



USAID
FROM THE AMERICAN PEOPLE

USAID
ASSIST PROJECT
*Applying Science to Strengthen
and Improve Systems*

TECHNICAL REPORT

Report on Voluntary Medical Male Circumcision Baseline and Follow-on Assessment for Continuous Quality Improvement



DECEMBER 2015

This report was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID) and authored by Tiwonge Moyo, Linley Hauya, and Franklin Kilembe of URC through the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project. The USAID ASSIST Project is made possible by the generous support of the American people through USAID. The project's support for continuous quality improvement of voluntary medical male circumcision services in Malawi is supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

Cover photo: Assessment team discussing findings with Lungwena site staff following the baseline assessment. Photo by Linley Hauya, URC.

TECHNICAL REPORT

Report on Voluntary Medical Male Circumcision Baseline and Follow-on Assessment for Continuous Quality Improvement

DECEMBER 2015

Tiwonge Moyo, University Research Co., LLC
Linley Hauya, University Research Co., LLC
Franklin Kilembe, University Research Co., LLC

DISCLAIMER

The contents of this report are the sole responsibility of University Research Co., LLC (URC) and do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

Acknowledgements

The authors of this report would like to acknowledge the Malawi Ministry of Health Department of HIV and AIDS, Zonal Health Offices, and the seven District Health Offices for their support during the baseline and the follow-on assessment of the quality of voluntary medical male circumcision (VMMC) services in Malawi, especially the demonstrated ownership and the technical leadership role they assumed. We also acknowledge the tremendous work done by the implementing partner staff and management of: Population Services International (PSI), Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), and Banja la Mtsogolo (BLM) and their 13 quality improvement teams in the seven targeted districts in addressing the quality gaps identified in the process.

This report was prepared by University Research Co., LLC (URC) under the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, which is funded by the American people through USAID's Bureau for Global Health, Office of Health Systems. USAID ASSIST's support for continuous quality improvement of voluntary medical male circumcision in Malawi is support by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

USAID ASSIST is managed by URC under the terms of Cooperative Agreement Number AID-OAA-A-12-00101. URC's global partners for USAID ASSIST include: EnCompass LLC; FHI 360; Harvard University School of Public Health; HEALTHQUAL International; Initiatives Inc.; Institute for Healthcare Improvement; Johns Hopkins Center for Communication Programs; and WI-HER LLC.

For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com.

Recommended citation

Moyo T, Hauya L, Kilembe F. 2015. Report on Voluntary Medical Male Circumcision Baseline and Follow-on Assessment for Continuous Quality Improvement. *Technical Report*. Published by the USAID ASSIST Project. Bethesda, MD: University Research Co., LLC (URC).

TABLE OF CONTENTS

List of Figures.....	i
Acronyms	ii
Executive Summary	iii
I. Introduction	5
II. Objectives	5
III. Methods	5
A. Assessment Tools.....	5
B. Orientation of the Assessors on the Tools.....	6
C. Selection of Sites and the Assessment Process	6
D. Composition of the Assessment Teams	6
E. Assessment Process	6
IV. Baseline and Follow-on Assessment Findings	7
A. Summary.....	7
B. Management Systems	7
C. Supplies, Equipment, and Environment.....	10
D. Registration of Clients and Group Education.....	10
E. Individual Counselling and HIV Testing	11
F. Surgical Medical Circumcision Procedure	11
G. Monitoring and Evaluation	12
H. Infection Prevention and Control.....	13
V. Discussion.....	13
VI. ASSIST’s CQI Activities	15
VII. Recommendations	15
VIII. Next Steps	16

List of Figures

Figure 1: Results of VMMC baseline and follow-on assessment.....	8
--	---

Acronyms

AIDS	Acquired immune deficiency syndrome
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
BLM	Banja La Mtsogolo
CQI	Continuous quality improvement
HC	Health center
HIV	Human immunodeficiency virus
IEC	Information, education, and communication
IP	Implementing partner
IPC	Infection prevention and control
Jhpiego	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MOH	Ministry of Health
M&E	Monitoring and evaluation
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PSI	Population Services International
QA	Quality assurance
QI	Quality improvement
STI	Sexually transmitted infection
UNAIDS	Joint United National Program on HIV/AIDS
URC	University Research Company, LLC
USAID	United States Agency for International Development
VMMC	Voluntary medical male circumcision
WHO	World Health Organization

Executive Summary

The Ministry of Health (MOH) in Malawi in its National Strategic Plan (2011-2016) endorsed voluntary medical male circumcision (VMMC) as an HIV prevention strategy. However, as a country poised to scale up VMMC, health facilities needed to prepare themselves to provide safe and quality services. Since then, Malawi's MOH has had many notable achievements, for example the development of a national policy, standard operating procedures, and a communication strategy. In 2015, USAID Malawi asked the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project to improve the quality of VMMC services being provided by USAID-funded implementing partners (IPs). ASSIST provides technical assistance to the MOH to help ensure quality services are delivered to all VMMC clients when they are needed using a continuous quality improvement (CQI) approach. ASSIST now supports three IPs: Population Services International (PSI), Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), and Banja La Mtsogolo (BLM), working in seven districts in Malawi (namely, Blantyre, Chikwawa, Thyolo, Mulanje, Chiradzulu, Zomba, and Phalombe).

