Capacity Development and Support Program (CDS)

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April 1, 2017, to June 30, 2017

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ACRONYMS

AGYW	Adolescent girls and young women
AIDS	Acquired Immunodeficiency Syndrome
AOR	Agreements Officer’s Representative
APS	Annual Program Statement
ART	Anti-retroviral therapy
ATC-HTS	Accelerating Targeted Community-based HIV Testing Services initiative
BMI	Body mass index
CAPRISA	Centre for the AIDS Program of Research in South Africa
CBIMS	Community Based Interventions Monitoring System
CBO	Community-based organization
CCW	Child care worker
CDS	Capacity Development and Support (program)
CEGAA	Centre for Economic Growth and AIDS in Africa
CHC	Community Health Center
CINDI	Children in Distress Network
COP	Country Operational Plan
CoS	Circle of Support
CYCW	Child and youth care worker
DATIM	Data for Accountability, Transparency and Impact
DBE	Department of Basic Education
DIMES	DREAMS Integrated Monitoring and Evaluation System
DOH	Department of Health
DQA	Data quality assessment
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DSD	Department of Social Development
DSP	District Support Partner
ECD	Early childhood development
ECHS	Early Childhood Household Stimulation
FPD	Foundation for Professional Development
FY	Fiscal Year
GBV	Gender-based violence
GDE	Gauteng Department of Education
HETTAS	Health and Education Training and Technical Services
HIV	Human Immunodeficiency Virus
HR	Human resources

HRM	Human resource management
HSRC	Human Sciences Research Council
HTA	High Transmission Area
HTS	HIV testing services
ICSM	Integrated Clinical Service Management
IEC	Information, education and communication
KP	Key populations
KZN	Kwazulu-Natal (province)
M&E	Monitoring and evaluation
m2m	mothers2mothers
MAM	Moderate acute malnutrition
MatCH	Maternal Adolescent and Child Health
MCWH	Mother, Child and Women's Health
MER	Monitoring, Evaluation and Reporting
MSM	Men who have sex with men
MSP	Male sex partners
MUAC	Mid-upper arm circumference
NACCW	National Association of Child Care Workers
NACOSA	Networking HIV/AIDS Community of South Africa
NACS	Nutrition Assessment, Counselling and Support
NDOH	National Department of Health
NDSD	National Department of Social Development
NGO	Non-governmental organization
NICDAM	National Institute Community Development and Management
OVC	Orphans and vulnerable children
OVCY	Orphans and vulnerable children and youth
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary health care
PLHIV	People Living with HIV
PMF	Performance Management Framework
PMM	Program management meeting
PMTCT	Prevention of mother-to-child transmission
PrEP	Pre-exposure prophylaxis
PSS	Psychosocial support
PVC	Post-violence care
QI	Quality improvement
R	South African Rand
RDQA	Routine data quality assessment

ReACH	Reaching Adolescents and Children in Households
RTQII	Rapid Testing Quality Assurance Improvement Initiative
SABS	South African Bureau of Standards
SAG	South African Government
SAHPRA	South African Health Products Regulatory Authority
SAM	Severe acute malnutrition
SFH	Society for Family Health
SIMS	Site Improvement through Monitoring System
SOP	Standard operating procedure
SPI-RT	Stepwise Process for Improving the Quality of HIV Rapid Testing
SRH	Sexual and reproductive health
SRI	Supportive Referral Initiative
STI	Sexually-transmitted infections
TA	Technical Advisor
TB	Tuberculosis
TVT	The Valley Trust
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VMMC	Voluntary medical male circumcision
WHO	World Health Organization
WRHI	Wits Reproductive Health and HIV Institute

EXECUTIVE SUMMARY

South Africa's HIV response is multisectoral, supported by both government and civil society. However, these stakeholders frequently experience capacity restraints which limit them from fully achieving their potential. In response, the United States Agency for International Development (USAID) created the Capacity Development and Support program (CDS), implemented by FHI 360, to develop the organizational management, technical capacity, and sustainability of local non-governmental organizations (NGOs) and South African Government (SAG) departments in order to sustain an improved, expanded, and country-led response to HIV and AIDS.

CDS contributes to achieving the United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 targets by promoting, facilitating and/or providing HIV testing services (HTS) in all of its programs, with a specific emphasis on reaching vulnerable populations such as orphans and vulnerable children and youth (OVCY), as well as adolescent girls and young women (AGYW) and their male sex partners. CDS strengthens referrals and linkages to treatment, and works with its partners to integrate ongoing care and support, including for long-term adherence, into their programming. CDS programs also address many of the social and structural factors which contribute to vulnerability to HIV infection, such as harmful gender norms and gender-based violence (GBV).

Project Achievements in FY 2017 Quarter Three

This quarter, CDS managed 23 agreements with 20 organizations and two individuals. CDS identified four organizations to implement the Bridge Project: Support, Prepare and Engage Vulnerable Youth, and the program is scheduled to begin on October 1, 2017.

In quarter three, the five **Early Childhood Household Stimulation** (ECHS) sub-awardees collectively achieved just under 200% of their annual target, delivering comprehensive services to 30,304 orphans and vulnerable children (OVC) and their caregivers. There was an improvement in the number of clients who reported knowing their HIV status from quarter two (from nearly 40%) to quarter three (more than 70%), and sub-awardees have begun tracking clients across the full HIV cascade, from screening and testing to initiation on treatment, adherence and viral suppression. CDS sub-awardees reported nutritionally assessing more than 20,000 ECHS clients.

CDS ended implementation of the **Supportive Referrals Initiative (SRI)** in quarter three. Cumulative achievements of the program include training and mentoring of 1,099 community care workers (CCWs) from 10 President's Emergency Plan for AIDS Relief (PEPFAR) OVCY partners, as well as providing HIV testing to a total of 74,476 OVCY clients (27,566 of these in quarter

three). The improved knowledge and skills of the CCWs to motivate clients to test for HIV, as well as strengthened linkage and referral capacity of the organizations, is expected to promote the long-term sustainability of the program's achievements.

The three CDS sub-awardees implementing **Reaching Adolescents and Children in Households (ReACH)** – Networking HIV/AIDS Community of South Africa (NACOSA), National Association of Child Care Workers (NACCW) and SAfAIDS - made significant implementation progress from quarter two to quarter three, reaching 89,081 OVC and their caregivers (with a specific focus on AGYW aged 10-17 years) with a range of needs-based services: 64% of its annual target. Sub-awardees began implementation of Vhutshilo HIV prevention curricula in quarter three, and will roll out Let's Talk parent curriculum after training in quarter four.

Humana People to People South Africa (Humana), CDS' implementing partner for **Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) HTS and Condom Promotion and Provision**, provided HTS to 75,345 AGYW and their male sex partners in quarter three. In addition, Humana distributed 743,010 condoms in the districts of eThekweni and uMkhanyakude in KwaZulu-Natal province during the quarter. Humana has now tested a total of 208,243 individuals: 80% of its overall HTS target. Overall HIV positivity rates ranged from 7% among AGYW aged 20-24 years and male sex partners aged 35-49, to 1% among AGYW aged 10-14 years. By sub-district, HIV positivity was highest among those tested in Mtubatuba (7%) and was lowest in eThekwini North (4%).

The three sub-awardees implementing **Community Mobilization and Norms Change, Post-Violence Care and Psychosocial Support** as part of the DREAMS initiative – Hope Africa, Project Empower and National Institute Community Development and Management (NICDAM) - delivered services to 9,652 individuals this quarter, bringing the progress toward the annual target to 78%. These services included community dialogues, where the highest proportion of participants were males aged 10-34 years old. The sub-awardees also provided post-violence care and psychosocial support to 3,059 AGYW who have experienced gender-based violence this quarter, reaching 77% of the annual target from quarter one to quarter three.

CDS sub-awardees implementing **Accelerated Targeted Community-based HIV Testing Services (ATC-HTS)** – HIVSA, Humana and Society for Family Health – reached 116,107 individuals with HTS in quarter three, bringing their achievement against the annual target to 85%. HIV positivity rates ranged from 3-8%. Analysis of HIV positivity rates indicate that the highest yield was achieved by targeting first time testers and women aged 25-49 years, as well as by implementing index case and workplace mobile modalities.

CDS completed its **organizational capacity development** re-assessments of ECHS sub-awardees in quarter three. Three of these organizations demonstrated notable capacity improvements of

between 10-47% in domains including sustainability, human resource management, strategic planning and leadership. CDS conducted six organizational capacity development trainings in quarter three, attended by 148 participants from 13 organizations.

The eight CDS-supported **SAG Technical Advisors (TAs)** contributed to a range of achievements in quarter three. Collectively, the TAs to the National Department of Health achieved the following results: conducted five site visits to assess warehouse readiness for local condom manufacturing; consolidated results and lessons learned from one year of implementation of the national *She Conquers* campaign; contributed to the finalization and dissemination workshops for the National STI Strategy; co-facilitated four HTS quality assurance workshops in three provinces; and facilitated a workshop on the National Specifications and Catalogue with 68 participants from seven provinces. The TAs to the National Department of Social Development refined the national standard package of services to OVC and collected input from experts on an early childhood development research agenda. The TA to the National Treasury researched Global Fund indicators and developed additional HIV/TB conditional grant indicators for more robust analysis of the HIV/TB grant performance and financial reporting by the National Department of Health.

CDS conducted mentoring and coaching at 31 health facilities supported by six District Support Partners (DSPs) to reinforce their implementation of **Nutrition Assessment, Counseling and Support** (NACS). CDS assessed ReACH sub-awardee NACOSA and subsequently conducted a three-day training to address the gaps identified. Participants achieved an average increase in knowledge of 60%. CDS supported HOPE worldwide to conduct cascade nutrition refresher training to 41 home visitors serving informal settlements Zandspruit and Diepsloot in the City of Johannesburg.

In quarter three, as one of several ongoing **research projects**, the DREAMS Pre-exposure Prophylaxis (PrEP) Demonstration Study, implemented by Centre for the AIDS Program of Research in South Africa (CAPRISA), recorded that 66% of young women offered PrEP have initiated prophylaxis. Of those initiated, 77% have remained on PrEP, indicating an emerging need for further research on treatment interruption and patterns of retention. Findings from the Male Characterization study under DREAMS include that 83% of the partners of AGYW aged 20-24 years are under 19 years of age and are HIV-positive. This implies a significant amount of sexual activity with male sex partners of similar age than previously thought, pointing towards more preventive and treatment interventions in males between the ages of 18-30 years.

PURPOSE AND STRUCTURE OF THE REPORT

This quarterly progress report is a reporting requirement established in the cooperative agreement between the United States Agency for International Development (USAID) and FHI 360. The report provides an overview of project activities and accomplishments that FHI 360's Capacity Development and Support project (CDS) has achieved from April 1 through June 30, 2017. The report is divided into the following sections:

Section 1: **Introduction and Background** gives an overview of the CDS goal, objectives and strategies.

Section 2: **Progress on Project Programming** provides details related to the administration of the CDS project, focusing on staffing, stakeholder management and meetings. This section also includes updates on the following five project components:

- **Component 1**: Provides an update on **grants management and partner contracts**, as well as the programming that took place in the reporting period.
- **Component 2**: Focuses on the project's achievements in strengthening the institutional capacity of indigenous organizations in terms of their **organizational capacity** (2a), as well as their **technical capacity** (2b).
- **Component 3:** Reviews CDS capacity development **assistance to the South African Government (SAG),** with a focus on recruitment and placement of Technical Advisors (TAs) (3a), as well as the CDS **Nutrition, Assessment, Counselling and Support (NACS)** program (3b).
- **Component 4:** Summarizes the project's **monitoring, evaluation and research (MER)** achievements, with updates on evaluations and assessments.
- **Component 5:** Summarizes the project's **knowledge management and communication** achievements.

Section 3: **Financial Management** provides a summary of project finance management data for the period of performance, including expenditures.

SECTION 1: INTRODUCTION AND BACKGROUND

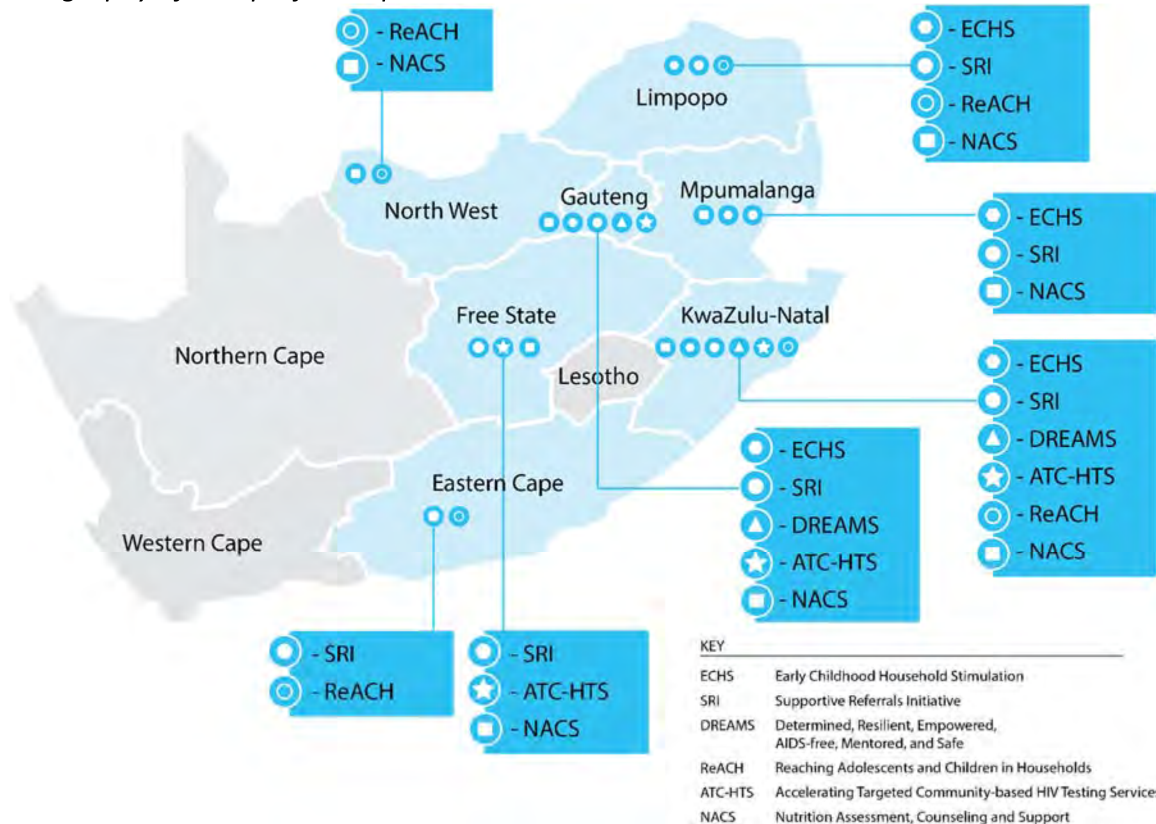
Program Overview

The CDS project was awarded to FHI 360 by USAID on June 10, 2014, under Cooperative Agreement No: AID-674-A-14-00009. The five-year award focuses on developing the organizational management, technical capacity, and sustainability of local non-governmental organizations (NGOs) and South African Government (SAG) departments in order to sustain an improved, expanded, and country-led response to HIV and AIDS. CDS is managed and led by FHI 360 and implemented with support from consortium partners, Deloitte South Africa and Foundation for Professional Development (FPD). CDS is designed to support the achievement of the goals in the President's Emergency Plan for AIDS Relief (PEPFAR) Partnership Framework Implementation Plan.

Geographic Scope

The CDS project is implemented in PEPFAR 3.0 high HIV prevalence priority districts within seven provinces: KwaZulu-Natal, Gauteng, Limpopo, Mpumalanga, Free State, North West and Eastern Cape. The map below shows the CDS program activities in each province.

Geography of CDS project implementation



Program Objectives and Components

The CDS project has the following strategic objectives:

1. Support the provision of sustainable high-quality services in HIV and AIDS in South Africa through strategic approaches that address specific needs with practical and pragmatic business plans for implementation
2. Develop sustainable institutional capacity and increase the effectiveness of local partners to achieve expanded and high quality services
3. Enhance local sub-partners' capacity in treatment, care (including support of orphans and vulnerable children) and prevention
4. Strengthen the overall health and social services system

Project activities are organized by the following program components:

1. Grant award and management
2. Institutional capacity development of indigenous organizations
3. Capacity development assistance to SAG
4. Monitoring, evaluation and research (MER)
5. Knowledge management and communication

Capacity Building Approach and Methodology

The CDS project utilizes a broad and flexible capacity strengthening methodology that incorporates a wide range of tools and approaches that are selected according to their suitability to meet the needs of specific requests received from USAID and SAG. CDS has ensured accountability for results by developing meaningful indicators and benchmarks for measuring project outcomes and results. The CDS capacity development methods include the following:

- Standardized trainings fill universal capacity gaps among CDS sub-recipients and other NGO partners, incorporating competency-based training principles and follow-up support to ensure application of new knowledge.
- Tailored trainings are customized to focus on a department or organization's specific needs and challenges, and develop skills and competencies to address them effectively.
- Mentoring and coaching provides technical and functional specialists, whether through secondment or regular mentoring visits, to teach and support individuals and units within an organization to respond to current needs and challenges, and develop skills to analyze and respond to future needs and challenges independently.
- Communities of practice include physical and virtual spaces for relevant stakeholders to discuss issues and challenges, share tools and resources, exchange information and

lessons learned, and ultimately develop greater capacity for collective learning and problem solving.

Program Monitoring

The CDS program monitoring focuses on the following approaches:

- Measurement of program progress through the collection, management, analysis, and use of data, while also tracking progress on performance indicators for established targets
- Provision of feedback for accountability, learning and quality through a range of activities and processes that encourage data use for timely, evidence-based decision-making
- Data quality assurance through application of a rapid validity check using the Data Verification Tool

SECTION 2: PROGRESS ON PROJECT PROGRAMMING

This section focuses on operational activities of the CDS project, such as staffing, grants management and partner contracts, consortium steering committee meetings, and stakeholder management meetings. This section also highlights progress and activities implemented under each of the program components during the reporting period.

Staffing Profile

The number of CDS staff increased to 115 in quarter three, with the addition of a Finance Officer and Sexual and Reproductive Health Specialist. There were also six voluntary separations in the quarter, including Quality Improvement (QI) Officer, Senior Finance Officer (KwaZulu-Natal), Nutrition Officer, Monitoring and Evaluation (M&E) Officer, ECHS Specialist and SAG Manager.

Meeting with CDS Agreement Officer’s Representative

A CDS Agreement Officer’s Representative (AOR) meeting was held on June 29, 2017. USAID presented a detailed overview of CDS achievements against its targets, as well as upcoming programming priorities such as a growing focus on those aged 15-17 years. CDS provided a comprehensive update on the project’s achievements to date. Discussion and action points included the following:

- **Data analysis to inform programming:** CDS presentation of all data must include age and sex disaggregation for each indicator by geographical location (sub-district), and it must be well-analyzed to inform programming improvements and replication of good practice. In addition, HIV testing yield is critical and will be used to make decisions about the best use of limited resources within CDS activities.
- **Technical support:** CDS presentation of technical support should be more detailed and supported by data. It should include assessment and other tools used, and how CDS is measuring the effects of its support.
- **Strengthening contribution to and alignment with PEPFAR priorities:** CDS should demonstrate how all its activities contribute to achieving the 90-90-90 targets and PEPFAR priorities. This includes aspects such as the PEPFAR training to orphans and vulnerable children and youth (OVCY) partners and the SAG Technical Advisors.
- **Full HIV cascade:** It is essential to support the entire HIV care and treatment cascade, from assessment to testing, to linkage to treatment and adherence support. This includes layering with other programs to ensure people who test HIV-positive receive all the services needed to stay in care and adhere to medication, as well as strengthening efforts to ensure HIV-negative girls stay negative.

Component 1: Grant Award and Management

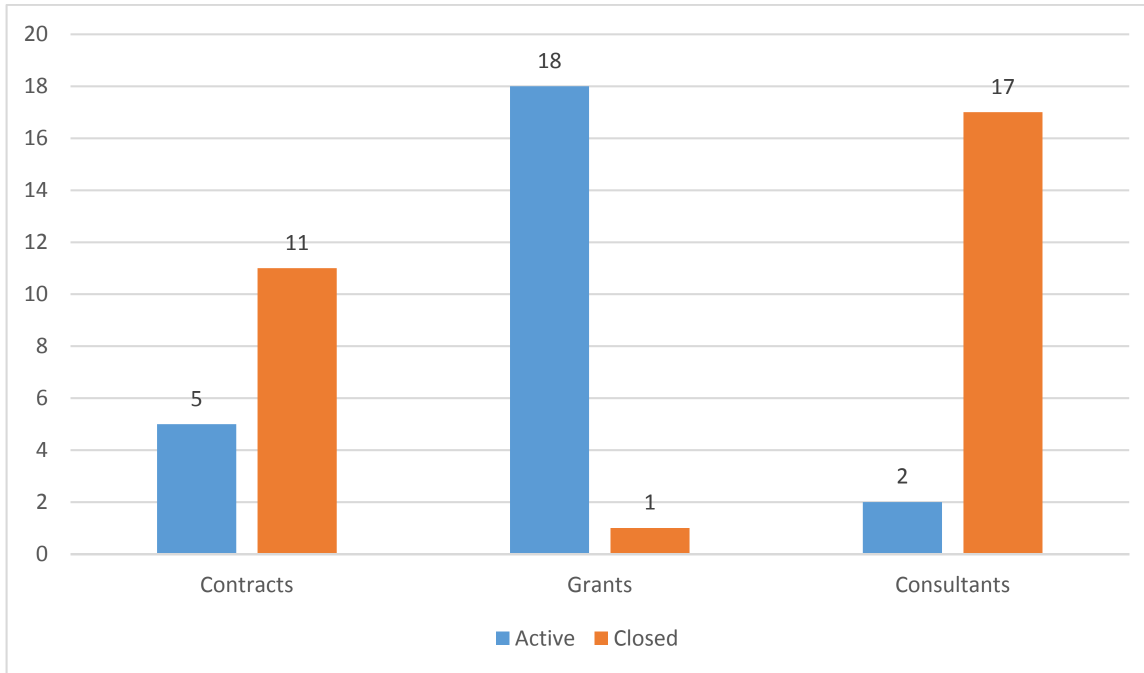
The activities of Component 1 are responsive to CDS strategic objectives one, two and four, and aim to ensure efficient and accountable administration of grant funding to support service delivery and scale-up.

Contracts, Grants and Consultant Agreements

Since inception, CDS has issued a total of 54 agreements as depicted in the chart below. In quarter three, CDS issued:

- A follow-on contract to Health and Education Training and Technical Assistance Services (HETTAS) to provide training and technical support to CDS and six USAID/PEPFAR partners in the implementation of the three Vhutshilo HIV prevention curricula.
- A request for proposals was issued for a general and support services consultant to provide technical support, guidance and capacity building for selected NGOs implementing interventions for orphans and vulnerable children (OVC). Interviews were held in June 2017 and CDS is conducting due diligence processes before the consultant agreement is finalized.
- An expression of interest was issued for a consultant to support the development of an implementation plan on the National Policy on HIV, STIs and TB; review the Department of Basic Education's Integrated Strategy on HIV, STIs and TB; and review and revise other key documents. Two applicants were shortlisted and CDS will hold interviews in quarter four.

CDS agreements by type: June 2014-June 2017



Annual Program Statements in Process

CDS finalized the review and selection process for the Bridge Project: Support, Prepare and Engage Vulnerable Youth annual program statement (APS) in quarter three. The goal of the Bridge Project is to improve the health and economic security of vulnerable youth by addressing the socio-economic factors associated with HIV risk, thereby reducing their risk and vulnerability, and providing them with structured support during their transition to becoming healthy, educated and socially well-adjusted adults. Four organizations were identified to implement this activity and CDS is finalizing the negotiation process. The anticipated start date for the project is October 1, 2017. Two of the organizations will service the City of Johannesburg and Tshwane in Gauteng province, and another two will service eThekwini North and eThekwini West in KwaZulu-Natal province.

Contract Modifications

In quarter three, CDS processed a no-cost extension for the Human Sciences Research Council (HSRC) contract. The organization is conducting a research study on the characteristics of male sex partners of AGYW as part of the DREAMS initiative in South Africa. HSRC experienced challenges in gaining access to the selected health facilities in Gauteng province for the study, and requested additional time to complete its contract deliverables.

Sub-award Modifications

In June 2017, CDS processed modifications for the ECHS sub-awardees to provide incremental funding to achieve increased targets until September 2017. The modifications also amended the tracking of cost share as a percentage of the total amount expended by the sub-awardees.

Sub-award close-out

The Supportive Referrals Initiative (SRI) program activities ended May 31, 2017. CDS conducted administrative closeout of the project in June 2017, and final programmatic and financial reports are due to CDS by July 15, 2017.

Component 2: Institutional Capacity Development of Indigenous Organizations

The activities reported under this component are responsive to all four CDS strategic objectives, and aim to increase the technical and organizational capacity of South African NGOs.

Component 2a: Program Management and Organizational Development

Program management involves communication, coordination, management of potential risk and tracking program progress with all CDS sub-awardees. Organizational development encompasses capacity development support to both CDS sub-awardees and other PEPFAR OVCY partners through customized trainings and technical assistance.

