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USAID ASSIST Project

Applying Science to Strengthen and Improve Systems

South Africa Country Report FY17

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Performance Period: October 1, 2016 - August 31, 2017

AUGUST 2017

DISCLAIMER
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Recommended citation
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## Abbreviations

<table>
<thead>
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<tr>
<td>ASSIST</td>
<td>USAID Applying Science to Strengthen and Improve Systems Project</td>
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<td>CDC</td>
<td>U.S. Centers for Disease Control and Prevention</td>
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<td>CHAPS</td>
<td>Centre for HIV and AIDS Prevention Studies</td>
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<td>CQI</td>
<td>Continuous quality improvement</td>
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<td>DHIS</td>
<td>District Health Information System</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>IP</td>
<td>Implementing partner</td>
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<tr>
<td>IPCHS</td>
<td>WHO's framework for integrated people-centered health services</td>
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<tr>
<td>KZN</td>
<td>KwaZulu-Natal</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<tr>
<td>NDOH</td>
<td>National Department of Health</td>
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<td>OHS</td>
<td>Office of Health Systems</td>
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<td>PDOH</td>
<td>Provincial Department of Health</td>
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<td>PDSA</td>
<td>Plan, do, study, act</td>
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<tr>
<td>PEPFAR</td>
<td>U.S. President's Emergency Plan for AIDS Relief</td>
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<td>QI</td>
<td>Quality improvement</td>
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<td>RTC</td>
<td>Regional Training Center</td>
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<tr>
<td>SACTWU</td>
<td>Southern African Clothing and Textile Workers' Union</td>
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<tr>
<td>TWG</td>
<td>Technical working group</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations Programme on HIV/AIDS</td>
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<td>URC</td>
<td>University Research Co., LLC</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>VMMC</td>
<td>Voluntary medical male circumcision</td>
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<td>WHO</td>
<td>World Health Organization</td>
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</table>
1 Introduction

HIV and AIDS is a major health concern in South Africa. HIV infection in the country ranks the highest globally with approximately 7 million people living with HIV and 19.2% of adults between 15 and 49 years infected with the virus (UNAIDS, 2015). Approximately 1,000 adults are infected with HIV daily.

The review of the National Strategic Plan on HIV 2007-2011 by the South African National Department of Health (NDOH) shows mixed achievements: much headway had been made, however there were key challenges to be addressed in order to scale up HIV prevention, treatment, care, and support in South Africa. University Research Co., LLC has worked in South Africa since 2000 through the Quality Assurance Project (QAP) and its follow-on, the USAID Health Care Improvement (HCI) Project. Since October 2013, URC through the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project has worked in the five USAID priority provinces at provincial and district levels to improve the quality of primary health care (PHC) through providing support and mentorship in planning, implementation, evaluation, and documentation. Starting in May 2014, ASSIST began working with approximately 134 PEPFAR-supported sites in all nine provinces to improve the quality and safety of voluntary medical male circumcision (VMMC) services.

In FY17, ASSIST in South Africa worked with three USAID-funded implementing partners (IPs) – the Centre for HIV and AIDS Prevention Studies (CHAPS), Right to Care, and Southern African Clothing and Textile Workers’ Union (SACTWU) – to improve the quality of their VMMC programs in 65 health facilities in five of the nine provinces in the country: Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, and North West provinces. We also worked to capacitate the Department of Health (DOH) staff at all levels on the use of continuous quality improvement (CQI) methodology and tools and support technical working groups (TWGs) at the national and provincial levels to incorporate quality improvement as a fundamental health system function.

ASSIST’s activities in South Africa closed in August 2017.