This report summarizes the findings of baseline assessments of services provided at 13 sites and follow-on assessments of services provided by six PSI VMMC teams. The baseline assessment was conducted by ASSIST in collaboration with the MOH's HIV and AIDS Department and Zonal and District Health Offices during June 7-13, 2015. The follow-on assessment was conducted October 25-31, 2015.

The following were the specific objectives of the baseline and the follow-on assessments:

- Assess compliance with VMMC program minimum standards, as defined by the national and international policies/guidelines.
- Identify best practices and gaps in VMMC service provision.
- Monitor progress on the identified priority gaps identified during the baseline assessment in VMMC service delivery.

A modified tool developed by the World Health Organization (WHO), previously used by ASSIST Uganda, was used to assess each site. After consultation with ASSIST colleagues in the US and Uganda, Malawi adapted the VMMC assessment tool and modified it for the Malawi context. The tool looks at seven areas of service provision.

PSI has six sites in three districts in the Southern Region: two in Blantyre District, one in Chiradzulu District, and three in Mangochi District. All six sites were selected for the follow-on assessment. At each site, data was collected using a combination of quantitative and qualitative approaches over four days. Observation, inspection, interviewing, and record audits were done. The following improvements were measured along the seven categories assessed:

Management systems: Four (66.7%) sites experienced improvements, with teams five and six registering great improvements from 63.6% and 45.5% to 90.9% and 81.8%, respectively. One team stagnated on 54.5%, while another team failed to sustain the high standard obtained during the baseline assessment by scoring 81.8% during the follow-on assessment from 90.9% during the baseline assessment.

Supplies, equipment and environment: Male circumcision is a surgical procedure, and adherence to high standards is a requirement to avoid adverse events. Apart from highly qualified human resources, there is need to have all the necessary equipment, medicines, and IP resources for the standards to be achieved. The VMMC in all (100%) sites improved from their previous scores to above 80%, with four sites scoring 100% while one site scored 83.3%.

Registration, group education, and information, education and counseling (IEC): Having a well-informed client leads to adherence to instructions, and clear documentation helps to generate credible data for decision making. The teams acknowledged that this category helped them to pay attention to

detail when collecting data, when setting up sites, and when doing group education sessions, as it broadens knowledge in different subject areas. Teams in five (83.3%) sites improved, while one team lost the level attained during the baseline assessment, declining from 83.3% to 66.7%.

Individual counseling and HIV testing: Teams in various sites struggled to improve in this area as manifested in three teams scoring less than what they had during the baseline assessment and one team maintaining the baseline assessment score level.

Male circumcision surgical procedure: Teams in all sites improved between the baseline assessment and the follow-on assessment by scoring above 80%. Most clinicians and nurses who are also providers are continuously involved in the quality improvement (QI) activities. Therefore, this trend indicates that the integration of QI is being consolidated.

Monitoring and evaluation (M&E): All teams in different sites improved from the baseline assessment scores. With this standard aiming at ensuring that all processes in QI are adhered to, the improvements indicate that the QI concepts are being consolidated.

Infection prevention: This standard ensures that any surgery is either sterile or aseptic and should not lead to unnecessary infections. The improvements achieved in all (100%) sites demonstrate that teams are becoming improvement-oriented.

Based on the findings of the baseline assessments, the MOH with technical assistance from ASSIST Malawi and Uganda, oriented VMMC service providers from the three IPs and 13 VMMC sites in QI. Following the training, 13 QI teams were formed, and these teams designed and implemented improvements in all their VMMC sites. The MOH with support from ASSIST began working with the VMMC service providers to address the gaps identified during the baseline assessment through coaching and mentoring visits.

The following are the general recommendations for all the VMMC sites:

- There is need to integrate CQI in the VMMC program in order to improve the quality of VMMC service delivery.
- All teams need to be trained in CQI for them to use the QI concepts when providing VMMC services.
- Teams need to strive to sustain their high standards which they have set for themselves. Whereas those teams which had the lowest scores should immediately establish the improvement plans for areas where they have challenges.
- All teams should identify lessons for sharing so that other teams can learn how the concept of CQI was used to attain such improvements.
- There is need to have the District VMMC Coordinators continuously engaged in QI issues so that the integration of QI approaches in the VMMC services can be sustained in all districts.

Going forward, ASSIST plans to conduct coaching in CQI and facilitate QI learning sessions so that teams can learn from each other on how to improve VMMC services. The MOH will continue to take the leading role in provision of quality and safe VMMC services by providing coaching support to the teams, provision of VMMC policies and standards where needed, and ensuring CQI is integrated in VMMC services.

I. Introduction

In March 2007, the World Health Organization (WHO) along with the Joint United National Program on HIV/AIDS (UNAIDS) recommended voluntary medical male circumcision (VMMC) as an effective intervention for HIV prevention in regions with high HIV prevalence and low male circumcision rates. The WHO endorsement was based on a series of studies which demonstrated that VMMC reduced the female-to-male sexual transmission of HIV by approximately 60%. The Ministry of Health (MOH) in Malawi in its National Strategic Plan (2011-2016) endorsed VMMC as an HIV prevention strategy.

