Voluntary Medical Male Circumcision Good Practices: Project 281K in South Africa

April 1st – July 31st, 2017

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

health

Department:
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Contents

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AE	Adverse Events
CDC	Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CHC	Community Health Centre
COP	Country Operational Plan
CQI	Continuous Quality Improvement
DMPPT	Decision-Makers Programme Planning Toolkit
EC	Eastern Cape Province
FS	Free State Province
FY	PEPFAR Fiscal Year
GP	Gauteng Province
HIV	Human Immunodeficiency Virus
KZN	KwaZulu-Natal Province
LP	Limpopo Province
M&E	Monitoring and Evaluation
MP	Mpumalanga Province
NC	Northern Cape Province
NDoH	National Department Of Health
NW	North-West Province
OGAC	Office of the Global AIDS Coordinator
PEPFAR	U.S. President's Emergency Plan For AIDS Relief
QA	Quality Assurance
STI	Sexually Transmitted Infection
TB	Tuberculosis
TMC	Traditional Male Circumcision
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WC	Western Cape Province

Executive Summary

- The Clinton Health Access Initiative (CHAI) has produced this report for the South African National Department of Health (NDOH) and the U.S. President's Emergency Plan For AIDS Relief (PEPFAR). The report details the activity undertaken to support the achievement of reaching 281,000 voluntary medical male circumcisions (VMMCs) with funding from PEPFAR.

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

- The key areas of work in the 281K Campaign are detailed below. These reflect the key points in each pillar of the project.

Programme Partners (Section One):

- The use of a matrix management structure for Project 281K ensured clear accountability for achieving campaign objectives at national, provincial and district service delivery levels through each of the partner consortia.

Management & Organisation (Section Two):

- NDoH, PEPFAR and CHAI undertook the management of Project 281K. Together, they worked with PEPFAR implementing partners to coordinate and evaluate their activities in order to surpass the overall target.

- Partner data was analysed by the three organisations to assess performance, identify challenges to achieving targets and promote good practices through use of a performance management cycle. These practices were shared between all the implementing partners.

- A key part of this included the promotion and development of district task teams, which were encouraged to promote and document new innovations to ensure that district targets were met. Where these innovations proved successful and showed additional potential to exceed the targets, these innovations were encouraged to continue.

- Collaboration between partners was promoted to both share effective methods of increasing partner performance and to identify effective demand generation initiatives, preferably on a locality basis and in identifying segments of the population yielding high numbers of VMMCs (e.g. in traditional initiation settings).

Demand Generation (Section Three):

- Project 281K showed the importance of brand consistency in increasing the uptake of services during a winter campaign (3 - 4 months) and the prominent impact derived from linking brands across different media strategies.

- Equally important findings were made in the deployment of skilled and trained social mobilisers that could be deployed flexibly to create demand in targeted districts. This allowed partners to move and establish mobilisers in different districts depending on the support required for demand generation. Some partners also offered incentive schemes to encourage the uptake of VMMC. Details of the successes and failures for these initiatives are listed in the report.

Programme Coordination (Section Four):

- The report lists the challenges and successes associated with the provision of VMMC services to isolated communities – either through mobile facilities, outreach teams or GPs based in communities. This flexibility in moving staff and services to locations where there were limited fixed facility support proved effective in areas where demand side factors exceed supply – for example, in informal settlements.

INTRODUCTION AND BACKGROUND

South Africa's National VMMC Programme was established in 2010 and has since undertaken over 3 million circumcisions amongst HIV-negative males. Each year an average of roughly 450,000 circumcisions were performed. In the previous five years, this peaked at 503,850 VMMCs during the 2014/2015 financial year, but has been decreasing since that year. This reduction in the VMMC uptake has been associated with the saturation of the available population for VMMCs due to the prompt participation of early adopters by district and PEPFAR partners. In response to this reduced performance rate, Project 281K was developed to respond to conditionalities placed on PEPFAR South African COP 2017 central funding availability.

Subsequently, the National Department of Health and PEPFAR South Africa with support from CHAI, implemented an accelerated scale-up campaign to increase uptake of VMMC nationally. The objective set was to collectively oversee the achievement of 281,000 circumcisions between April 1 and July 31, 2017. The cumulative total was compromised of the shortfall in targets from COP 15 (approximately 60,000 circumcisions) combined with the current year's COP 16 target.

Following the announcement of Project 281K, NDoH, PEPFAR SA, CHAI and the PEPFAR implementing partners devised an accelerated scale-up programme to reverse the three-year trend of reducing performance in circumcision rates in South Africa. At the conclusion of the Project, 296,850 medical male circumcisions had been conducted nationally against the project objective cumulative target of 281,000 circumcisions. This total represents 106 per cent performance against the target goal and represents a substantial improvement in VMMC performance when compared with cumulative historical totals.

The primary factor driving this performance were the PEPFAR funding partners' responses to the performance management interventions implemented by PEPFAR and NDoH with collaboration and support from CHAI. This inclusive performance management review structure maximised the efficiency of NDoH and PEPFAR partners, enabling robust coordination, supervision and analyses of the project partners and their demand generation initiatives. Effective M&E, partner collaboration, improved demand generation initiatives and more prominent linkages to the traditional sector during the winter circumcision season also played a role in the performance of Project 281K.

In order to institutionalise the processes responsible for the increase in the productive capacity of NDoH and its primary VMMC partners, the good practices associated with Project 281K are identified within this report. This report also details the lessons learnt at each level of VMMC implementation while emphasising the responsibility each partner has to continue to improve upon the many successful initiatives and processes utilised and implemented throughout Project 281K.

The report also recognises the importance of these highly targeted interventions during the winter season (April-July). In South Africa, this season is known to be the busiest period for circumcision culturally, and therefore the benefits of assertively meeting demand at this time offers a potentially higher number of circumcisions.

1. PROGRAMME PARTNERS

NDoH and PEPFAR organised Project 281K with CHAI support under a matrix management structure. This structure, detailed further in Section 2, highlights the partners, including the prime implementing partners, involved in the development and implementation of Project 281K's demand generation initiatives into three groups. These 'prime implementing partners' bore the substantial responsibility of coordinating the implementing and service delivery partners within their consortia as well as the district-specific schemes of these organisations. Historically, PEPFAR had allocated the distribution of partners across districts determined by the needs of the HIV treatment programme. The scope and focus of each prime implementing partner is detailed in Table 1 below.