Scale of USAID ASSIST’s Work in South Africa

2 Program Overview

<table>
<thead>
<tr>
<th>What are we trying to accomplish?</th>
<th>At what scale?</th>
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<tbody>
<tr>
<td>1. Continuation of continuous quality improvement in VMMC programs</td>
<td></td>
</tr>
<tr>
<td>• Improve the quality and safety of VMMC services by applying CQI methodology</td>
<td>Provinces: 5 (USAID priority)</td>
</tr>
<tr>
<td>• Capacitate NDOH and Provincial Department of Health (PDOH) staff on CQI methodology</td>
<td>Facilities: 65</td>
</tr>
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### What are we trying to accomplish?

<table>
<thead>
<tr>
<th>At what scale?</th>
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<tr>
<td>QI teams: 61</td>
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#### Assist with development of, and participation in, technical working groups at NDOH and PDOH

- Support communication between NDOH, PDOH, and PEPFAR partners, regarding CQI initiatives

#### Provision of training in CQI in VMMC programs

<table>
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<tr>
<th>At what scale?</th>
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<tr>
<td>National and 5 USAID priority provinces</td>
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- Update and standardize VMMC CQI training curricula
- In collaboration with PEPFAR IPs and DOH, provide CQI training for 250 IP and DOH staff
- Harmonize CQI inputs with the AIDSFree web-based training platform

#### Sustainability and scale-up of CQI in VMMC

<table>
<thead>
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<th>At what scale?</th>
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<tr>
<td>National and 5 USAID priority provinces</td>
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- Build the CQI capacity of the Department of Health’s Regional Training Centre
- Strengthen direct involvement and ownership by DOH in VMMC services across all facilities
- Develop technical briefs on CQI
- Institutionalize CQI by training DOH Quality Assurance Coordinators at all levels


<table>
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<tr>
<th>At what scale?</th>
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<tr>
<td>10 pilot intervention sites and 10 comparison sites in Nelson Mandela Bay Metro Municipality in Eastern Cape Province</td>
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</table>

- Pilot integrated health services in one district in Eastern Cape Province
  - Assessment of patient, provider, and decision maker perceptions regarding integration and patient centeredness
- Training in quality improvement and IPCHS concepts and methodology

### 3 Key Activities, Accomplishments, and Results

#### Activity 1. Continuation of continuous quality improvement in VMMC programs

**BACKGROUND**

VMMC has been shown to be one of the most effective strategies in preventing the rise in new HIV infections. Currently, the NDOH is implementing the VMMC program in partnership with PEPFAR implementing partners. While much work has been done to increase the number of circumcised men in South Africa, more work is needed to ensure the provision of safe, effective, and high-quality VMMC services. One of the main goals of PEPFAR and the NDOH is to improve and sustain the quality of the VMMC program, in accordance with national and international standards. Strengthening the implementation and maintaining quality in the VMMC program will enable the NDOH to scale up the VMMC program and to reach 80% of HIV-negative men aged between 15-49 years (4.3 million men) in order to avert 500,000 new infections. Strengthening the NDOH and Provincial DOH (PDOH) systems to integrate CQI in the VMMC program is also critical for scale-up and sustainability of the program.

**ACCOMPLISHMENTS AND RESULTS**

- Conducted CQI follow-up assessments and coaching for 45 of the 65 CQI sites ASSIST supported in VMMC (Oct 2016-Jul 2017). Assessments were conducted in CQI-supported sites to determine the quality of services provided using the World Health Organization (WHO), DOH and PEPFAR adopted tool on VMMC minimum quality standards. Assessments were conducted every
three to 12 months depending on the type of support given to the health facility, which was determined by the dashboard score during each site’s baseline assessment. Hence there are overlapping sites during the reporting period. For example, between October 2016 and July 2017, 39 sites received their 5th assessment, and six sites received their 6th assessment. Results of the assessments revealed significant improvements in compliance with VMMC quality standards (see Figure 1 for results from sites in the five provinces supported during FY17): most sites (38 of 45 sites) achieved >80% in all standards in the 5th and 6th assessments, with the exception of the Leadership & Planning standards, where performance remains below 80% for all sites assessed. This is mainly due to the lack of dedicated staff from the DOH to support the implementing partner during the provision of VMMC services.