However, as a country poised to scale up VMMC, health facilities needed to prepare themselves to provide safe and quality services. Since then, Malawi's MOH has had many notable achievements, for example the development of a national policy, standard operating procedures, and a communication strategy.

In 2015, USAID Malawi asked the USAID Applying Science to Strengthen and Improve Systems project (ASSIST) to improve the quality of VMMC services being provided by USAID-funded implementing partners (IPs). ASSIST provides technical assistance to the MOH to help ensure quality services are delivered to all VMMC clients when they are needed using a continuous quality improvement (CQI) approach. ASSIST Malawi now supports three IPs, including Population Services International (PSI), JHPIEGO, and Banja La Mtsogolo (BLM), working in seven districts in Malawi (namely, Blantyre, Chikwawa, Thyolo, Mulanje, Chiradzulu, Zomba, and Phalombe districts).

This report summarizes the findings of baseline assessments provided at 13 sites and follow-on assessments of services provided by six PSI VMMC teams. The baseline assessment was conducted by ASSIST in collaboration with the MOH's HIV and AIDS Department, Zonal and District Health Offices during June 7-13, 2015 and a follow-on assessment was conducted October 25-31, 2015.

The report outlines the specific objectives, methodology used, and findings from the baseline and follow-on assessments. The report also provides recommendations on the way forward for implementing sites and stakeholders in VMMC service provision.

II. Objectives

The following were the specific objectives of the baseline and the follow-on assessments:

- Assess compliance with VMMC program minimum standards, as defined by the national and international policies/guidelines.
- Identify best practices and gaps in VMMC service provision.
- Monitor progress on the identified priority gaps identified during the baseline assessment in VMMC service delivery.

III. Methods

A. Assessment Tools

A modified WHO tool, previously used by ASSIST Uganda, was used to assess each site. After consultation with ASSIST colleagues in the US and Uganda, Malawi adapted the VMMC assessment tool and modified it for the Malawi context. The tool was reviewed by the Malawi National VMMC Technical Working Group led by the MOH and was first used in Malawi during the baseline assessment in June 2015. The same VMMC assessment tool was used during the follow-on assessment in October 2015. Seven broad areas and standards for each were assessed, namely:

1. Management Systems

2. Supplies, Equipment, Medication and Infrastructure
3. Registration of Clients and Group Education
4. Individual Counselling Sessions for HIV testing and for Medical Male Circumcision
5. VMMC surgical procedure
6. Monitoring and Evaluation
7. Infection Prevention and Control (including waste management).

B. Orientation of the Assessors on the Tools

The tool was sent to the assessing teams for review and familiarization before using it. Before the beginning of the assessments, the assessors were briefed on how to use the tool and how to score the observations.

C. Selection of Sites and the Assessment Process

PSI has six sites in three districts in the Southern Region and these sites are distributed as follows: two in Blantyre District, one in Chiradzulu District, and three in Mangochi District. The six sites are mobile VMMC clinics so their physical locations in their district change based on demand, though the personnel remain the same. All six sites were selected for the follow-on assessment. These sites were assessed over a period of four days. On the first day, one team jointly assessed one site to ensure everyone had a common understanding of the process. On the second and the third day, the team was split into two and each team simultaneously assessed one site per day in different districts and jointly assessed the last site on the fourth day. At each site, data was collected using a combination of quantitative and qualitative approaches including observation, inspection, interviewing, and record audits.

D. Composition of the Assessment Teams

Teams consisted of MOH and ASSIST staff. MOH assessors had a clinical background and had the following characteristics: experienced with assessment and evaluations and/or who were knowledgeable about HIV programs and strengthening health systems; and who had been trained on the VMMC program and oriented on the baseline assessment tool.

ASSIST assessors had experience on HIV programs and strengthening health systems; and were knowledgeable of VMMC program. A total of six MOH personnel and three ASSIST personnel participated in the assessment. All MOH personnel who participated in assessment had a clinical background; these included one National VMMC Coordinator, three District VMMC Coordinators, and two Clinical Officers representing the MOH headquarters. The team visiting each facility was comprised of at least three people.

E. Assessment Process

When a facility was visited, the team met with the facility manager and partner staff present to introduce themselves and the purpose of the visit, as well as to be introduced to the facility staff. The team leader usually gave a brief overview of the components of the assessment and explained to the facility team leader who would be assessing which section of the VMMC service delivery. At this



Nankhwali Mobile VMMC Site (Team 2). Photo by Franklin Kilembe, URC.

initial briefing, the team leader also mentioned that preliminary feedback will be provided to the facility and partners at the end of the assessment exercise. The facility team leader then took the assessors through their process flow of the VMMC services. During the assessment, the facility team leader would allocate each member of the assessment team to the appropriate person within the facility. The allocation of tasks within the team was as follows:

- One or two people assessing the clinical areas: Infection prevention, surgical procedure and surgical equipment, medicine and commodities. The assessors for these sections were clinical officers with experience in VMMC and infection prevention.
- One or two people assessing the non-clinical areas: Monitoring and evaluation (M&E), registration, group education and IEC, and non-surgical commodities. The assessors for these sections were clinicians and/or non-clinical staff knowledgeable in health care systems including assessment/interviewing skills.

