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SYSTEMATICALLY COORDINATING VMMC DEMAND AND SUPPLY IN MOZAMBIQUE:

A SUCCESS STORY

Cover picture: VMMC National Campaign, November 2015, Mozambique Ministry

AIDSFree
Strengthening High Impact Interventions for an AIDS-free Generation

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SYSTEMATICALLY COORDINATING VMMC DEMAND AND SUPPLY IN MOZAMBIQUE: A SUCCESS STORY

October 2018

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DISCLAIMER

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ACRONYMS

CIHO	Communication for Improved Health Outcomes
COP	Country Operational Plan
CQI	Continuous Quality Improvement
EQA	External Quality Assessment
FY	Fiscal Year
HC3	Health Communication Capacity Collaborative Project
JHCCP	Johns Hopkins University Center for Communication Programs
MOH	Ministry of Health
OHA	USAID Office of HIV/AIDS
SBCC	Social and Behavior Change Communication
SCPT	Site Capacity and Productivity Assessment Tool
SOPs	Standard Operating Procedures
VMMC	Voluntary Medical Male Circumcision

EXECUTIVE SUMMARY

This case study illustrates how a coordinated approach between USAID's service delivery and demand creation partners helped the Ministry of Health (MOH) improve the voluntary medical male circumcision (VMMC) landscape in two provinces in Mozambique – Manica and Tete. Concerted coordination, joint planning and improved use of data resulted in a significant increase in VMMC uptake among the priority age group of 15–29-year-old males who were previously not accessing services. The collaborative process began in 2015 and resulted in a nearly five-fold increase in the number of adolescents and men accessing VMMC services in Fiscal Year 2017, with the proportion of clients in the priority age group increasing from 48 to 58 percent during the same period.

CHALLENGE | Although VMMC had been a national priority for the HIV and AIDS response in Mozambique since 2010. By 2015, in Manica and Tete, the program was still not reaching sufficient numbers, particularly in the priority age groups necessary for achieving more immediate impact on epidemic control.

RESPONSE | In response to the underperformance, the MOH requested technical assistance from USAID, through PEPFAR. The implementing partners in Manica and Tete led a multipronged effort to address demand- and supply-side challenges to VMMC uptake in the two provinces.

Lessons Learned

- To improve program performance, it was critical that all players, including the Ministry of Health and supply and demand partners, invested in a **collaborative approach,** which included sharing data, creation of joint plans and targets, and tracking of combined results.
- Collaborative, **regular use of data** facilitated by a comprehensive suite of tools was central to achieving optimal site-level performance in both quality and efficiency.
- For transparency and open communication between demand creation and service delivery teams, regular **joint planning and review meetings** were necessary at all program levels (site, provincial and headquarters).
- To increase VMMC uptake among males 15-29 years of age, **community mobilizers** were essential for a tailored approach due to their unique ability to adapt messages, address clients' specific concerns, and provide individual follow-up.
- To ensure program quality, key elements included **targeted selection of staff, comprehensive training and supportive supervision** of all cadres.
- For improved client engagement in VMMC across the continuum, including long-term HIV risk reduction, **refresher training on effective communication** was important for all staff, from mobilizers to service providers.

The approach was initially informed by an external quality assessment conducted by the PEPFAR team in September 2015, during which it was noted that VMMC sites in Manica and Tete were operating at less than 50 percent of their capacity. Through this process, USAID, along with the Mozambique MOH, identified a need to improve behavior change communication activities, including demand creation, in-service communication and counseling to improve VMMC demand. Upon bringing in a specialized social and behavior change communication partner, strategic adjustments to the community-led approach resulted in a sharp increase in demand. However, as a result, targeted health facilities were soon overwhelmed. This was due, in part, to an inadequate number of trained personnel to meet the increased demand, and initially, a lack of coordination between the demand creation and service delivery teams. To correct this, the program developed a coordinated approach to both demand and supply side gaps. This approach was informed by a new tool developed by USAID to coordinate resources and plans, the *Site Capacity and Productivity Assessment Tool (SCPT)*.