Figure 1. Overall performance scores for 8 CQI standards, baseline and re-assessment at 5-27 months for VMMC sites receiving two to five assessments, 5 provinces (Jul 2014–Jul 2017)

- **Supported CQI sites to improve reporting and analysis of performance indicators** (i.e., follow-up rate and adverse events reporting) (Oct 2016– Jul 2017). ASSIST staff also provided on-site orientation on the importance of reviewing, analyzing, and reporting VMMC CQI data and acting upon it. Highlights include: Figure 2 shows the proportion of VMMC clients who experienced adverse events in 25 CQI-supported sites compared to 312 non-CQI sites in KwaZulu-Natal Province between August 2015 and February 2017. The non-CQI sites consistently showed higher rates of adverse events compared to CQI-supported sites. Staff at CQI-supported sites receive ongoing mentoring on the identification, classification, management, and reporting of adverse events as well as prevention of adverse events.

- **Figure 3** shows that VMMC client follow-up rate at 48 hours increased from <1% to 98% in Botlokwa Hospital (CQI-supported site in Limpopo Province) from January 2016 to June 2017. Tested changes included consistent emphasis of follow-up messages at every station of VMMC service, telephonic reminders to clients, confirmation of follow-up with referral facilities, and revisiting the outreach camps where clients were circumcised.

- At the CQI-supported sites, average follow-up rate at 48 hours improved from 45.5% in January 2015 to 60.2% by the end of June 2016 (see section 5. Improvement in Key Indicators on p. 10). Tested changes include the re-emphasis of client messages on the importance of follow-up visits at
the appropriate time as well as advising clients to come back to facilities at 48 hours to get their bandages removed.

Figure 2. Proportion of moderate or severe adverse events, 25 CQI and 312 non-CQI sites, KwaZulu-Natal Province (Aug 2015 – Feb 2017)

Figure 3. Proportion of VMMC clients presenting for 48-hour follow-up, Botlokwa Hospital, Limpopo Province (Jan 2016-Jun 2017)
- Conducted follow-up data validation assessments at ten sites (Oct 2016–May 2017). About 20 client records per site were reviewed by examining the client record completeness for key elements such as unique client identifier, age, HIV status, consent, vital signs, sexually transmitted infections (STI) screening, surgical methods, anesthetic dosing, follow-up visits, and adverse event status. Following the development of QI plans, involving the provision of intensive feedback on data quality gaps as well as the development and use of data quality control checks, the project noticed some significant improvement in data completeness for key variables such as consent forms, vital signs, follow-up, and adverse event documentation (see Figure 4). Follow-up CQI support also sought to ensure good data quality at all levels of data use and management.

Figure 4. Improving completion of key elements in client records, 10 CQI-supported sites (Jan 2016-May 2017)

SPREAD OF IMPROVEMENT

- **Improvement in VMMC 48-hour client follow-up.** There has been an overall improvement of ~15% in 48-hour client follow-up across CQI-supported sites since the start of support in 2015 (see section 5. Improvement in Key Indicators).

- **Lower rates of adverse events.** VMMC sites receiving CQI technical assistance experienced fewer moderate and severe adverse events than sites not receiving CQI support. A comparison performed between 25 CQI sites and 312 non-CQI sites in KwaZulu-Natal Province showed that adverse event rates at non-CQI sites were on average more than five times higher than at sites implementing CQI (1.39% and 0.26%, respectively) (Figure 2).

- **Notable improvement in completion of client records** for sites receiving CQI support. Findings from data validation conducted at 10 sites (Figure 4) indicate significant improvement in recording and data completion rates. Over and above the 10 sites where formal data validation was conducted, the majority of CQI-supported sites showed improvement in client record completion. This is ascribed to peer-to-peer learning and experience sharing among CQI-supported teams.