Once a particular section was completed the facility staff continued with their work. The assessment team member would either move onto assessment of another area, or wait for the rest of the team to complete their sections. Once all sections were completed a summary feedback was given to the respective section staff in the presence of the facility team leader and IP staff when available.

IV. Baseline and Follow-on Assessment Findings

A. Summary

A total of 13 sites were assessed for the first time to collect baseline information during June 7-13, 2015. During the follow-on assessment in October 2015, only six VMMC sites supported by PSI were assessed because some of the sites had closed due to funding for the project activities. **Figure 1** shows the dashboard of baseline and follow-on assessment findings in the 6 PSI-supported sites and baseline findings of JHPIEGO (3 sites) and Banja la Mtsogolo (4 sites) that had a second assessment.

B. Management Systems

In this service area, the teams were assessed on the standards to ensure the VMMC site had relevant VMMC guidelines, standards, site work plans and ability to meet targets, clearly defined roles and responsibilities of staff, client flow charts, use of data for VMMC program improvement, availability of adequate human resources, effective referral systems, effective supplies ordering system, and ability to manage adverse events and complications. During the baseline assessment one out of the 13 sites scored above 80% and this improved during the follow on assessment to 50% of all the six assessed sites scoring above 80%.



A Team manager showing a client flow chart developed by the team at Kholo VMMC site. Photo by Tiwonge Moyo, URC.

Figure 1: Results of VMMC baseline and follow-on assessment in 13 PSI, JHPIEGO and Banja la Mtsogolo supported mobile and static VMMC sites, May-June and October 2015

Site	Baseline Assessment (May & June 2015)							Follow-on assessment (2 nd) October 2015						
	Management Systems	Supplies, equipment & environment	Registration, group education & IEC	Individual counseling & HIV testing	MC surgical procedure	M&E	Infection Prevention	Management systems	Supplies, equipment & environment	Registration, group education & IEC	Individual counseling & HIV Testing	MC Surgical procedure	M&E	Infection prevention
1	54.5	33.3	100	66.7	40	64.3	60	54.5	83.3	100	83.3	93.3	71.4	66.7
2	63.6	83.3	66.7	72.2	71.9	71.4	88.9	72.7	100	100	23.5	84.8	71.4	90
3	90.9	66.7	83.3	72.2	75.8	21.4	87.5	81.8	100	66.6	72.2	96	78.6	80
4	54.5	83.3	83.3	61.1	90.6	28.6	77.8	72.7	100	100	100	96.6	71.4	80
5	63.6	83.3	66.7	88.9	78.8	85.7	66.7	90.9	100	83.3	66.6	90.9	92.8	100
6	45.5	33.3	66.7	72.2	74.2	71.4	70	81.8	100	83.3	66.6	100	92.8	90
7	27.3	33.3	25	0	66.7	50	54.5							
8	36.4	50	50		50	78.6	83.3							
9	45.5	33.3	0	50	33.3	0	60							
10	36.4	50	100	88.9	56.7	21.4	100							
11	27.3	33.3	50	17.6	28.1	78.6	54.5							
12	18.2	83.2	50	66.7	50	28.6	77.8							
13	18.2	66.7	80.7	66.7	42.9	71.4	77.8							

Key	>80%	50%-<80%	<50%	Not observed
-----	------	----------	------	--------------

Note: In the above table, site is synonymous with team¹

- | | |
|-------------------------------------|--------------------------------------|
| Team 1 = Bangwe then Khola site | Team 2 = Namwera then Nankhwali site |
| Team 3 = Sakata then Mauwa site | Team 4 = Chimwala then Lungwena site |
| Team 5 = Dziwe then Katema CBO site | Team 6 = Maravi then Lundu site |
| Team 7= Zomba Police | Team 8= Thyolo |
| Team 9= Makhwira | Team 10=Migowi |
| Team 11=Chisitu | Team 12=Malambwe |
| Team 13=Thembe | |

¹ The site name changes because of the geographical location where the teams were providing VMMC services was different but the assessments followed the same Mobile VMMC teams.

The following are the strengths and gaps that were commonly cited in the management service area in the assessed sites.