Critical Role of the Community Mobilizer

Morgen Baptista Massavla, a 27-year-old married man living in Manica Province, had heard about circumcision from friends several years ago, but he didn't have much information and felt his particular concerns had never been addressed. It wasn't until a community mobilizer came to visit his family and spoke with him about the benefits of VMMC and where to get the service that Morgen began to consider VMMC for himself. "Mr. Neva (mobilizer at Manica District Hospital) came to my house many times to invite me to do circumcision, but I was not willing. I even asked him not to bother me. After a lot of insistence, I sent my brother first to do circumcision in Manica. When he came back, I understood that wound healing was fast, and I also decided to go do it. Everything went well."

The SCPT was critical in helping the senior program management team and site managers clearly identify where low site utilization was occurring and informed a strategic process to help the team better align demand and supply resources. Specifically, it helped ensure that demand creation activities were better targeted to underutilized sites and that adequate staff complements were trained and available to match VMMC demand levels in a manner which reduced client wait times and facility bottlenecks.

LESSONS | Although Mozambique has yet to reach global coverage targets for VMMC, it has seen considerable increases in uptake of the procedure among the priority age groups. The VMMC program in Mozambique continues to progress as a model, demonstrating how effective coordination between supply and demand enables an increase in VMMC uptake, particularly among men aged 15–29 years.

MOZAMBIQUE'S VMMC CHALLENGE

Voluntary medical male circumcision (VMMC) has historically been a priority for the Mozambique Ministry of Health (MOH), as documented in its *Third National Strategic Plan for the HIV-AIDS Response 2010–2014*. However, at the end of Fiscal Year (FY) 2015, the VMMC program was underperforming nationally, with low uptake of VMMC services, particularly among males 15-29, identified in PEPFAR 3.0 as the critical age band for most immediate impact on the HIV epidemic.

Manica and Tete were the lowest-performing provinces across all age groups, but particularly among the priority population. VMMC coverage among boys and men aged 15–29 was 17 percent in Manica and 4.9 percent in Tete – far below the national average of 40 percent for this age band.

USAID, through PEPFAR, has supported the VMMC program as a priority intervention for HIV prevention since 2013, beginning with a mandate to support high-quality VMMC services for adolescents and adults. The MOH requested additional assistance to improve VMMC coverage, focusing on technical assistance to eight sites in Manica and Tete. In response, USAID, PEPFAR, and implementing partners have supported demand-creation and strengthening of VMMC clinical service delivery and supported the MOH in a multi-step performance improvement process to increase availability, quality and demand. The process began in 2015 and has resulted in a nearly five-fold increase in the number of adolescents and men accessing VMMC services in FY 2017, with the proportion of clients in the priority age group increasing from 48 to 58 percent during the same period.

This case study documents lessons learned from using a collaborative, data-driven approach to improve coordination between demand and supply partners working on Mozambique's VMMC program.

IDENTIFYING PERFORMANCE GAPS IN SUPPLY AND DEMAND

In September 2015, an interagency team led by PEPFAR's Male Circumcision Technical Working Group traveled to Mozambique to assist the MOH in an external quality assessment (EQA) of 12 fixed VMMC sites in Maputo, Gaza, Manica and Sofala provinces. The team used the standard EQA tools available through the VMMC Continuous Quality Improvement (CQI) EQA Toolkit.

During the EQA and a subsequent USAID technical support visit, USAID-supported sites in Manica and Tete were found to be underutilized, with many operating at less than half their capacity. Because some sites had been operating for less than a year, considerable attention had been placed on facility readiness (e.g., renovation, staff training, procurement of equipment and supplies), with less attention on generating demand for services. Figure 1 summarizes the EQA scores for 2015 for two sites in Manica.

Mobilizers recruit men for VMMC at a local taxi rank in Chimoio city, Manica province.
Credit: JHCCP-Mozambique

Figure 1. Summary of September 2015 EQA scores for two sites in Manica Province

EQA Score Summary		Score
Tool A – SOPs, Guidelines, Policies, Job aides	Assessment	75%
Tool B – Facilities, Supplies & Equipment	Assessment	94%
Tool C – Client Records Review	Assessment	78%
Tool D – Emergencies Management	Assessment	75%
Tool E – Adequacy of Staffing	Assessment	77%
Tool F – Surgical Equipment and Procedures	Assessment	81%
Tool G – Communication with Clients	Assessment	69%
Total Performance		78 %

Performance score: ≥85%: Green = Good 70–85%: Yellow = Fair, <70%: Red= Poor
Source: ASSIST presentation dated June 28, 2017.