**Activity 2. Provision of training in CQI in VMMC programs**

**BACKGROUND**

To facilitate scaling-up of VMMC, the need for a deliberate and concerted effort towards CQI was identified by PEPFAR in 2014. One of the important areas still requiring specific attention was the need to
develop and provide comprehensive and consistent CQI capacity building/ training for DOH and IP staff involved in VMMC service provision.

**ACCOMPLISHMENTS AND RESULTS**

- No training or learning sessions were conducted during FY17 due to unavailability of funding for this activity. The training target for FY17 was 250 individuals (implementing partner and DOH staff).
- During FY17, ASSIST has developed comprehensive CQI and External Quality Assessment (EQA) training materials for the VMMC Online Training Hub (web-based training platform hosted by AIDSFree). Training moderators received orientation on the course materials in August 2017.

**Activity 3. Sustainability and scale-up of CQI in VMMC**

**BACKGROUND**

Sustainability and scale-up of CQI is important for the DOH and is referred to in the National Guidelines for Medical Male Circumcision 2016, to which ASSIST contributed content for a section on quality assurance and quality improvement. During FY17, ASSIST focused on skills transfer and leadership strategies aimed at fostering sustainability and continuation of CQI after the completion of ASSIST activities in South Africa. Coaching and mentoring continued to be provided at supported sites to capacitate individual staff and QI teams to implement CQI and make use of CQI tools to improve the quality and safety of VMMC.

**ACCOMPLISHMENTS AND RESULTS**

- Continued to work with all CQI-supported facilities to foster more involvement of NDOH staff and program ownership in VMMC (Oct-Jul 2017). One of the major challenges in the VMMC CQI program is the weak involvement of DOH staff in the program. The program seems to be driven predominately by the implementing partners, raising some concern about ownership and sustainability of the program from the DOH management perspective. Hence, ASSIST technical assistance promoted the CQI VMMC program all levels of the DOH by:
  - Participating in and providing technical support to the NDOH VMMC QA/QI sub-group quarterly meeting (Nov-Jul 2017).
  - Participating in National VMMC TWG quarterly meeting (Nov-Jul 2017).

**Activity 4: OHS Funded: Application of WHO’s Framework for IPCHS: Phases I and II**

**BACKGROUND**

Since FY16, ASSIST has worked with the DOH to support the implementation of high-quality HIV and AIDS services at all levels in Eastern Cape Province, South Africa. Specifically, ASSIST leveraged the principles of the WHO global strategy on integrated people-centered health services (IPCHS), released in 2014, to pilot integrated health services in one district in Eastern Cape Province. Ten sites that provide antiretroviral therapy (ART) were randomly selected in Nelson Mandela Bay District in the Eastern Cape Province to be part of the sample for the pilot. The pilot project consisted of a baseline assessment to harvest patient, provider, and decision maker perceptions regarding integration and patient centeredness within services at onset of the project; training in quality improvement and IPCHS concepts and methodology; facility-based identification and analysis of problem areas; facility- and district-based implementation of improvement interventions; and an endline assessment. Ten other sites in Nelson Mandela Bay District were included in the project as control sites. The control sites received baseline and endline assessments and no interventions.

**ACCOMPLISHMENTS AND RESULTS**

- Endline data collection was carried out in the 10 pilot sites in October 2016 and in the 10 control sites in February 2017. IPCHS pilot sites demonstrated a marked improvement in patient satisfaction in the majority of indicators measured. Control sites demonstrated little improvement and a decline in patient satisfaction in most indicators measured.

**Empowering and engaging people/ Creating an enabling environment for IPCHS**

- **Figure 5** shows improvement in various indicators measured as part of empowering and engaging people and creating an enabling environment for IPCHS. The results show clear improvement in all
indicators for the pilot sites while there was no or insignificant improvement among control sites (and even a negative trend in more than half of the indicators).

