360	0	935 (69%)	726 (53%)
02-May-23	Sipho Zungu Clinic	Umkhanyakude	Thathenda	Fixed	Campaign	12	110	100	10	1 (0.1%)	110 (100%)	110 (100%)
25-May-23	Waterval DCS	Amajuba	TB HIV Care	DCS	Outreach	10	46	-	46	0	37 (81%)	24 (52%)
KwaZulu-Natal total						**163**	**8296**	**100**	**8196**	**1.2%**	**6520 (78%)**	**6136 (73%)**

Table 11: Characteristics of the MMC sites assessed in the Limpopo Province

Date of EQA	Site	District	Imple-menting Partner (IP)	Type of Site	Service type	EQA period assessed (months)	Total	MMC Age groups		HIV positive	Follow up	
								10-14 y	15+ y		48hrs	7 days
09-May-23	Duiwels-kloof	Mopani	Right to Care	Fixed	Outreach	12	837	-	837	0	836 (99.9%)	787 (94%)
	Seshego	Capricorn	Right to Care	Fixed	Routine	12	2164	-	2164	10	2075 (96%)	1609 (74%)
02-Jun-23	Kutama Sinthumule DCS	Vhembe	TB HIV Care	DCS	Outreach	12	48	-	48	9	48 (100%)	48 (100%)
10-May-23	Grace Mugodeni	Mopani	Right to Care	Fixed	Routine	12	1779	-	1779	1	1778 (99.9%)	1726 (97%)
Limpopo total							**4828**	**-**	**4828**	**20**	**4689 (98%)**	**4170 (86%)**

Table 12: Characteristics of the MMC sites assessed in the Mpumalanga Province

Date of EQA	Site Name (6)	District	Imple-menting Partner (IP)	Type of Site	Service type	EQA period assessed (months)	MMC Age groups		HIV positive	Follow up	
							10-14 y	15+ y		48hrs	7 days
03-May-23	Dr Zelda Mkhonto	Ehlanzeni	RTC	Fixed, Private	Routine	12	**0**	1646	3	1646 (100%)	1646 (100%)
25-Apr-23	Dr Khosa GP	Ehlanzeni	RTC	Fixed, Private	Routine	12	**0**	208	1	208 (100%)	208 (100%)
09-May-23	Wakkerstroom CHC	Gert Sibande	SHF	Fixed	Routine	12	**-**	651	0	598 (92%)	510 (83%)
10-May-23	Dr Masinga	Gert Sibande	Dr Masinga	Fixed, Private	Routine	No data	**0**	0	0	0	0
11-May-23	Embuleni CHC	Gert Sibande	RTC	Fixed	Campaign	12	**0**	**186**	**1**	**186 (100%)**	**186 (100%)**
12-May-23	Lilian Mambakazi CHC	Gert Sibande	JPSA	Fixed	Outreach	12		**2108**	**31**	**1686 (80%)**	**1686 (80%)**

Table 13: Characteristics of the MMC sites assessed in the Northern Cape Province

Date of EQA	Site	District	Imple-menting Partner (IP)	Type of Site	Service type	EQA period assessed (months)	Total	Total MMC done		HIV positive	Follow up	
								10-14 y	15+ y		48hrs	7 days
31-May-23	Dr Moremi	Francis Baard District	JGALT	Fixed, Private	Routine	12	614	478	136	3	203 (33%)	75 (125%)
29-May-23	Dr Chika	John Taolo Gaethewe	JGALT	Fixed, Private	Routine	12	1673	1260	413	1	1494 (89%)	408 (24%)
30-May-23	Hopetown clinic	Pixley ka Seme	JGALT	Fixed	Outreach	12	115	33	82	0	99 (86%)	0
Northern Cape total							**2402**	**1771**	**631**	**4**	**1796 (74%)**	**123 (5.1%)**