Strengths

On the availability of relevant male circumcision policies, guidelines and standards four of six PSI sites (66.7%) had relevant and accessible male circumcision policies, guidelines and standards during the baseline assessment while during the follow-on assessment all six sites (100%) had them in their sites. Four (66.7%) of the sites were able to meet demand for services during the baseline assessment and this improved to five (83.3%) sites during the follow-on assessment. All the sites had clearly defined staff roles and responsibilities during the baseline assessments and this was maintained during the follow-on assessment. Four (66.7%) sites had clients' flow charts in the clinics during the baseline assessments while all (100%) sites had the clients' flow charts during the follow-on assessments. The minimum levels of human resources according to the Malawi male circumcision service delivery plan were available in all sites during both the baseline and the follow-on assessments. Only 50% of the sites were reviewing and managing the moderate and severe adverse events or complications during the baseline assessments while all (100%) the sites were doing so when the follow-on assessment were done. An effective referral system was already established in four (66.7%) sites during the baseline assessments while all (100%) had established the effective referral system during the follow-on assessments. Only two (33.3%) sites had an effective supply and equipment ordering system during the baseline assessments while all (100%) the sites had the system in place by the time the follow-on assessments were done. There were three (50%) sites with the QI teams during the baseline assessments which slightly improved to four (66.7%) sites during the follow-on assessments. One site (16.6%) had an effective supply and equipment ordering system in place during the baseline assessment and this improved to four (66.7%) sites during the follow-on assessments. No site had records showing clients feedback during the baseline assessments while all (100%) had records in place during the follow-on assessments. An example is a picture shown of a site that introduced client feedback registers at the point of discharging the client. A QI team member was placed at the end of the process to source any client feedback regarding the services accessed at the site. Information on delays in the VMMC services is provided and the team is alerted to improve the timing of some steps in the service delivery. A picture is shown of a register that was introduced at Lungwena team to obtain client feedback on the timing of the VMMC services.



A client feedback register instituted by a QI team to obtain clients feedback on the VMMC services provided. Photo by Tiwonge Moyo, URC.

Gaps

Developing the annual service delivery plans with targets and required commodities was a gap in all six sites during the both the baseline and the follow-on assessments. Lack of documentation on mentorship activities and support for clinic staff and provision of feedback remained the gap in all the sites. The use of service delivery data for planning and improvement of services was a common gap in all sites. It also remained a challenge in all sites to have the circumcised men come back for review on the seventh day after circumcision. Two (33.3%) were still having problems with having updated requisition and commodity stocks documents. All sites have QI teams but only two (33.3%) of the six sites use data for the action plans.

C. Supplies, Equipment, and Environment

In this service area, the sites were assessed on the appropriateness of the physical structures for VMMC service delivery, availability of VMMC equipment, supplies, tools, and medicines for performing the male circumcision procedure. During the baseline four out of 13 sites scored above 80%, and three of these sites were also assessed during the follow-on assessments. During the follow-on assessment, all six sites scored above 80% with four sites scoring 100% while two scored 83.3%. The following are the strengths and gaps that were common in the supplies, equipment, and environment service area for the assessed sites.

Strengths

All six (100%) sites had appropriate physical structures for VMMC service provision for various components in VMMC service delivery such as reception, health education and group counseling, pre-operative and post-operative evaluation spaces, and surgical procedure rooms during both the baseline and the follow-on assessments. Four (66.7%) sites had an emergency resuscitation system and medication for immediate access during an emergency during the baseline assessment and this improved to all (100%) sites during the follow-on assessments. Five (83.3%) sites had well defined measures for managing moderate to severe complications and adverse events during the baseline assessments while all (100%) sites had them during the follow-on assessments. The necessary equipment for performing VMMC surgeries was available in five (83.3%) sites during the baseline assessments and was available in all (100%) the sites when follow-assessments were done. The emergency resuscitation system was in place in four (66.7%) sites during the baseline assessments and improved to all (100%) sites having the system in place by the time the follow-on assessments were done. Only three (50%) had necessary commodities for performing surgeries during the baseline assessments while five (83.3%) had the commodities during the follow-on assessments. Great improvements were achieved in the adequate supplies of medicine and commodities standard where no site had adequate supplies during the baseline assessments and five (83.3%) had adequate supplies during the follow-on assessments.

Gaps

In this category there were very few gaps during the follow-on assessments only one (33.3%) site did not have an inventory of drugs and supplies on site and also only one (33.3%) site didn't have a required drug for the treatment of sexually transmitted infections (Ciprofloxacin).

D. Registration of Clients and Group Education

In this area, the sites were assessed on how they registered their clients, availability of education materials, and techniques and skills in provision of group education. In this category half of the PSI sites scored above 80% during the baseline assessments while five sites scored above 80% with three sites scoring 100%, and two sites scoring 83.3% during the follow-on assessments. The following are the common strengths and gaps observed for the sites in registration of clients and group education.

Strengths

In all six sites clients were correctly recorded in the register and given a client identification during both the baseline assessments and the follow-on assessments. The group education was delivered with appropriate techniques in five (83.3%) sites during the baseline assessments and improved to all six (100%) sites during the follow-on assessments. Only three (50%) sites delivered group education with correct information during the baseline assessments improving to five (83.3%) during the follow-on assessments. Four (66.7%) sites had appropriate information and education materials on VMMC and other reproductive health during the baseline assessments, registering a slight improvement to five (83.3%) sites during the follow-on assessments.

Gaps

There were outstanding gaps related to group education during the follow-on assessments. For example one site had no reproductive health materials to provide information to clients, in two sites providers did not give information on other sexual and reproductive health to clients during the group education sessions, and one site did not summarize the key points.

E. Individual Counselling and HIV Testing

In this service area, sites were assessed on the skill, techniques and materials used for provision of individual counselling, routine HIV testing, appropriateness of giving results, post- test counseling, demonstration and provision of condoms where applicable. One site scored above 80% during the baseline assessments while two sites scored above 80% during the follow-on assessments. The following are the common strengths and gaps observed in the individual counseling and HIV testing service area.