Program Management

Program management units in Gauteng, Eastern Cape and KwaZulu-Natal provided support to CDS sub-awardees through effective communication and technical assistance from all CDS components to achieve the expected program targets and outcomes. CDS is managing 14 sub-awardees implementing seven programs.[1] The table below provides a summary of CDS sub-awardees as of June 2017.

Current CDS sub-awardees

<table>
<tr><th>Program</th><th>Sub-awardee</th><th>Province</th><th>District</th></tr>
<tr><td rowspan="5">Early Childhood Household Stimulation (ECHS)</td><td>Kheth'Impilo</td><td>KwaZulu-Natal</td><td>eThekwini, uMgungundlovu</td></tr>
<tr><td>mothers2mothers</td><td>Mpumalanga</td><td>Nkangala</td></tr>
<tr><td>The Valley Trust</td><td>KwaZulu-Natal</td><td>eThekwini</td></tr>
<tr><td>Woz'obona</td><td>Limpopo</td><td>Mopani</td></tr>
<tr><td>HOPE worldwide</td><td>Gauteng</td><td>City of Johannesburg</td></tr>
<tr><td>Supportive Referrals Initiative (SRI)</td><td>Human People to People South Africa (Humana)</td><td>Six provinces</td><td></td></tr>
<tr><td rowspan="4">Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS)</td><td>Humana</td><td>KwaZulu-Natal</td><td>eThekwini, uMkhanyakude</td></tr>
<tr><td>National Institute Community Development and Management (NICDAM)</td><td>Gauteng</td><td>City of Johannesburg</td></tr>
<tr><td>HOPE Africa</td><td>KwaZulu-Natal</td><td>uMkhanyakude</td></tr>
<tr><td>Project Empower</td><td>KwaZulu-Natal</td><td>eThekwini</td></tr>
</table>

[1] Several of these sub-awardees are implementing more than one program.

Program	Sub-awardee	Province	District
	National Association of Child Care Workers (NACCW)	Gauteng	City of Johannesburg
Reaching Adolescents and Children in Households (ReACH)	NACCW	Eastern Cape	OR Tambo, Alfred Nzo, Buffalo City
	Networking HIV/AIDS Community of South Africa (NACOSA)	KwaZulu-Natal	Harry Gwala, Ugu, Uthungulu
	SAfAIDS	Limpopo	Mopani
		North West	Dr. Kenneth Kaunda
Accelerated Targeted Community-based HIV Testing Services (ATC-HTS)	Humana	Free State	Thabo Mofutsanyana
	HIVSA	Gauteng	City of Johannesburg
	Society for Family Health	KwaZulu-Natal	eThekwini

Program Management Meetings

In quarter three, program management support focused on strengthening the technical and supervisory support to CDS sub-awardees to achieve 80% of their targets by June 2017. Weekly Program Management Meetings (PMMs) were initiated in March 2017 following the development of "catch-up plans" by the CDS sub-awardees, which assisted CDS to identify gaps early and implement corrective measures with sub-awardees. Key activities that assisted the sub-awardees in achieving 80% of their targets include:

- Weekly and daily tracking of targets
- Weekly internal progress review meetings with program and M&E staff
- Monthly data quality assessments (DQAs) to identify and address challenges related to data collection and analysis

Key activities and outcomes of PMMs

Program	Key Activities and Outcomes
ECHS	• ECHS sub-awardees have improved understanding of indicators and data capturing and collection following six CDS-implemented DQAs and one external DQA conducted by Khulisa. • All negotiations related to ECHS budget modifications for the program until September 2017 were completed. • The Valley Trust was supported to adopt the Ages and Stages Questionnaire (ASQ) in their ECHS program implementation. • Two exchange visits between Kheth'Impilo and The Valley Trust were coordinated, which led to following outcomes: – Implementation of a toy library by Kheth'Impilo – Establishment of circles of support and male groups by The Valley Trust
SRI	• SRI sub-awardees verified reported numbers, developed revised catch-up plans and updated data collection tools following three CDS-implemented DQAs.

Program	Key Activities and Outcomes
	• The Valley Trust mobilized additional clients to be tested by Humana following a meeting between the two organizations. • SRI close-out meetings were coordinated to discuss processes and track required deliverables. Implementation of the program concluded at the end of May 2017 and sub-awardee close-out reports are due in July 2017.
DREAMS	• DREAMS sub-awardees have improved data and indicator understanding and stronger data management following five CDS-implemented DQAs. • A DREAMS Steering Committee Meeting was held in June 2017 to review quarterly data captured into DREAMS Integrated Monitoring and Evaluation System (DIMES) from April 2016-May 2017. This meeting led to a more detailed review of data reported and clarification of discrepancies, and development of catch-up plans. • DREAMS Community Mobilization sub-awardees developed revised catch-up plans and have improved data and indicator understanding following an all-partners meeting coordinated by CDS on May 16, 2017. • The roll-out of Stepping Stones training to community caregivers of community-based organizations under NICDAM was completed. Following this training, the community caregivers are able to identify AGYW who have experienced sexual violence and fast-track referrals to key services. • Meetings were held between NICDAM and NACCW in Gauteng province to strengthen partnerships and enhance the layering of services for gender-based violence (GBV). • CDS participated in a DREAMS Annual Performance Review meeting in KwaZulu-Natal and reinforced the outcome of the meeting with sub-awardees: to have a stronger emphasis on linkage of clients tested HIV-positive to care and anti-retroviral therapy (ART).
ReACH	• ReACH sub-awardees have improved data and indicator understanding as well as stronger data capturing and collection processes following eight CDS implemented DQAs and Community Based Interventions Monitoring System (CBIMS) training. • Coordinated technical support visit to ReACH sub-awardees for improved service delivery to clients. • Following the introduction of NACOSA to Harry Gwala District Department of Health (DOH), the organization has better working relationships, facilitating its delivery of the program.
ATC-HTS	• ATC-HTS sub-awardees improved their data management and implemented corrective measures following six CDS-implemented DQAs. • ATC-HTS sub-awardees developed revised catch-up plans and implemented daily tracking of targets following an all-partners meeting coordinated by CDS on May 4, 2017. • Society for Family Health now has access to HIV test kits following an introduction by CDS to the eThekwini District DOH. This has contributed to the organization reaching its testing targets. • Society for Family Health appointed 30 locum staff members to assist with testing over weekends and data collection following a CDS technical support visit. • Following the introduction of Humana to Dihlabeng Local Municipality in the Free State, the organization has better working relationships, facilitating its delivery of the program.

Organizational Development

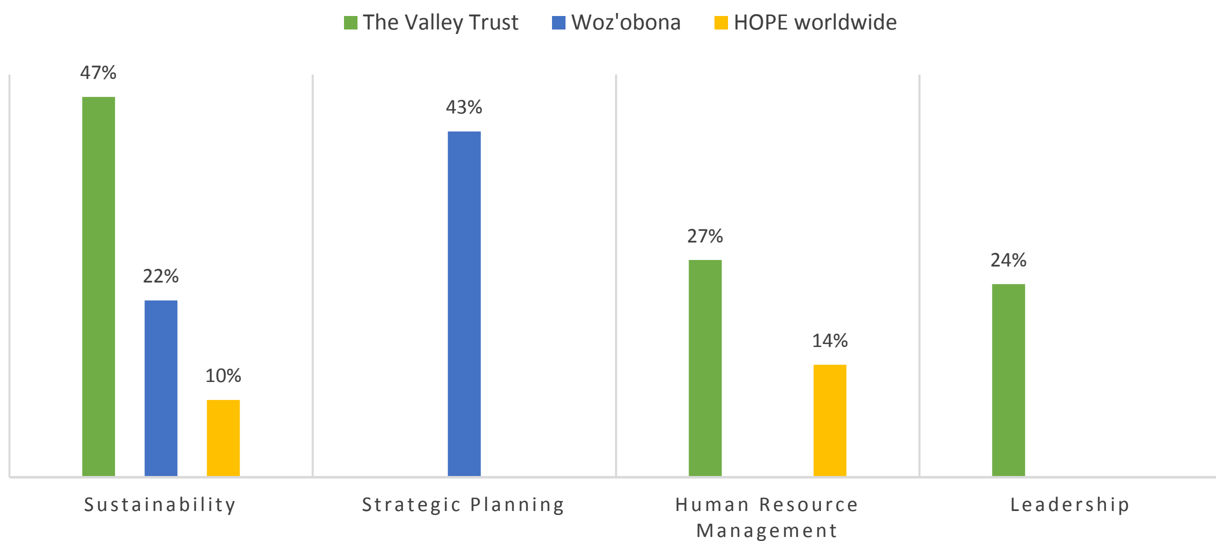
CDS provides customized organizational development support to its sub-awardees as a critical element of their capacity to provide high-quality services over a sustained period. For example, strong human resource management (HRM) ensures that organizations have a committed and motivated workforce with appropriate skills. Leadership and governance capacity fosters internal collaboration, cohesion and accountability for results.

ECHS Organizational Capacity Re-assessments

In quarter three, CDS completed its capacity re-assessment of the five ECHS sub-awardees to determine the effect of CDS interventions. Since the baseline assessments were conducted in August and September 2017, CDS has provided standardized and tailored trainings, mentoring and coaching, communities of practice and technical assistance across six organizational capacity domains[2] to all ECHS sub-awardees. This support has contributed to the sub-awardees' implementation and maintenance of satisfactory organizational systems, processes and structures, which have supported their programmatic performance and service delivery.

While CDS did not observe significant increases in overall scores per organization, there were notable institutional capacity improvements in particular domains among three sub-awardees: The Valley Trust, HOPE worldwide and Woz'obona. These domains included sustainability, strategic planning, HRM, and leadership.

Institutional capacity percentage increases from baseline to re-assessment: The Valley Trust, Woz'obona and HOPE worldwide



[2] These include financial management, HRM, leadership, governance, strategic planning and sustainability.

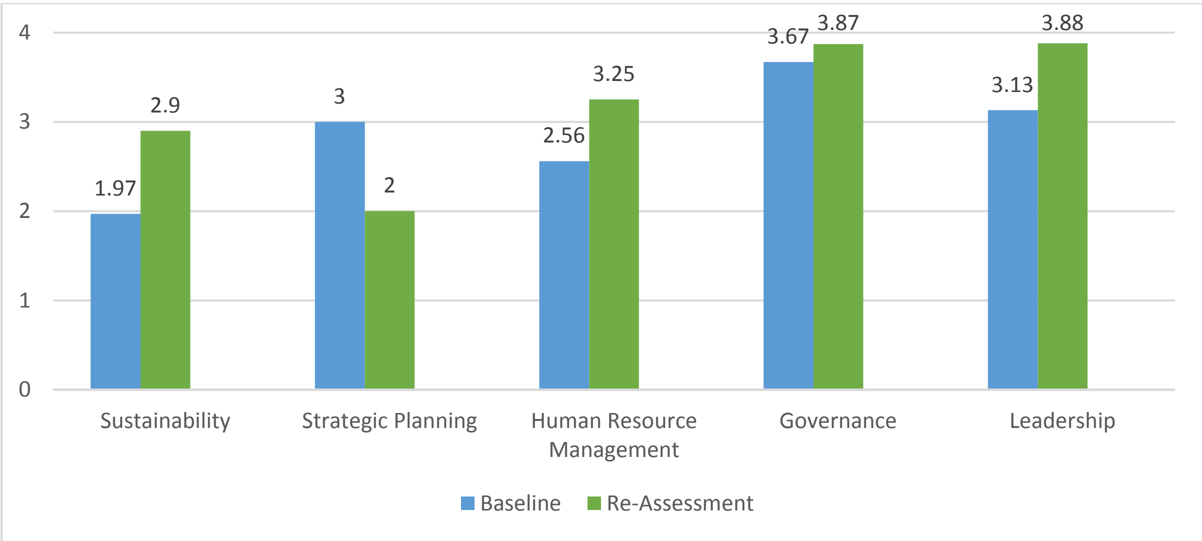
During the baseline capacity assessment, most organizations demonstrated a need for capacity support in the HRM domain, achieving an average score of 2.7 out of 4. Through CDS training and mentoring, sub-awardees have improved their human resource management systems and developed policies to guide and promote organizational effectiveness, values and culture. Sub-awardees have implemented performance management systems which link programmatic goals and targets to individual staff member performance indicators, supporting organizational performance.

A deeper look: The Valley Trust

Due to the provision of sustainability training and mentoring, The Valley Trust conducted a thorough sector analysis in their areas of operation to enhance operational efficiency. The organization has identified and strengthened partnerships with other local NGOs, particularly related to program delivery and exposure to different approaches for child health programs. The Valley Trust also improved its governance systems, reviewing and updating the board of directors' roles and responsibilities, which assisted in improving its functionality and accountability, and contributed to the organization's programmatic performance.

The Valley Trust's re-assessment score decreased in the strategic planning domain. At baseline, the organization had a strategic plan in place, but by re-assessment, the document was outdated. In addition, CDS program management technical support to ensure alignment of activities with program targets provided The Valley Trust with more critical thinking which may have contributed to a more realistic assessment of the organization's capacity in this area than was seen at baseline. CDS contributed to The Valley Trust's annual strategic retreat in quarter two, which helped inform its strategic and operational planning held in March 2017.

The Valley Trust: baseline and re-assessment scores



Lessons learned from Kheth'Impilo and mothers2mothers

Kheth'Impilo and mothers2mothers demonstrated a slight decline in their average scores between baseline and re-assessment. These organizations displayed already-strong institutional capacity in leadership, HRM, governance and strategic planning at baseline assessment. Factors contributing to lower re-assessment scores include changes in leadership and re-assessments being conducted with different representatives from those who participated in the baseline assessment. In addition, CDS support and attention to detail likely led to more stringent scoring by sub-awardee participants during the re-assessments. In addition, Kheth`Impilo declined several opportunities for capacity development support in areas identified from the baseline capacity assessment in the first year. CDS has however noted specific capacity improvements due to its support. After CDS leadership and governance training with mothers2mothers, the organization created a platform for employees to engage in country management and strategic framework development as part of enhancing active participation and employee engagement. This platform further resulted in monthly reflection meetings where project managers and district coordinators hold meetings with family mentors and clients to discuss adjustments and improvement measures needed to enhance the ECHS program.

"There is a lot to learn when people come together and interact. While we are advanced in some ways, we can learn more about close community engagement and collaboration from smaller, community-based organizations. I appreciated that the workshop promoted active learning, where we had time to sit and think and develop specific action plans. I trust that this is not the end, but the beginning of further engagement and support."
– Carolyne Opinde, Business Development Grants Manager, mothers2mothers

Lessons learned in capacity development

CDS has experienced challenges in the capacity development process. These include creating an understanding of the balance needed to implement capacity development without compromising the time partners require for program implementation. CDS is working to document the process and lessons learned that can be used to improve capacity development support to sub-awardees. These include:

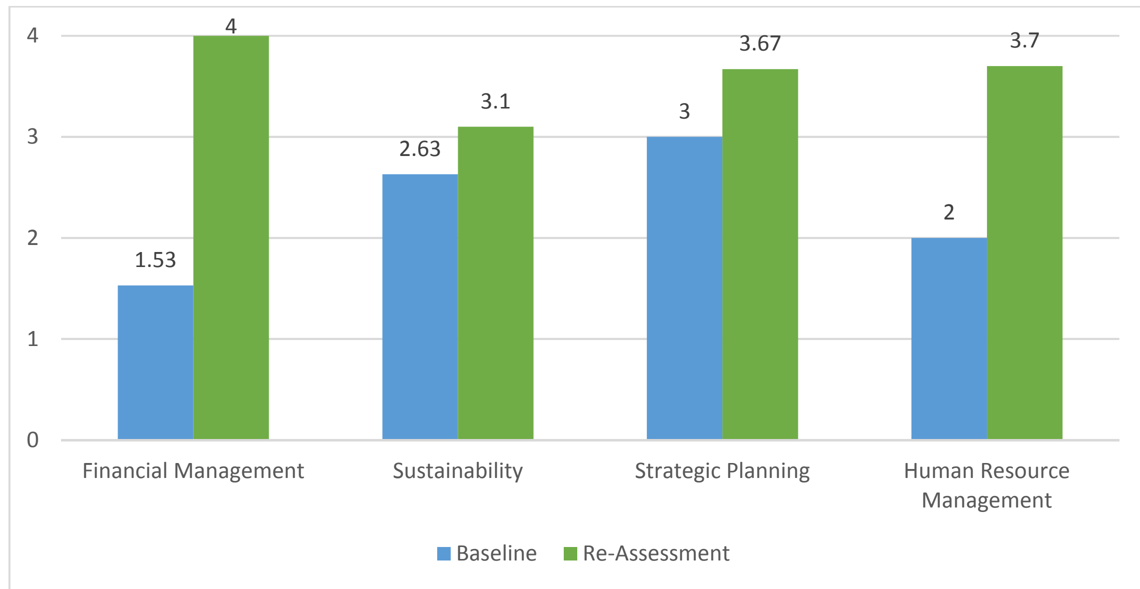
- A "one-size fits all" approach to capacity development is not effective; support must be customized and tailored to partners needs
- Successful capacity development requires strong partnership support and commitment between service provider and implementing partners
- Capacity development does not only focus on identified gaps, but also strengthens existing skills
- Capacity development creates a holistic view of the various domains needed for success to get periodic snapshots of the organization

- It is essential to provide standardized tools (electronic or paper based) at the outset of the project to facilitate tracking and measurement of progress

Centre For Economic Growth and AIDS in Africa (CEGAA) Organizational Capacity Re-assessment

As part of continued capacity development support to CEGAA, CDS completed the organization's capacity re-assessment in quarter three. Though the baseline assessment conducted in August 2015 was based on all six domains, the re-assessment focused on four prioritized domains which indicated a high need for capacity development support, and where CDS focused its efforts.

CEGAA: baseline and re-assessment scores



The re-assessment results revealed an improvement in all priority domains, and particularly in the financial management domain. With the provision of CDS technical support, training and mentoring, CEGAA improved its financial management and administration functions, developing and implementing financial management policies which enhanced its systems, processes and procedures. CEGAA also implemented a performance management system to ensure that staff are motivated and evaluated as per expected organizational outcomes. CEGAA has expressed a need for governance support, and the organization will attend Governance training offered as part of the CDS PEPFAR Annual Training Plan in quarter four.

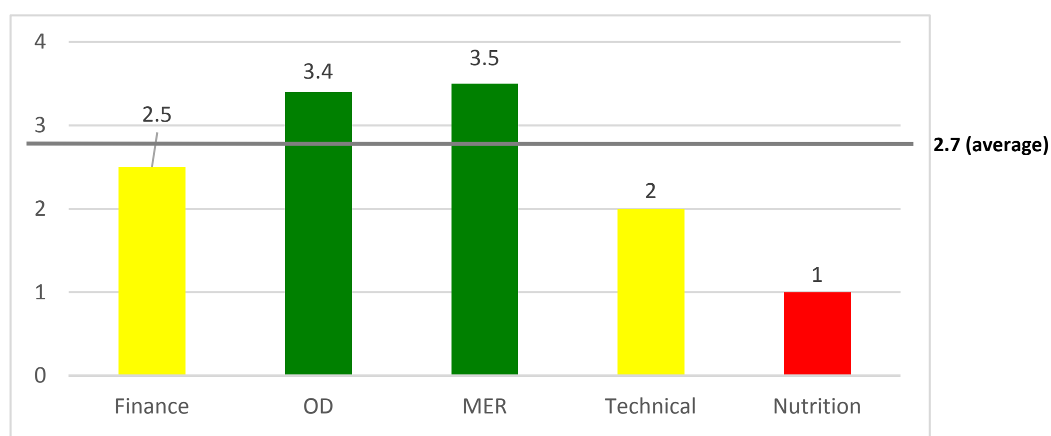
"The assessment process and scoring system was helpful to us to highlight the gaps where we need to improve, as well as celebrate where we are strong. We learned so much at the workshops: they increased our awareness and confidence, as well as our capacity to work as a team. We appreciate each other more – the detail and complexity of each staff member's role – and can

better support each other because we are familiar with the requirements and challenges of each component. When we started, we were concerned that CDS was there to point out our faults, but we were pleasantly surprised and have been loving it."
– Nhlanhla Ndlovu, Executive Director, CEGAA

ReACH and DREAMS Sub-awardees' Baseline Organizational Capacity Assessments

In quarter three, CDS conducted baseline capacity assessments with ReACH sub-awardee NACOSA and DREAMS sub-awardees Hope Africa and NICDAM. The baseline assessments revealed the sub-awardees' institutional capacity at organizational and programmatic level, and mapped out interventions for capacity improvements. The baseline assessments use a rating ranging from one (poor) to four (excellent).[3] CDS began implementation of a more integrated model of capacity assessment in quarter three, combining finance, organizational development, MER, technical and nutrition domains into one tool.

NACOSA baseline capacity assessment results

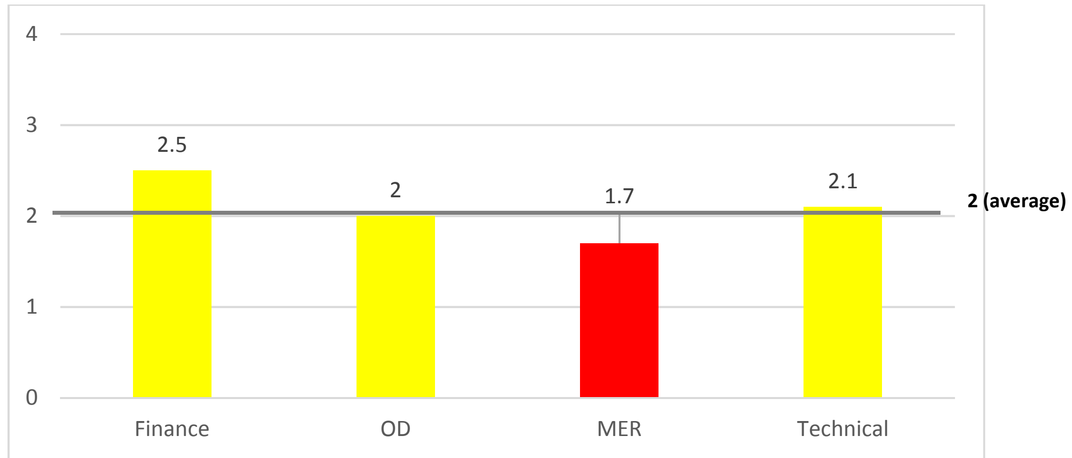


NACOSA obtained an average score of 2.7 out of four across all domains assessed. The organization has functional organizational systems, processes and procedures in place that support its ability to provide sustained program delivery, particularly in governance, leadership, HRM, sustainability, strategic planning and M&E. Nutrition is an area that will require intense capacity development support to strengthen the organization's ability to provide a more comprehensive package of services. Recognizing this gap, NACOSA staff members attended the

[3]In the organizational capacity baseline assessment results charts, the colors of each bar indicate the capacity level of the partner in that domain, with red indicating poor capacity (1-1.9), yellow indicating moderate capacity (2-2.5), light green indicating good capacity (2.6-3) and dark green indicating excellent capacity (3.1-4).

Nutrition Assessment, Counselling and Support (NACS) PEFPAR training from May 30-June 1, 2017, and have begun implementation of nutrition interventions.

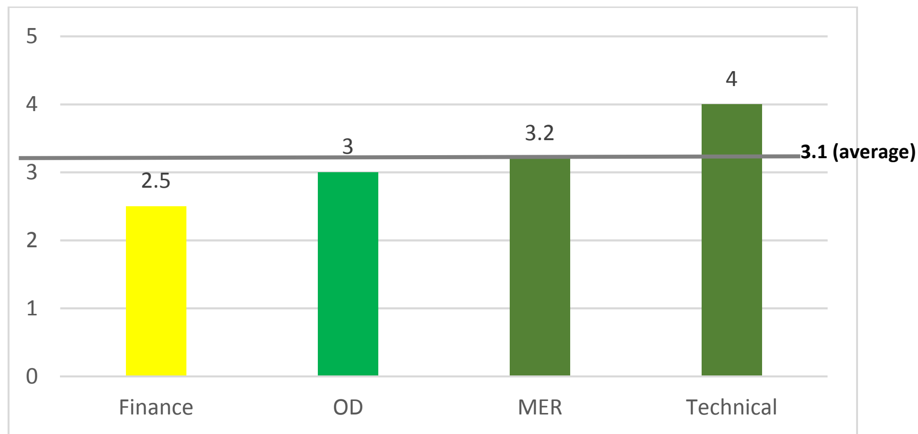
Hope Africa baseline capacity assessment results



Hope Africa obtained an average score of 2.0 out of four across all domains assessed. The organization has some systems and processes in place to support program implementation and continuity; however, there is a need for capacity improvement support in the areas of governance, strategic planning, HRM and sustainability. Program and operational staff from Hope Africa have attended HRM, Financial Management and M&E trainings, and are implementing action plans developed at each respective training.

Though the organization has adequate data management tools and templates matching the scope of the program, the assessment discussion indicated a need for immediate support in M&E, including data quality and clear definitions of key project indicators. CDS is providing intensified M&E support to promote quality data collection and recording.

NICDAM baseline capacity assessment results



NICDAM obtained an average score of 3.1 across all domains assessed. The baseline assessment revealed that the organization has organizational systems, processes and procedures in place that support sustained program delivery, particularly in governance, leadership, sustainability and strategic planning. The assessment identified areas for improvement in HRM and sustainability[4]. One staff member attended the HRM 101 and 201 training courses conducted in April and May 2017, and several staff members registered for the Sustainability training scheduled for July 2017.