Partner Organisations, Emphases and Districts

Prime Partners	Cooperative Partners	Initiative Emphasis	Supervised Districts
Aurum	***Funding Partner:*** **CDC** ***Service Delivery Partners:*** **JPS Africa; SFH; PHRU** ***Implementing Partners:*** **CCI**	• Mass Communications • Small Media • Social Mobilisation • Innovative Schemes	• Ekurhuleni • Tshwane • Sedibeng • Johannesburg • Dr. Kenneth Kaunda • Ngaka Modiri Molema • DCS
Right to Care Consortium	***Funding Partner:*** **USAID** ***Service Delivery Partners:*** **URC; CHAPS** ***Implementing Partners:*** **CHAPS; CCI**	• Social Mobilisation • Flexible Expansion • Fostering VMMC/TMC Partnerships • Mass Communications • Small Media	• Lejwe Leputswa • Ekurhuleni • Johannesburg • Tshwane • Sedibeng • eThekwini • Ugu • Umkhanyakude • Zululand • Capricorn • Mopani • Ehlanzeni • Gert Sibande • Bojanala Platinum
TB/HIV Care Consortium	***Funding Partner:*** **CDC** ***Service Delivery Partners:*** **URC; JPS** ***Implementing Partners:*** **CCI; CareWorks; JPS; URC**	• Fostering VMMC and TMC Partnerships • Mass Communications • Small Media • Flexible Expansion	• Alfred Nzo • Amathole • Buffalo City • Chris Hani • Oliver Tambo • Thabo Mofutsanyane • eThekwini • Harry Gwala • uMgungundlovu • uMkhanyakude • Uthukela • Uthungulu • Gert Sibande • Ugu • Cape Town

Table 1

2. MANAGEMENT AND ORGANISATION: INTRODUCTION

The announcement of Project 281K and the potential withholding of the COP 2017 central funding pending FY 17 target achievements necessitated the development of an accelerated scale-up plan. The collective management structures that emerged from this re-development stressed the need for NDoH to coordinate and guide partners, including establishing more robust communications with PEPFAR and between partners, as well as the need for improvements to be made to iterative analytical and initiative processes. The structures implemented by NDoH that led to the greatest gains in VMMC uptake promoted accountability, rapid weekly performance analyses and the early identification of challenges, effective remedial measures and good practices.

2.1 – National Strategy and Implementation

The implementation of Project 281K necessitated PEPFAR, NDoH and CHAI to design a programme capable of increasing national uptake of VMMC without compromising the quality of individual procedures or the collection of programme data. To do so, NDoH, PEPFAR and CHAI coordinated communication and implementation processes between the partner organisations by implementing weekly meetings, facilitating collaboration and standardising data analyses processes. Data was drawn on a weekly basis from PEPFAR systems. Based on these data, high and low performance trends were identified and partners were asked to investigate, evaluate or make new interventions where needed. The impact of these interventions was then assessed in the following fortnight.

The centralised matrix management approach of Project 281K aimed to increase the coordination, communication and monitoring and evaluation of PEPFAR data, which was utilised in place of DHIS data to expedite the results reporting of the partners. DHIS data typically is only available three months after the reporting period and was therefore not suited to make rapid assessments of partner performance. The development of the 281K working group by PEPFAR and NDoH sought to foster a more efficient management accountability and performance against agreed targets by championing rapid analyses and collaboration between individual districts and partners. This cyclical structure is pictured below in Figure 1.

Cycle of Performance Management – Project 281K

Figure 1

This management system was aided by NDoH's introduction of stricter guidelines for data submission, data analysis and result consolidation. Alongside the increase in macro-communications championed throughout Project 281K, the submission of site and district level data also minimised the underreporting previously experienced throughout the programme through the promotion of greater partner accountability. Another alteration made to the structure of the VMMC programme prior to the initiation of Project 281K was an increase in communication between the PEPFAR implementing partners, NDoH and CHAI. The weekly performance review meetings led by NDoH and PEPFAR aligned prime implementing partner efforts and allowed for rapid identification of interventions and remedial actions. The efficacy of these systemic changes was enhanced by the collegial structure of open collaboration and communication embraced by the prime implementing partners and Project 281K management.

2.1.1 – District Task Teams

As a part of the performance management cycle (Figure 1), district task teams were created within provinces to facilitate accelerated uptake within districts expected to offer the highest VMMC yields. The emphasis was placed on achieving the overall 281k target rather than individual district targets. Therefore, districts that showed early promise of meeting their respective targets were encouraged by the PEPFAR implementing partners to push ahead, even if their targets were already met. Given

the localised focus of these groups, these district task teams held regular meetings with prominent provincial and local leaders, as well as relevant implementing partners (sub-contracted from Lead Partners), to ensure that the district performances were closely monitored against their allocated targets.

Each task team also worked closely with the Implementing Partners and assisted in the development of weekly schedules designed to improve overall district VMMC performances by adjusting demand generation activities in response to analytical feedback. The goal of these task teams was to increase the robustness of partner demand generation activities within high-priority districts by adjusting messages to their appropriate local contexts. For example, these task teams aided in the implementation of VMMC initiatives within traditional male initiation districts.

2.2 – Prime Implementing Partner Strategies

With coordination from PEPFAR, NDoH and CHAI, the PEPFAR funded implementing partners were given responsibility for the implementation of the majority of Project 281K's demand generation initiatives. The subsequent success of these apportioned initiatives can largely be viewed as the result of both consistent investments in reliable demand generation activities, partnership developments with traditional communities and PEPFAR and NDoH's management of a more collegial structure of cross-partner communication and coordination, focusing on rapid sharing practices that were shown to be effective and adjusting or challenging sub optimal performance against agreed objectives through effective monitoring.

2.2.1 – Partner Collaboration

For the partners operating at the district level, the structural adjustments implemented by NDoH reflected the overriding need for increased collaboration as well as the need for the coordinated consolidation of data and initiative-specific analyses. As such, where improvement in performance was required within respective districts, major variations in data (both positive and negative) were identified and reviewed against overall targets. This schedule of rapid review and adjustment developed by PEPFAR, NDoH and facilitated by CHAI ensured each district was analysed and given data-driven strategies that enabled each partner to proactively mobilise their resources.

Communication of the good practices arising from these analyses also permitted each collective to capitalise on the performance of overachieving districts by redistributing supplies and services in an efficient and timely manner. PEPFAR and NDoH's commitment through collaborative management practices led to the facilitating of previously withheld good practices, demand generation schemes and verified data by competitive programme partners should be recognised as an effective mechanism. Furthermore, though competition between partner organisations continued to hinder programmatic operations around the fringes of the campaign, the development of rapid solutions to disputes related to attribution of success ensured that gains were sustained and expanded.

2.2.2 – Centralised Communication

The flow of information between partners (mapped in Figure 2 below) created a dashboard for instantaneous review, which served to highlight the commonalities within overachieving initiatives.