Strengths

Four (66.7%) sites conducted appropriate individual and couple's counseling on VMMC during the baseline assessment and the same level was achieved during the follow-on assessments. Routine HIV testing for all clients was done in five (83.3%) sites during baseline assessment and the level dropped to two (33.3%) sites during the follow-on assessments. Informed consent for VMMC was obtained from clients or guardians in four (66.7%) sites during both the baseline assessments and the follow-on assessments. Adequate information provided during individual counselling on VMMC was given to clients in three (50%) sites during the baseline assessments and improved to four (66.7%) during the follow-on assessments. In three (50%) sites providers used appropriate counseling skills during the baseline assessments while four (66.7%) sites had appropriately counseled clients during the follow-on assessments. Condoms were offered to clients together with appropriate instructions in five (83.3%) during the baseline assessments dropping to three (50%) sites during the follow-on assessments.

Gaps

The follow-on assessments established a number of outstanding gaps related to individual counseling. For example, in two (33.3%) sites checking on whether minors or guardians understood the potential risks and complications of VMMC before assenting or consenting was not done. Inadequate information provided during individual counselling on MC in three (50%) sites during the follow-on assessments. Inappropriate counselling skills, such as the counsellor not emphasizing the importance of abstaining from sex for six weeks post circumcision, were observed in some sessions in two (33.3%) sites. Clients were not offered condoms and/or condom demonstrations were not performed in two (33.3%) sites. In two (33.3%) sites, the provider did not emphasize inviting female partners to attend counselling with clients. In three sites, the provider did not tell clients how to contact the site and to stop them anytime if the client had questions.

F. Surgical Medical Circumcision Procedure

In this service area, the sites were assessed on provision of pre-operative care, operative care, and post-operative care and during the baseline assessments, one site scored above 80% while all six sites scored above 80% during the follow-on assessments. The following strengths and gaps were observed in most of the sites for surgical MC procedure.

Strengths

There were great improvements in this area. During the baseline assessments clients' history taken correctly in five (83.3%) sites while it was done in all six (100%) sites during the follow-on assessments. Clients were properly prepared for surgery in five (83.3%) sites during the baseline assessments improving to achieving this in all sites during the follow-on assessments. Pre-operation examination according to standard, administration of anaesthesia according to standards, were done in three (50%)

sites during the baseline assessments while all six (100%) sites had these done according to standard during the follow-on assessments. The achievement of haemostasis, correct wound suturing and correct application of dressing was in four (66.7%) sites during the baseline assessments and in all six (100%) sites during the follow-on assessments. The administration of anaesthesia and the correct performance of either dorsal slit or forceps guided surgical circumcisions were done in only two (33.3%) sites during the baseline assessments while great improvements were registered during the follow-on assessments to all 100% sites. While immediate post-operative clients were escorted to the post-operation care area in three (50%) sites during the baseline assessments, an improvement to four (66.7%) was registered during the follow-on assessments. Immediate post-operative monitoring was done in five (83.3%) sites during the baseline assessments and improved to all (100%) during the follow-on assessments. Providers were able to respond appropriately to an emergency situations in four (66.7%) sites during the baseline assessments and in all (100%) sites during the follow-on assessments. Clients' records were updated and completed prior to discharge in five (83.3%) sites during the baseline assessments improving to all six (100%) sites during the follow-on assessments. Another area where great improvements were registered was in the provision of post-operative care instructions where only two (33.3%) sites provided sufficient instructions during the baseline assessments and five (83.3%) sites were able to do the same during the follow-on assessments.

Gaps

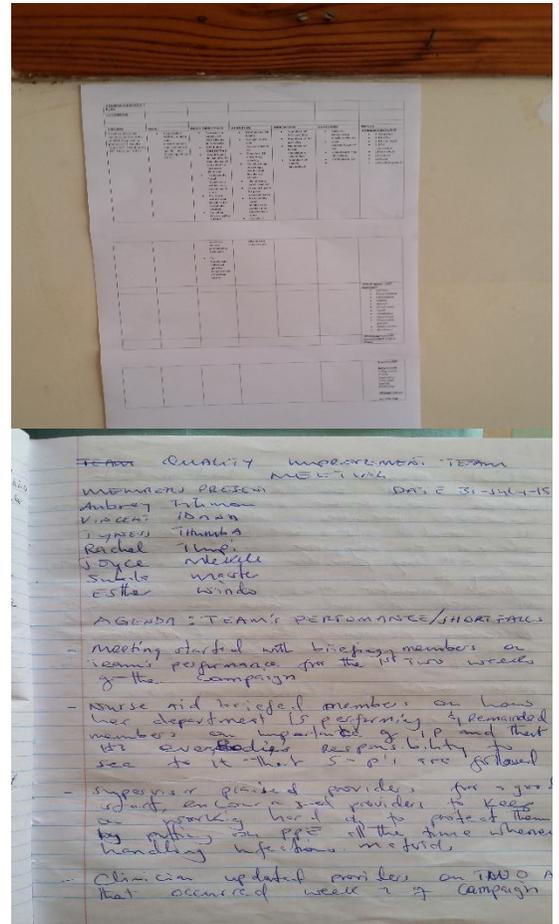
There were outstanding gaps after the follow-on assessments especially in the management of follow-ups. There were inadequate post-operative care instructions to clients in two sites. There was also very minimal initiative by providers in probing about the healing process of the circumcision wound. For example in two sites clients were not asked if there were any problems since the last visit and the contact information were not verified. HIV prevention messages were not reinforced during the follow-up visit at one site and condoms were not offered during the follow-up visit at one site.