The team identified an immediate need for additional support in two areas – **demand-creation** (focusing on 15–29-year-olds) and quality improvement for **in-service communication and counseling**. USAID requested technical assistance through its partner, the Johns Hopkins Center for Communication Programs (JHCCP), which implemented the Health Communication Capacity Collaborative Project (HC3). In October 2015, an HC3 behavior change consultant, accompanied by local JHCCP staff, conducted a communication needs assessment in USAID-supported sites in Manica and Tete.

A 2015 EQA revealed the following:

- Most clients were young (10–14 years)
- Near-universal uptake of HIV testing
- Low HIV prevalence among clients
- Variable client follow-up rates across sites – most more than 80%, but some below 50%
- All sites consistently referred those who tested HIV positive for care and treatment services

Together, these assessments determined the focus of the first of a series of performance improvement plans for VMMC between 2015 and 2017, collaboratively managed by the service delivery and communication partners, in partnership with the MOH.

ADDRESSING GAPS IN VMMC DEMAND-CREATION AND IN-SERVICE COMMUNICATION

To address the identified gaps, HC3 (Communication for Improved Health Outcomes or CIHO, as of late 2017) took immediate corrective action to improve demand-creation and in-service communication with two specific objectives: 1) Improve demand generation to increase uptake of services among men ages 15–29 years and, 2) Improve the quality of in-service communication and counseling for all men, while ensuring the needs of younger clients were being met.

Support addressed specific communication gaps, which are summarized in Figure 2 and Figure 3.

FIGURE 2. GAPS AND SOLUTIONS FOR DEMAND CREATION

Identified Gap	Solution
Community-based organization mobilizers were underperforming, particularly with older men.	• Strengthened mobilizer recruitment with clear eligibility criteria (e.g., secondary education) • Conducted refresher training for mobilizers in VMMC and group and interpersonal communication techniques • Strengthened supportive supervision; established monthly targets and quarterly performance reviews • Replicated model from two sites in Manica, which assigned community counselors to each site and improved coordination with mobilizers from community-based organizations • Aligned mobilizers with sites based on ability and background (e.g., older, mature mobilizers placed in workplaces) • Actively recruited satisfied clients; leveraged testimonials from satisfied clients in mobilizer materials, community events, across all channels • Fine-tuned methodology using personal invitations, including mobilizer contact information to facilitate client follow-up and bookings • Improved mobilizer subsidy through phone credit • Provided group based, performance incentives for high performing teams, i.e. t-shirts, phone credits