Web of Project 281K's Communication Channels

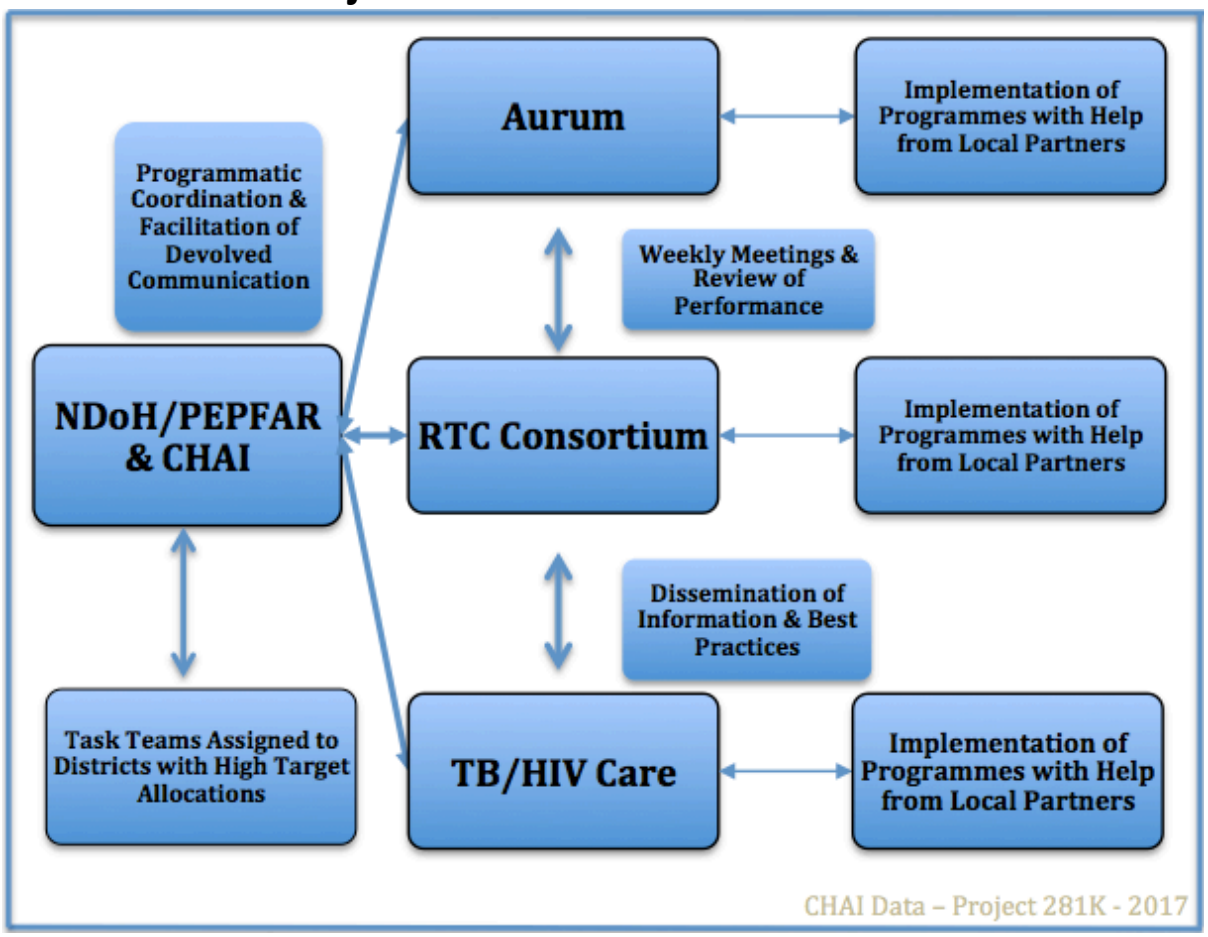


Figure 2

The web of programme implementation illustrated in Figure 2 above flows initially from left to right, with PEPFAR, NDoH and CHAI responsible for facilitating communication between the various partners by coordinating meetings and discussions.

2.2.3 – VMMC in Traditional Initiation Settings

A critical aspect of Project 281K's programmatic structure was the development of sub-district partnerships. The political commitment of the partners to include champions of VMMC in the development of Project 281K provided the partners with the means necessary to offset the challenges of reaching men within TMC communities, such as a lack of information and social acceptance. This emphasis on the formation of communal relationships was supported by NDoH and CHAI at the request of the prime implementing partners, who opted to stretch the reach of social mobilisers and IPC initiatives into previously underperforming (mainly rural) areas. As such, supplemental efforts to recruit local and traditional leaders to support VMMC doubled as attempts to foster a sense of collective programme ownership. Evidence suggests that pressure from NDoH helped the prime implementing

partners localise, which in turn increased the impact of various demand generation initiatives.

The impact of these initiatives was furthered by improved access to VMMC in traditional camps, which had previously promoted TMC[1] practices only. Following NDoH negotiations with TMC leaders within these areas, the partners were able to implement a variety of impactful schemes using accepted medical doctors and male nurses to provide VMMC services. Initiatives targeting the traditional sphere utilised local and traditional leaders (as well as VMMC champions) to promote medical circumcision. One of the most successful strategies operating in these areas employed targeted celebrities and local leaders to reach formerly marginalised populations. The PEPFAR implementing partners compiled an expansive group of diverse resident ambassadors to address VMMC concerns at widely attended public events (such as concerts and sports matches). This diverse group of celebrities included DJs, athletes and actors such as local TV star Kagiso Modupe, as well as local leaders like Prince Nhlanganiso Zulu, whose affirmation of VMMC shifted the local population's mind-set and led to increased interest in VMMC within the target province of KwaZulu-Natal (KZN). In addition, TB/HIV Care's 'Peer to Peer' initiative, which was designed to encourage men to discuss their decision to circumcise with their peers, aided efforts to reach traditional populations. The impact of these connections was significant, driving gains in VMMC uptake in areas formerly reliant on TMC by addressing public safety concerns and matching the cultural requirements of traditional leaders.

2.2.4 – Demand Generation Development

In terms of initiative methodology, as aforementioned in Section One regarding individual programme partners, each prime implementing partner implemented multiple initiatives ranging from small to mass media schemes based on the resources available and the supporting data. The main schematic categories (condensed for the purposes of subsequent analysis) can be found in Table 2 below.

[1] TMCs are performed annually, mainly in rural areas, with deaths being reported as a consequence of, among other reasons, dehydration, improper medical practices and failed support systems of initiates. One of the spin-offs for Project 281K has been the radical formalisation of relationships with the TMC sector to continually promote formal medical practices along with a concomitant reduction in deaths.

Type of Initiative	Description	Sample Initiatives	Local Champions
Mass Media	Initiatives with more general messages aimed at promoting VMMC by providing citizens with information and believing widely held concerns	• Televised and radio advertisements • Billboard advertisements • Distribution of informational flyers • Advertising at bus stations	Community Media Trust and Centre for Communication Impact
Small Media	Smaller-scale initiatives targeting specific populations with specific messages	• Pamphlet distribution • Location-specific road shows • Public VMMC presentations • Language-Specific Local Radio	All Consortia
Online Media	Initiatives utilising online platforms to espouse generalised VMMC information or to advertise targeted messages to specific online users	• Utilising Facebook and other social media sites to promote VMMC • Advertising for other VMMC initiatives	All Consortia
Inter-Personal Communication	Schemes emphasising the importance of communal support as well as local and familial bonds to improve demand for VMMC. Often utilises the recruitment, training, and mobilisation of social mobilisers to discuss VMMC	• Recruitment of social mobilisers • Producing IPC sessions in district-specific locations to bring together men who have undergone VMMC and men who haven't • Conducting workplace (farms, industries, businesses etc.) IPC sessions	TB/HIV Care; Right to Care; Brothers for Life; Care Works
Innovative Initiatives	New initiatives utilising either a combination of two or more of the previous forms of outreach or implementing a unique foundation to increase either national or provincial uptake of VMMC	• Mobile messaging schemes • Advertising and outreach collaborations with ride-share partners • Improved transportation and voucher incentive initiatives • Recruitment of radio DJs and champions to promote VMMC	All Consortia

Table 2

As is evidenced by the range of initiatives listed in Table 2, Project 281K involved a diverse set of initiatives aimed at increasing VMMC uptake by utilising varied demand generation initiatives. NDoH management maximised the impact of these demand generation schemes by assisting the partners in the identification of the good practices and successful initiatives discussed at the weekly performance reviews. The development of impactful demand creation initiatives, as discussed below in Section 3, amplified the impact of these NDoH management practices.