G. Monitoring and Evaluation

In this area sites were assessed on availability of relevant data collection tools, completeness and consistency of records in client forms and registers availability of report and use of data for planning and improvement of VMMC service delivery. In this area, one site scored above 80% during the baseline assessments while two sites scored above 80% during the follow-on assessments. The following are the common strengths and gaps identified in M&E in most of the clinics.

Strengths

There were improvements in the availability of relevant VMMC tools from five (83.3%) sites during the baseline assessment to six (100%) sites during the follow-on assessments. The transfer of male circumcision clients' data to the Male Circumcision Client Counseling, HIV testing and counseling (HTC) and STI registers was done correctly in four (66.7%) sites during the baseline assessments while it was done correctly in all six (100%) sites during the follow-on assessments. During the baseline assessments



Top photo: QI team action plan Photo taken from Lugwena PSI VMMC mobile team. **Bottom photo: QI team minutes taken by one of the VMMC teams at PSI sites.** Photos by Tiwonge Moyo, URC.

only two (33.3%) sites had QI teams that were partially functional (the teams meet weekly but do not use data for improvement change) and during the follow-on assessments all six (100%) sites had QI teams.

Gaps

The follow-on assessments highlighted several outstanding gaps. Only three (50%) sites had completely filled client records that correspond with the Male Circumcision Client Counseling, HTC and STI register during the follow-on assessments. The monthly data summaries and/or reports were not available in three (50%) sites during the follow-on assessments a slight improvement from four (66.7%) sites during the baseline assessments. Service delivery data used for planning and improvement of service delivery in only three (50%) sites.

H. Infection Prevention and Control

In this area, the sites were assessed on preparation of antiseptics, disinfectant cleaning solutions, the process of room cleaning, cleaning of instruments, decontamination and high level disinfection, and waste management. During the baseline assessments two (33.3%) sites scored 80% while five (83.3%) sites scored above 80% during the follow-on assessments. The following are the common strengths and gaps identified in infection prevention and control in most of the clinics.

Strengths

During the follow-on assessments a number of strengths were identified. For example, during both the baseline and the follow-on assessments, four (66.7%) sites prepared the concentration and used antiseptics according to standards. Five (83.3%) sites had the processes of cleaning rooms between and after procedures performed according to standards during both the baseline assessments and the follow-on assessments. All six (100%) sites had preparation of disinfectant cleaning solution performed according to standards during both the baseline assessments and the follow-on assessments. Decontamination of instruments and other articles (immediately after use and before cleaning) was performed according to standards in five (83.3%) sites during the baseline assessments and improved to all six (100%) sites during the follow-on assessments. Storage process of sterile or high-level disinfected items was performed according to standards in all six (100%) sites during the baseline assessments and the follow-on assessments. The process of packaging items to be sterilized was performed according to the standards in all sites.

Gaps

The follow-on assessments highlighted some gaps in Infection prevention and control. Two standards evolved from strengths to gaps for example, the handling and disposal of waste particularly color coding of bin liners was properly done in five (83.3%) sites during the baseline assessments while four (66.7%) achieved the same during the follow-on assessments. Providers were not putting on protective eye wear in three (50%) of the sites. The HTC counselor was not washing hands after putting off gloves at one site and there was one utility glove at one site which the cleaner was putting on one hand while working.

V. Discussion

Generally there were great improvements within the teams in different sites during the period of between the baseline assessments and the follow-on assessments.

Management systems: Four (66.7%) sites experienced improvements with teams five and six registering great improvements from 63.6% and 45.5% to 90.9% and 81.8% respectively; one team stagnated on 54.5% while another team failed to sustain the high standard obtained during the baseline assessment by scoring 81.8% during the follow-on assessment from 90.9% during the baseline assessment.

Supplies, equipment and, environment: Male circumcision is a surgical procedure and adherence to high standards is critical to avoid adverse events. Apart from highly qualified human resources, there is need to have all the necessary equipment, medicines, and IP resources for the standards to be achieved. The QI assessment team members who conducted the baseline assessments provided very specific feedback to the teams who responded positively by working towards improving. The VMMC in all (100%) sites improved from their previous scores to above 80% with four sites scoring 100% while one site scored 83.3%.

Registration, group education, and IEC: Having a well-informed client leads to high adherence to instructions and clear documentation assists in having credible data for decision making. In this category the teams in different sites improved during the follow-on assessment. The teams acknowledged that this category helped them to pay attention to details when collecting data and when setting up the site, and that it broadens knowledge in different subject areas when doing group education sessions. Teams in five (83.3%) sites improved while one team lost the level attained during the baseline assessment from 83.3% to 66.7%. This could possibly be due to the nature of the services (mobile clinics) and the fact that the team members were still in the infant stage of learning the QI concepts.