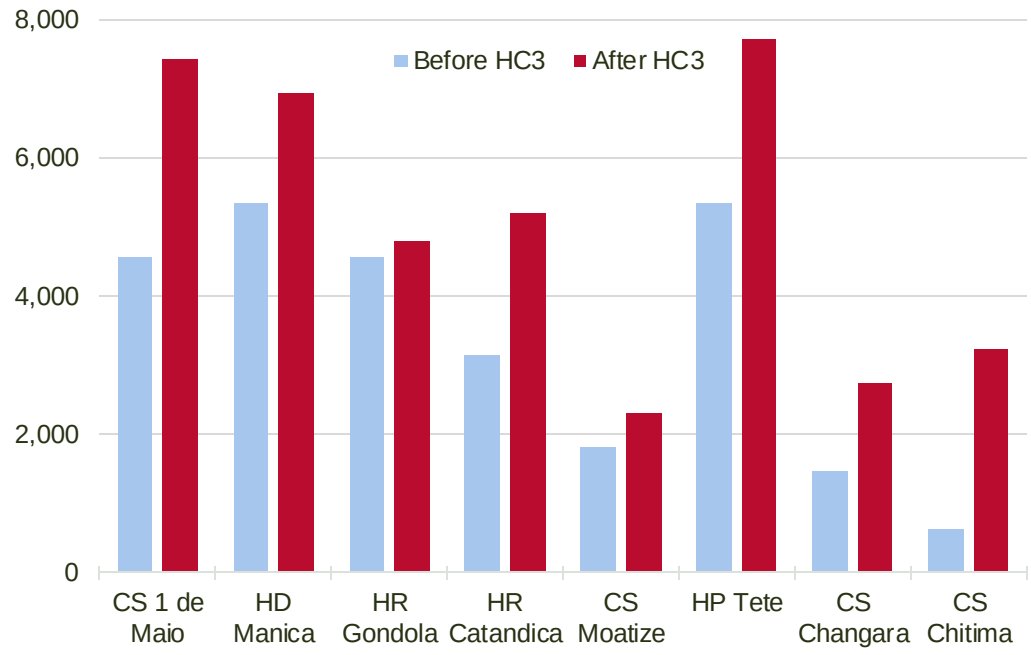
Identified Gap	Solution
	• Branded mobilizers with caps and shirts to identify them and lend credibility • Employed outreach teams focused on rural clients through "mobile brigades" • Developed a standard referral tracking procedure and trained all mobilizers • Reoriented community mobilization activities to target places where large groups of boys and men congregate (e.g., schools, soccer clubs, workplaces) • Trained phone operators working at the Ministry of Health's *Alo Vida* Hotline and equipped them with information and guidance on how to respond to VMMC questions and how to direct clients to services in the local area • Held regular technical meetings of mobilizers at the district and provincial level
Limited data use. The service delivery partner was collecting useful data on a routine basis, including information sources, but the data were not routinely used to inform demand-creation approaches.	• Began analyzing these data to help inform demand-creation efforts (e.g., data indicated 80% of clients received VMMC information from mobilizers)
Insufficient signage at VMMC clinics.	• Placed signs and banners on roads near sites with information about designated clinics offering VMMC (health facility location, hours of service, contact information), and contact information for the Ministry of Health program contact • Placed signboards at each site
Lack of transportation to services for potential clients.	• Coordinated with local leaders and other key stakeholders to provide transport for men who lived a long distance from designated clinics
Limited use of an appropriate mix of communication channels.	• Developed a call-in community radio program that included satisfied clients as guests • Aligned radio program broadcasts with the targeted facilities' service delivery catchment areas • Renegotiated for competitive airtime rates from community radio stations in Manica and Tete • Oriented phone operators of the Ministry of Health's *Alo Vida* Hotline on where to direct clients and cross-promoted the hotline in social and behavior change communication (SBCC) materials • Negotiated with taxis, minibuses and taxi bikes for branding opportunities

FIGURE 3. GAPS AND SOLUTIONS FOR IN-SERVICE COMMUNICATION AND COUNSELING

Identified Gap	Solution
Pre- and post-op counseling did not address men's unique barriers to male circumcision.	• Revised SBCC materials (posters, fliers, desk calendars) to improve counseling, address key VMMC barriers and motivators (e.g., fear of pain, impotence, infertility, abstinence period), including younger clients' issues, and reduce provider bias • Conducted on-the-job training in VMMC, HIV risk reduction, and in-service communication and counseling techniques, referencing the *VMMC In-Service Communication: Best Practices Guide* • Trained providers on post-operative and follow-up counseling procedures to appropriately address healing time, wound care, and risk reduction
Sites were not taking advantage of general health services to cross-promote and drive traffic to VMMC services (e.g., pharmacy, pediatric care, maternal health).	• Placed print materials throughout each facility with key VMMC information • Showed locally produced VMMC videos with basic information and client testimonials throughout each facility
Poor management of communication materials.	• Developed system to track, stock, and inventory materials • Placed posters and fliers strategic points in clinic waiting areas and service delivery areas

As a result, VMMC uptake improved in the eight USAID-supported sites among males aged 15–29 in comparison to the reference period – December 2014 to November 2015 (see **Figure 4**).