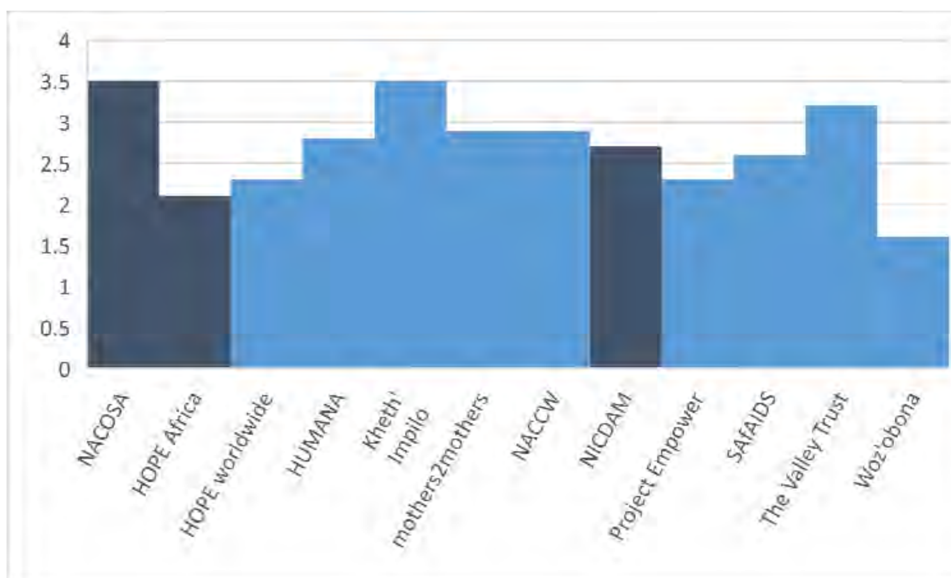
Across these three partners, CDS' assessments have identified priority domains including HRM, sustainability, strategic planning and M&E. CDS plans to address these needs primarily through sub-awardee participation at training courses.

Sustainability Assessment and Capacity Development

As part of the overall CDS baseline organizational capacity assessments, CDS conducted baseline sustainability assessments for NACOSA, Hope Africa and NICDAM in quarter three.

[4] NICDAM displayed both strengths and weaknesses in sustainability. For example, NICDAM is structured as a social enterprise and its income is earned, not donated. However, NICDAM has low reserves and limited diversification of funds.

CDS sub-awardee sustainability assessment scores



Key cross-cutting findings from the sustainability assessments of CDS sub-awardees, as well as associated planned interventions, are highlighted in the table below. The ECHS sub-awardees will be provided with transition planning support in quarter four.

Sustainability findings and core support being provided to CDS sub-awardees

Key Findings	Intervention
• No (or partially developed) sustainability plan • Low operating reserve • No (or partially developed) marketing and communications plan • Limited diversification in the funding base • No (or limited) income generating activities • Insufficient board involvement in, or support for, sustainability and fundraising activities • No transition/ exit strategy in place • Positions critical to sustainability are not filled	• Sustainability curriculum and training • Governance training • Social enterprise workshop • Development of sustainability as well as transition plan templates and provision of follow-up support • On-site workshops to support sustainability and marketing and communications planning • Financial sustainability technical assistance • Database mapping of potential ECHS funders/prospective supporters

Limited sustainability activities will be conducted with Humana and Woz'obona given that they are transitioning out of CDS programs. Support to Woz'obona is being restricted to transition planning and the development of marketing and communications plans.

Social enterprise learning

CDS' sustainability assessment results show that 92% of its sub-awardees have either no or limited income generating activities in place to support the organization. However, most of them have income generation ideas and need more information on how to implement and scale these ideas. A new social enterprise module has been incorporated into the existing Sustainability

Curriculum. CDS is planning a social enterprise workshop in quarter four to strengthen the financial sustainability of its sub-awardees.

Prospect Database Development Project

CDS is finalizing an ECHS prospect database project to map potential funders/supporters (prospects) as part of the transition planning support for ECHS sub-awardees. Initial contact has been made with 223 prospects that fund or otherwise support one or more impact areas in South Africa relevant to ECHS. Prospects include contacts from the private sector (related to corporate social investment), public sector, international organizations and private philanthropy (foundations, trusts and other NGOs). CDS will assist the ECHS sub-awardees to use the database to access additional funding and support.

Training

PEPFAR Annual Training Plan

The CDS PEPFAR Annual Training Plan for 2017 began in quarter three, with a total of 16 PEPFAR-funded organizations (as well as their sub-awardees) invited to attend the trainings.[5] CDS held six trainings in quarter three, attended by 148 participants from 13 organizations.

Trainings provided in quarter three

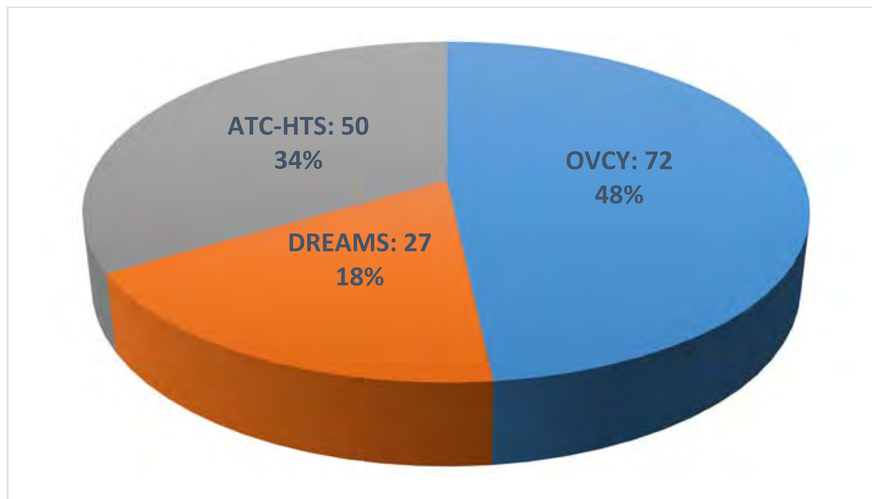
Training Course	Location	# of attendees	Dates
Human Resource Management 101	Johannesburg, Gauteng	30	April 11-12
Human Resource Management 201	Pretoria, Gauteng	13[6]	May 9-10
Financial Management 101	Pretoria, Gauteng	28	May 3-4
Financial Management	Durban, KwaZulu-Natal	20	May 16-17
Nutrition Assessment, Counselling and Support	Pinetown, KwaZulu-Natal	30	May 30- June 1
Monitoring & Evaluation 101	Pretoria, Gauteng	27	June 5-8
Gender at Organizational Level	Training cancelled due to inadequate registration of participants[7]		May 22-24

[5] The organizations invited included CDS sub-awardees implementing its OVCY, DREAMS and ATC-HTS programs.

[6] CDS experienced low attendance at two trainings due to participant challenges such as illness and unanticipated work events, and has subsequently implemented a re-confirmation system for attendance which will allow for closer monitoring.

[7] CDS requires a minimum of 20 for the Gender training courses two weeks prior to the training.

Number of participants by type of program



Participant profiles for the trainings included operational support and program staff. Based on discussions during the trainings, there is an increasing appreciation of the value of operational systems such as HRM and Financial Management in an organization reaching its targets. For example, a participant from the HRM training noted, "I am not in HR, but as a supervisor I am involved with recruitment of staff. I now have the knowledge to recruit the right staff."

Operational staff are also increasingly aware of the role they play in an organization's success and how working with program staff amplifies this success. A program staff member from Hope Africa who participated in the M&E training stated that she now sees the value of collaboration between these two units to achieve program objectives and goals.

Promoting training effectiveness

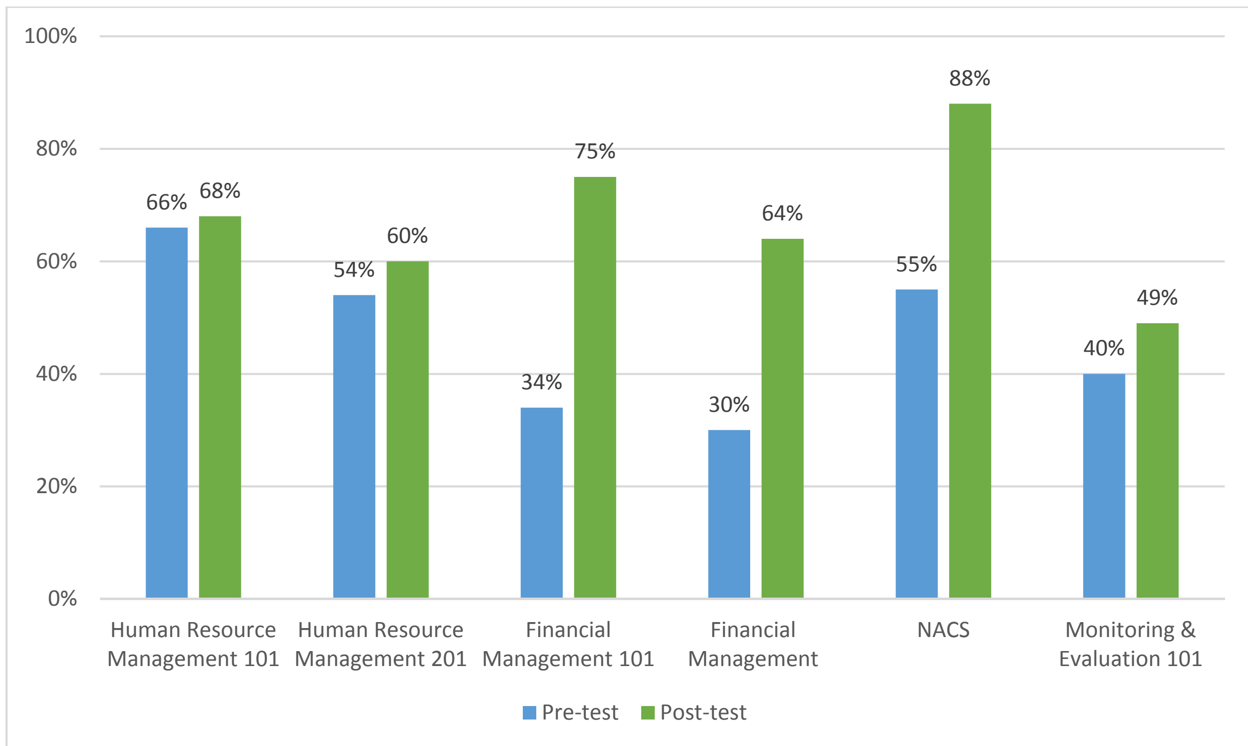
In an effort to customize the content and assess the effect of a training, CDS implements the following four measures:

- Pre-survey to identify areas of importance to organizations and specific challenges
- Pre- and post-training evaluations to measure changes in knowledge
- Training evaluation forms to gain feedback on the training from participants
- Completion of action plans which are followed up three months following the training

Pre-survey: The pre-survey is implemented to provide targeted and tailored trainings to organizations based on existing needs and challenges. Pre-surveys were circulated two weeks prior to each training to identify areas of importance to the organizations, and the results were used to adjust the training agenda and content. CDS will follow up with participants in quarter four to identify whether their needs were fully addressed during the training.

Pre- and post-test evaluations: There was an average knowledge increase of 50% across the six trainings conducted in quarter three.

Pre- and post-test evaluation results: quarter three trainings



Training evaluation forms: In total, 98% of the 148 participants evaluated the facilitation, presentation and course content of the training as good or excellent. A universal challenge identified by participants in the training evaluation forms was inadequate allocation of time for the training. Feedback from the trainings included:

"The team was very knowledgeable and professional in the way this training was delivered and coordinated."

"The training was well organized and the facilitators were knowledgeable and made us feel comfortable to ask questions."

Action plans: Action plans were developed by each organization that attended each training to reinforce the knowledge and skills gained, and promote application of learning to improve organizational capacity and performance. CDS will assess the completion of action plans in quarter four.

Six trainings are scheduled for quarter four, all of which will be held in Pretoria, Gauteng province.[8]

[8] Training in KwaZulu-Natal has been postponed until October 2017.

Training courses scheduled for quarter four

Training Course	Date
Sustainability	July 25-27
Gender Household Level 201	August 15-17
Monitoring & Evaluation 201	August 22-24
Leadership	August 29-31
Governance	September 12-14
Gender Household Level 301	September 19-21

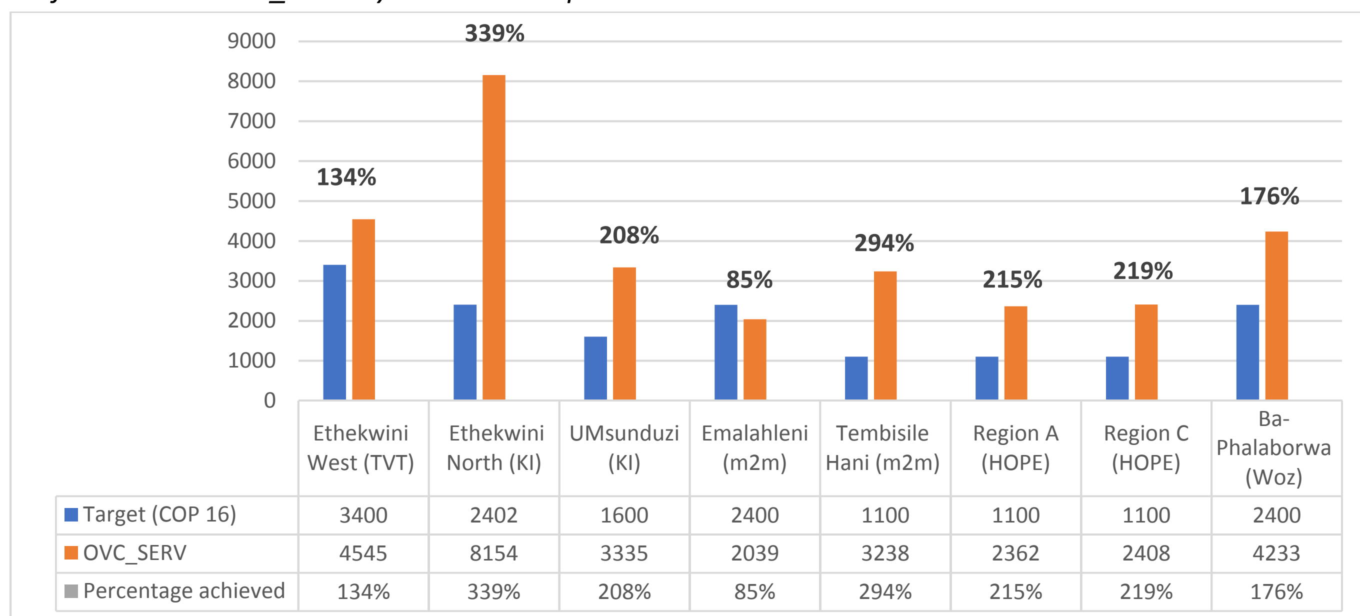
Participants from the M&E 101 training in June 2017

Component 2b: Technical

Early Childhood Household Stimulation

In quarter three, the five ECHS sub-awardees continued to provide comprehensive and integrated services to their clients. Together the ECHS sub-awardees reached 30,304 clients in quarter three. All sub-awardees achieved more than 100% of their targets for the quarter and collectively exceeded the overall FY16 program target of 15,502 individuals.[9] Performance at sub-district level significantly improved across all ECHS sub-awardees, with the highest reach in eThekwini North in KwaZulu-Natal province by Kheth'Impilo, and Thembisile Hani in Mpumalanga province by mothers2mothers.

Performance in OVC_SERV by sub-district: quarter three



	Ethekwini West (TVT)	Ethekwini North (KI)	UMsunduzi (KI)	Emalahleni (m2m)	Tembisile Hani (m2m)	Region A (HOPE)	Region C (HOPE)	Ba-Phalaborwa (Woz)
Target (COP 16)	3400	2402	1600	2400	1100	1100	1100	2400
OVC_SERV	4545	8154	3335	2039	3238	2362	2408	4233
Percentage achieved	134%	339%	208%	85%	294%	215%	219%	176%

ECHS sub-awardees' performance was attributed to consistent provision of OVC core services to all active clients within the program as well as enrollment of additional clients who were found to be at risk and vulnerable following intensive HIV risk assessments at household level. Strategies used in KwaZulu-Natal province, for example, included:

- Continued close collaboration with the local Ward Councilors and participation in the War Rooms[10], which assisted in identifying households and areas which require ECHS services

[9] This target serves as both an annual and quarterly target: beneficiaries must be reached each quarter to be counted toward the OVC_SERV indicator

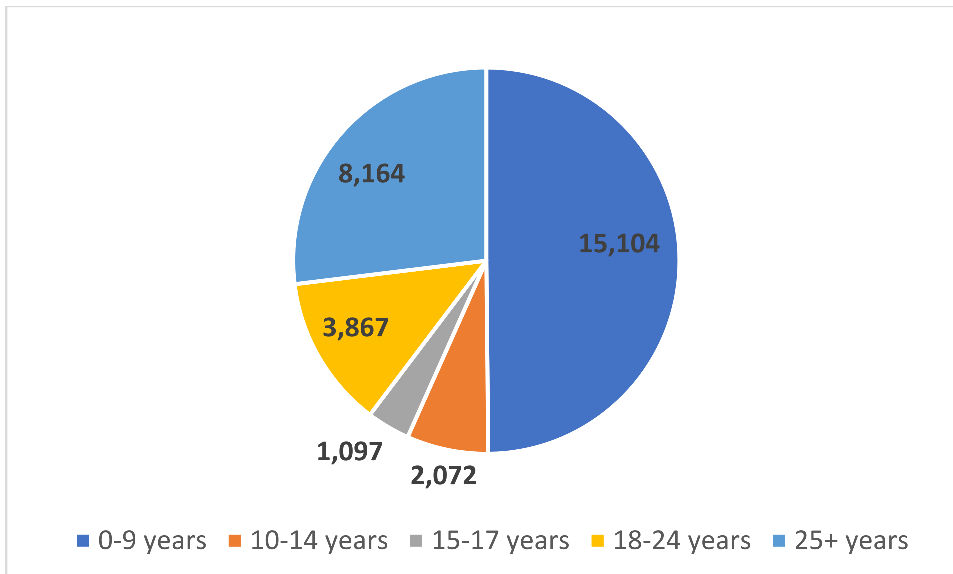
[10] War Rooms are collaborative meetings attended by government and civil society stakeholders to share and consolidate their efforts to address HIV.

- Kheth'Impilo in eThekwini North intensified its provision of Circles of Support (CoS), play groups and home visits to ensure provision of regular services to clients
- Close monitoring and management from all supervisors to ensure that the OVC_SERV and OVC_HIVSTAT targets were reached

OVC_SERV by age disaggregation

ECHS services were delivered to the appropriate target groups: half of the clients that received services were under nine years old, followed by caregivers, at 27%. This confirms the programmatic relevance of ECHS activities, which seek to support children in receiving physical, cognitive and emotional stimulation in their households and strengthen caregivers' capacity to establish positive relationships with their children.

Performance in OVC_SERV by age: quarter three



OVC status in the program

In quarter three, most of the clients (98%) remained active in the program, with only 1% exiting without graduation due to relocation or migration from the implementation sites. A small proportion of clients (less than 1%) graduated from the program because they reached 18 years of age. As ECHS sub-awardees approach the end of the program, they have embarked on a scale-down process in preparation for exiting implementation areas. Scale-down strategies include conducting a vulnerability assessment to re-evaluate the needs of households. This will then inform decisions to graduate households/clients or retain them. Clients with low levels of vulnerabilities will be linked to other resources available in the community, and follow-up will be

conducted to ensure graduated clients access required services. Sub-awardees will continue to provide interventions to those most in need, including:

- Poverty-stricken households (no access to social grants or any other source of income)
- HIV-positive clients newly initiated on ART
- HIV-positive children
- Households with domestic violence

Provision of Physical, Cognitive and Emotional Stimulation

ECHS sub-awardees provided a range of services to clients, including educational support, health and nutrition, child protection, parenting/caregiver support, social protection and economic strengthening. In quarter three, 90% of clients were reached with health and nutrition services. Half of those who received health and nutrition services were children under nine years old, followed by caregivers (39% of those who received the services). Out of the 14,869 clients who received education support, 81% were children under nine years old. Approximately equal numbers of males and females received this support.

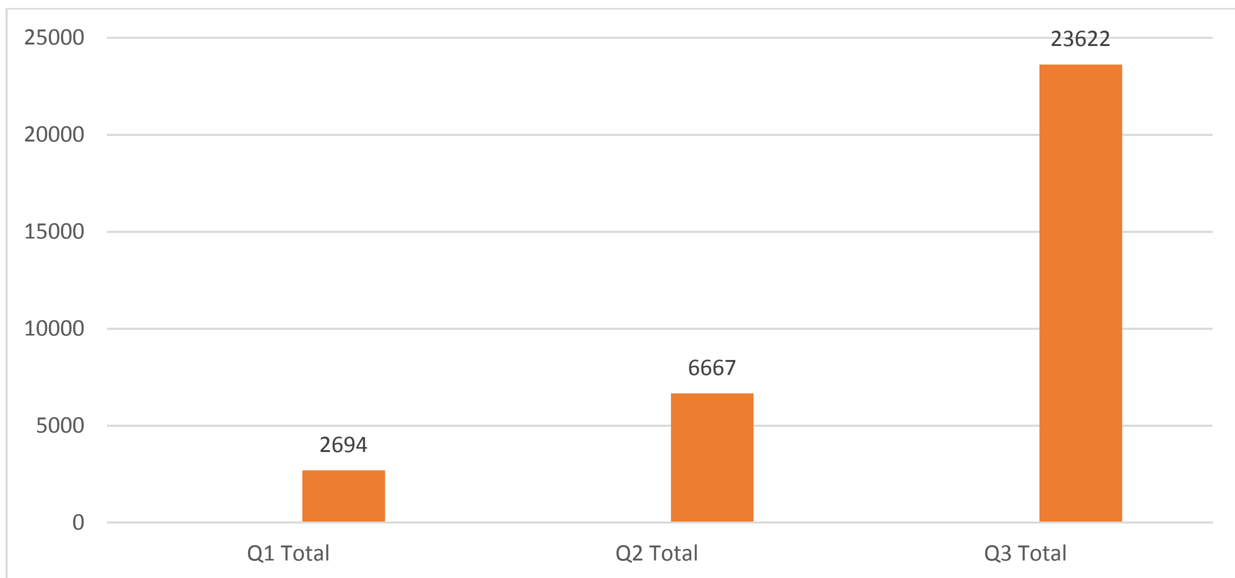
While the focus for health services in quarter three primarily targeted children under nine years old, the ECHS sub-awardees will work toward ensuring that OVC aged 10-14 years who are not yet sexually active are targeted for risk avoidance interventions in quarter four. In addition, OVC aged 15-17 years will be offered interventions to reduce their risk of HIV infection through the implementation of a core package that includes social and economic activities. CDS will support its sub-awardees to strengthen their case management systems and monitor the HIV cascade, including improving linkages to HIV care and treatment for those who are HIV-positive, and providing support for treatment adherence.

The provision of child protection services remained relatively low in quarter three, as home visitors are not fully capable of identifying child abuse at the household level, and caregivers are reluctant to disclose sensitive information, particularly if family members are implicated. CDS will address these challenges, improving identification of child abuse by its sub-awardees, through the provision of Thogomelo Child Protection training by Johannesburg Child Welfare and HIVSA in July and August 2017. The training will be followed by mentorship support to ensure home visitors can engage caregivers on sensitive matters related to GBV and implement child abuse identification and protection interventions.

Nutrition Assessment, Counselling and Support

In quarter three, CDS provided technical assistance to ECHS sub-awardees related to nutrition service provision through on-site mentoring and coaching and teleconference discussions.[11] CDS' support since quarter one has resulted in increasing numbers of clients nutritionally screened using mid-upper arm circumference (MUAC). Of those screened, 64 were found to have moderate acute malnutrition (MAM), and 52 were found to have severe acute malnutrition (SAM). Most of the malnourished cases identified were found to be in the eThekwini and uMgungundlovu districts in KwaZulu-Natal province. The sub-awardees reported referring all malnourished clients to a health facility for nutrition support.

ECHS clients screened for MUAC: quarters one to three



CDS will continue to provide supportive mentoring to emphasize and reinforce nutrition as a core activity within the 90-90-90 strategy. CDS will also reinforce linking the HIV cascade with nutrition services by encouraging sub-awardees to screen all clients for both malnutrition and HIV risk, as this strengthens case management because of the synergistic nature of disease and nutrition. One of the underlying complications of HIV is malnutrition; therefore, nutrition screening can assist in identification of undiagnosed HIV-positive clients.

[11] Read more about CDS' nutrition support to the ECHS sub-awardees in the NACS section of this report.