A QI coaching session at Jhpiego site at Makhwira site in Chikwawa District. Photo by Linley Hauya, URC.

Individual counseling and HIV testing: Teams in various sites struggled to improve in this area as manifested in three teams scoring less than what they had during the baseline assessment and one team maintaining the baseline assessment score level. This was attributed to high turnover of HTC counselors. Different HTC counselors are used for a minimum of one week.



QI team coaching session at Koche PSI site in Mangochi District. Photo by Linley Hauya, URC.

Male circumcision surgical procedure: Teams in all sites improved between the baseline assessment and the follow-on assessment by scoring above 80%. Most clinicians and nurses who are also providers are continuously involved in the QI activities therefore this trend indicate that the integration of QI is being consolidated.

Monitoring and evaluation: All teams in different sites improved from the baseline assessment scores. With this standard aiming at ensuring that all processes in QI are adhered to the improvements indicate that the QI concepts are being consolidated.

Infection prevention: Any surgery is either sterile or aseptic and should not lead to unnecessary infections. The improvements achieved in all (100%) sites entail that teams are becoming QI oriented.

VI. ASSIST's CQI Activities

Based on the findings of the baseline assessments, the MOH with technical assistance from ASSIST Malawi and Uganda, oriented a total of 28 VMMC service providers from the three IPs and 13 VMMC sites in QI on 25-27th May 2015. The VMMC service providers were taken through a series of presentations on how to develop an improvement plan with specific objectives and changes to test to improve the quality of services, how to analyze problems in the VMMC services, reviewing of the baseline findings, action planning to resolve the baseline findings, developing and tracking data collection measures, integrating gender in VMMC services, benefits that are observed after integrating gender in VMMC services and the process of testing changes to discover which changes lead to improvement in quality of services. Following the training, 13 QI teams were formed, and these teams designed and implemented improvements in all their VMMC sites.

ASSIST supported the MOH to conduct two QI coaching sessions in all six VMMC sites on 14-19th June 2015 and 15-20th November 2015. ASSIST in collaboration with District Health Offices conducted QI coaching to all the mobile teams to follow up on their improvement work after the baseline assessment process. The MOH with support from ASSIST began working with the VMMC service providers to address the gaps identified during the baseline assessment. During the first on-site QI coaching visits the team supported the VMMC service providers to assess the progress on their action plans that were developed to address the priority red and yellow highlighted areas in the baseline dashboard. The teams were also supported on providing an overview of the roles of the QI team and its composition. The team discovered that only a few members were oriented in QI in the teams and it was only very few people who were involved in the improvement meetings and the other team members were not well versed with what their role and contributions could be in the team. During the coaching sessions it was agreed to include other service providers providing VMMC services in the mobile teams so that the teams were well acquainted with what they were trying to accomplish as a team. After the coaching other service providers were oriented and brought in the teams to participate in improvement work.

In the second QI coaching session the VMMC Coordinators from the District Health Offices supported by ASSIST mentored the teams in development of improvement plans in addition to the action plans. The purpose for this was to move the teams to start resolving complex problems the teams faced in VMMC service provision. Templates for how to develop improvement plans were discussed and shared. The teams were assisted on how to develop improvement plans, how to introduce changes to improve the quality of VMMC services, how to develop indicators to collect data from and how to brainstorm the problems to develop potential solutions. The QI coaching team also followed up on previous gaps identified in the baseline assessment to get an update on how the teams were introducing changes to improve the quality of VMMC services as mobile teams.

VII. Recommendations

The following are the general recommendations for all the VMMC sites:

- There is need to integrate CQI in the VMMC program in order to improve the quality of VMMC service delivery.
- All teams need to be trained in CQI for them to use the QI concepts when providing VMMC services.
- Teams need to strive to sustain their high standards which they have set for themselves. Whereas those teams which had the lowest scores should immediately establish the improvement plans for the challenging areas.
- All teams should identify the case studies areas for sharing so that other teams can learn on how the concept of CQI was used to attain such improvements.
- There is need to have the District VMMC Coordinators continuously engaged in QI issues so that the integration of the QI approaches in the VMMC services can be sustained in all districts.

VIII. Next Steps

ASSIST should plan to conduct the following activities: Disseminate the follow-on assessment findings; conduct coaching in CQI; facilitate the identification of case study areas; and facilitate QI learning sessions so that teams can learn from each other on how to improve VMMC services.

The MOH will continue to take the leading role in provision of quality and safe VMMC services by providing coaching support to the teams; providing VMMC policies and standards where needed; and ensuring CQI is integrated in VMMC services.

ASSIST will work with all IPs to plan and conduct trainings for CQI and to integrate continuous improvement into VMMC services.

**USAID APPLYING SCIENCE TO STRENGTHEN
AND IMPROVE SYSTEMS PROJECT**

University Research Co., LLC
7200 Wisconsin Avenue, Suite 600
Bethesda, MD 20814

Tel: (301) 654-8338

Fax: (301) 941-8427

www.usaidassist.org