FIGURE 4. VMMC PERFORMED IN FACILITIES BEFORE (DECEMBER 2014–NOVEMBER 2015) AND AFTER (DECEMBER 2015–NOVEMBER 2016) COMMUNICATION INTERVENTION



Source: CIHO (November 2017)

ADDRESSING GAPS IN SERVICE DELIVERY

The 2016 EQA revealed several challenges, including the following:

- Bottlenecks in service delivery and significant variation in performance
- Insufficient numbers of qualified staff to assist during surgery
- Insufficient staff capacity in key skill areas
- Lack of routine CQI
- Inadequate referral systems/documentation for HIV- and STI-positive clients
- Inadequate HIV counseling, limited on prevention and risk reduction (abstinence, partner reduction, condom use)

Improvements after the 2015 assessment were a move in the right direction, but challenges with the program remained, including a change in the service delivery partner from FHI 360/CHASS to AIDSFree in May 2016. PEPFAR requested a follow-on EQA in September 2016 to assess progress at the USAID-supported sites under the new partner.

Conducted at four fixed sites, the follow on EQA showed a number of improvements, including a significant improvement in overall demand. Individual counseling quality had also improved, and many facilities had adopted standard operating procedures (SOPs) and clinic policies. However, a number of gaps remained: there was significant variation among sites regarding service delivery performance against targets, and several sites faced service delivery bottlenecks resulting from inadequate staffing to meet the increased demand. The cumulative EQA score across all sites was 70 percent, or fair.

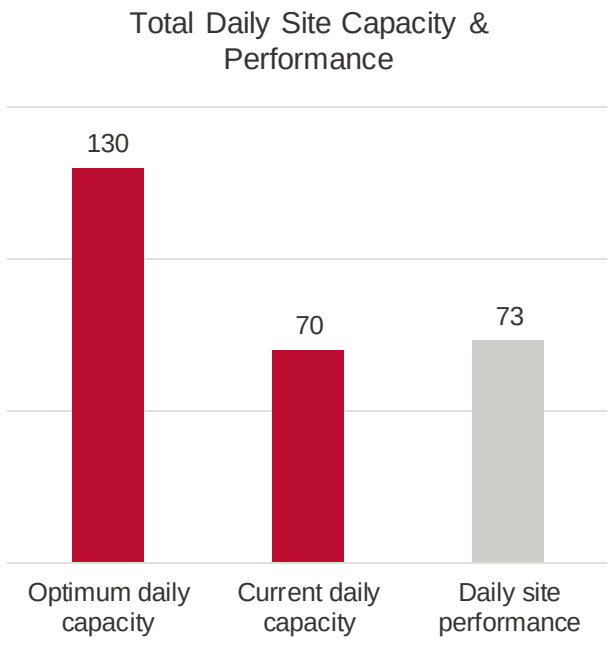
The assessment also revealed a number of opportunities to improve day-to-day coordination and routine communication between the service delivery and demand creation partners.

SITE EFFICIENCY AND PRODUCTIVITY ANALYSIS

During the 2016 EQA, the team used USAID's new *Site Capacity and Productivity Assessment Tool (SCPT)*, to conduct a detailed analysis of optimum VMMC site capacity and utilization. The capacity analysis showed that the four sites operated, on average, at 54 percent of optimum capacity with significant variation between sites.

Figure compares current and optimum daily site capacity and actual daily site performance. The data indicated that if all four sites optimized efficiency and demand-creation, an additional 57 VMMCs could be performed each day.

FIGURE 5. OPTIMUM DAILY CAPACITY, CURRENT DAILY CAPACITY, AND CURRENT DAILY SITE PERFORMANCE, EIGHT USAID-SUPPORTED SITES, OCTOBER 2015–AUGUST 2016*