- Common changes tested and implemented for creating an enabling environment included:
  - District management supported the creation of an enabling environment through policy, resources, and supervisory support.
  - Cleaning and maintenance of facilities
  - Empowerment of providers through IPCHS, CQI, and comprehensive care training.
  - Monthly mentorship and coaching to plan, implement, and measure changes.

**Figure 5.** Percentage point improvement from baseline to endline in indicators measuring governance, accountability, and service integration, 10 pilot sites and 10 control sites, Nelson Mandela Metro District (baseline: Oct-Nov 2015 vs endline: Oct 2016-pilot and Feb 2017-control)

- **Figure 6** shows baseline and endline scores for explanation of patient condition, reported as good to excellent. The percentage difference between baseline and endline was 27.9% for pilot sites and negative 17.3% for control sites.

  - Changes introduced to engage and empower clients included:
    - Daily health education for clients waiting for service.
    - Explaining each patient’s condition to them and providing take-home information where possible.
    - Explaining treatment, side-effects of treatment, and how to react when experiencing side-effects to each patient.
    - Developing a leaflet in local languages with information on how to take medication and common side effects and management thereof.
    - Involving patients in decision making on how best they can comply with treatment in their family and community situation.
Figure 6. Percent of patients reporting explanation of patient condition by provider as good to excellent, 10 control and 10 pilot sites, Nelson Mandela Metro District (baseline: Oct-Nov 2015 vs endline: Oct 2016-pilot and Feb 2017-control)

Strengthening governance and accountability/ Reorienting the model of care

- **Figure 7** shows improvement in various indicators measured as part of governance and accountability and integration of services. Intervention sites managed to improve on governance and accountability and reorienting the model of care indicators. Control sites demonstrated almost no improvement on the indicators.
  - Changes introduced to strengthen governance and accountability included:
    - Feedback from community focus groups and patient interviews was shared with facilities, and the problem areas identified were included in facility improvement plans.
    - Clinic committees that were not functional were revived/established.
    - Suggestion/complaint/compliment boxes were placed at the entrances to facilities and their use was explained to clients. Facilities adopted procedures to routinely check and respond to feedback.
    - Patients were informed about the role of community health workers and support groups and how to access support.
  - Changes introduced to reorient the model of care included:
    - Community health workers have been working in the Nelson Mandela Metro providing services such as health screening, education, and mapping of communities. Results from baseline assessments showed that most clients and community members were not aware of this service. As part of the IPCHS intervention, the CHWs and clinics started to integrate their services, and CHWs improved referral to clinics while clinics contacted CHWs for follow-up and support. Results show an increase of 89.1% amongst clients receiving support from CHWs (from 5.9% at baseline to 95% at endline).

Coordination of services

- Reorienting the model of care and coordination of services overlap in many areas, such as the community health worker service and clinic service coordination. Coordination within a facility setting improved through the improved integration of services – one provider treating several conditions, as well as services from nurses, doctors, pharmacists and other associated health services.
- Improvement teams contributed to the coordination through representation in the team from administrative services, pharmaceutical, medical, nursing, and community health services. This lead to improved working relations, better referral practices, and coordinated planning for improvement.
Figure 7. Percentage point improvement from baseline to endline in indicators measuring governance and accountability, and integration services, 10 pilot sites and 10 control sites, Nelson Mandela Metro District (baseline: Oct-Nov 2015 vs endline: Oct 2016-pilot and Feb 2017-control)
# Improvement in Key Indicators