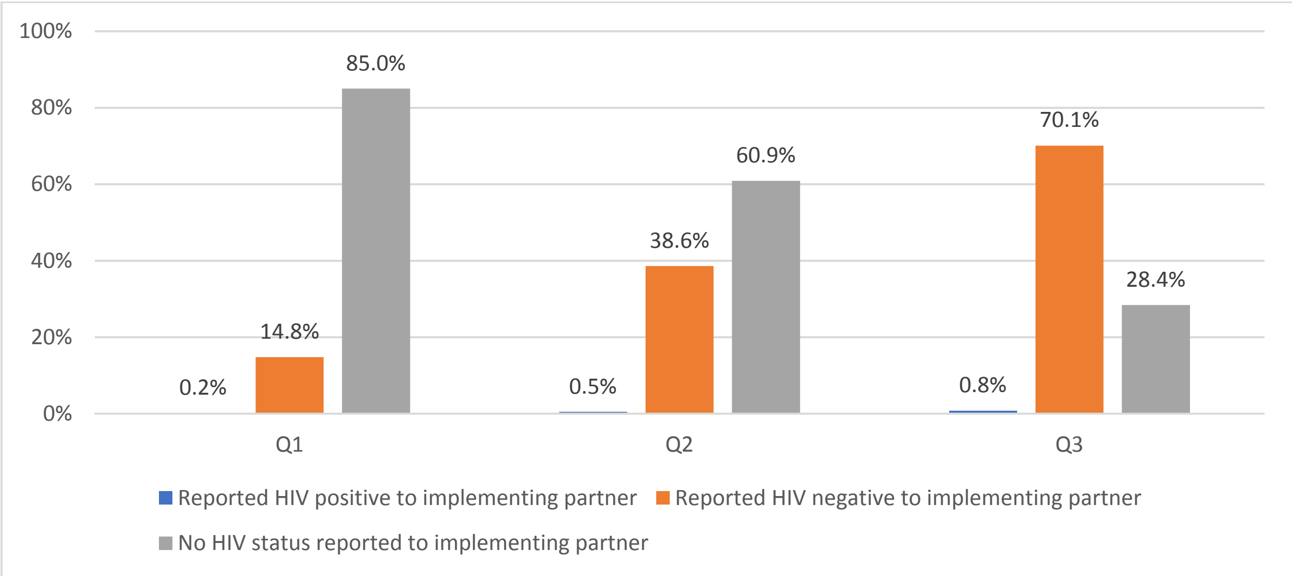
Promoting acceptance, access and uptake of HTS among OVC

A key priority of the ECHS program is ensuring that all OVC under 18 years old know their HIV status, and those who are HIV-positive are initiated on and adhere to treatment. In quarter three, ECHS sub-awardees continued to improve access to HTS through the SRI. This involved home visitors providing motivation and sensitized counseling, and facilitating HIV testing at household level.

Using the HIV risk assessment tool, clients were screened for risk to HIV exposure. This included identifying children who have a history of chronic illnesses or being admitted to the hospital, signs of malnutrition, loss of one or both parents, and/or suspected GBV in the household. These assessments inform referrals for testing, and home visitors counselled and prepared clients for home-based testing by Humana.

CDS achieved 100% of the target for OVC_HIVSTAT in quarter three. Of the children served, 0.8% reported being HIV-positive, 70.1% reported being HIV-negative and 28.4% did not report their HIV status to the sub-awardees. CDS sub-awardees are demonstrating significant progress in categorizing client HIV status.

Performance in OVC_HIVSTAT: quarters one to three



A deeper look: mothers2mothers

ECHS sub-grantee mothers2mothers made notable progress in quarter three. In quarter two, the organization had 2,686 OVC active clients, but only 729 had reported their HIV status. This gap was related to incomplete retrospective updating of client status on CBIMS, non-recording of HIV-unexposed infants and babies under two years of age, poor reach of OVC of school-going age for HIV risk assessments and/or HIV testing, and non-disclosure of HIV status. mothers2mothers

addressed these gaps by increased HIV testing through weekend services, school-based mobilization for HIV testing, and leveraging of health facility linkages for case finding of children under two years old for early infant diagnosis. In quarter three, of 2,719 active OVC clients, a total of 2,450 had reported their HIV status. With improved screening, clients whose HIV status was unaccounted for "other reasons" decreased in quarter three; for example, in Emalahleni sub-district, from 93% to 30% of all clients reporting an unknown status. This reduction in clients classified under "other reasons" indicates that sub-awardees are better able to identify people who need to be tested and link them to testing and treatment.

Linkages to care and treatment

CDS continued to provide technical assistance to improve linkages to care and treatment for HIV-positive clients in quarter three. To ensure effective linkage to care and treatment, ECHS sub-awardees used a tracking tool to monitor clients with an HIV-positive diagnosis and document their anti-retroviral therapy (ART) start date and the last viral load date and results.

Woz'obona and Kheth'Impilo demonstrated excellent case management of their clients, accompanying HIV-positive clients to nearby health facilities for ART initiation. Woz'obona reported that of 126 newly diagnosed HIV-positive clients, 93% were initiated on ART and followed up with adherence support in quarter three. Kheth'Impilo reported that of 508 HIV-positive clients diagnosed this quarter, 94% were initiated on ART and provided adherence support. The organization continues to follow the clients to ensure retention in treatment and promote viral suppression.

Woz'obona HIV cascade: quarter three[12]

	First 90		Second 90		Third 90
OVC clients ever enrolled (4,821)	**Total with known HIV status 4,821 (100%)**	**No. found HIV-positive 126 (2.6%)**	**No. on ART 117 (93%)**	**No. supported with ART adherence 117 (100%)**	**No. reporting viral suppression Being followed up**

[12] Data as reported by Woz'obona.

Kheth'Impilo HIV cascade: quarter three[13]

	First 90		Second 90		Third 90
OVC clients ever enrolled (11,489)	Total with known HIV status 8,780 (76%)	No. found HIV-positive 508 (5.8%)	No. on ART 480 (94%)	No. supported with ART adherence 480 (100%)	No. reporting viral suppression Being followed up

Strengthening Parent/Caregiver Capacity

Children under the age of five years continued to receive early childhood stimulation support.[14] In the City of Johannesburg, HOPE worldwide reached 2,697 children through early childhood play and stimulation activities in quarter three, including play with home-made toys, Legos, and the toys acquired by CDS in quarter two. HOPE worldwide conducted 13 playgroups where children and their caregivers engaged with books and toys, increasing the child-caregiver bond.

Play activities with children under the ECHS program

In eThekwini, Kheth'Impilo supported 3,714 children under 36 months old with cognitive stimulation. This included hearing and identifying different noises (a knock at the door or a

[13] Data as reported by Kheth'Impilo.

[14] The partner-specific data in this section is reported by partners and has not been verified by CDS.

barking dog). It also included imitating others, comparing sizes using words like “bigger” and “smaller,” matching and sorting similar pictures and objects, and play-acting thoughts and ideas (such as pretending to be a cat). A total of 1,330 children aged 36-60 months learned to plan before acting (such as searching for a ball or doll before playing), use words related to time (such as “sleep time”), sing, dance, act and show independence. They learned to differentiate colors, count from 1-5, and recognize their names and surnames. Following CDS’ toy distribution, sub-awardees were able to start toy libraries and distribute toys in households, which contributed to early childhood stimulation at household level.

Capacity Building of Community-based Organizations (CBOs)

To enhance CBO capacity to promote ECHS in the community, ECHS sub-awardees supported local organizations, including training them on nutritional assessments, creating awareness on child abuse during Child Protection Week and sharing economic strengthening strategies.

During the Child Protection Week (May 28-June 4, 2017), mothers2mothers participated in a child protection awareness-raising march in Moloto in Thembisile Hani sub-district. The march was a collaboration with 40 learners from three local schools, with participation from Department of Social Development (DSD) and civil society organizations Khulisa Social Solutions and loveLife. mothers2mothers delivered a child abuse prevention message to the learners. The organization is partnering with two local CBOs (early childhood development centers) to share and mobilize scarce community resources. mothers2mothers shared age-appropriate toys with the two early childhood development (ECD) centers to support play and child stimulation.

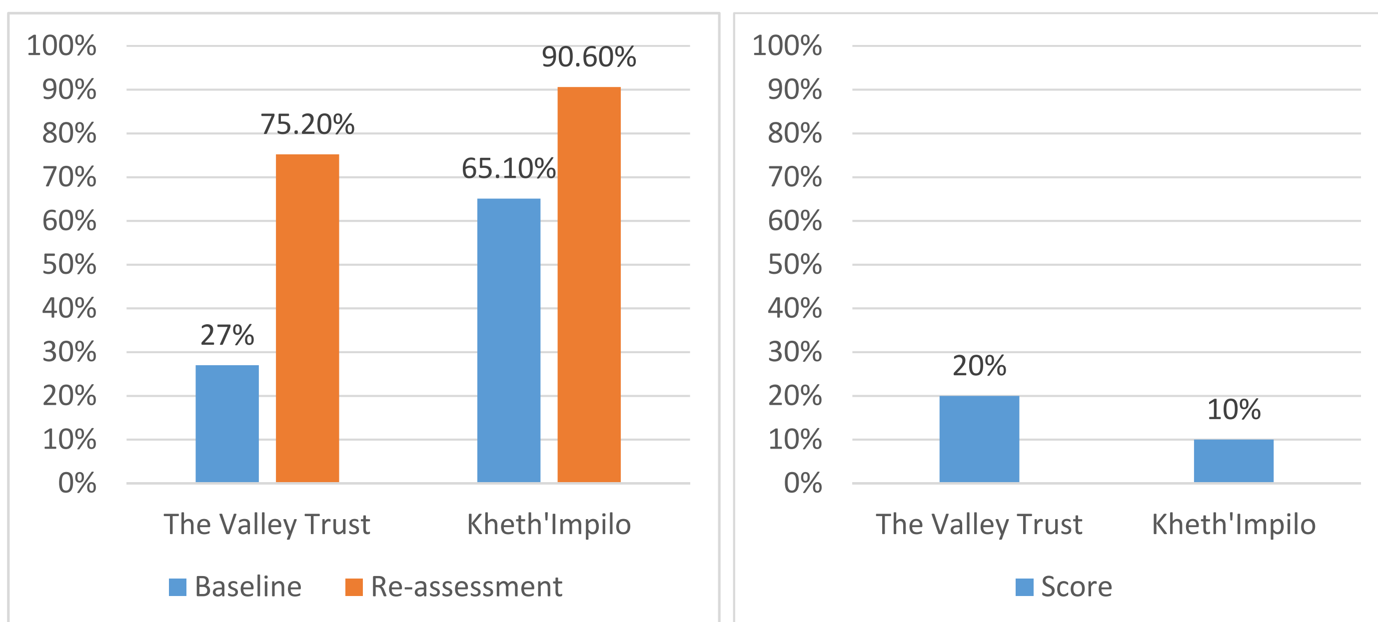
In the City of Johannesburg, HOPE worldwide also participated in Child Protection Week, facilitating a child protection campaign in each of its sites and participating in a community child protection march. A total of 350 ECHS clients participated in the child protection campaigns and educated others on child protection and safety measures for children by distributing educational pamphlets. HOPE worldwide trained its site coordinators on nutrition assessment using the MUAC. This was followed by MUAC assessments for 1,773 children across 15 ECD centers. In quarter four, HOPE worldwide will provide technical assistance to the site coordinators to promote high-quality ECHS programming. The organization plans to assist the site coordinators with analysis of the MUAC data and assessment of their overall systems.

Kheth’Impilo provided MUAC training to nine CBOs in eThekwini. The organization plans to meet the parents of the children at the CBOs during the weekends to capacitate them on parenting skills and nutrition. Kheth’Impilo collaborated with the Department of Agriculture to visit the CBOs to assess their vegetable gardens or grounds and conduct two-day gardening training.

Quality Assurance

CDS conducted technical capacity re-assessments, Site Improvement through Monitoring Systems (SIMS) assessments[15], and Stepwise Process for Improving the Quality of HIV Rapid Testing (SPI-RT) Checklist with sub-awardees The Valley Trust and Kheth'Impilo in quarter three. The SPI-RT is an audit of the quality, efficiency and effectiveness of HTS, using a scoring system of level 0 (a score of less than 40%) to level 4 (a score of 90% or above). Both organizations demonstrated notable improvement in their technical capacity to implement the program. Both organizations recently began provision of HTS and scored poorly in the SPI-RT Checklist. They have stopped the provision of HIV testing until the gaps identified are addressed with CDS support.

Technical capacity re-assessment (left) and SPI-RT (right) scores: The Valley Trust and Kheth'Impilo



Kheth'Impilo

Kheth'Impilo's performance has improved in all eleven domains of the CDS technical capacity assessment tool[16] since the baseline was conducted in August 2015. The overall score improved from 65.1% at baseline to 90.6% during the re-assessment. At baseline, the organizations

[15] A PEPFAR quality assurance tool, CDS supports its sub-awardees to prepare for the USAID-conducted SIMS by conducting practice assessments to identify and address gaps.

[16] Domains include program design, targets, childhood stimulation interventions, capacity building: caregivers (parents and guardians), capacity building: home visitor, linkages and coordination, service delivery: health and nutrition, service delivery: PSS and protection, gender, quality improvement and quality assurance

performed below average in five domains, and did not achieve the highest score in any domain. At re-assessment, all domains performed above average, and three domains achieved the highest score. The greatest progress was made in the service delivery domain, particularly in terms of health and nutrition and educational support.

Kheth'Impilo performed well on the SIMS re-assessment,[17] a reflection of the organization's determination to maintain high-quality standards of service to its clients. CDS will support the organization to address the following areas which need to be strengthened:

- Preventing HIV in girls: consistent implementation of the HIV Risk and Vulnerability Assessment Tool
- Referral and linkages to HIV testing: strengthen referral and linkages mechanisms
- Nutrition: strengthen the practice of MUAC assessment and relevant referrals

Kheth'Impilo scored 10% on the SPI-RT, a level 0 performance, requiring urgent intervention. CDS made the following recommendations:

- Testers need urgent training on current national HTS procedures and guidelines, including on-site training on how to use the job aids and the testing procedure
- Testers must receive guidance on the proper waste management process
- Testing sites must provide supervision and on-site training on blood collection
- Testing sites must obtain the standardized HTS registers from the district or provincial DOH for recording of data
- Testing sites must obtain all relevant policies and guidelines for HTS, quality assurance, health and safety, and waste management

The Valley Trust

The Valley Trust's performance has improved in all eleven domains of the CDS technical capacity assessment tool. The overall score improved from 27% at baseline to 75.2% during the re-assessment. At baseline, the organization performed below average in eight domains, while at the re-assessment, the organization performed above average in all 11 domains, and achieved the maximum possible score in three domains. Gender remains an area for improvement after the re-assessment.

The Valley Trust scored 20% on the SPI-RT, a level 0 performance, requiring urgent intervention. CDS and The Valley Trust agreed on the following corrective measures:

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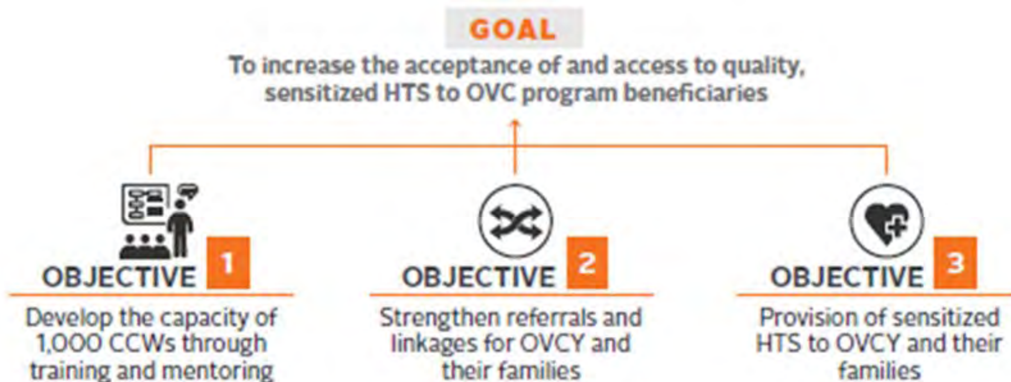
[17] CDS assessed Kheth'Impilo on SIMS Set 1a and 1b (any populations), and Set 3 (orphans and vulnerable children).

- CDS to provide training on HTS for all testers and The Valley Trust to record their attendance
- CDS made an interim arrangement with the local clinic for storage of the test kits; The Valley Trust to explore other options
- The Valley Trust to obtain all the relevant HTS guidelines and job aids as per list provided by CDS
- The Valley Trust to obtain national HTS registers from the local clinic
- CDS to provide training on Rapid Testing Quality Assurance Improvement Initiative (RTQII) that will cover both Independent Quality Control and External Quality Control

Supportive Referrals Initiative (SRI)

CDS began implementation of the SRI in May 2016. The aim of the project was to train and mentor OVC partners as they develop context-specific HTS in non-clinical settings to create an environment with increased opportunities for OVC, their families and communities in PEPFAR scale-up districts to access sensitized HTS, and improve referrals and linkages to HIV services. CDS implemented the SRI through three sub-awardees: FPD, NICDAM and Humana.

SRI goal and objectives



Develop the capacity of 1,000 CCWs through training and mentoring

Ten OVCY partners received capacity building through the SRI. Three of the 13 OVCY partners selected by USAID (HIVSA, CINDI and mothers2mothers) conducted their own training and mentoring, and therefore declined the capacity building component of the SRI.

SRI OVCY partners

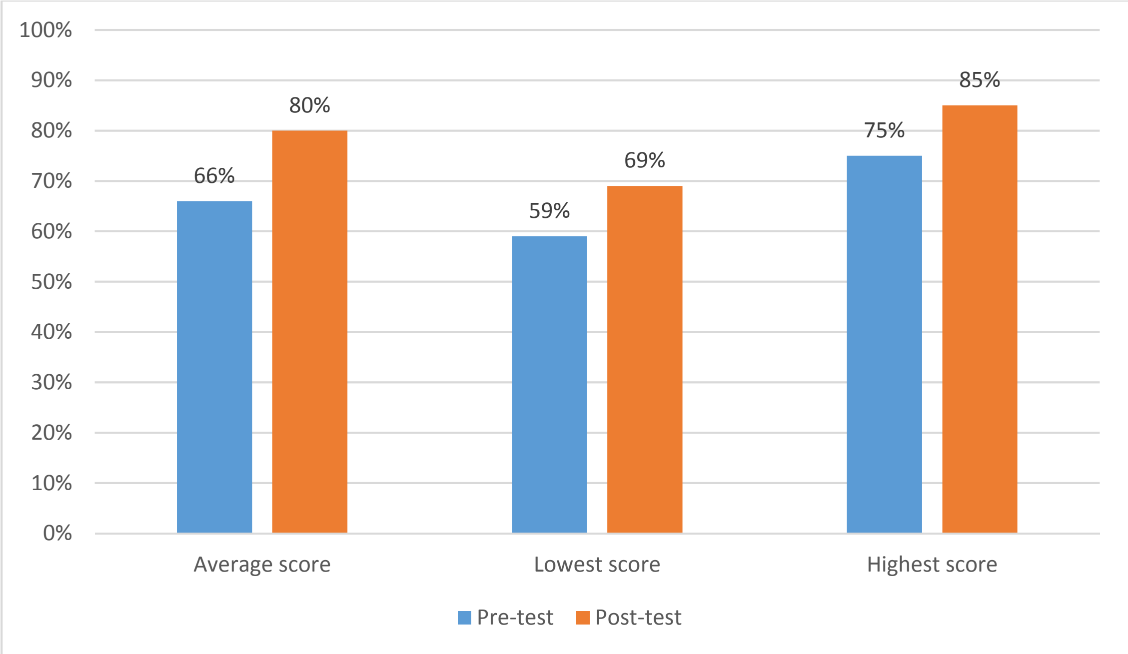
NICDAM	FPD
• NACOSA • Woz'obona • The Valley Trust • Kheth'Impilo • Childline Mpumalanga and Free State • Child Welfare Bloemfontein • Future Families • HOPE worldwide	• Pact • NACCW

Training of community care workers (CCWs)

Prior to the training, FPD and NICDAM conducted needs assessments with the ten OVCY partners to ensure the SRI capacity development addressed CCW needs. This included a desktop review of HIV and other relevant training materials, documents and tools from OVCY partners, as well as interviews on the knowledge, skills and practices of CCWs. Knowledge gaps were found in voluntary medical male circumcision (VMMC), ART as prevention (including post-exposure prophylaxis) and sexual and reproductive health. Skills gaps were found in counselling, motivation, and addressing barriers to HTS.

CDS supported FPD and NICDAM to develop a standardized HTS training curriculum for CCWs to ensure quality sensitized HTS was provided to OVCY, their caregivers and families. FPD and NICDAM conducted a total of 38 HTS training workshops, reaching 1,099 participants (CCWs, mentors and supervisors) from the OVCY partners. The HTS trainings followed a family-centered approach that consisted of ten outcome-based modules focused on increasing HIV prevention knowledge and skills using practical exercises such as roleplays and case studies. The average increase in knowledge after the trainings was 14 percentage points, with a range of 8.3 percentage points to 31.5 percentage points.

Pre- and post-test assessment results



Mentoring of CCWs

Mentoring the trained CCWs from the OVCY partners took place monthly, reinforcing knowledge and creating a supportive environment to apply HIV and counselling skills from the training. The program assisted CCWs with the provision of HIV education and creation of demand for HTS among OVCY, caregivers and their families, as well as ensuring an improved continuum of care through referrals and linkages. Mentoring was conducted through both individual and group sessions with the CCWs. The mentoring program included the following elements:

- Use of structured mentoring approaches
- Individual baseline assessment of core skills and implementation of action/skills plans
- Use of standardized data reporting tools
- Active support and feedback during household visits

SRI implementation model

NICDAM mentoring

During the implementation of the SRI, CDS observed improvements in the mentoring program through consistent and regular site visits by NICDAM mentors who supported the CCWs in creating demand for HTS and cascading the mentorship program. NICDAM's mentoring approach focused on:

- **In-service training of CCWs:** NICDAM provided in-service training to 755 CCWs as part of the mentoring model, as well as to an additional 421 CCWs not officially part of the program.
- **Mid-term core skills verification**: NICDAM's mentors and partners' mentors conducted a verification process of the mid-term core skills in Mpumalanga, KwaZulu-Natal, Free State and Gauteng. The scoring was based on observation of roleplays, household visits and presentations by CCWs. The verification revealed improved knowledge and skills on HIV,

interviewing and presenting among CCWs, as well as capacity to motivate clients for HTS and related services.

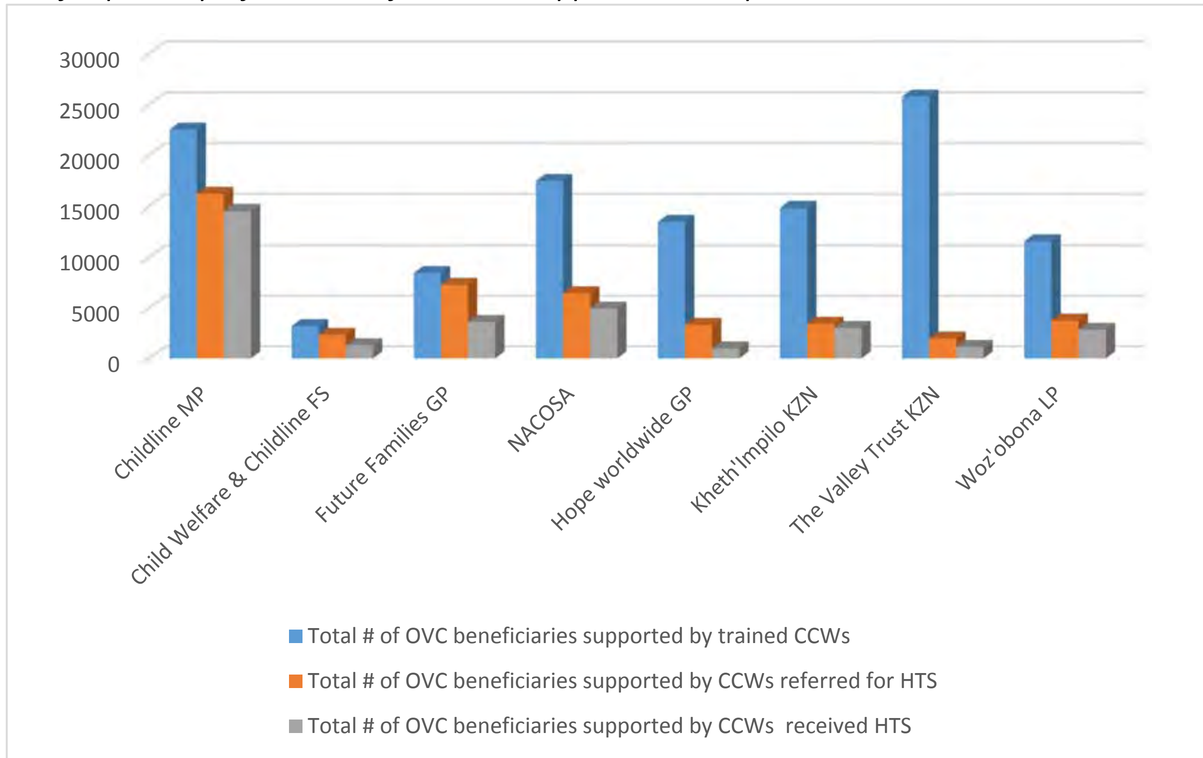
- **On-going mentoring/coaching**: NICDAM conducted a total of 255 site visits to provide mentoring and training support to partners. Mentors also provided virtual support via phone calls and WhatsApp to answer questions and address challenges.
- **Strengthening linkages and referrals:** NICDAM mentors further strengthened linkages to care by orienting mentees on the procedures for referring clients for health and social services, using the community circle of service maps developed by FPD, and tracking referral completion as per the SRI standard operating procedures (SOPs).