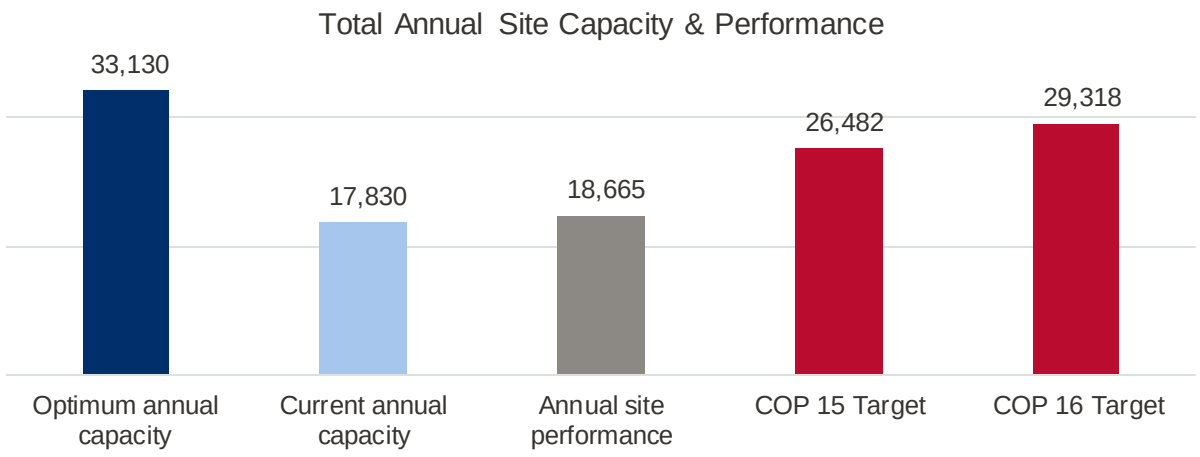
Source: EQA Country Report, 2016

*Although only 4 sites were assessed in the EQA the SC/SPT was conducted for all 8 sites

The productivity analysis then compared current and optimum capacity and actual performance on an annual basis, relative to Country Operational Plan (COP) 15 and COP 16 targets, for the four sites (**Figure 6**). At optimum capacity (i.e., if operating with an adequate number of nurses), the sites could have performed an additional 14,465 VMMCs each year.

It was clear that filling the demand-creation gap revealed a gap in the supply side. VMMC sites had inadequate staff to meet the expanded demand. As a result, clients faced long waiting times and service delivery bottlenecks. In response, the team recommended that clinics increase their nursing staff.

FIGURE 6. CURRENT ANNUAL SITE CAPACITY, OPTIMUM ANNUAL SITE CAPACITY, ACTUAL ANNUAL PERFORMANCE AND COP 15 AND COP 16 TARGETS, FOUR SITES ASSESSED EQA, OCT. 2015–AUG. 2016



Source: Findings of External Quality Assessment for VMMC Mozambique: August 29-September 8, 2016. USAID ASSIST Project, p. 14.

The team made the following recommendations, focusing on three areas: (1) increase the number of trained staff, including nurse providers; (2) train assistants; and (3) introduce CQI at each site. Additionally, partners identified a number of challenges with coordination between the service delivery team and the demand creation team:

- Inconsistent communication about outreach (mobile brigade) schedules to give the demand-creation team time to generate demand in new communities
- Limited sharing among partners of service delivery statistics relevant to demand-creation and audience insights
- Poor coordination of transportation for male clients
- Lack of routine and open data sharing between partners

AIDSFree and HC3 performing a team-building exercise.
Source: AIDSFREE Mozambique

"It was during this team building process that we all came to realize we all shared the same end goal and only through improved coordination would we achieve the desired success."
–AIDSFree Mozambique Chief of Party, Francisco Zita

During this assessment visit, a team from the USAID Office of HIV/AIDS led team-building exercises and facilitated a process to address the coordination and inter-partner communication. This intervention kicked off a longer-term change management process for the two implementing partners and provided guidance on how they would improve coordination through alignment of goals and work plans and through improved communication at all levels – headquarters, provincial, and site – throughout the system.

SITE-LEVEL PLANNING FOR QUALITY IMPROVEMENT

To operationalize coordination and improved facility level planning, HC3 and AIDSFree signed a letter of collaboration, which outlined the way in which they would jointly implement a quality improvement plan. The resulting plan, owned by the implementing partners and by the Ministry of Health, focused on the following coordination priorities:

Create site-level service delivery targets	Using site capacity and productivity analysis data, the partners created monthly, weekly and daily site-level service delivery targets (disaggregated by age). The plans were tailored to each site and outlined priorities for quality improvement activities, identifying persons responsible; timelines and overall goals. Each plan was submitted to the MOH and USAID for review.
Devise appropriate staffing and training plans	Optimal site-level staffing and training, support supervision plans and performance targets were developed for clinical staff, mobilizer teams and satisfied clients. Provider training and support supervision to improve clinical quality was led by the MOH. The number of mobilizers recruited and assigned to each site was determined by monthly and daily service delivery targets.
Regularly review progress	On a weekly basis, site staff reviewed progress against targets and discussed quality issues. AIDSFree technical advisors and the HC3 team also met to discuss progress against targets each week. USAID and MOH conducted monthly progress monitoring with the partners using the VMMC SCPT to continuously monitor site capacity and demand creation. Findings were used to identify necessary changes, including staff reallocations to meet fluctuating demand. Staff shared through daily emails the number of circumcisions performed and the level of project performance.