3. DEMAND GENERATION – Project 281K

3.1 – Consistent Branding

Many of the most effective demand generation initiatives retained thematic congruity, linking the messages of each scheme to enhance recognition. The RTC Consortium and the TB/HIV Care Consortium both relied on the concept of brand consistency to magnify interest in VMMC amongst Project 281K's target population. For example, the 'Brothers for Life' Campaign sponsored by the RTC Consortium has been credited with expanding the reach of the consortium's demand generation activities by utilising consistent messaging related to this brand. RTC's implementing partners also used standardised communications, which primarily referenced the barriers to, rather than the benefits of VMMC, to reach targets. Correspondingly, the "ManUp" Campaign coordinated by one of the TB/HIV Care's Implementing Partners, the Community Media Trust (CMT), also relied on the connection of various initiatives. The ManUp campaign incorporated mass media, small media, social media and celebrity initiatives to address segmented populations more receptive to different methods of communication.

Improved organisation of referral systems also aided the facilitation of these processes. For example, the clear and prominent display of RTC's call centre number has been credited with converting interest into action. These strategies led to the RTC Consortium receiving over 19,000 calls to the call centre over the final two months of Project 281K.

3.2 – Social Mobilisation

The demand generation schemes activated for Project 281K benefitted from the development and implementation of improved social mobilisation initiatives to generate demand for VMMC.

Social mobilisation, a component of the category of IPC, demonstrated once more its vital role as the cornerstone of VMMC demand generation activities. The success of the social mobilisation schemes implemented during Project 281K can be traced back to two central operational changes made by the partners prior to the implementation of Project 281K. The first of these alterations related to the flexibility of social mobilisation initiatives. Changes made to social mobilisation flexibility saw the RTC Consortium employ upwards of 750 social mobilisers across the consortium, which produced high conversion rates amongst the VMMC target population. The TB/HIV Care Consortium also increased their number of mobilisers within high priority districts to ensure the achievement of district targets.

The second development associated with the improved impact of social mobilisers relates to the robustness of training schedules and the qualifications of chosen mobilisers. The operations and performance of one of the RTC Consortium's main

Implementing Partners, CareWorks, illustrates the importance of selecting and training quality mobilisers rather than employing a large quantity of untrained personnel. To ensure quality, the selection process utilised by CareWorks during Project 281K was more selective, identifying leaders with the potential to impact the greatest number of uncircumcised males. Similarly, to increase the output of each individual mobiliser, CareWorks promoted an extensive training system to ensure each mobiliser could act as an effective community liaison on behalf of the VMMC programme. Each of these social mobilisers then had their performances tracked by CareWorks staff to retain quality control. The use of these organised tactics assisted CareWorks social mobilisers in producing over 100,000 calls a month to their call centre during each of the final two months of Project 281K.

3.3 – Incentive Schemes

The other standout initiatives arising from Project 281K were incentive schemes. Though often the most expensive type of initiative, TB/HIV Care and Aurum both made use of incentive schemes, promoting various financial vouchers in attempts to rapidly improve performance in challenged districts. Though the sustainability of these initiatives has been questioned, the impact of some of these initiatives, particularly those implemented by Aurum, was instantaneous. Aurum's use of vouchers in Ekurhuleni galvanised local demand toward VMMC. While regional initiatives were impactful, similar schemes implemented by TB/HIV Care failed to meet pre-implementation expectations.

As such, the performance of incentive schemes seems to have been directly related to the relevance of the incentive to local populations. For example, though the majority of clients preferred food vouchers to airtime coupons, rural citizens with no access to retail chain grocery stores often had no use for many of the brand-name vouchers. These lessons highlight the need for further research dedicated to the use of region specific vouchers to ensure future rollouts improve the cost-effectiveness of this strategy.

Without the gains attributed to social mobilisers, local and traditional leaders/VMMC champions and certain incentive schemes, it is unlikely Project 281K would have been a success. Collectively, improved recruitment and training standards for social mobilisers, coherent branding and incentive schemes improved demand for VMMC within targeted districts.

3.4 – Underperforming Initiatives

Just as the most impactful demand generation initiatives implemented throughout Project 281K were aided by their adaptable designs, the underachieving initiatives were often restricted by inflexibility and immeasurability. The least successful initiatives were reliant on rigid forms of communication, such as pamphlet distribution and other types of small media schemes. When incorrectly targeted, these highly specified initiatives were the most ineffectual. One example relates to the distribution of pamphlets near clinics, which aimed to increase demand within groups with the fewest barriers (transportation, funding, etc.) for VMMC uptake. A lack of pre-distribution data limited the ability of the prime implementing partners to gauge initial responses of these initiatives. The finality of printed communications also limited the ability of the partners to effectively redevelop these failing adverts. Fortunately, small media schemes are relatively cost-effective in comparison to larger mass media

initiatives, suggesting that they need to be used in partnership with other processes rather than being eliminated.

Other innovative initiatives also suffered from a lack of iterative refinement. Due to a lack of oversight, unforeseen barriers, such as technical deficiencies, limited the impact of some of the partner's schemes (such as incentivised Uber ride-share initiatives). The CDC and Aurum's Blue Label initiative, which distributed airtime vouchers related to VMMC performance, also typified these challenges. Meant to generate contacts for a call centre in KZN, insufficient capacity and links to local clinics meant that requests for VMMC were not responded to quickly enough to ensure men attended. These failures, which stem from improper preparation and poorly managed call centre capacities, threaten the sustainability of the programme by increasing negative associations with VMMC and limiting the impact of peer-referral networks. The inflexibility and lack of coordination of similar initiatives compounded deficiencies related to pre-distribution testing, restricting the impact of these schemes. Thankfully, analyses coordinated by NDoH were able to identify many of these challenged initiatives.

4. – PROGRAMME COORDINATION

4.1 – Partner Flexibility

One of the prime successes of Project 281K relates to the performances produced in rural districts. In several areas where demand for VMMC had previously faced challenges related to inadequate clinical support and knowledge of VMMC services, the partners involved with Project 281K utilised their institutional flexibility to exceed allocated target totals. To reach otherwise marginalised males, all three prime partners oversaw the implementation of either mobile outreach units or roving teams, which limited barriers related to travel and isolation that had previously hindered access to VMMC in rural areas. Both Aurum and the RTC Consortium utilised versatile mobile units, which acted as both demand creation vehicles and centres for VMMC performance.

Similarly, the TB/HIV Care Consortium utilised 'roving teams' based in mobile vehicles to drive demand schemes throughout each of their target districts. The targeting of informal workplaces and informal settlements improved the impact of these mobile centres. The willingness of the partners to invest resources in districts with low-targets offset the totals of underachieving districts in urban areas.

4.2 – Staff and Facility Coordination

The success of the demand generation initiatives implemented throughout Project 281K could have been undermined by insufficient preparation and institutional capacity had it not been for the flexibility of facility structures and partner coordination. Cautious analysis of the uptake in demand historically associated with South Africa's winter months enabled PEPFAR agencies, NDoH, CHAI and the implementing partners to proactively address this surge by increasing facility capacity, expanding clinic hours and hiring personnel to meet the increased need.