The CCWs under NICDAM-supported OVCY partners reported that 28% of their clients tested for HIV. A total of 72% of referred clients were reported to have received HTS – a relatively strong linkage rate. The graph below illustrates a cascade of the number of OVC clients supported by the trained CCWs, the number of OVC clients referred for HTS, and the number of OVC clients who received HTS.[18] The percentage of clients who received HTS varied significantly among the OVC partners. For example, Childline Mpumalanga reported testing 64% of its clients: 16,207 clients were referred for HTS and 14,530 (89% of those referred) received HTS. However, The Valley Trust reported testing just 4% of its clients: 1,977 clients were referred for HTS and 1,137 (57% of those referred) received HTS. These differences in reported performance may be related to the following reasons:

- OVCY partners had no obligation to submit monthly SRI data reports. In some months, partners indicated they had other priorities and could not submit reports.
- The provision of HTS by Humana, the SRI testing partner, was higher in districts where it had existing operations.
- Historically, OVCY partners have focused on the provision of social services, and the transition to health service provision has taken time; some partners demonstrated more commitment than others.

[18] These numbers are based on the data reports received from the OVC partners and were not verified by CDS.

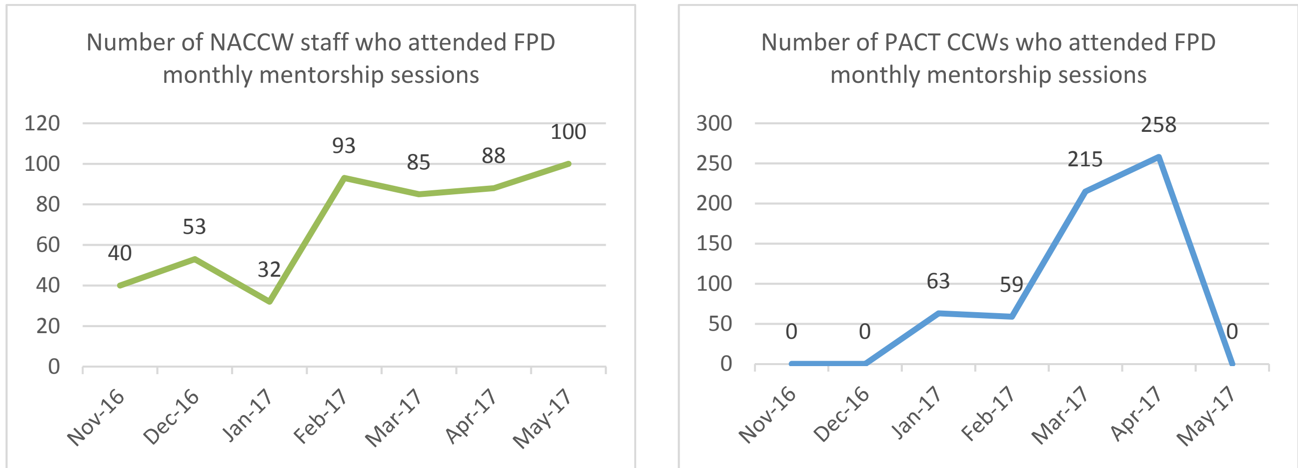
Self-reported performance of NICDAM-supported OVCY partners



FPD mentoring

FPD mentored a total of 710 individuals, including 141 staff members (child and youth care worker mentors trained in the SRI and NACCW mentor supervisors) and 569 Pact-affiliated CCWs and social workers. FPD facilitated a series of six monthly group mentorship sessions at NACCW provincial and district offices in six provinces from November 2016 to May 2017. NACCW mentors cascaded the mentorship to the child and youth care workers (CYCWs) they supervise at CBO sites. Each provincial/district mentor supervisor mentored three to five CYCW mentors, who in turn were responsible for cascading information and skills to three to four Isibindi CBO sites, with CYCW mentorship teams of 20-30 each.

Number of NACCW staff (left) and Pact CCWs (right) reached at FPD monthly mentorship sessions

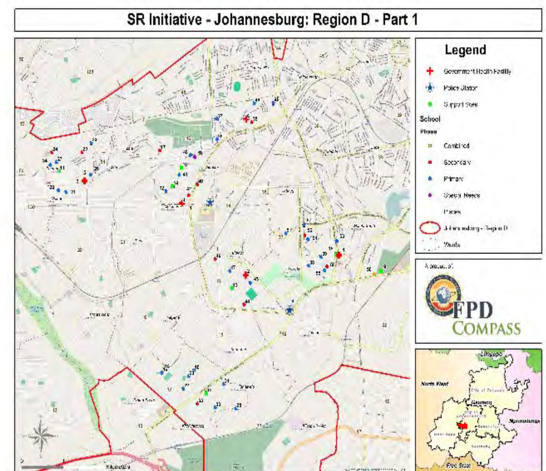


FPD encountered significant delays in mentorship to Pact-affiliated CBOs due to challenges in obtaining DSD and Pact permission to proceed with the activity with their partners. Addressing these challenges required time-intensive district meetings to explain the program and clarify logistics. FPD implemented an abridged version of the program for Pact-affiliated CBOs as part of its transition from the SRI, and facilitated a three-day HIV and mentoring workshop for 35 NACCW and DSD social workers and coordinators as part of the transition, which covered key HIV concepts and the SRI mentoring tools.

Strengthen Linkage and Referrals for OVCY and their Families

CDS and FPD developed and disseminated a Referral and Linkage SOP to strengthen the referral system between OVCY implementing partners and a wide range of service delivery points, promoting access to a full continuum of care. The SOP provides a standard and systematic process for making and receiving referrals, and ensuring referrals are completed. It explains different types of referrals, the referral process (including roles and responsibilities) and a list of recommended service providers for various referral requirements.

FPD also mapped community-level resources and relevant service providers, distributing 44 unique community-based circle of services maps and printing 61 maps for OVCY partners in districts within Gauteng, Mpumalanga, Limpopo, North West and KwaZulu-Natal provinces to promote referrals and linkages.



Example of GIS map: Johannesburg region D

Providing HTS to OVCY, Caregivers and Families

The SRI training and mentoring program equipped CCWs from OVCY partners with knowledge and skills to promote HTS uptake, link clients to appropriate health and social services and to provide treatment adherence support. HTS partner, Humana, supported these partners by providing community-based HTS at household level.[19] A total of 74,476 clients were tested under the SRI program between June 2016 and May 2017.

SRI implementation was planned for June 2016 to September 2017, with an initial testing target of 320,000. The project experienced challenges including:

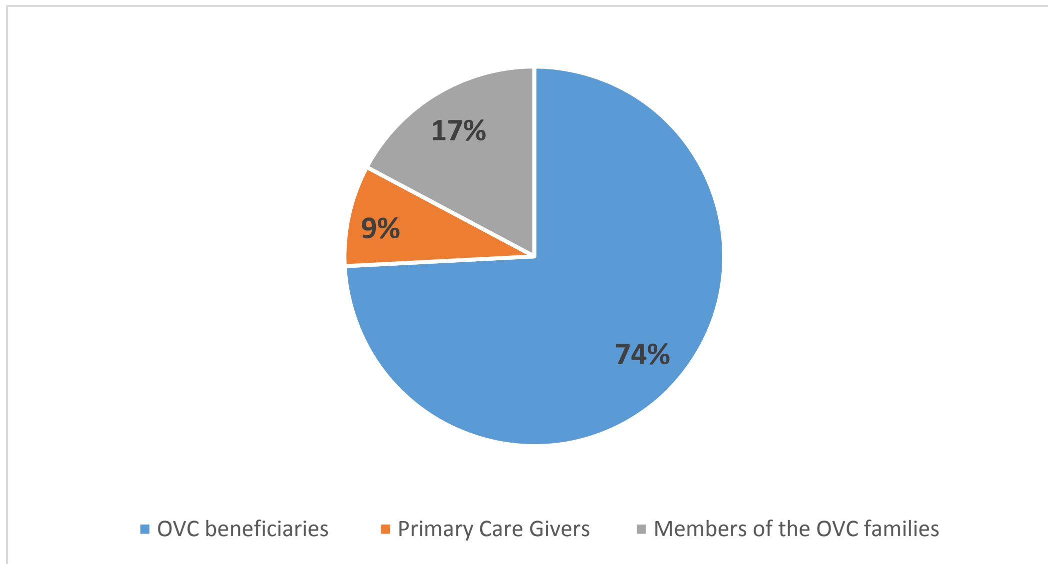
- Low demand for services by OVCY partners and inadequate preparation of clients for testing, resulting in fewer clients tested than anticipated
- Difficulty coordinating the services delivery between Humana and OVCY partners
- Delays is gaining entry into some of the implementing districts

CDS implemented streamlining processes to improve the uptake of testing and coordinate testing arrangements between Humana and the OVCY partners. CDS also facilitated meetings between Humana and district-level DOH leadership to gain permission to deliver services and facilitate access to testing consumables required for the HTS. Delays with Pact, which carried the highest expected contribution (58%) toward the testing targets, significantly affected the SRI program performance. After a decision to scale down the SRI, CDS and USAID agreed on a revised testing target of 48,255 for the period February-September 2017, and there was a further decision to close the SRI implementation in May 2017.

According to the SRI proposal, 80% of clients tested should be OVC and 20% should be primary caregivers and members of the OVC families. As indicated in the graph below, 74% of those tested were OVC, 17% were family members of OVC and 9% were primary caregivers.

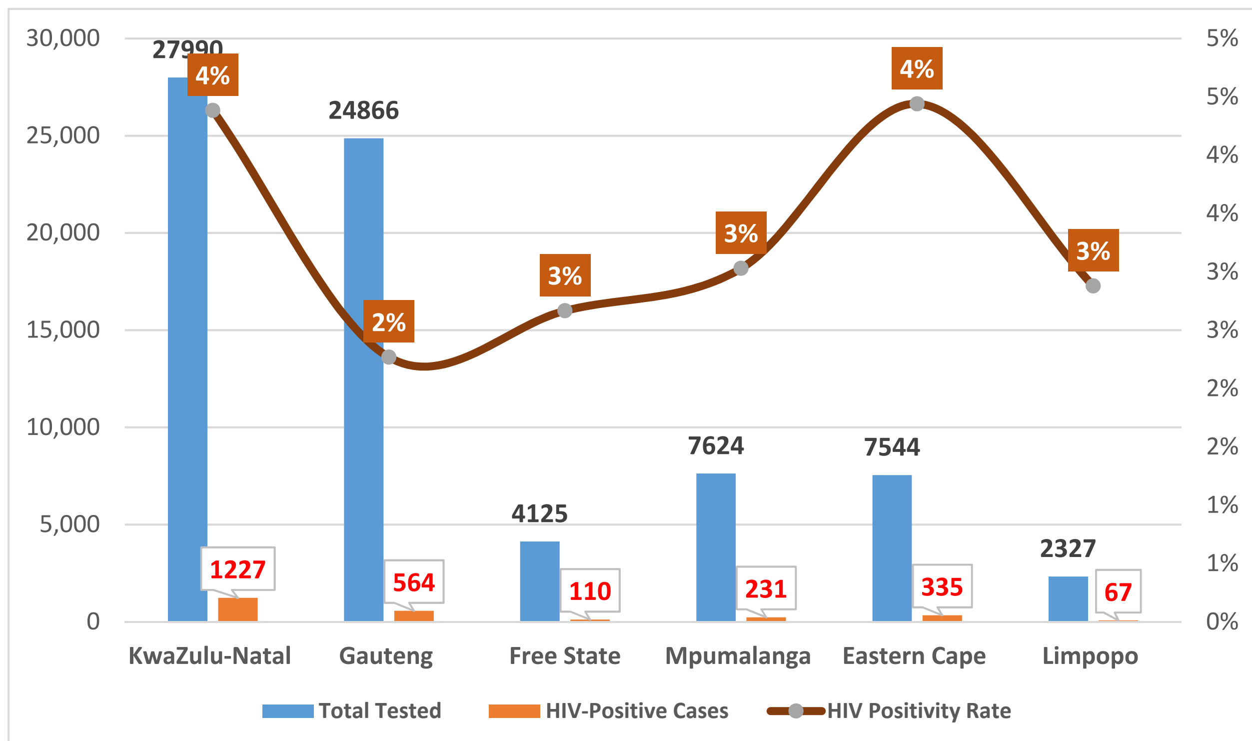
[19] OVCY partners also tested beneficiaries through other service providers.

Proportion of HTS uptake by client group: June 2016-May 2017

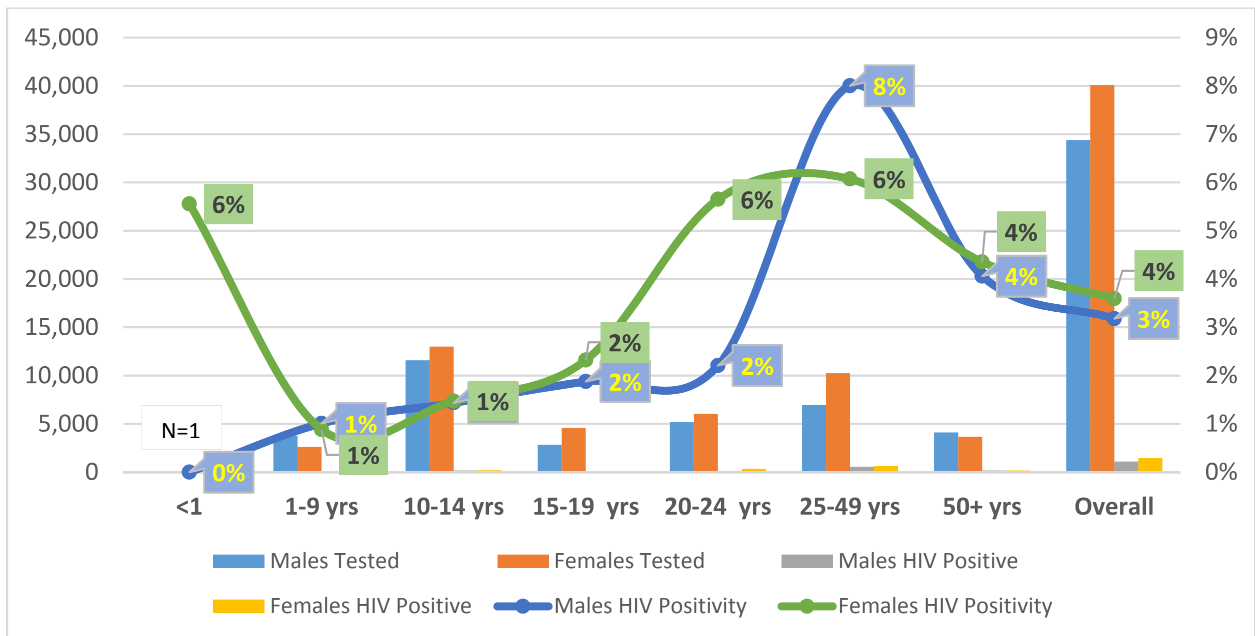


The overall HIV positivity rate for the testing done under the SRI was relatively low at 3%, which was consistent across most provinces. KwaZulu-Natal and Eastern Cape provinces had positivity rates of 4%, indicating that these provinces may benefit from increased testing services to identify more HIV cases.

HIV positivity by province: June 2016-May 2017



HIV positivity by age category and sex: June 2016-May 2017



Positivity rates differed based on sex and age. There was low positivity among those aged 1-9 and 10-14 years, which may point to success in the prevention of mother-to-child transmission (PMTCT) program in South Africa[20]. The positivity rate of females was higher than that of males across most age categories, which is consistent with the higher female disease burden in the country. Positivity rates among females increased sharply between the age groups 15-19 and 20-24 years, and among males between the age groups 20-24 years and 25-49 years, confirming the need to target these age groups with prevention programs as well as HTS.

Conclusion

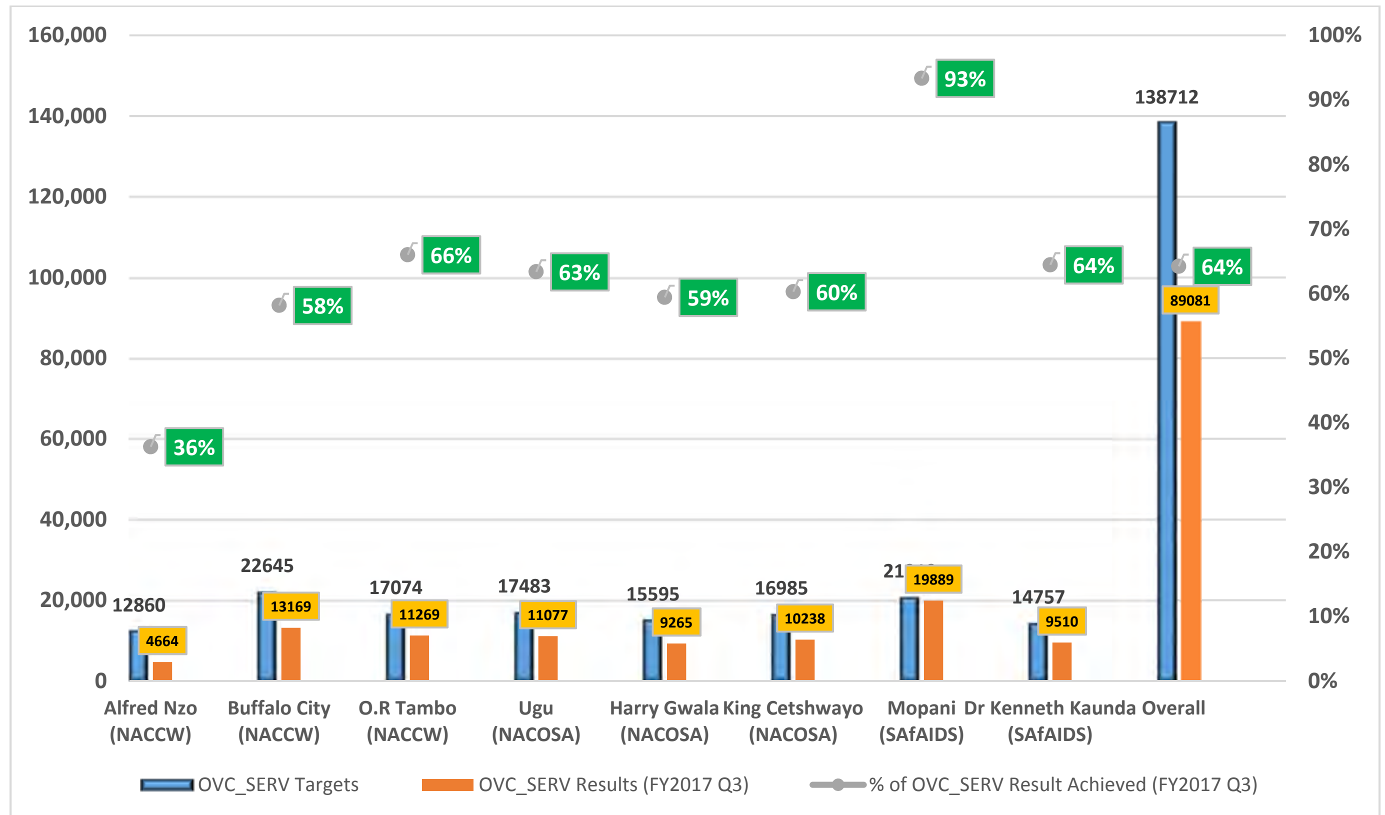
The SRI implementation model was designed to the foster long-term sustainability of the OVCY partners and their programming, as the program built the knowledge and skills of the CCWs directly serving OVC clients, as well as the referral and linkage capacity of each organization. The final months of SRI implementation saw a marked increase in requests for HTS, better preparation of the clients for testing, and smoother and more coordinated delivery of testing services by Humana. The program has provided OVCY partners with increased capacity and tools (including the referral and linkage SOP and service maps) for ongoing high-quality HTS delivery and linkage to care. This capacity will support the OVCY partners to report to PEPFAR on the OVC_HIVSTAT indicator and support their HIV-positive clients to adhere to the full HIV treatment cascade.

[20] The 6% positivity rate for females under one year old is due to one HIV-positive case out of 18 tested.

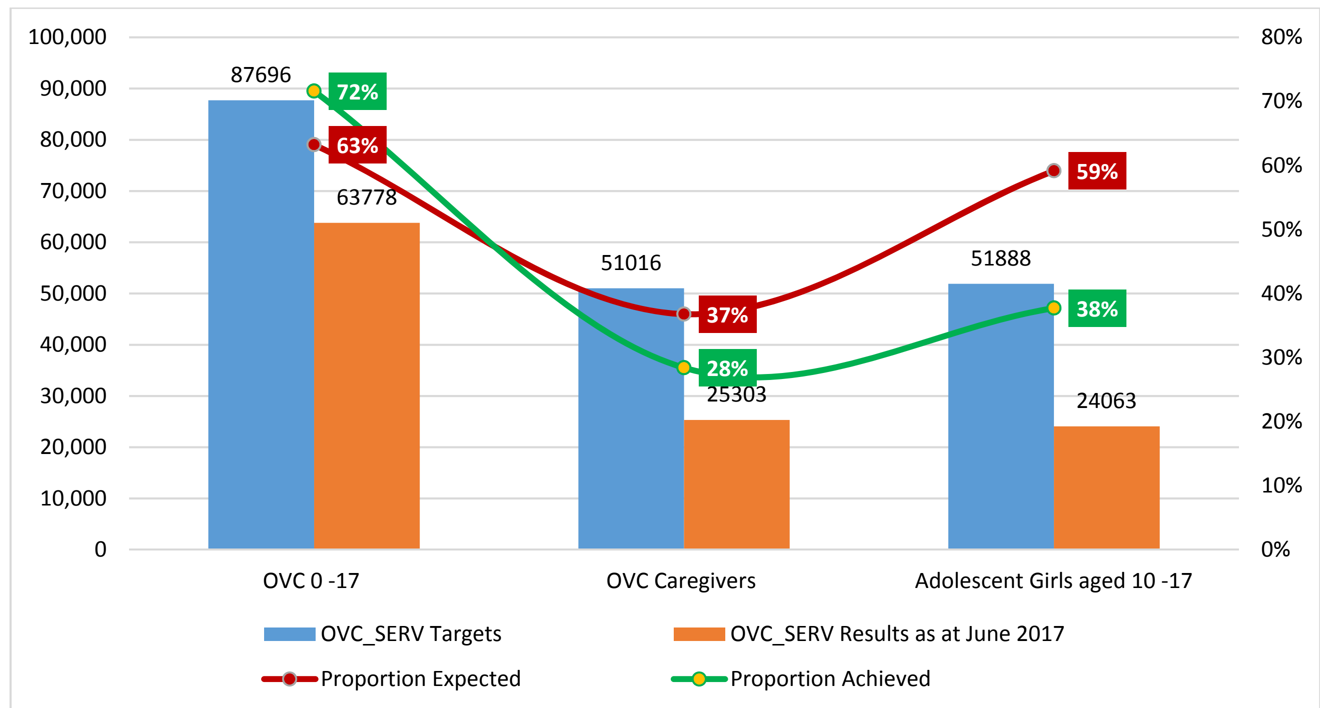
Reaching Adolescents and Children in Households

ReACH seeks to strengthen family stability and promote children's resilience through socio-economic interventions that reduce HIV risk and support retention in HIV services in the PEPFAR scale-up districts. CDS is implementing the program with three sub-awardees – NACCW, NACOSA and SAfAIDS – in four provinces.

Performance in OVC_SERV by District: quarter three



Overall performance in OVC_SERV by target groups: quarter three

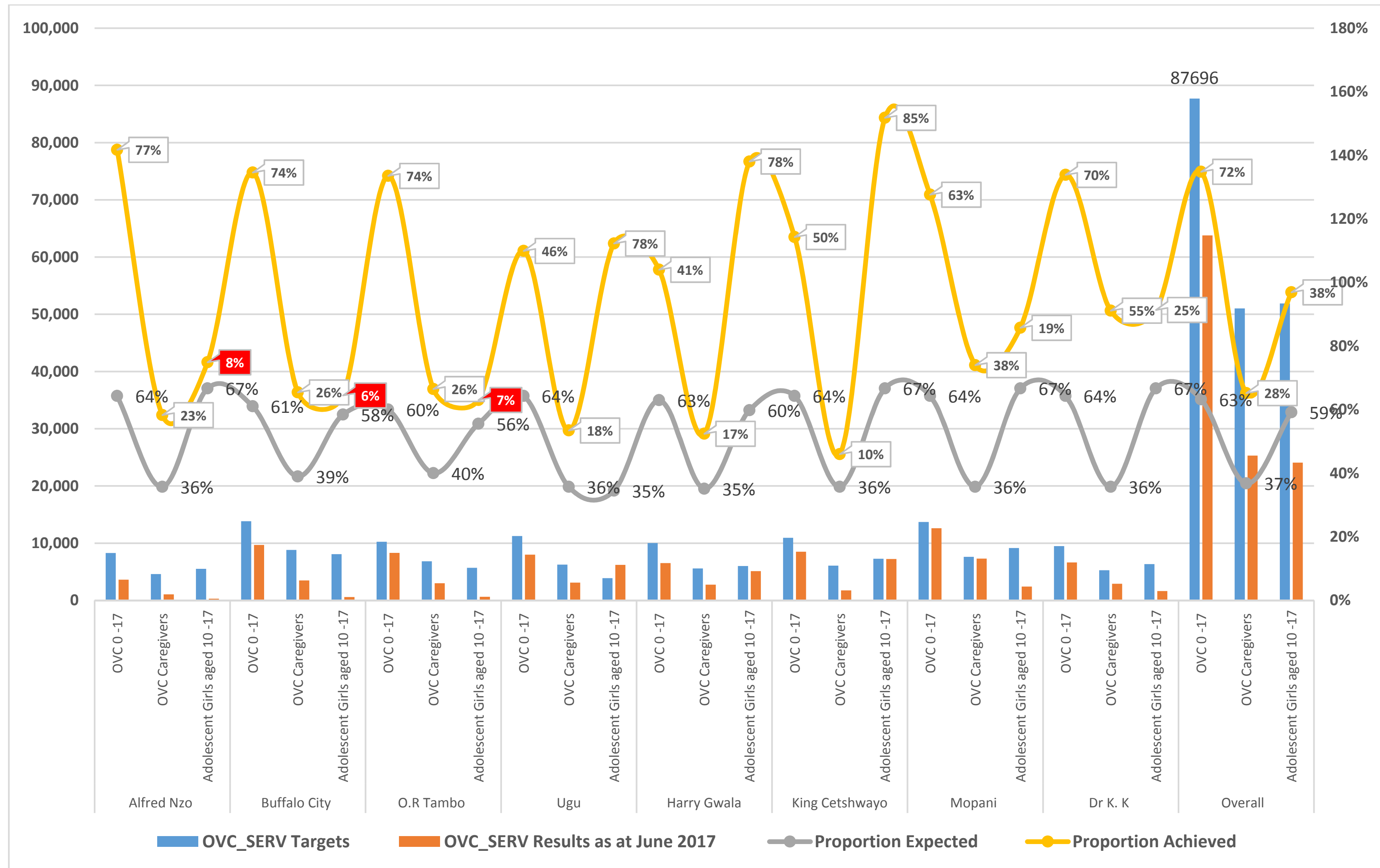


ReACH specifically focuses on OVC aged 0-17 years, adolescent girls aged 10-17 years, and their caregivers to provide required services. There was significant improvement in performance from the previous quarter, with sub-awardees reaching 89,081 individuals -- 64% of the overall target of 138,712 individuals. CDS implemented intensified monitoring and support to fast-track implementation, which included provision of services to all enrolled/recruited clients. In quarter three, sub-awardees implemented the OVC HIV risk assessment tool, which enabled all implementing partners to identify the specific needs of clients.