Annex I presents a sample site-level plan. The plans are organized around four key components:

1. Site-level daily, weekly and monthly targets disaggregated by age
2. Site-level staffing and training plan
3. Interventions to address the data quality issues
4. Interventions to address other quality gaps

POSITIVE IMPACT ON VMMC UPTAKE

Between 2015 and 2017, Mozambique experienced a considerable increase in the productivity of VMMC sites and VMMC uptake among men aged 15–29 (the target age group) at facilities in Manica and Tete. The number of adolescents and men receiving VMMC services increased from 21,824 (FY 2015) to 100,636 (FY 2017)), a 4.6-fold increase. The proportion of 15–29-year-old males receiving VMMC services increased from 48 percent to 58 percent during the same period. In 2017, the VMMC program surpassed its targets, achieving 105 percent of the FY 2017 targets (See **Figure 7**).

Importantly, despite this rise in client volume, quality of services remained high as evidenced by the fact that adverse event rates remained stable at below two percent.

FIGURE 7. AIDSFREE MOZAMBIQUE PROJECT: CHANGES IN VMMC INDICATORS, 2015–2017

Indicator	FY 2015	FY 2016	FY 2017
VMMC target	65,054	62,166	95,296
VMMC done	21,824	35,389	100,636
Achievement vs. target (%)	34%	57%	105%
Proportion of 15–29 years (%)	48%	50%	58%
Proportion of ≥15 years (%)	48%	54%	60%
Site utilization (%)	38%	50%	100%
Adverse events rate (%)	0.07%	0.14%	0.14%

Source: Abstract presented by AIDSFree at the 2018 International AIDS Symposium

LESSONS FOR OTHER VMMC PROGRAMS

The VMMC program in Manica and Tete provinces continues to progress as a model, demonstrating that effective coordination between supply and demand, informed by data and deliberate collaboration, enables an increase in VMMC uptake, particularly among men aged 15–29 years.

Mozambique's experience offers a number of lessons for other VMMC programs:

Consistent Collaboration 	• Government (administrative and political leadership) buy-in is critical. The central Ministry of Health led the design and facilitation of new provider clinical training, participated in clinical site visits and oversaw performance improvement strategies, which led to more open communication, better collaboration and improved outcomes. • Mutually establishing a clear, documented plan of collaboration with specific roles, timelines and outputs using site level planning ensures mutual accountability. • Fostering a collaborative approach and transparency through team-building exercises, and regular status meetings among all players working in demand and supply, and at all staff levels helps optimize staff availability and alignment with site-level capacity and planning. • Using multiple channels to communicate among partners, including creating *Skype* and *WhatsApp* groups among providers and counselors, in addition to in-person meetings ensures consistent and inclusive daily communication. • Coordinating transport needs between demand and supply teams – ensuring vehicles are available at the right location and time – are critical to addressing distance and transport cost barriers.
Using Data for Decision-Making 	• Participating in EQAs, while sometimes intimidating to program teams, and taking action to address findings, helps to both understand the factors tied to performance gaps and to identify ways to improve program quality and safety. • Monitoring the performance of VMMC sites against their optimal output is important for improving site performance to meet set targets, including the priority age group. • Analyzing data generated from the *VMMC Site Capacity and Productivity Assessment Tool* and sharing it quickly at site level enables facility managers to set, adjust and track daily targets in real time, rather than waiting for month's end data. • Management use of the SCPT tool enables more responsive staff planning, including, when necessary, moving staff between higher and lower performing sites. • Leadership support of systems and process, including regular team meetings and chat groups to understand and broadly share data with all levels of program staff enables broad understanding among staff about the purpose of the data and how it improves their jobs and performance, resulting in broader adoption of tools and processes.
Strengthening Mobilization 	• Engaging community leaders so they can facilitate proper entry into the community and identify members of their communities who can help mobilize locally ensures broader acceptance. • Carefully selecting mobilizers, dividing them according to their abilities and backgrounds, and assigning them to appropriately matched groups and locations (e.g., younger mobilizers in schools, working men at workplaces) improve effectiveness. • Providing strong training, management/supervision support, and motivation of community mobilizers is key to reaching targets. • Registering men, securing their contact information, and giving them the contact information of a team mobilizer in addition to information on locally available service delivery points during community events enables follow-up.