Table 14: Characteristics of the MMC sites assessed in the North West Province

Date of EQA	Site Name	District	Imple-menting Partner (IP)	Type of Site	Service type	EQA period assessed (months)	# MCs last 12 Months	HIV status		Follow-up rate	
								HIV-	HIV+ %	48 hours	Day 7
29-May-23	Mamusa Clinic	Dr Ruth Segomotsi Mompati	AURUM	Fixed, Mobile	Outreach	12	339	*No data	*No data	*No data	*No data
30-May-23	Dr Mokgosi GP	Dr Ruth Segomotsi Mompati	AURUM	Fixed, Private	Routine	12	2108	*No data	*No data	*No data	*No data
31-May-23	Ganyesa CHC	Dr Ruth Segomotsi Mompati	AURUM	Fixed, Mobile	Outreach	12	665	535	0	612 (92%)	15 (2%)
06-Jun-23	Dr Kgoputso GP	Ngaka Modiri Molema	Right to Care	Fixed, Private	Routine	12	815	815	0	815 (100%)	815 (100%)
07-Jun-23	Tshepong Hospital	Dr Kenneth Kaunda	Right to Care	Fixed	Routine	12	1148	979	16 (1,39%)	774 (67%)	463 (40%)
North West total							**5075**	**2329**	**0.3%**	**2201 (43%)**	**1293 (25%)**

Table 15: Characteristics of the MMC sites assessed in the Western Cape Province

Date of EQA	District	Site	Imple-menting Partner (IP)	Type of Site	Service type	EQA period assessed (months)	Total	Total MMC done		HIV positive	Follow up	
								14-Oct	15+		48hrs	7 days
22-May-23	Overburg	Caledon Hospital	SHF	Fixed	Outreach	12	67	25	42	0	65	66
23-May-23	Cape Winelands	TC Newman	JGALT	Fixed	Outreach	12	359	56	303	0	78	42
26-May-23	Cape Metro	Dr Ndlumbini	JHPIEGO	Fixed, Private	Routine	12	2750	0	2750	7	2746	2170
25-May-23	Cape Metro	Wynburg Gifted Hands	JHPIEGO	Fixed, Private	Routine	12	84	0	84	0	82	68
26-May-23	Eden	Knysna Hospital	SHF	Fixed	Outreach	12	146	54	92	0	146	146
22-May-23	Western Cape	Beaufort West CDC	JGALT	Fixed	Outreach	12	28	-	28	0	0	0
Western Cape total							**3434**	**135**	**3299**	**7**	**3117**	**2492**

Table 136: Tool A performance assessment per province

Province	% SOPs
Eastern Cape	76
Free State	85
Gauteng	84
Kwa-Zulu Natal	79
Limpopo	87
Mpumalanga	79
North West	62
Northern Cape	81
Western Cape	71
National total	78

Table 17: Tool B performance assessment per province

Province	General	HTC/Exam room	Theatre	Recovery room	Medicine	Disposa-bles and MMC kits	Supplies	Equip-ment	Waste	Total
Eastern Cape	78	100	95	100	31	83	79	75	100	74
Free State	92	100	100	100	77	82	97	88	100	89
Gauteng	84	98	100	92	87	82	96	88	100	90
KZN	87	92	92	90	92	91	90	92	92	90
Limpopo	100	100	97	100	53	84	97	88	100	84
Mpumalanga	100	100	98	89	93	88	90	96	100	93
North West	80	84	80	80	87	86	75	70	80	82
Northern Cape	100	80	100	78	43	72	38	75	77	67
Western Cape	95	93	93	95	67	76	63	88	78	78
National total	91	94	95	92	70	83	81	84	92	83

Table 18: Tool C performance assessment per province

Province	Storage	Filling	Adult Infor-med Consent	Minor Infor-med Consent	Minor's parental Supporting Docs	History taking	Physical exam	BP	Weight	Date of Surgery	Anaesthetic Dosing/ Weight	Follow up
Eastern Cape	100	95	84	90	77	93	90	90	90	90	88	83
Free State	100	100	100	100	100	100	100	100	100	100	100	96
Gauteng	100	87	98	90	87	96	97	95	95	98	96	98
KwaZulu-Natal	100	100	99	93	93	100	100	100	99	99	100	97
Limpopo	99	100	100	100	100	100	100	99	100	100	100	100
Mpumalanga	100	50	100	100	100	100	100	100	99	100	100	100
North West	50	50	100	98	98	100	100	100	100	100	97	100
Northern Cape	100	60	100	77	65	100	100	100	100	98	100	74
Western Cape	100	81	100	93	87	95	95	95	95	93	92	62
National total	94	80	98	93	90	98	98	98	98	98	97	90