The sub-awardees collectively reached 63,778 OVC aged 0-17, achieving 72% of the target due to a focus on core OVC services in the quarter. There was lower reach of adolescent girls aged 10-17 years and OVC caregivers due to delays in the rollout of specific interventions (*Let's Talk* and Vhutshilo, respectively) for these target groups. NACOSA, operating in Harry Gwala, Ugu and Uthungulu Districts in KwaZulu-Natal province, achieved 61% of its target. NACCW, operating in Alfred Nzo, Buffalo City and OR Tambo Districts in Eastern Cape province, achieved 55% of its target. SAfAIDS, operating in Mopani District in Limpopo province and Dr. Kenneth Kaunda in North West province, achieved 82% of its target.

SAfAIDS' performance was due to implementation of a multi-pronged catch-up strategy. The organization employed a rigorous recruitment process in both sub-districts, and clients were offered services at household level as well as through support groups in communities, including at churches, drop-in centers and schools.

Performance in OVC_SERV by District and target group: quarter three



At district level, the highest overall achievement in OVC_SERV was Mopani District in Limpopo province, which reached 19,889 individuals: 93% of the district target. Performance across other districts ranged between 58-64%. The lowest performance, at 36% of the target (4,664 individuals reached), was in Alfred Nzo District in Eastern Cape province. An analysis of OVC_SERV achievement by age category in each district demonstrated the need to increase reach of AGYW aged 10-17 years, particularly in Alfred Nzo, Buffalo City and OR Tambo (NACCW), as well as Dr. Kenneth Kaunda and Mopani (SAfAIDS). CDS expects this reach to increase in quarter four with the rollout of Vhutshilo sessions targeting this age group. The ratio of OVC to caregivers was appropriate across districts, at approximately 80% OVC to 20% caregivers reached.

Provide a comprehensive package of services to OVC

ReACH partners use an integrated, comprehensive approach to implement evidence-based activities, including case management/home visiting, structured HIV prevention education, *Let's Talk* parenting/caregiver program, educational support, early childhood development, child protection interventions, and referrals and linkages to health services. The program focuses on early identification of the most vulnerable children and their families to support retention of children affected by, exposed to, and infected with HIV, as well as on improving stability of families, with a specific focus on layering services for adolescent girls.

Sub-awardees prioritized risk avoidance strategies for girls aged 10-14 years to ensure that they stay HIV-negative though Vhutshilo 1, and target girls aged 15-17 years through Vhutshilo 2 to discuss issues around sexuality and safe sex. NACOSA, operating in three districts in KwaZulu-Natal province, made significant progress in engaging adolescents, meeting over 100% of its target of 17,147 for adolescents aged 10-17 years. Both NACCW and SAfAIDS under-performed on their targets, achieving 37.6% and 46%, respectively. CDS will support its sub-awardees to ensure adolescents are targeted with relevant interventions including sexual and reproductive health, HIV testing, educational subsidies and HIV prevention services.

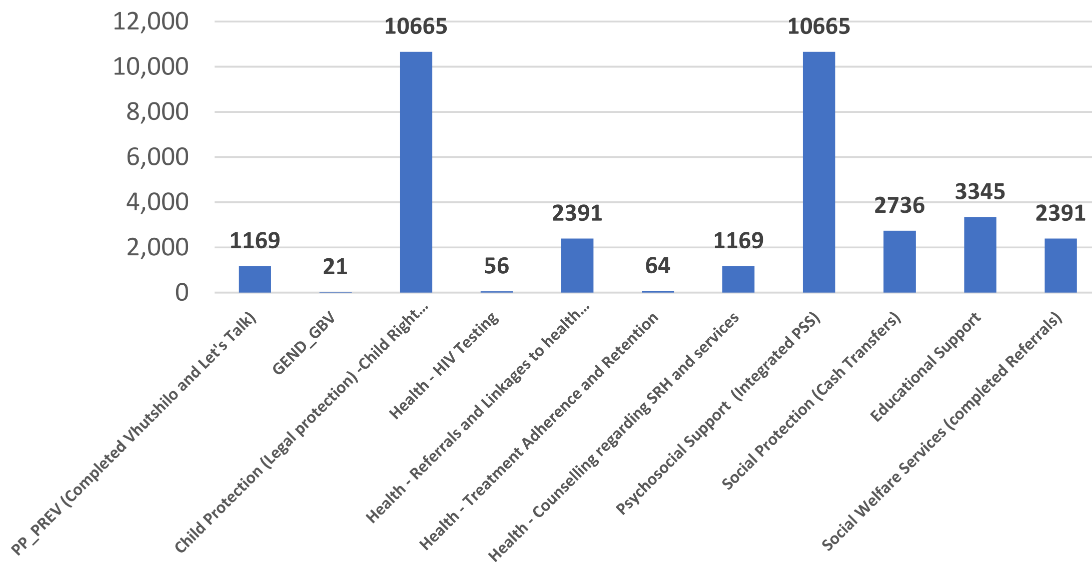
Participants at Vhutshilo training under NACOSA

NACOSA began implementation of Vhutshilo in quarter three, with sessions of both Vhutshilo 1 and 2 underway by June 2017. NACOSA's sub-partners Give a Child a Family, Isibane Sezwe Ubumbano, and Vukuzithathe are currently training AGYW on Vhutshilo. As of June 2017, most Vhutshilo training groups had covered 4-9 sessions, with 20 adolescents per group. The selection of adolescents was done through household and school enrollment of eligible OVC. These clients were then screened

using the risk and vulnerability assessment tool to identify those who needed additional services.

CDS sub-awardees provided a range of OVC services to clients in quarter three. Services provided most often included child protection, psychosocial support, educational support and referrals for social protection.[21] The chart below depicts the services rendered in Alfred Nzo District in Eastern Cape province. Clients are likely to receive multiple services in a single quarter based on their identified needs.

Services provided under OVC_SERV in Alfred Nzo District: quarter three[22]



OVC status in the program

Most clients are still active in the program; however, exits without graduation have been observed across all districts, particularly in Eastern Cape province. This includes children who have moved to other areas, died, and those who have dropped out for other reasons. CDS will support its sub-awardees to monitor client status in quarter four and minimize drop-out by conducting follow-up during home visits.

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[21] Read more about CDS support to ReACH sub-awardees to provide nutrition services in the NACS section of this report.

[22] Data as reported by NACCW.

OVC program status in the Eastern Cape and KwaZulu-Natal: quarter three

	Harry Gwala - Ingwe LM	Harry Gwala - KwaSani LM	Harry Gwala - Ubuhlebezwe LM	O.R Tambo - Qaukeni LM	O.R Tambo - Nyandeni LM	O.R Tambo - King Sabata Dalindyebo LM	Total	Proportion
Active	13169	3721	943	2744	3609	4880	29066	92%
Graduated	1	0	0	0	109	76	186	1%
Transferred	0	0	0	0	0	0	0	0%
Exited without Graduation	428	770	299	249	295	255	2296	7%
Total	13598	4491	1242	2993	4013	5211	31548	

Strengthen OVC caregiver and family capacity

In quarter three, CDS sub-awardees orientated parents and caregivers on sexual risk behavior, positive relationships with their children, and HIV and violence prevention to strengthen their capacity to communicate and address key issues facing their children. For example, NACOSA implemented Circles of Support (CoS) in an eight-session intervention. A total of 36 CoS groups were started in quarter three to engage caregivers on topics including:

- HIV and AIDS (HIV education, testing, treatment and disclosure)
- Encouraging self-discipline among children
- Sexual and reproductive health
- Understanding the child
- Psychological wellbeing of the caregiver

NACOSA also facilitated 52 parenting groups in all the three supported districts (Ugu, Harry Gwala and King Cetswayo) through its sub-awardee MIET. Workshop sessions were held with parents and caregivers, covering the following topics:

- Gender-based violence and sexual abuse
- Teenage pregnancy together with understanding OVC in their teenage years
- HIV and AIDS issues among HIV infected and affected OVC
- Financial wellbeing at the household level, including accessing social grants

CDS began training its sub-awardees on *Let's Talk* implementation in quarter three.[23]

Promote HIV status knowledge, testing and retention in care

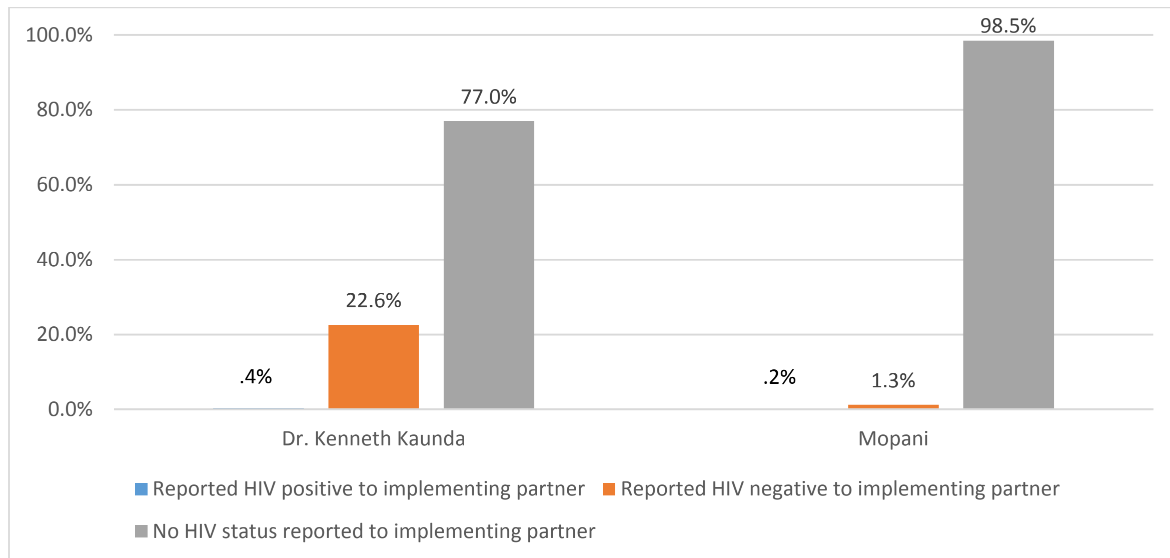
In quarter three, CDS sub-awardees began implementing the OVC HIV risk screening assessment. This assisted them to identify OVC who are at risk, including those who have lost

[23] Read more about the Let's Talk training with SAfAIDS in the HIV prevention education section of this report.

one or both parents, as well as children with failure to thrive, malnutrition, or a history of frequent hospitalization.

The ReACH sub-awardees achieved 100% of the OVC_HIVSTAT target for the quarter. However, the example of the OVC_HIVSTAT results from SAfAIDS in the chart below demonstrate that the ReACH sub-awardees need to focus on identifying and documenting the HIV status of their clients, and ensure HIV-positive clients are initiated on treatment. The high proportion of clients who have not reported their status reflects either resistance from families to discuss HIV testing, or there is still a gap in the way clients are engaged in discussions around knowing their HIV status. In Dr. Kenneth Kaunda District, 25 clients reported their HIV-positive status. Of these, 64% are on ART. In Mopani District, 21 clients reported their HIV-positive status. Of these, 76% are on ART. ReACH sub-awardees will follow up with clients not yet on ART to ensure they are initiated on treatment.

Performance in OVC_HIVSTAT in Dr. Kenneth Kaunda and Mopani Districts: quarter three



In KwaZulu-Natal province, 81% of the OVC who were screened for HIV by NACOSA did not disclose their HIV status. Poor testing behavior in rural settings such as Harry Gwala and parts of Ugu districts, especially among those under 15 years old, as well as reluctance by clients to discuss their status, are contributing factors to non-disclosure.

CDS will intensify its support to sub-awardees in quarter four to improve referrals and linkages to HTS and relevant care and treatment for OVC clients. This will include ensuring that the HIV risk assessment tool is correctly administered by the home visitors, and that they have the capacity to provide sensitized counseling. These home visitors will work with clients to build trust and HIV knowledge over time to support HIV testing, disclosure, and access to appropriate care and treatment.

Quality Assurance

CDS conducted a baseline SIMS assessment at NACOSA where the aggregated score achieved was only 24%. Gaps noted included:

- Community dialogues are conducted, but the assessment point (NACOSA office in Ugu District) has no written strategy or plan in place for engaging clients/clients.
- There are quality management systems in place. There is a focal person for QI, but no functional quality management/QI committee/team.
- The assessment point does not have a written statement or policy promoting client/client rights and protections from stigma and discrimination that applies to all staff.
- The AGYW Vulnerability and Risk assessment tool is not implemented by the organization.
- The organization could not demonstrate a standard process to facilitate linkages to HIV testing for children and families, (i.e. assessment form, home visit form, SOP).
- Nutrition screening not performed.

An intensive quality improvement plan was instituted with NACOSA to improve the performance and overall program implementation.

DREAMS Initiative

CDS is implementing several interventions under the DREAMS initiative. These include:

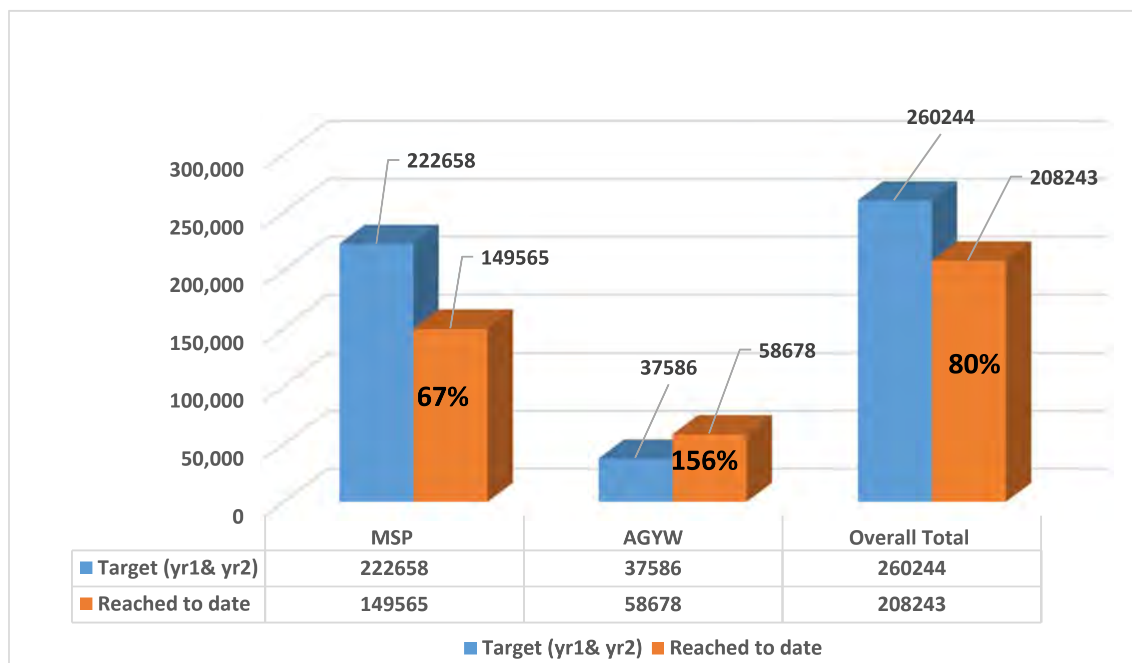
- HTS and Condom Promotion and Provision
- School-based HIV and Violence Prevention
- Community Mobilization and Norms Change, Post-Violence Care and Psychosocial Support

HTS and Condom Promotion and Provision

HTS

CDS is partnering with Humana to implement HTS and Condom Promotion and Provision to reach the most vulnerable AGYW and their male sex partners in the districts of eThekwini and uMkhanyakude in KwaZulu-Natal province. A total of 75,345 individuals were tested for HIV in quarter three, with a cumulative achievement of 208,243 individuals tested – 80% of the overall testing target. Quarter three testing included 19,689 AGYW and 55,656 male sex partners, constituting a cumulative achievement of 156% of the overall target for AGYW and 67% of the overall target for male sex partners. CDS will support Humana to sustain its performance, with the aim of reaching 100% of the target by the end of September 2017.

Cumulative performance in HTS by target group



	MSP	AGYW	Overall Total
Target (yr1& yr2)	222658	37586	260244
Reached to date	149565	58678	208243

Activities for the quarter focused on providing HTS and condom promotion and provision to the individuals tested, improving referrals and linkages to care and treatment, and layering with other DREAMS and non-DREAMS implementing partners to deliver all services required by clients. Field workers targeted AGYW and their male sex partners in high-risk communities, also providing screening for tuberculosis (TB), sexually-transmitted infections (STIs) and other non-communicable diseases, and referring individuals for further care and management where applicable.

The increased testing among male sex partners from quarter two is a result of improved targeting, including using mobile testing in male-dominated workplaces and other areas such as men's hostels. CDS is working with Humana to develop further strategies to promote men's participation in HTS.

HTS by type and age category: cumulative reach

The table below provides the number of individuals tested, as well as testing yield, for the different DREAMS age and sex categories. The table also includes rates of linkage to care and initiation on ART for both females and males across the five sub-districts.

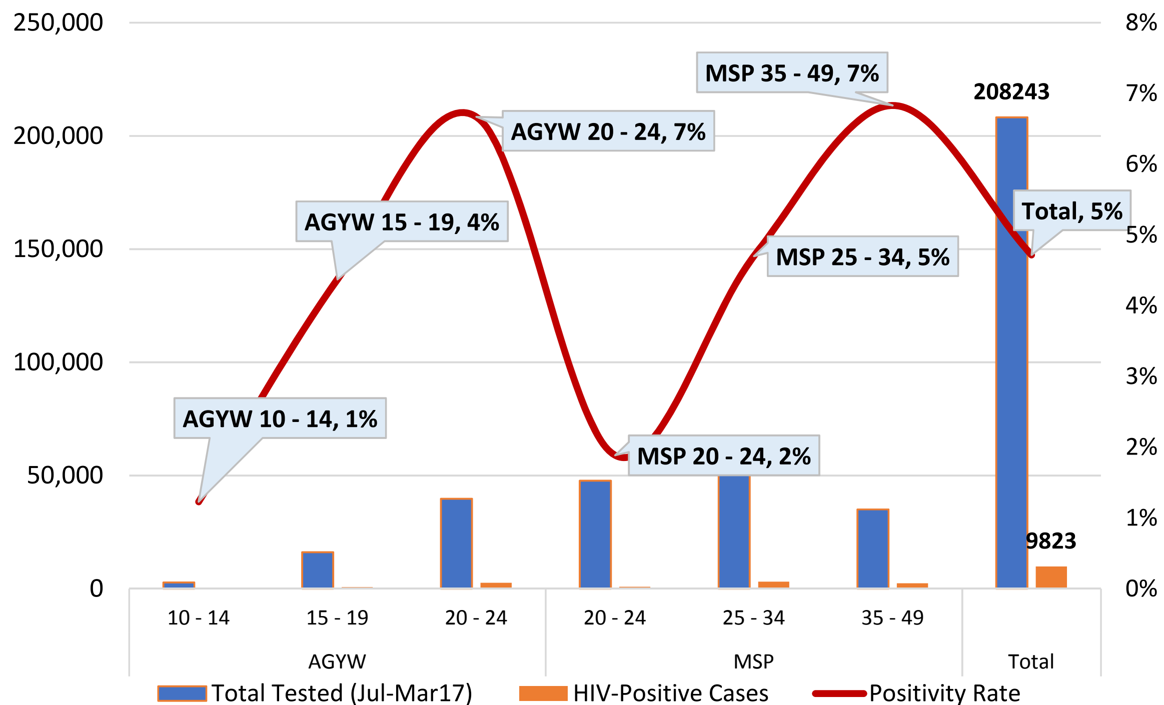
Cumulative performance for DREAMS HTS

<table>
<tr><th>Sex/Age Category</th><th>Target</th><th>HIV Tested</th><th>% of Target Achieved</th><th>HIV-Positive</th><th>HIV Positivity Rate</th><th>Referred for Care and treatment</th><th>Initiated on ART</th><th>Initiation Rate</th></tr>
<tr><td>Out of School AGYW (10-14)</td><td>174</td><td>2768</td><td>>100%</td><td>34</td><td><1%</td><td>34</td><td>4</td><td>12%</td></tr>
<tr><td>Out of School AGYW (15-19)</td><td>1075</td><td>16176</td><td>>100%</td><td>707</td><td>4%</td><td>707</td><td>93</td><td>13%</td></tr>
<tr><td>Young Women (20-24)</td><td>36337</td><td>39734</td><td>>100%</td><td>2650</td><td>7%</td><td>2650</td><td>585</td><td>22%</td></tr>
<tr><td>Male Sex Partners of AGYW (20 – 24)</td><td>55665</td><td>47728</td><td>91%</td><td>900</td><td>2%</td><td>900</td><td rowspan="2">1300</td><td rowspan="2">20%</td></tr>
<tr><td>Male Sex Partners of AGYW (25 – 49)</td><td>166993</td><td>101837</td><td>71%</td><td>5532</td><td>5%</td><td>5532</td></tr>
</table>

Positivity rates by age and sex

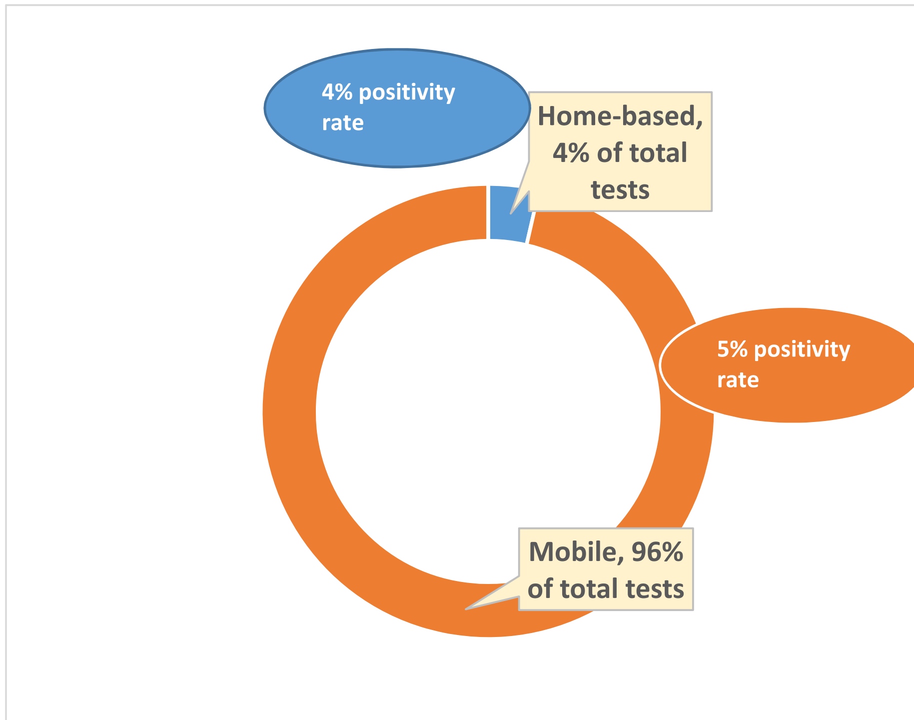
The testing data disaggregated according to age groups shows a pattern similar to the transmission model diagram for *She Conquers*, the national campaign for girls and young women aged 15-24 years. The highest positivity is seen among females in the age group 20-24 years (at 7%), and among males in the age group 35-49 years (at 7%). The positivity rate among females aged 20-24 years (7%) is more than three times that of men in the same age group (2%). As males with the highest positivity rate are aged 35-49 years, these men may be the older sex partners who infect females aged 15-19 years and 20-24 years (which have positivity rates of 4% and 7%, respectively). This data is consistent with relationship patterns in South Africa, where younger women are often in relationships with older male partners.