Various municipal facilities initially struggled to cope with the demand for VMMC generated during Project 281K, while others found it difficult to create space for VMMC in areas where the Department of Basic Education restricted the provision of

VMMC services at school sites. In response to these challenges, NDoH and the prime partners increase the quantity of healthcare providers available at high volume facilities and near restricted areas. Financial resources provided by the TB/HIV Care Consortium offered the flexibility necessary to implement a robust recruitment drive to identify and employ knowledgeable clinicians at these challenged VMMC clinics. This process, which paired qualified Medical Officers with Registered Nurses and Clinical Associates, assisted the consortium in its progress toward the Project 281K targets. The hours of operation of VMMC clinics were also expanded to include weekend and evening hours, resulting in greater turnout by increasing client flexibility.

The ability of the partners to increase facility capacity and staff employment rates boosted moral and performances within these districts. One of TB/HIV Care's Implementing Partners, CareWorks, conducted a camp-based initiative that promoted VMMC activation within informal settlements. This initiative also eliminated a variety of barriers inhibiting VMMC uptake. Aurum utilised a similar strategy in peri-urban areas, deploying mobile units to assist with the high demand for circumcisions associated with Project 281K. This resulted in the performance of over 100 VMMCs per day amongst the local target population. The willingness of the partners to adjust their initiatives in response to NDoH and CHAI's data analyses ensured that only the most effective practices were sustained throughout Project 281K.

5. – PROGRAMME CONSTRAINTS

5.1 – Facility and Safety Constraints

The rapid uptake in demand for VMMC that occurred during Project 281K also overwhelmed several smaller, understaffed medical clinics. All three prime implementing partners reported concerns linked to the capacity of local facilities, with demand often outstripping supply in rural areas. Some provincial facilities struggled to acquire an adequate number of beds and rooms for VMMC procedures and recovery. The RTC Consortium faced these issues in their priority districts, with men often having to be rebooked due to facility disruptions and overlap with other programmes. In other facilities, such as the Chris Hani Baragwanath Hospital overseen by Aurum, the number of circumcisions performed fell far below the feasible estimated total of 2560 VMMCs. To manage these institutional issues, the partners, NDoH and CHAI coordinated with district managers to redistribute resources to prioritise uptake for VMMC within districts with high demand. In many cases this adjustment freed new beds and operating rooms within high-volume clinics and aided in improving VMMC uptake amongst rural and peri-urban populations.

In addition to these constraints, there were also concerns related to safety and quality control standards. The accelerated scale up of demand generation initiatives, supply chain management and facility capacities compounded challenges related to Continuous Quality Improvement (CQI) and the avoidance of Adverse Events (AEs). The TB/HIV Care Consortium reported a drop in CQI upkeep throughout their districts. Similarly, Aurum experienced challenges related to waste management and disposal while the RTC Consortium also referenced both CQI and waste disposal as primary health and safety concerns. Fortunately, many AEs and other safety concerns related to improper CQI were averted by rapid identification of AE trends

by NDoH as well as rigorous partner responses to AE due to increased awareness and properly enforced counselling rolled-out in clinics and camps.

5.2 – Data Constraints

The slow pace of DHIS data upload would have limited the ability of CHAI to analyse Project 281K fast enough to deliver strategic advice to the prime implementing partners. However, this crisis was averted by the implementing committee, which used a high level Excel-based reporting system. This system enabled the continuation of weekly performance reviews by NDoH, ensuring good practices and programmatic challenges could be identified quickly. The data would ultimately feed in DATIM and the DHIS at the end of the month and quarter (PEPFAR Q3).

PEPFAR agencies, NDoH and CHAI monitored any data disruptions and coordinated institutional responses to address these issues through the prime partners. It must be noted that the Excel based system was not used to monitor Project 281K's data related to AEs and CQI. This lesson further illustrates the need for M&E processes that are both accurate and capable of facilitating rapid collection and analyses, especially throughout specialised projects.

6. STATISTICAL RESULTS

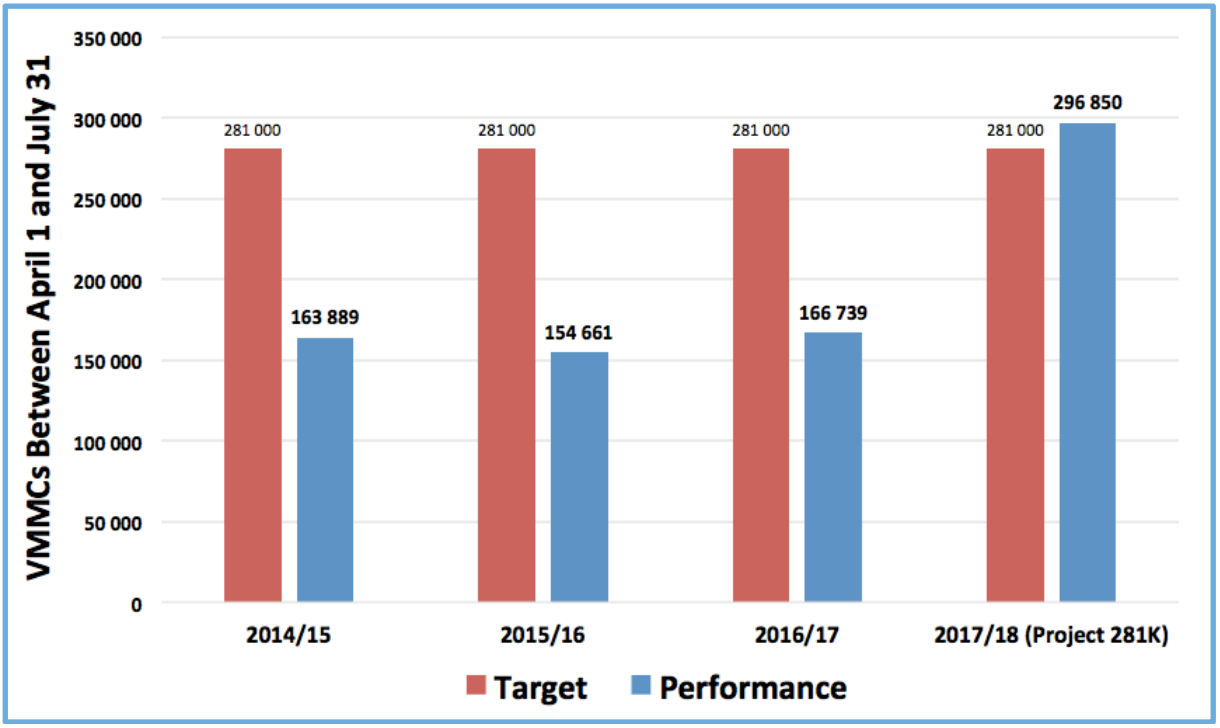
6.1 – Target Allocations

The cumulative target for Project 281K was comprised of shortfall in targets from previous COP years (approximately 60,000 circumcisions) combined with this year's COP targets. The Male Circumcision Decision-Makers Programme Planning Toolkit (DMPPT) informed the setting of the annual and seasonal COP objectives. However, final Project 281K targets were set at a meeting between PEPFAR and the prime implementing partners. Factors incorporated into the initial allotment of targets included, but were not limited to, district populations, geographic demand for VMMC, the state of existing infrastructure and equipment, the state of district referral networks, the accessibility of facilities, local support for VMMC and the potential demand for VMMC services amongst the target population.

6.2 – Overall Performance

The PEPFAR agencies and implementing partners responsible for Project 281K oversaw the performance of 296,850 VMMCs between April 1 and July 31. This result represents a completion rate of 106 per cent against the allocated target of 281,000 circumcisions. This successful performance represents a considerable improvement when compared historically to the VMMC totals tallied over the previous three annual reporting periods and reflects the strong partnership between NDoH, PDoH and CHAI. Graph 1 below presents the substantial gains made by Project 281K over previous totals for the same period.