Table 19: Tool D performance assessment per province

Province	PEP	Emergency Trainings	Emergency Trolley	Emergency Supplies	Emergency Equipment	Tool D Total
Eastern Cape	92	0	78	100	75	77
Free State	92	50	72	94	71	79
Gauteng	89	64	79	99	93	89
KZN	98	46	77	95	96	83
Limpopo	100	83	72	94	100	90
Mpumalanga	92	33	81	100	96	80
North West	83	0	100	100	100	77
Northern Cape	75	17	39	67	59	51
Western Cape	80	0	50	98	80	62
National	89	33	72	94	86	76

Table 20: Tool E performance assessment per province

Province	Staffing	Training	Tool E
Eastern Cape	75	44	60
Free State	72	40	56
Gauteng	81	62	72
KwaZulu-Natal	87	50	68
Limpopo	79	49	64
Mpumalanga	96	18	57
North West	87	27	57
Northern Cape	64	33	49
Western Cape	62	31	46
National	78	39	59

Table 141: Tool F performance assessment per province

Province	History Observation	History Documentation	Examination Observation	Examination Documentation	Surgical Preparation	Surgical procedure	Surgical Dressing	Waste Disposal	Tool F Total
Eastern Cape									
Free State	97	97	100	100	94	84	100	100	96
Gauteng	100	100	82	87	87	86	100	98	96
KZN	83	93	96	93	91	89	98	78	75
Limpopo	98	100	97	96	91	91	100	100	97
Mpumalanga	90	94	86	92	76	89	100	97	90
North West	100	100	100	100	80	90	100	100	96
Northern Cape	95	95	100	100	76	75	100	50	87
Western Cape	81	83	91	89	89	80	100	96	89
National	93	95	94	95	86	86	100	90	91

Table 15: Tool G performance assessment per province

Province	Group Education	Individual Education	HIV Testing	HIV Test Negative	HIV Test Positive	Post-operative care	Follow-up care	IEC material	Total Tool G
Eastern Cape	99	93	91	100	100	96	69	81	91
Free State	98	93	98	81	96	85	73	97	90
Gauteng	90	91	91	53	84	89	73	79	81
KZN	95	91	90	73	78	99	66	93	86
Limpopo	100	97	91	75	69	93	80	95	87
Mpumalanga	90	93	93	66	64	92	78	74	86
North West	57	81	95	80	92	59	59	80	75
Northern Cape	64	0	81	75	50	92	94	67	65
Western Cape	82	89	88	55	95	80	67	83	80
National	86	81	91	73	81	87	73	83	82

Table 23: Tool H performance assessment per province

Province	Standard CQI	Mobilisation	Records	Education	HTS	Screening	Pre-operation	Procedure	Post-operation	Follow-up	Adverse Events	Total Tool H
Eastern Cape	67	17	67								17	15
Free State	95	50	63	25	6	6	25	38	38	31	31	36
Gauteng	90	58	79	79	75	58	58	71	67	54	58	68
KwaZulu-Natal	74	48	63	58	63	43	65	58	73	43	65	59
Limpopo	90	25	94	25	25	13	31	50	13	31	38	39
Mpumalanga	75	31	69	44	38	56	56	63	38	38	63	52
North West	55	50	31	0	0	0	38	50	31	31	50	31
Northern Cape	50	13	25	0	0	0	0	0	0	0	0	8
Western Cape	80	13	50	0	0	0	63	38	38	38	25	31
National	75	34	60	26	23	20	37	41	33	30	39	38