	• Providing mobilizers with team-based incentives helps to maintain enthusiasm to achieve program targets. • Mobilizing during regularly scheduled social events and at bus stops and other places men gather at night increases reach among men who work during the day. • Leveraging satisfied client testimonials through public speaking events, community radio, videos shared on Facebook, and on mobilizers' tablets and at health facilities helps to address men's concerns and questions about VMMC
Delivering Client-Centered Services 	• Building staff capacity in effective communication with clients, at all stages of VMMC services, ensures client satisfaction and engagement in VMMC across the continuum, including long-term HIV risk reduction. • Identifying all clinical teams working in service delivery areas and updating them on upcoming VMMC services ensures clinical readiness, commodity availability and appropriate response for emergency cases. • Including mobilizer contact numbers on invitations allows men to ask follow-up questions and book their appointments more privately following group and individual sessions. • Providing evening and weekend services (Saturdays), makes service more accessible to older, working men. • Regularly analyzing data and making staff changes when necessary based on demand helps to reduce long waiting times and service delivery bottlenecks.

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ANNEX 1. SAMPLE SITE-LEVEL PLAN, MANICA PROVINCE

Country: Mozambique **Province:** Manica **Site:** 1° Maio CS II

TARGETS BY AGE GROUP || SITE REQUIREMENTS BASED ON TARGETS

Age Group	Annual Target	Monthly Target	Weekly Target	Daily Target	Site Requirements	Optimum
10–14 years	1,872	156	31	8	Providers	3
15–19 years	2,246	187	37	9	Assistants	4
20–24 years	1,872	156	31	8	Counselors	2
25–29 years	1,123	94	19	5	Data Clerks	1
30–49 years	374	31	6	2	Receptionists	1
TOTAL	*7,487*	*624*	*125*	*32*	Beds	2

Note: Circumcisions are performed four days a week. One day is reserved for dressings and program review.

ACTION PLAN

Activity	Person Responsible	Frequency	Indicator	Comment
Objective 1: Improve quality of data recording on patient records				
1.1 Randomly select 10 records for review of completeness			Proportion of patient charts filled completely	
1.2 Is patient consent filled in accordance with Ministry of Health guidelines				
1.3 Is anesthetic dosage correct volume				
1.4 Method of surgery				
Objective 2: Improve use of guidelines and Standard Operating Procedures (SOPs)				
2.1 Confirm availability of required Standard Operating Procedures [SOPs] and guidelines				
2.2 Ensure guidelines and SOPs are properly displayed				
Objective 3: Improve completeness of registers				
3.1 Are HTC registers correctly				

Activity	Person Responsible	Frequency	Indicator	Comment
filled and page totals completed?				
3.2 Is the AE register continuously updated correctly				
3.3 Are referral linkage records complete?				
Objective 4: Are VMMC procedures done in accordance to national guidelines for VMMC?				
4.1 Is staffing adequate for workload?				
4.2 Are HIV+ patients receiving circumcision in accordance with Ministry of Health guidelines?				
4.3 Is the emergency trolley up to date?				
Objective 5: Are targets disaggregated by age groups being met?				
5.1 Are we meeting the targets per age group?				
5.2 Is data analysis done and displayed?				
Objective 6: Coordination				
6.1 Is there joint monthly planning with HC3 and health facility/province				
6.2 Is there monthly joint review with HC3 & health facility/DPS?				
6.3 Is there a weekly facility data review meeting?				
Objective 7: Supervision				
7.1 Are supervisory visits conducted weekly?				
7.2 Is the supervision book up to date?				
7.3 What is the proportion of recommendations for which actions were taken?				