DREAMS HTS positivity rates by age: cumulative results



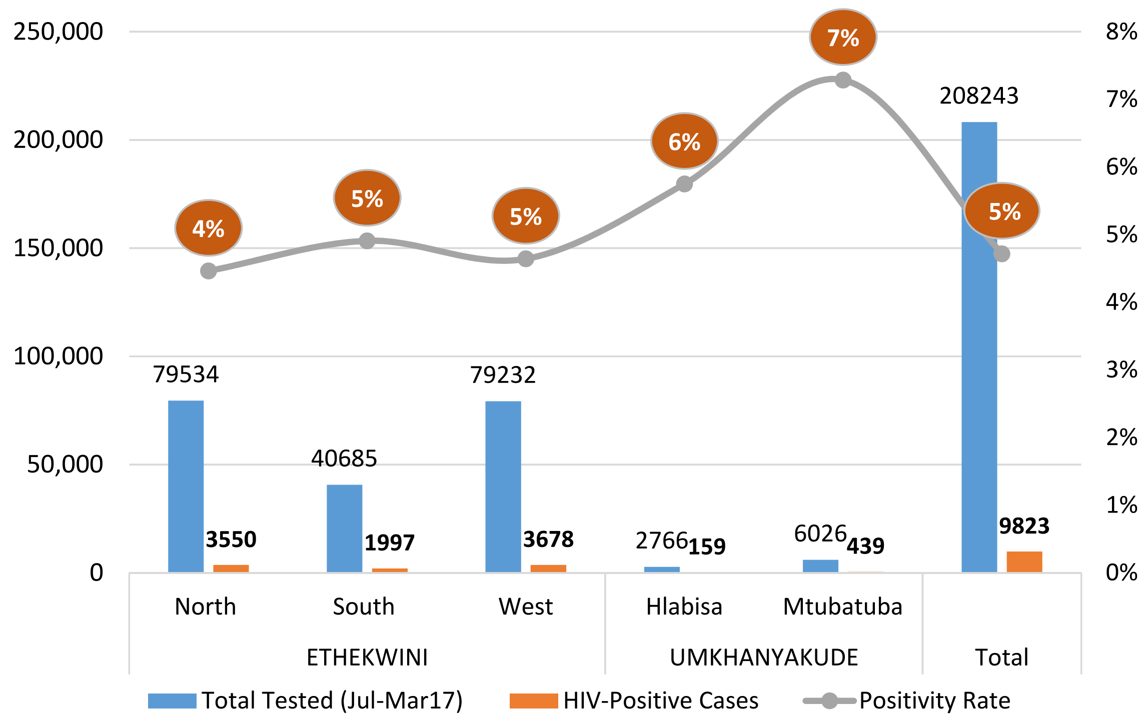
This data indicates that adolescent girls who are out of school should be targeted with prevention interventions before they reach 15 years of age, as the positivity rate starts to increase from the 15-19 years' age bracket. Prevention interventions should also target the older male sex partners who are part of the transmission cycle, with the provision of condoms as a part of the prevention package. In order to increase case finding, testing services should target young women aged 15-19 years and male sex partners aged 25-34 years and 35-49 years, as these groups are more likely to be HIV-positive.

HTS modalities and associated positivity rates



The modality used most often is mobile testing, which reaches more men than the home-based testing initially used by Humana. The positivity rate for tests done with mobile testing is 5% compared to positivity for home-based testing, at 4%. Mobile testing demonstrates its value in terms of reaching much higher numbers of male sex partners, as well as providing a slightly higher positivity rate among those tested. Humana will continue using this modality for the remaining three months of testing.

HTS provided by sub-district and associated yield: cumulative results

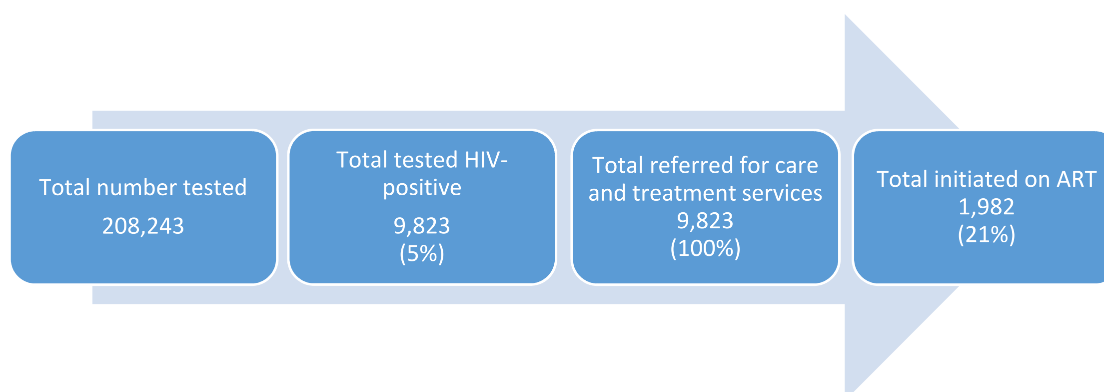


Humana's cumulative HIV positivity rates in the five sub-districts ranged from 4% in eThekwini North to 7% in Mtubatuba. Although the numbers tested in both sub-districts of uMkhanyakude were lower than the other three sub-districts, the HIV yield was high due to the testing being conducted in hard-to-reach rural and peri-urban settlements with high HIV prevalence. These areas often have populations who cannot access health facilities due to distance and cost involved for transportation.

This data suggests that more testing services should be directed at the two uMkhanyakude sub-districts Hlabisa and Mtubatuba, with higher testing targets, as these two sub-districts have been showing consistently higher positivity rates and have great potential for new HIV case finding. In addition, prevention programs that focus on behavioral change and condom promotion should be targeted at the out of school AGYW as well as male sex partners in these two areas.

Linkages to care and treatment

Linkages to care and treatment summarized treatment cascade for the five sub-districts[24]



The proportion of all clients who are linked to treatment and initiated on ART after testing HIV-positive is low across all the sub-districts, at 21%. Women aged 20-24 years have the highest ART initiation rates among females (22%), while the ART initiation rates for females aged 10-14 years and 15-19 years are 12% and 13%, respectively – slightly more than half that of the older females. This may indicate that younger women are not empowered enough to seek out health care after a positive diagnosis. It may also indicate that facilities are not providing a youth friendly environment for young people to access health care on their own. There may also be other barriers to younger girls accessing care, such as a lack of transport to reach facilities. Consequently, adolescent girls who test HIV-positive may need a stronger support system and someone to whom they can disclose their status and be supported through the process of accessing treatment.

Male sex partners also had a low initiation rate, at 20%. Due to the mobile nature of the testing services, it may be difficult to find clients within the facility records after a referral; therefore, it is possible that more male sex partners initiated treatment than this dataset indicates. In addition, men may be taking longer to present at the facilities for treatment due to their poorer health-seeking behavior. CDS will assess sub-awardees' provision of post-test counselling, as it is critical to fully educate the client about the importance of starting treatment immediately to support optimal outcomes, in alignment with the DOH Universal Test and Treat policy.

Linkages are still a major challenge, as most clients testing HIV-positive do not go to the health facilities within the 72-hour stipulated time period. To ensure that the 90-90-90 strategy is attained, Humana field workers, who are professional nurses, reported conducting follow-up with all individuals that tested HIV-positive within 72 hours to confirm linkages to care, treatment and support. The field workers applied several follow-up strategies, including

[24] Data as reported by Humana.

home visits, phone calls and collaboration with health facilities to encourage and track linkages.

CDS, with consortium partner FPD, provided technical assistance to ATC-HTS sub-awardees in eThekwini to support higher rates of linkage to and enrolment in care. This included on-site support and standardization of the data capturing tools and data disaggregation. CDS provided input on the processes included in each sub-awardee's referral and linkages SOP. In quarter four, CDS will provide similar technical assistance to Humana for the DREAMS testing to ensure that the organization improves retention throughout the entire HIV cascade, particularly where linkage and initiation rates are currently poor.

A key aspect of CDS' approach to linkages has been to ensure that each sub-awardee has a master tool containing all HIV-positive and referred clients, which captures all the required data such as dates of arrival at the health facility, services received (such as CD4 counts and blood taken), each follow-up with clients, and the date of ART initiation. Strategies used to improve the process for linking clients to care in eThekwini included:

- Allocate dedicated people to support linkages to care
- Strengthen relationships with the District Support Partner
- Compile a spreadsheet of all referred clients which is updated as linkages to care are confirmed
- Conduct telephone follow-up of all clients who have previously tested HIV-positive
- Negotiate access to the Tier.Net system at health facilities
- Each field worker to track and follow up on his/her referred clients

These best practices will be replicated across the DREAMS project in quarter four.

Layering of services

Humana complemented DREAMS interventions by working with stakeholders including civil society, faith-based organizations and community structures. These stakeholders included Operation Sukhuma Sakhe, District AIDS Councils, Ward Committees, and the eThekwini Nerve Centre. In quarter three, Humana collaborated with NACCW, Miluve, Maternal Adolescent and Child Health (MatCH), Kheth'Impilo, and Project Empower, providing HTS to AGYW and male sex partners referred by these partners. For example, Humana provided HTS to males before MatCH conducted VMMC, and provided HTS to females participating in *Stepping Stones* under Project Empower. Humana also continued to rely on both provincial and municipal health facilities to provide HTS consumables to ensure that the AGYW and male sex partners receive HTS.

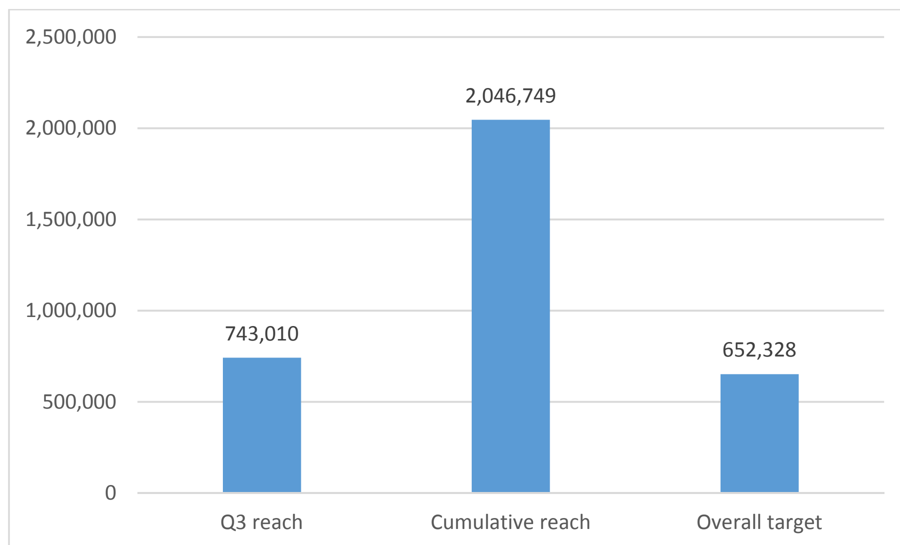
Screening and referrals

In quarter three, Humana field workers provided a comprehensive package of health screening services which included TB, STIs, PMTCT and non-communicable diseases. All AGYW and male sex partners reached under DREAMS were screened for TB and STIs, and referred for further diagnosis if found to have more than one symptom. Male sex partners were also referred for VMMC. A total of 829 males were referred for VMMC, 50 individuals were referred for STI services, and 51 individuals were referred for TB testing.

Condom Promotion and Provision

In quarter three, CDS received clarification from the USAID HIV Prevention team on the indicator for condom promotion and provision. The target set for this indicator refers to numbers of condoms distributed to the different age and sex categories under DREAMS HTS. A total of 721,740 male and 21,270 female condoms were distributed in quarter three. The accompanying condom messaging promotes the correct and consistent use of condoms for HIV prevention, with demonstrations on both the male and female condoms. Humana provides these condoms to AGYW and their male sex partners during HTS pre- and post-test counselling, as well as during community awareness and mobilization campaigns.

Condom distribution: quarter three and cumulative

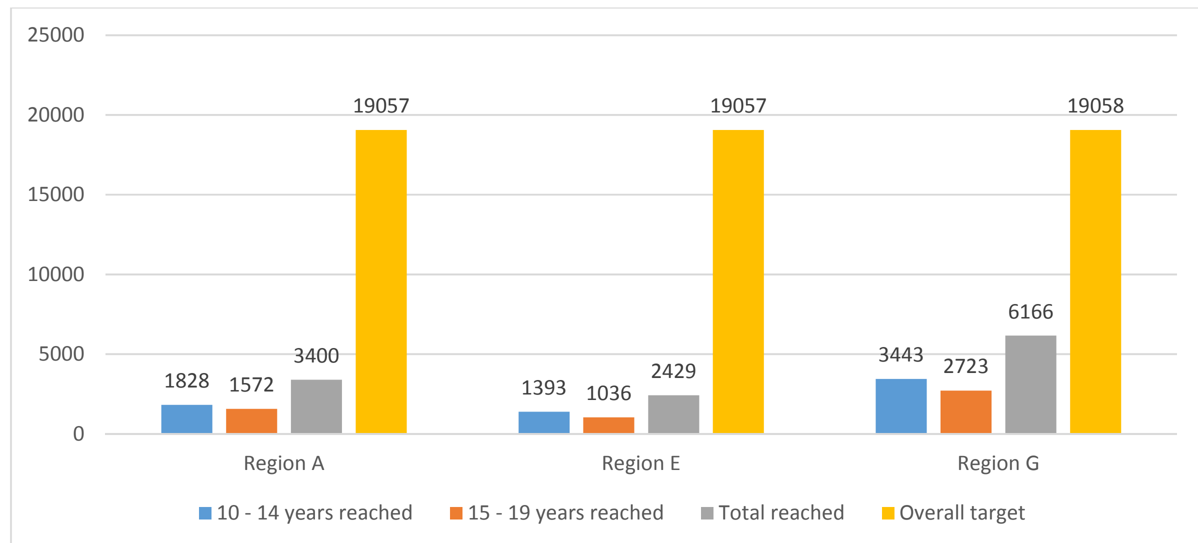


School-based HIV and Violence Prevention Program

The School-based HIV and Violence Prevention program aims to reduce HIV infection and violence among in-school AGYW aged 10-14 and 15-19 years in the City of Johannesburg (regions A, E and G) in Gauteng province. In quarter three, CDS sub-awardee NACCW focused on recruitment, enrollment and implementation of the Vhutshilo HIV prevention program.

NACCW's reach of AGYW through the program has significantly improved in quarter three following the new implementation strategy, as well as the appointment of an additional 52 CYCWs who were placed in communities to recruit school-going AGYW. NACCW reached 21% of its overall FY16 target of 57,172 in quarter three. The majority of the AGYW were aged 10-14 years, as this age group was found to be more available after school hours to participate in the program. Older students typically have a heavier work load and more limited time for extra-curricular activities.

Performance in PP_PREV by region and age category: quarter three



Recruitment of AGYW was conducted using a two-pronged approach -- both in schools and at community level -- to fast-track implementation. Community recruitment was done through after care programs at safe parks, churches and other community structures. AGYW recruited from safe parks were then traced back to their respective schools within the allocated wards. Schools provided letters to parents/caregivers to support their children's participation in Vhutshilo workshops at community level.

NACCW facilitated implementation of Vhutshilo through after-school activities, weekend camps and school holiday camps. A total of 11,995 AGYW completed the Vhutshilo program in quarter three, including 6,664 girls aged 10-13 years who completed Vhutshilo 1 and 5,331

girls aged 14-18 years[25] who completed Vhutshilo 2.[26] CDS provided technical support to monitor appropriate allocation of AGYW to Vhutshilo 1 and 2, as well as the quality of sessions (facilitation, content, participation and execution of practical activities). Layering of services was done through other DREAMS and non-DREAMS partners as discussed below.

Region G contributed to 53% of the overall performance due to the higher number of schools allocated for implementation. CDS provided technical support to review data quality as well as strengthen NACCW's implementation approach, with specific focus on:

- Developing a system to track learners who drop out from the program
- Developing a catch-up strategy to assist learners who miss sessions[27]
- Ensuring that all AGYW are correctly assessed to ensure appropriate layering of services
- Ensuring all AGYW participating in Vhutshilo are in a Buddy Group[28] and are correctly recorded

An additional 7,289 AGYW are currently attending Vhutshilo sessions and will complete the program in quarter four.

Layering of Services for AGYW

Prior to the commencement of Vhutshilo workshops, AGYW are screened and assessed to identify specific risks and vulnerabilities. NACCW screened AGYW using a Child Protection Indicator tool[29] adopted from its OVC program. A total of 817 AGYW were identified to have health and social needs, all of whom were referred and linked to other service providers. NACCW partnered with Anova Health Institute, Thuthuzela Care Centers and the Department of Home Affairs to provide required services. CDS also linked NACCW with NICDAM to strengthen its GBV services.[30] Anova Health Institute facilitated youth dialogues on post-violence care to vulnerable girls that attended the school holiday camps in regions E and G in April 2017. During the camps, NACCW mentors worked with the school-based teams to distribute dignity packs[31] to AGYW. The majority of the young girls (94%) were linked to educational subsidies, demonstrating a high need in this area. Notably, 3% of young girls were

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[25] Girls aged 19 years are also included in Vhutshilo 2.

[26] CDS is in the process of finalizing Vhutshilo pre- and post- questionnaires, and will roll them out to implementing partners in quarter four.

[27] The AGYW are required to complete at least 80% of the Vhutshilo sessions.

[28] Buddy Groups are clusters of five AGYW who attended Vhutshilo together and meet at least monthly to provide mutual support. They are supervised by the CYCW who facilitated the Vhutshilo sessions.

[29] NACCW's tool is an observation checklist which assesses vulnerability based on exposure to behaviors such as bullying and substance abuse.

[30] NICDAM is implementing the Community Mobilization and Norms Change, Post-Violence Care and Psychosocial Support under DREAMS in regions A, D, E and G in the City of Johannesburg.

[31] Dignity packs contain hygiene products including sanitary towels, deodorant, soap, Vaseline and cream to support young girls who have limited access to these basic resources.

identified to be exposed to sexual violence. NACCW will continue working closely with NICDAM and Anova Health Institute to ensure these girls are provided with the necessary services, including long-term psychosocial support. NACCW will follow up the referrals in quarter four to ensure that all AGYW receive the appropriate services.

Layering and referrals of AGYW: quarter three

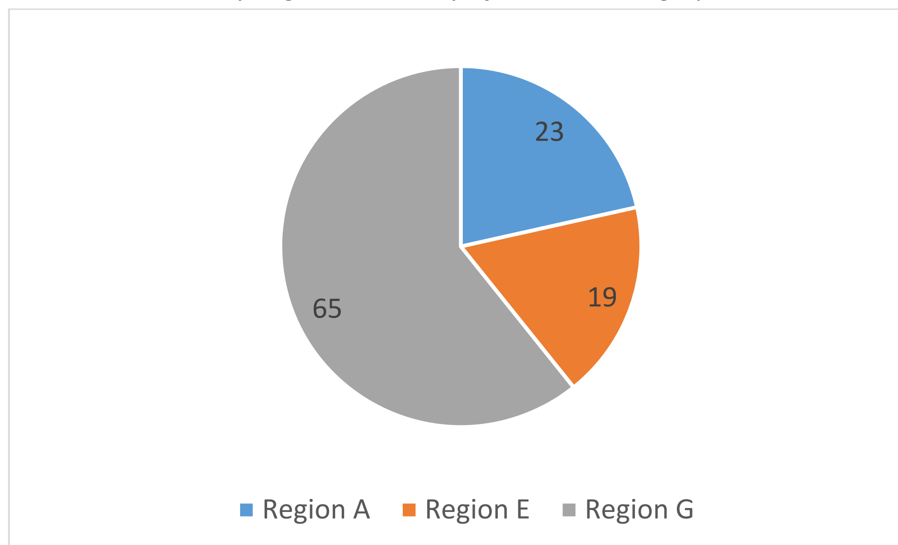
Types of vulnerabilities	Number of referrals	Layered services	Receiving organizations
Neglect and sexual abuse	26 (3%)	-Child protection services -Post-violence care -Legal services (opening of case) -Sexual and reproductive health (HTS, PMTCT)	DSD, Thuthuzela Care Centers, Child Welfare Anova Health Institute, South African Police Services
Lack of educational resources	771 (94%)	-School uniforms -Dignity packs -Stationery	NACCW[32], DSD
Emotional difficulties, including attempted suicide and bullying	9 (1%)	-Psychosocial support -Counselling -Family group conferences -Case conferencing with School-based Support Teams	NACCW, DSD Childline Thuthuzela Care Centers
Lack of IDs and birth certificates	11 (1%)	-Social protection services	Department of Home Affairs
Total	**817**		

[32] NACCW is implementing several programs under DREAMS.

School Enrollment in the City of Johannesburg's Regions A, E and G

NACCW has been allocated 107 schools across the three regions to implement this program. In quarter two, CDS and NACCW notified the Gauteng Department of Education (GDE) that some of the schools allocated to the program in regions A and E were not participating in the program. These included schools with adequate or similar services offered by other DREAMS and non-DREAMS partners. In quarter three, this issue was addressed by the allocation of 50 additional schools from region G. The majority of schools (65) are within region G, which has a high burden of HIV risk-taking, teenage pregnancies and substance abuse among AGYW in areas such as Orange Farm, Lenasia, and Eldorado Park. The additional allocation was endorsed by the District Manager in region G, who expressed support for the program.

School allocation by region in the City of Johannesburg: quarter three



Stakeholder Engagement

As a program implemented in partnership with South Africa's Department of Education, ongoing engagement and meetings are key to maintain programmatic progress. CDS held several meetings with NACCW and GDE in quarter three to track progress, address challenges and develop solutions. The outcomes of these meetings were critical in contributing to achievements in the quarter.

NACCW project progress review meeting

On May 9, 2017, CDS facilitated a project review meeting with NACCW's senior management team to discuss financial and programmatic performance, including progress against targets, a catch-up strategy to meet 80% of the target by June 2017, challenges and solutions. NACCW was advised to increase the number of CYCWs and mentors to fast-track implementation. CDS committed to engage GDE to advocate for additional schools. NACCW was advised by HETTAS,

the Vhutshilo service provider, not to exceed 25 young girls per group to avoid compromising the quality of the sessions.

Following this meeting, CDS conducted a data quality check to ensure that Vhutshilo implementation guidelines were being followed, resulting in a significant improvement in the facilitation and recording of Vhutshilo sessions.

GDE consultative meeting

CDS facilitated a teleconference with GDE on May 12, 2017, to discuss the challenges that NACCW was experiencing in accessing schools and the limited time allocation at schools. CDS held a follow-up meeting with GDE and NACCW on May 15, 2017, to discuss the selection of additional schools and the roll-out of weekend and school holiday camps to fast-track implementation. GDE agreed to allocate additional schools from region G, and high schools were prioritized for Vhutshilo 2, in line with PEPFAR priorities. GDE committed to support weekend camps by compiling a Memorandum of Agreement notifying district officials about the camps. NACCW was requested to submit an analysis on the estimated number of AGYW to be reached through the active schools to inform the number of additional schools required to meet the target.

DREAMS Steering Committee meeting

CDS participated in the DREAMS Steering Committee meeting on June 15, 2017, to review the quarterly data as captured onto DIMES from April 2016-March 2017. Layering between DREAMS partners and government stakeholders was emphasized, and partnerships and co-planning of events were encouraged. The Department of Basic Education (DBE) highlighted the need for DREAMS partners implementing school-based interventions to work within DBE parameters, and GDE expressed commitment to work with NACCW and CDS to increase project performance.

On June 19, 2017, CDS facilitated a follow-up teleconference between NACCW and NICDAM to strengthen layering of services for GBV cases. NACCW and NICDAM agreed on the development of a referral system that will help both sub-awardees achieve their targets and ensure their clients receive all required services.

Implementation Challenges and Corrective Measures

Challenges	Solutions
Limited time allocated for Vhutshilo sessions by schools and limited availability of learners during exams	Vhutshilo sessions to be facilitated after schools and during weekend in community halls
Lack of safety for learners after school hours	Parents sign consent forms and communicate continuously with CYCWs and mentors
Region A and E schools have been saturated due to other DREAMS partners facilitating Vhutshilo curricula	NACCW has been encouraged to recruit AGYW through safe parks within the priority wards
Non-active schools and limited cooperation by school management	Discussion with GDE to engage all schools and give guidance on non-participating schools/wards

By the end of June, NACCW had achieved only 21% of its overall target. To meet 100% of the target by the end of quarter four, NACCW will need to reach 45,177 young girls with interventions. This will require reaching 15,059 girls monthly (7,095 girls aged 10-14 years and 7,964 girls aged 15-19 years). To achieve this, NACCW plans to assign 60 CYCWs to mobilize and recruit young girls into the program, while 145 CYCWs will continuously facilitate Vhutshilo sessions. Each of these CYCWs will be expected to facilitate at least four groups of 25 AGYW per month.