Total Project 281K VMMCs Plotted With Historical Totals

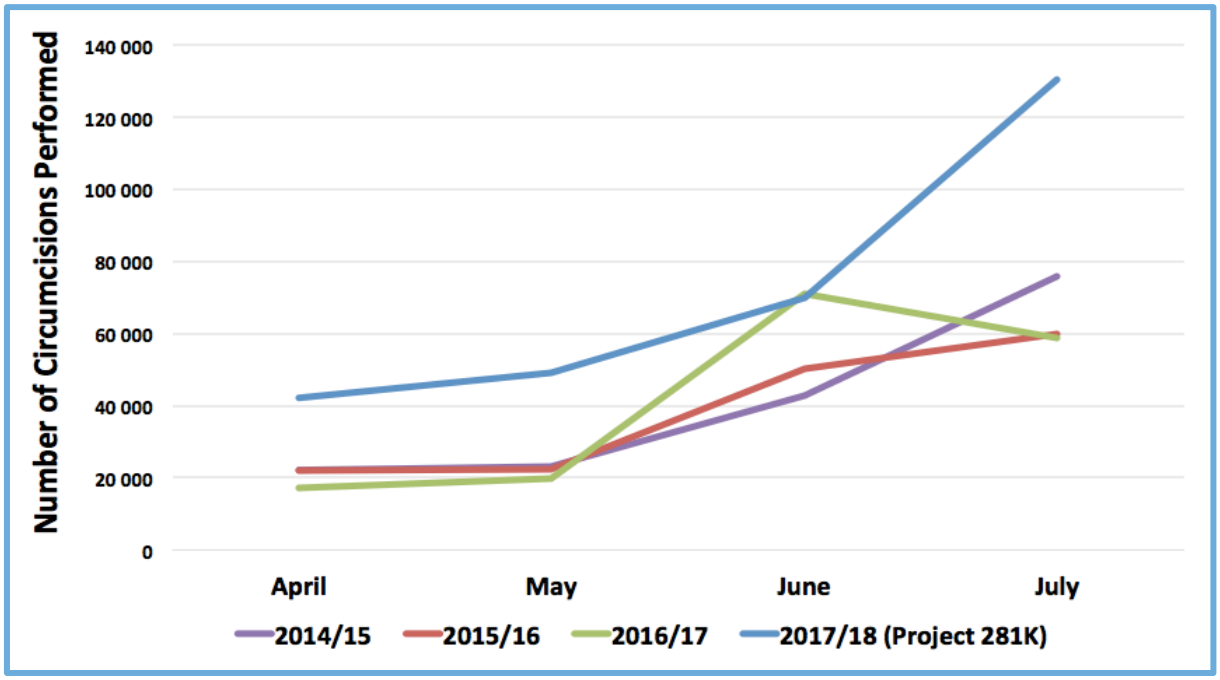


Graph 1

As depicted in Graph 1, Project 281K outperformed recent totals by a substantial margin. The quantity of VMMCs carried-out during the most recent period (296,850) represents the substantive increases that were made over the course of Project 281K. The total quantity of VMMCs conducted for this period generated over 130,000 more than the next-highest recent historical aggregate recorded over the same period. This improvement represents a notable 83.5 per cent increase when compared to the mean performance tally accumulated between April 1 and July 31 over the previous three reporting intervals.

These totals have far-reaching consequences, priming the national VMMC programme to achieve NDoH nationally targeted total of 650,000 VMMCs for the 2017/2018 Financial Year for the first time since 2010.

Historical Monthly Performance (April 1st – July 31st)



Graph 2

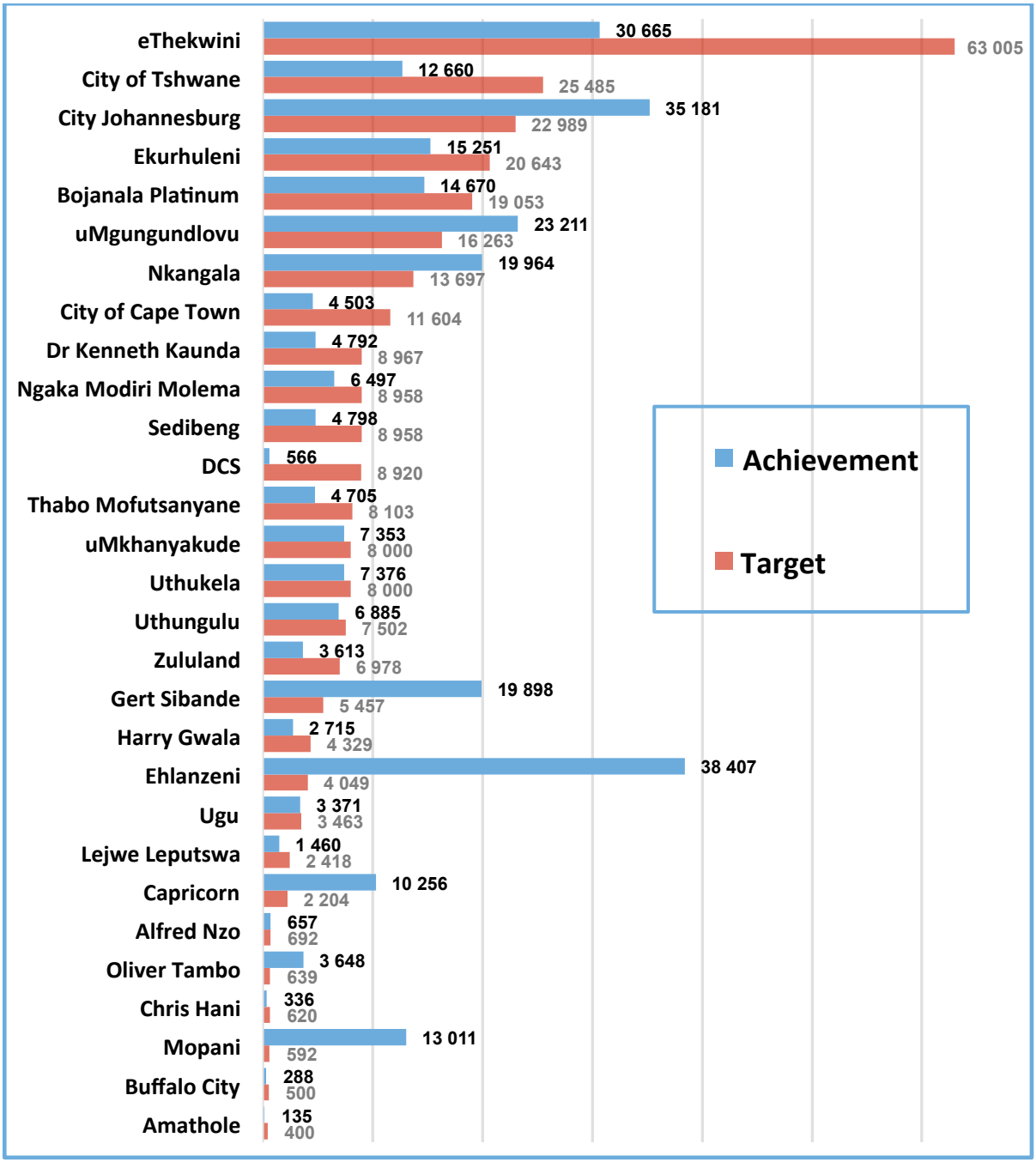
When compared month-on-month against the performances of the three previous reporting periods, the aggregate quantity of VMMCs conducted during Project 281K's 10-week timeframe illustrates both Project 281K's overall achievement and notable consistency. In each year since 2012, there has been a seasonal increase in demand for VMMC during the winter months due to a variety of cultural factors. However, totals had decreased overall prior to Project 281K. These results, illustrated in Graph 2 above, compare the previous downward trend with the performance of Project 281K. The seasonal peak is again reflected in this performance, but at notably higher rates than in previous years. This overall performance reflects the impact of NDoH management and coordination as well as partner communication, demand generation efforts and the integration of VMMC within traditional settings.