**Activity** | **Indicators** | **Baseline Apr-Jun 2015** | **Sept 2015** | **Dec 2015** | **Mar 2016** | **Jun 2016** | **Sep 2016** | **Dec 2016** | **Mar-June 2017**
--- | --- | --- | --- | --- | --- | --- | --- | --- | ---
Continuation of CQI in VMMC programs | # of MMCs performed | 42,695 -69 sites | 84,809 Cumulative -69 sites | 96,226 Cumulative -69 sites | 110,983 Cumulative -69 sites | 146,914 Cumulative -69 sites | 177,889 Cumulative -69 sites | 191,877 Cumulative -62 sites | 203,575 Cumulative -62 sites
| Aggregated quality standards score | 74% (July-Sept 2014) -123 sites | 87.9% (Sep 2015) - 108 sites | 89.1% by end of March 2016 - 84 sites | 91.2% by end of June 2016 - on 51 sites received 4th assessment | 90.1% by end of Sept 2016 - on 8 sites received 5th assessment | 86.7% by end of Dec 2016 - on 27 sites received 5th assessment | 87.4% by end of Mar 2017 - on 39 sites received 5th assessment | No assessments done after Mar 2017
| % of VMMC clients who came for 48-hour follow-up | 45.5% (Jan 2015) - 53 sites In process of collecting this data in other provinces | 39.3% (Sept 2015) - 53 sites In process of collecting this data in other provinces | 47.6% (Dec 2015) - 53 sites In process of collecting this data in other provinces | 47.6% (Mar 2016) - 53 sites In process of collecting this data in other provinces | 49.6% (June 2016) - 53 sites In process of collecting this data in other provinces | 64.6% (Sep 2016) - 94 sites Data in other sites is incomplete | 79.9% (Dec 2016) - 35 sites Data in other sites is incomplete | 60.2% (Jun 2016) - 20 sites Data in other sites is incomplete
Rates of moderate or severe adverse events (2-day follow-up) | KZN – 0.09% (Jan 2015) - 25 sites In process of collecting this data in other provinces | KZN – 0.17% (Sept 2015) - 25 sites. In process of collecting this data in other provinces | KZN – 0.23% (Dec 2015) - 25 sites. In process of collecting this data in other provinces | KZN – 0.15% (Mar 2016) - 25 sites. In process of collecting this data in other provinces | KZN – 0.14% (July 2016) - 25 sites. In process of collecting this data in other provinces | KZN – 0.04% (Sep 2016) - 25 sites. Data in other provinces is poorly recorded | KZN – 0.06% (Jan 2017) - 25 sites. Data in other provinces is poorly recorded | KZN – 1.36% (Feb 2017) - 25 sites. Data in other provinces is poorly recorded
Provision of training in CQI in VMMC programs | # of individuals trained on CQI | 0 (July-Sept 2015) | 0 (Mar 2016) | 222 (Mar 2016) | 237 (June 2016) | 442 (Sept 2016) | 0 (Dec 2016) | 0 (Mar 2017) | 0 (Jun 2017)

*Data has been updated and limited to the USAID sites only, hence data might differ from what was reported previously. Data source is DHIS which is released quarterly, thus the most recent data is not yet available for inclusion.*
6 Sustainability and Institutionalization
The USAID ASSIST Project built the capacity of the South African DOH staff at national, provincial, and district levels to continue with quality improvement activities through formal quality assurance/quality improvement mentorship and technical assistance. In support of VMMC programs, ASSIST worked with each of the provinces and districts to build implementing partner and DOH capacities to utilize CQI methodologies and programmatic data to identify priority areas, gauge performance, and plan for scale-up of services. ASSIST also supported the National and Provincial Departments of Health and IPs to standardize VMMC QI tools and develop performance indicators. ASSIST worked with District Management Teams to support VMMC supervision and advocate for the integration of the VMMC program into overall PHC service provision. In FY17, ASSIST focused on skills transfer and leadership strategies aimed at fostering sustainability and continuation of CQI after ASSIST ends.

7 Knowledge Management Products and Activities
- **VMMC CQI Tool Box** – The tool box comprises tools that have been developed/adapted and tested by USAID ASSIST program staff offering continuous quality improvement technical assistance to facilities providing VMMC services in South Africa. Tools include: Improvement Team Register, Monthly Summary Data Form, Quality Improvement Assessment, Quality Improvement Plan, CQI Prioritization Matrix, Action Plan Matrix, Plan-Do-Study-Act Worksheet, and CQI Documentation Journal. This resource is included in the recently launched [VMMC CQI and EQA Toolkit](#).