The steady improvement month-to-month over the course of Project 281K's four-month process is also encouraging, illustrating gains made despite the risk of programme fatigue. The performance of nearly 140,000 VMMCs in Project 281K's final month of activation corresponds with NDoH and PEPFAR efforts to expand good practices and successful partner initiatives.

6.3 – District Performances

While the total number of VMMCs conducted over the Project's timeframe increased substantially, these gains were not distributed uniformly across provinces or districts. Graph 3 below contains Project 281K's compartmentalised results, which highlight the performance of various districts in relation to their allocated targets.

District VMMC Performance Against Project 281K Targets



Graph 3

Though the total performance of 15,850 more circumcisions than the initial target of 281,000 VMMCs was unprecedented, totals varied vastly by district. In 19 of the 28 VMMC districts the difference between performance and initial target was greater than 40 per cent. In districts with targets greater than 8,000 VMMCs (a number constructed in part based on district population) only 3 of 15 districts exceeded their targets. This runs contrary to preliminary targeting determined by modelling analyses.

The improved performance of rural and peri-urban districts was aided by the enhancement of partnerships with local leaders and the participation of populations previously associated with TMC. The dramatic increases seen in districts such as

Ehlanzeni and Gert Sibande can partially be attributed to improvements in this area, with proper coordination and partner buy-in crucial to expanding the scope of VMMC to complement traditional methods. In areas outside traditional settings, NDoH management of partners and partner use of cross-organisational initiatives drove performance by further segmenting male populations. Improved supply chain management, mobile outreach coordination and responsiveness to staff and facility challenges also aided the progress seen in these outlying districts. Furthermore, CHAI's Provincial Coordinators were instrumental in the organisation and performance of VMMCs within these districts, assisting with logistics, CQI, data verification and analyses. In many cases, performances exceeded targets in districts where saturation was predicted to limit achievements.

Underperforming districts also shared several commonalities, including their primarily urban compositions. However, due to the additive structure of Project 281K's target allocations, the binary performance/target splits of underachieving districts (such as eThekwini, Ngaka Modiri Molema and City of Cape Town), belie the relative improvements that were made in these areas. In eThekwini, the district with the largest overall gap, the performance of 30,665 VMMCs was actually more than triple the total from the same period in 2016. Similarly, the Project 281K totals for the other selected outlying districts more than doubled. Furthermore, in only 5 districts were 2016 winter totals greater than their comparable performance during Project 281K (and each by less than 1,000 VMMCs).

6.4 – Prime Partner Performances

Faced with a diverse set of variables and specific district constraints, performances amongst the three prime partner groupings varied substantially. Table 3 illustrates the various targets and totals of the partner groupings as well as the final percentage achieved against their allocated total targets.

Prime Partners and Performance Totals

Prime Partners	Target	Total Circumcisions	Per cent of Target Achieved
Aurum	63,155	30,739	49%
Right to Care Consortium	131,054	157,157	109%
TB/HIV Care Consortium	110,453	103,628	94%

Table 3

6.5 – Initiative Costings

Meta costing sheets for the partners were requested, but were unavailable at the time of writing this report.

7. LESSONS LEARNT

The processes realised during Project 281K commendably reversed the recent downward trend in total performance related to the circumcision of HIV-negative males in South Africa. To discern which initiatives and structural developments drove the substantial gains associated with Project 281K, the outcomes related to both specific initiatives and the implementation of overarching methodological structures are summarily analysed below.

7.1 – Successful Developments

7.1.1 – Management and Collaboration

The performance of Project 281K has reiterated the need for a standardised model for national programme management. The redevelopment of the programme's structures of management and collaboration under the centralised coordination of NDoH focused partner efforts and accelerated the responsiveness of the programme to unforeseen challenges. The construction of a cyclical strategy of inter-partner coordination, partnership development and data sharing by NDoH, PEPFAR agencies and CHAI also fortified communication channels. Though this process required constant stewardship to encourage open cooperation between the partner organisations, NDoH, USAID, CDC and CHAI, helping to mitigate challenges related to partner competition by enhancing programmatic accountability and promoting collective responsibility. When compared historically, the gains seen month-to-month throughout Project 281K's timeline back the notion that centralised management and coordination was vital to the success and upkeep of Project 281K.

7.1.2 – Flexible Programming

Representatives from all three prime implementing partners identified the programme flexibility as a practice vital to Project 281K's operational success. Project 281K illustrated the need to improve partner understanding of the socio-economic barriers limiting VMMC participation. Success was most evident where the programme could be adjusted to mitigate these hurdles. In areas with formerly low rates of uptake, improvements in coordination and transportation enabled easy facility access and ensured that local concerns (often made by the TMC community) were addressed prior to Project 281K's rollout. Targeting rural populations with mobile VMMC units and localised demand generation schemes similarly helped offset deficits resulting from lower performance in larger urban and rural areas. Partners used these tactics to increase demand for VMMC by reducing client financial and logistical barriers. Other barriers were addressed by increasing facility capacities, hours of operation and staff competencies. This preparation ensured that VMMC supply chains and clinics were equipped to handle seasonal demand increases as well as the demand generated by partner initiatives.

7.1.3 – Traditional Partnerships

Collaborating with local and traditional community leaders also proved a worthwhile investment. Implementing locally accepted practices, such as hiring locality-based GPs medically certified and traditionally accepted to conduct VMMC within traditional settings further allowed the partners to increase performance by adapting safe practices to traditional areas. These diversified engagements increased demand for VMMC throughout rural and peri-urban areas that had previously prioritised TMC, further illustrating the importance of localised and culturally acceptable programming in driving VMMC uptake.

7.1.4 – Demand Generation Initiatives

Social mobilisation once again proved the most reliable demand generation initiative throughout the duration of Project 281K. With proper training and placement, social mobilisers acted as the strongest drivers of demand for VMMC. Improving the impact of social mobilisers by increasing initial selectivity and training regiments also proved a worthwhile investment. Partnering with VMMC champions as well as local and traditional leaders also improved the impact of these demand generation schemes

by localising issues and providing targeted populations with relatable personalities. Lost wage compensation initiatives, which typically relied on the provision of food and airtime vouchers, also improved VMMC performance in targeted districts when properly contextualised to address local financial barriers.

7.1.5 – Monitoring and Evaluation

The importance of robust data collection was evident as analyses presented at the weekly performance meetings provided the partners with crucial information on good practices and failing demand generation strategies. The performance totals provided to the partners using the PEPFAR data enabled rapid analyses and structural adjustments that aided in improving performance week-on-week. The use of pre-implementation testing through focus groups was shown to be particularly useful in determining potential social barriers and the eventual impact of select initiatives. The decision made by NDoH, PEPFAR and CHAI to prioritise the weekly submission of partner data enabled rapid analyses of VMMC data throughout Project 281K. Furthermore, the collection of VMMC in traditional initiation settings benefitted from the identification and designation of reporting units that were capable of reporting the VMMCs undertaken in camps nearby.

7.2 – Project 281K Challenges

7.2.1 – Communication Challenges

Inefficiencies in Project 281K underscored the need for greater vertical and horizontal communication by the partners. Inconsistent vertical coordination between the prime implementing partners and facility personnel hindered performance by delaying iterative processing and the rapid identification of challenges. Similarly, a lack of communication between each prime implementing partners delayed the direct application of good practices and hindered further cross-partner collaboration. Just as the managerial successes of Project 281K illustrated the importance of improved collaboration, these lessons need to be expanded vertically by the prime partners to address communications at the district and facility levels.

7.2.2 – Challenges to Operations

The challenges faced by demand generation activities throughout Project 281K highlighted the dangers related to inflexibility within challenging districts. Underperforming initiatives highlighted the need for further coordination between partners when implementing demand generation initiatives. Lack of facility capacity and staff buy-in during the initial stages of the campaign limited early uptake. Future campaigns should aim to maintain performances against targets by learning from early warnings capable of utilising the data to project potential failures.

7.2.3 – M&E Challenges

Project 281K highlighted the challenges posed by M&E systems to programme sustainability. The delays caused by Project 281K's time constraints and limited analytical tools added to the struggle to implement proper iterative refinement strategies for data upload. In the future these deficiencies could limit the impact and sustainability of implementation processes and demand generation initiatives. The state of monitoring and collection systems also delayed the response of the prime partners to the safety and supply chain management issues that occurred during the acceleration of Project 281K. Collectively, though current data structures were crucial to the success of Project 281K, inadequacies related to M&E systems need to be addressed to ensure that these developments do not hinder the rollout of

upcoming projects. Furthermore, deviations from the Working Practice Guideline for Data Upload also limited the quality of data uploaded during Project 281K.

8. RECOMMENDATIONS

8.1 – Management and Communication

- **Sustain the system of centralised NDoH management that proved vital to the success of Project 281K**
- **Retain a set schedule for meetings between PEPFAR, the prime implementing partners, NDoH and CHAI to ensure good practices are communicated while retaining a collective sense of responsibility**
- **Routine communication between VMMC stakeholders and local leaders/champions should be formalised to ensure collaboration on VMMC is sustained**
- **Ensure District VMMC Task Teams are organised and implemented within priority districts.**

8.2 – Monitoring and Evaluation

- **Enhance the DHIS centralised data system to improve both the speed and accuracy of data collection and data analyses for management monitoring purposes**
- **Develop data collection standards and indicators to ensure demand generation initiatives can be assessed rapidly (this is particularly important when operating within a multi-sector context)**
- **Improve responsiveness of current collection systems to AEs and other safety concerns**
- **Improve iterative processes and pre-production strategies to improve initial DG initiative performances**

8.3 – Programmatic Organisation

- **Standardise a national winter campaign capable of generating and accommodating the greater demand associated with the winter season**
- **Formally connect channels of supply-chain management and VMMC procedures to the demand generation sector (particularly within rural areas)**
- **Develop guidelines for the use of compensation initiatives that limit wasteful overlap between partners**
- **Map programme gaps across partners in order for NDoH to develop a comprehensive plan for segmentation and multi-sector programming**
- **Facilitate the uptake of research capable of informing the partners and NDoH of contemporary trends and developments within the target population**

Appendices: Comparison of Outputs Between April – July for FY 2016/17 and 2017/18 (281K)

District	16-Apr	16-May	16-Jun	16-Jul	Total	Apr-17	May-17	Jun-17	Jul-17	Total	Difference	% Change
Alfred Nzo	131	189	345	217	**882**	150	20	154	333	**657**	-225	**-26**
Amathole	0	0	0	0	**0**	10	19	43	63	**135**	135	**-**
Bojanala	273	651	2829	4230	**7983**	861	596	1981	11232	**14670**	6687	**84**
Buffalo City	38	70	118	332	**558**	36	42	77	133	**288**	-270	**-48**
Capricorn	566	638	3742	3095	**8041**	580	703	3610	5363	**10256**	2215	**28**
Chris Hani	0	0	0	0	**0**	6	23	103	204	**336**	336	**-**
City of Cape Town	398	390	606	668	**2062**	756	954	1078	1715	**4503**	2441	**118**
CoJ	2030	2332	12815	8997	**26174**	4750	3161	8000	19270	**35181**	9007	**34**
CoT	792	1233	5601	4835	**12461**	1472	1042	3576	6570	**12660**	199	**2**
DCS	0	0	0	0	**0**	0	150	244	150	**544**	544	**-**
Dr Kenneth Kaunda	319	400	1902	2290	**4911**	805	258	1144	2585	**4792**	-119	**-2**
Ehlanzeni	1182	1663	5393	4105	**12343**	10499	7849	8293	11766	**38407**	26064	**211**
Ekurhuleni	955	1466	5276	4311	**12008**	1946	1594	5027	6684	**15251**	3243	**27**
eThekwini	1667	1771	3623	2977	**10038**	3329	3500	10037	13799	**30665**	20627	**205**
Gert Sibande	1051	1677	2336	1927	**6991**	4655	4988	3259	6996	**19898**	12907	**185**
Harry Gwala	452	750	244	243	**1689**	552	779	546	838	**2715**	1026	**61**
Leweleputswa	208	378	751	988	**2325**	390	153	198	719	**1460**	-865	**-37**
Mopani	844	449	4456	2602	**8351**	700	236	2920	9155	**13011**	4660	**56**
Ngaka Modiri Molema	165	204	1319	1578	**3266**	697	396	1848	3556	**6497**	3231	**99**
nkangala	208	552	1457	2046	**4263**	3945	10271	3572	2176	**19964**	15701	**368**
Oliver Tambo	167	200	365	211	**943**	135	94	185	3234	**3648**	2705	**287**
Sedibeng	240	256	1234	1123	**2853**	202	238	1795	2563	**4798**	1945	**68**
Thabo Mofutsanyana	447	1607	1095	1100	**4249**	458	492	1355	2400	**4705**	456	**11**
Ugu	573	524	692	545	**2334**	601	657	730	1383	**3371**	1037	**44**
umgungundlovu	690	790	966	950	**3396**	1950	6688	6818	7755	**23211**	19815	**583**
Umkhanyakude	378	310	495	820	**2003**	823	1255	2173	3102	**7353**	5350	**267**
uthukela	1463	1167	957	838	**4425**	862	1247	1535	3732	**7376**	2951	**67**
uthungulu	951	385	923	1067	**3326**	655	990	2667	2573	**6885**	3559	**107**
Zululand	856	631	1582	1345	**4414**	354	687	800	1772	**3613**	-801	**-18**
Total	**17044**	**20683**	**61122**	**53440**	152289	**42179**	**49082**	**73768**	**131821**	296850	144561	**95**

Number of VMMCs Performed by District between April 1 and July 31: 2016 vs. 2017