- **Potential Solutions to Common Quality Gaps in VMMC Programs** - The document comprises recommendations for addressing challenges that are commonly experienced during the implementation of VMMC programs. The quality gaps described and the associated recommendations are based on the experiences of USAID ASSIST technical staff working directly with service delivery sites on the improvement of VMMC service quality in South Africa. The gaps addressed include: Adverse events, low client follow-up rates, inconsistent infection prevention and control, inadequate demand generation, lack of integration with other health programs, inconsistent messaging to clients, and insufficient leadership involvement in quality improvement. This resource is also included in the recently launched [VMMC CQI and EQA Toolkit](#).

- **ASSIST South Africa presented the following seven posters at this year’s Southern Africa AIDS Conference**, which took place June 13-15, 2017 in Durban:
  1) The impact of CQI on voluntary medical male circumcision post-procedure follow-up rate and management of adverse events in Gauteng Province, South Africa
  2) The impact of CQI on infection prevention and control at sites performing voluntary medical male circumcision in eight provinces of South Africa
  3) The role of CQI in facilitating collaboration to link HIV positive voluntary medical male circumcision clients to care and treatment
4) The effect of CQI on adverse event rates within the voluntary medical male circumcision program
5) Referral mechanisms and reasons for uptake of voluntary male medical circumcision in KwaZulu-Natal province, South Africa
6) How the implementation of CQI teams at VMMC sites in South Africa leads to a reduction in the rate of adverse events
7) Leadership lessons: Improving the quality of VMMC through involvement and accountability of managers at different levels of care

- In November 2016, ASSIST co-authored an article titled “Medical male circumcision offers a gateway to HIV testing and medical check-ups”, published by the Mail&Guardian’s Center for Health Journalism. The article highlights the benefits of VMMC and the role of VMMC in linking men to other health services.

- IPCHS assessment tools and baseline assessment report. The baseline assessment findings and tools used (including interview and focus group discussion guidelines) in Activity 4 were published in November 2016 in the ASSIST technical report, “Integrated People-centered Health Services: Baseline Assessment in Nelson Mandela Metro Municipality in Eastern Cape Province, South Africa.”

8 Gender Integration Activities

- During FY17, ASSIST integrated gender by incorporating female involvement in VMMC into its CQI improvement. This is done by asking:
  - Clients if their partners/wives/mothers were involved in making the decision to be circumcised, as an attempt to improve demand creation strategies.
  - Follow-up clients about any assistance and support received from their partners/wives or mothers related to coming back for follow-up, wound care, and abstinence, as an attempt to improve follow-up rates.

- ASSIST South Africa staff were sensitized and trained on gender integration in February 2017 by Dr. Taroub Faramand of WI-HER, LLC. The training focused on integrating gender and gender-based violence considerations into VMMC and nutrition improvement activities. Training included defining gender and related concepts; understanding the process of conducting a gender analysis; analysis of sex-disaggregated data and gender-sensitive indicators; and identifying and addressing gaps and issues related to gender in improvement activities. The training also addressed gender-based violence (GBV), discussing how GBV affects individuals, families, and communities. All staff identified activities to address gender-related gaps directly affecting program implementation and outcomes. USAID/South Africa staff attended part of the training and asked Dr. Faramand to present at USAID on the ASSIST gender integration approach.

- At the provincial partners’ meeting in Mpumalanga Province in March 2017, attended by VMMC implementing partners and DOH staff from provincial, district, and facility levels, ASSIST incorporated integrated service delivery and gender integration into its presentation and discussed gender-sensitive indicators with participants.

- ASSIST worked with NDOH and IPs to promote the inclusion of women as advocates and partners in VMMC decision-making, including HIV testing services and family planning. However, as the intervention was being targeted at a population-level through various media messages, it was difficult to correlate with data at facility level.