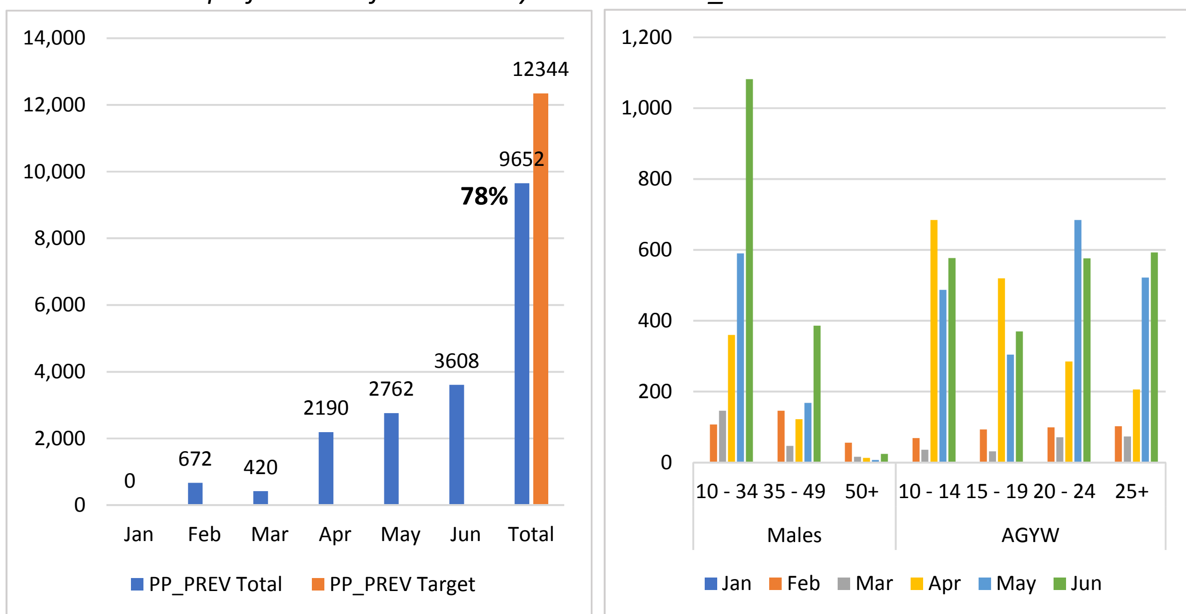
In quarter four, CDS will support NACCW in ongoing program improvement through:

- Aligning interventions with the DBE Policy on HIV, STIs and TB (No. 395 of 2015) launched at the South African AIDS conference in June 2017
- Strengthening referral and layering systems by forging relationships between DREAMS partners and other community stakeholders
- Prioritizing AGYW aged 15-17 years in line with PEPFAR priorities
- Assisting CYCWs to work with the Integrated School Health Program to link AGYW to health facilities for increased uptake of sexual and reproductive health (SRH) services

Community Mobilization and Norms Change, Post-Violence Care and Psychosocial Support

CDS is implementing the Community Mobilization and Norms Change, Post-Violence Care and Psychosocial Support initiative to reduce GBV and the risk of HIV among AGYW in the City of Johannesburg in Gauteng province, and in eThekwini and uMkhanyakude in KwaZulu-Natal province. The objectives are to: a) strengthen communities to promote and sustain gender equality, and prevent GBV and HIV among AGYW; and 2) provide quality and timely post-violence care (PVC) and psychosocial support to AGYW who have experienced GBV, and reduce any related negative effects and/or repeated assault of AGYW in targeted communities.

Sub-awardees' performance from January-June 2017: PP_PREV



In quarter three, the sub-awardees made significant progress from quarter two, reaching 8,560 individuals. This brings the cumulative reach for PP_PREV to 9,652 – 78% of the target.

Performance in PP_PREV by district: cumulative

District	Cumulative achievement	Target	% achieved against target
City of Johannesburg (NICDAM)	2,058	2,600	79%
uMkhanyakude (Hope Africa)	2,404	2,600	92%
eThekwini (Project Empower)	5,189	7,144	73%
Total	9,652	12,344	78%

Sub-awardees improved their performance through: a) employment of additional staff to build capacity; b) training additional *Stepping Stones* facilitators; and c) increasing numbers of cases for referral through enhancing layering and linkage systems and mechanisms. Overall, most clients who completed community dialogues were males aged 10-34 years old (2,285), due to their greater availability than other age groups: South Africa's youth unemployment rate is 38.6%, with 58% of unemployed people aged between 15-34 years[33]. The second-highest group to complete community dialogues were females aged 10-14 years (1,853).

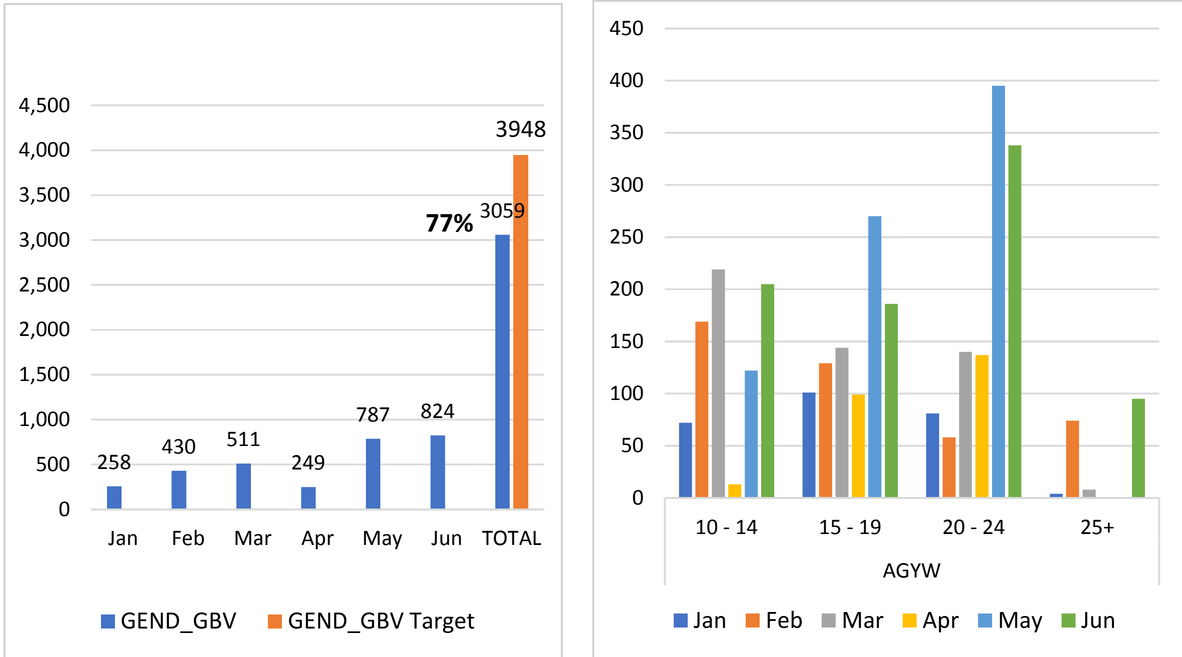
In eThekwini and the City of Johannesburg, more males than females attended community dialogues and workshops, while in uMkhanyakude, more females than males attended the sessions. In the City of Johannesburg, the highest attendance among males was those aged 35-49 years; among females, it was those aged 25+ years. In eThekwini, the highest attendance among males was those aged 10-34 years; among females, it was those aged 20-24 years. In uMkhanyakude, the highest attendance among males was those aged 10-34 years; among females, it was those aged 10-14 years. Many older participants who participated in the community dialogues reside in the two cities of Durban (eThekwini) and City of Johannesburg, whereas most rural participants (uMkhanyakude) were from the younger age groups (males 10-34 years and females 10-14 years).

The urban and rural divide as related to age and sex disaggregation has implications for programming for the DREAMS Community Mobilization and Norms Change, PVC and psychosocial support (PSS) initiative. The data suggest that for eThekwini and the City of Johannesburg, community mobilization and dialogues should address risk factors affecting the 10-49 years' male cohort (for example, unemployment and economic strengthening opportunities, and referral to prevention services such as VMMC). On the other hand, in

[33] StatsSA Quarterly Employment Statistics, March 2017

uMkhanyakude, the mobilization and dialogues should be customized to respond primarily to issues and risk factors affecting younger age groups such as the 10-14-year female cohort, specifically focusing on the out-of-school females.

Sub-awardees' performance from January-June 2017: GEND_GBV



In quarter three, the sub-awardees reached 1,860 individuals through the provision of PVC and PSS services to AGYW who have experienced GBV. This brings the cumulative reach for GEND_GBV to 3,059 – 77% of the target. Sub-awardees improved in terms of layering and linkages with DREAMS and non-DREAMS partners, which is reflected in the higher number of AGYW who received PVC and PSS services in quarter three.

Performance in GEND_GBV by district: cumulative

District	Cumulative achievement	Target	% achieved against target
City of Johannesburg (NICDAM)	1,703	2,328	73%
uMkhanyakude (Hope Africa)	267	286	93%
eThekwini (Project Empower)	1,089	1,334	82%
Total	3,059	3,948	77%

The age group reached most often with services were AGYW aged 20-24 years, constituting 38% of the total reach. This was followed by AGYW aged 15-19 years, constituting 30% of the total reach. In the City of Johannesburg and eThekwini, many of the females aged 20-24 years who participated in community dialogues were young mothers and unemployed. During the dialogues, these participants reported experiences of discriminatory practices, emotional and psychological abuse perpetrated by their elderly caregivers (such as grandmothers), peer pressure and suicidal tendencies, and economic dependence on male partners, often putting them at risk of being involved in unhealthy and abusive relationships.

The *Stepping Stones* intervention shows promising results in addressing some of these challenges. AGYW from all the community mobilization and PSS sites have reported increased: a) self-esteem, resilience and positive image; b) openness and assertiveness; c) ability to set short and long terms goals; d) anger management; e) improved communication with sexual partners; and f) confidence in decision making.[34] Sub-awardees have also experienced higher levels of GBV disclosure after *Stepping Stones* interventions.

Although there has been improvement toward achieving the GEND_GBV target, sub-awardees continued to experience low levels of recently-experienced GBV disclosures during assessments. AGYW have also not reported intra-family violence. Findings from a recent Rapid Assessment and Gap Analysis report conducted by FPD[35] indicate that health facilities often have limited resources and are unable to provide services needed by those who experience GBV. The Rapid Assessment also identified a shortage of essential staff such as social workers, psychologists and/or trauma counselors to provide short and long term counselling for survivors of GBV. People living in more rural areas face additional challenges

[34] Read more about the value of the Stepping Stones approach in the Success Story section of this report.

[35] Foundation of Professional Development, Rapid Assessment and Gap Analysis of Facilities on PVC Services, 2017

in accessing services due to the distances they are required to travel. Together, these factors present a challenge in terms of linkages and layering, and ultimately in effectively addressing GBV in these communities.

CDS is supporting its sub-awardees to provide services that meet the needs of their clients. In providing PSS, consideration should be given to the experiences, needs and constraints of the AGYW, and they should be referred and linked to services that cater for their needs. For example, pre-adolescent and adolescent girls aged 10-19 years should be linked to adolescent and youth friendly services, while those that are out of school should be linked to Isibindi programs. CDS will continue to support the sub-awardees in quarter four, including for efficient and effective data tracking and management, as well as support with layering.

Quality Assurance

CDS conducted a SIMS baseline with sub-grantees NICDAM and Hope Africa in quarter three.

SIMS baseline performance: NICDAM and Hope Africa

	NICDAM	Hope Africa
SET 1A: Any Populations - Score at Community Assessment Point (Required)	12	12
SET 1B: Any Populations - Score at Community Assessment Point	27	9
Aggregated performance	**76%**	**41%**

Hope Africa

Hope Africa scored 41% on the SIMS assessment. CDS will support the organization to address the following gaps in quarter four:

- There is no written strategic plan for engaging clients and no policy on stigma and discrimination.
- There is a QI team that meets regularly, but the meetings are not documented and there is no QI plan.
- There is no standardized DQA monitoring system available or SOP on internal DQA processes.
- Referral tools are available, but there is no tracking of referred clients.

NICDAM

NICDAM scored 76% in the SIMS assessment. While the organization was strong in client engage ment, HIV quality management and staff training on key policies and SOPs (child

safeguarding, stigma and discrimination, risk reduction counselling and GBV response in the community), gaps included:

- Lack of formal review of performance data to identify areas for improvement
- No evidence that all staff were trained on client protection such as confidentiality
- Facilitators' performance assessments are not used to improve the quality of their facilitation and program activities
- Lack of SOPs to be followed for data quality assessments

CDS and NICDAM developed the following actions to address the gaps:

- NICDAM to identify at least one focal person (champion) to be capacitated on quality assurance and im/provement by CDS
- NICDAM to create a training register for all training, and staff performance to be regularly assessed by supervisors (at least every 3 months)
- CDS to share the M&E data quality assessment SOP for implementation by NICDAM

Accelerated Targeted Community-based HIV Testing Services (ATC-HTS)

ATC-HTS seeks to increase uptake of high-quality, community-based HTS among high-risk and undiagnosed HIV-positive individuals and to ensure referrals and effective linkages of all individuals diagnosed with HIV to care and treatment programs. CDS is partnering with three sub-awardees in three provinces: Society for Family Health (KwaZulu-Natal province), Humana (KwaZulu-Natal and Free State provinces) and HIVSA (Gauteng province).

The dashboard below summarizes quarterly achievements and cumulative progress against testing targets. CDS has made significant progress in meeting its targets from quarter two, and achieved 85% of its annual target, testing a total of 116,107 individuals. Cumulatively, 129,081 individuals have been tested since services began in February 2017.

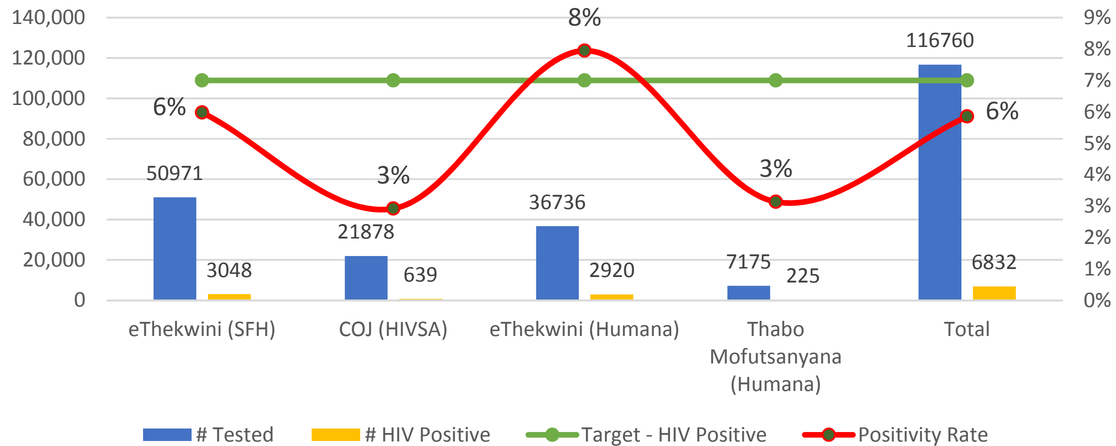
HIV testing achievements against targets in quarter three

Location and sub-awardees	Overall Target	Achieved in quarter three	Cumulative achievement (Feb-June 2017)	% of target achieved	Status
Region D, City of Johannesburg, Gauteng (HIVSA)	35516	21878	28970	82%	
eThekwini, KwaZulu-Natal (Society for Family Health)	70000	50971	56200	80%	
eThekwini, KwaZulu-Natal (Humana)	30559	36083	36736	120%	
Dihlabeng, Thabo Mofutsanyana, Free State (Humana)	15512	7175	7175	46%	
Total	**151587**	**116107**	**129081**	**85%**	

CDS sub-awardee Humana underperformed in the sub-district of Dihlabeng in Thabo Mofutsanyana District, Free State province, due to challenges including lengthy negotiations with the provincial and sub-district DOH leadership.

CDS supported all sub-awardees to implement their catch-up plans following poor performance in quarter two. CDS instituted weekly progress monitoring, with weekly discussions on achievements, challenges and further interventions. Sub-awardees implemented strategies including rapid hiring of additional testing staff, conducting mass testing events, and providing services during the weekends and public holidays in targeted areas.

HTS uptake and positivity rates

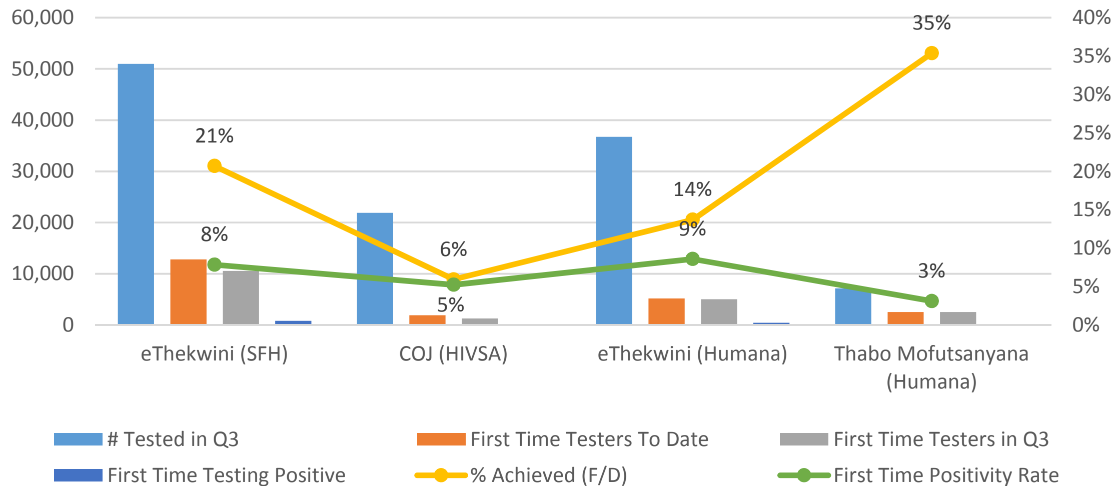


Society for Family Health in eThekwini achieved consistently higher positivity rates (13%) in quarter two. In quarter three, the number of individuals tested increased significantly, but the positivity rate decreased to 6%. This decrease was attributed to inadequate targeting as additional teams were added to increase the number of individuals tested. In quarter four, the organization will re-focus on the application of high-yield modalities such as index case testing and providing services in hard-to-reach areas.

Humana, also working in eThekwini, achieved the highest positivity rate in quarter two, at 8%. Positivity rates in Dihlabeng sub-district, Thabo Mofutsanyana District (Humana), and Region D in the City of Johannesburg (HIVSA) had positivity rates of 3% in quarter three. The varying positivity rates seen under one organization (Humana) working in two different locations is likely due to differences in staffing, with a smaller team in Dihlabeng, and challenges in accessing communities in the sub-district.

Testing in the City of Johannesburg has resulted in relatively low positivity rates (3%) despite providing services in Region D around Soweto and in neighbouring informal settlements where positivity rates are expected to be high. With CDS technical support, HIVSA has been monitoring its positivity rates on a weekly basis and is implementing measures to improve its targeting and HIV yield. This includes implementation of home-based testing on an appointment basis to increase its testing modality mix.

First time testers and positivity rates



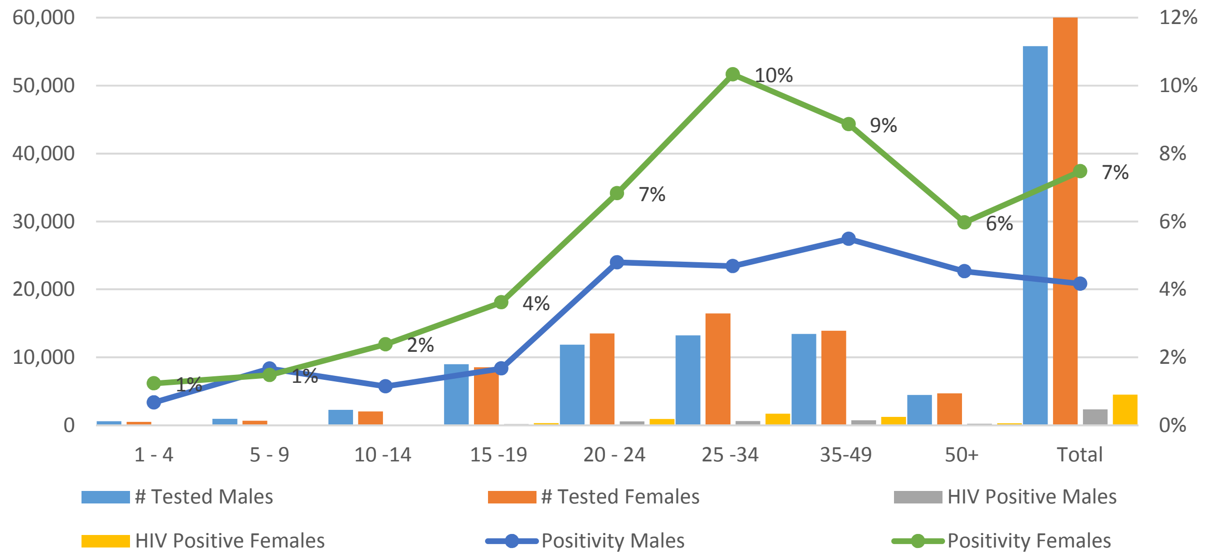
The highest proportion of first time testers was in Dihlabeng, with 35% of the individuals testing reporting that it was their first HIV test. Humana has been implementing home-based and mobile testing services in semi-rural areas surrounding Bethlehem, some of which have not been reached with HTS before. In eThekwini, the proportion of first time testers was 21% under Society for Family Health.

The positivity rates for first time testers was higher than repeat testers in all the sub-districts except in Dihlabeng, where the positivity rates were equivalent. Even in the City of Johannesburg, where the overall positivity rate is low at 3%, those testing for the first time had a higher positivity rate of 5%. These results indicate that in order to identify new undiagnosed cases of HIV, sub-awardees should target hard-to-reach and under-serviced populations in their districts.

In quarter four, sub-awardees will focus on improving their positivity rates through strategies including:

- Better targeting of higher-yield areas
- Implementing higher-yield modalities such as index client testing and workplace mobile testing
- Using performance improvement plans with set targets for yield
- Testing more women, as the data shows that more women are testing HIV-positive, particularly those in the age groups 25-34 years and 35-49 years
- Using run-charts to monitor positivity rates on a weekly basis
- Accessing hard-to-reach locations to test those who have never been tested before, as the data show that positivity rates are higher in first time testers

HTS and positivity rates by sex and the target age groups

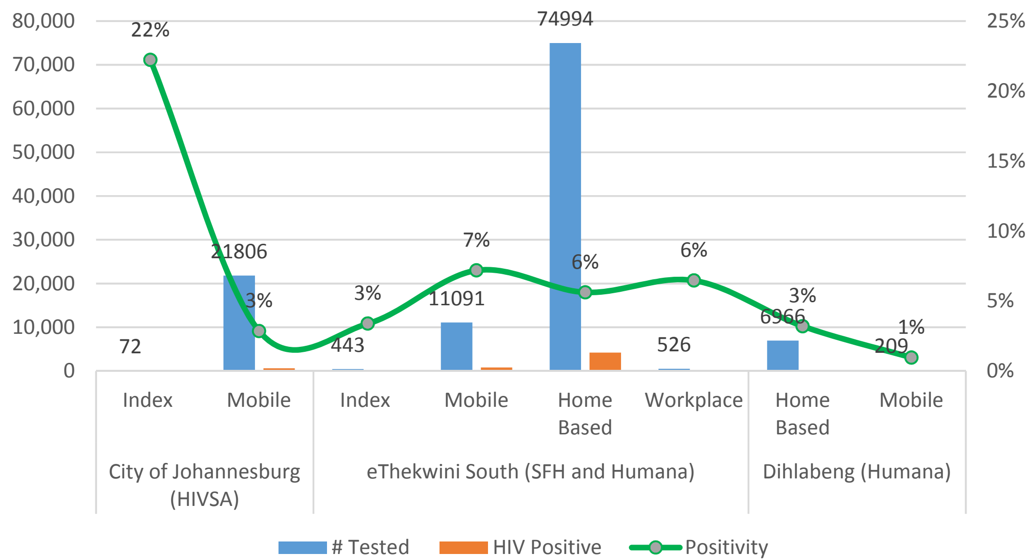


The testing data disaggregated according to age groups shows a pattern similar to the transmission model diagram for *She Conquers*, the national campaign for girls and young women aged 15-24 years. More females than males have been tested, with 60,298 females and 55,809 males tested. Positivity rates were consistently higher in females compared to males after nine years old, with the greatest difference among those aged 25-34 years, when women had double the positivity rate (10%) of men.

The positivity rates are low – at or below 2% – among those under 14 years of age for both females and males. Positivity rates increase among those aged 15-19 years, with higher positivity among females (4%) compared to males (2%). This implies that the male sex partners of these girls may be older men rather than boys and men their own age. In the age group 20-24 years, the positivity rate among women is 7% compared to males of the same age, at 5%. While positivity is highest among females when they are aged 25-34 years, it is highest among males when they are aged 35-49 years. These males are the likely sex partners of the females aged 15-19 years. Positivity rates decline for both females and males after 50 years of age.

Based on this program data, HIV prevention programs should target women before they reach the ages of 15-19 years, when their positivity rates start to increase. Prevention messages should always include condom promotion and provision. HTS should target females aged 25-34 years and 35-49 years, as program data indicate testing yield is higher in these groups.

HIV testing and positivity rates by sub-district and modality

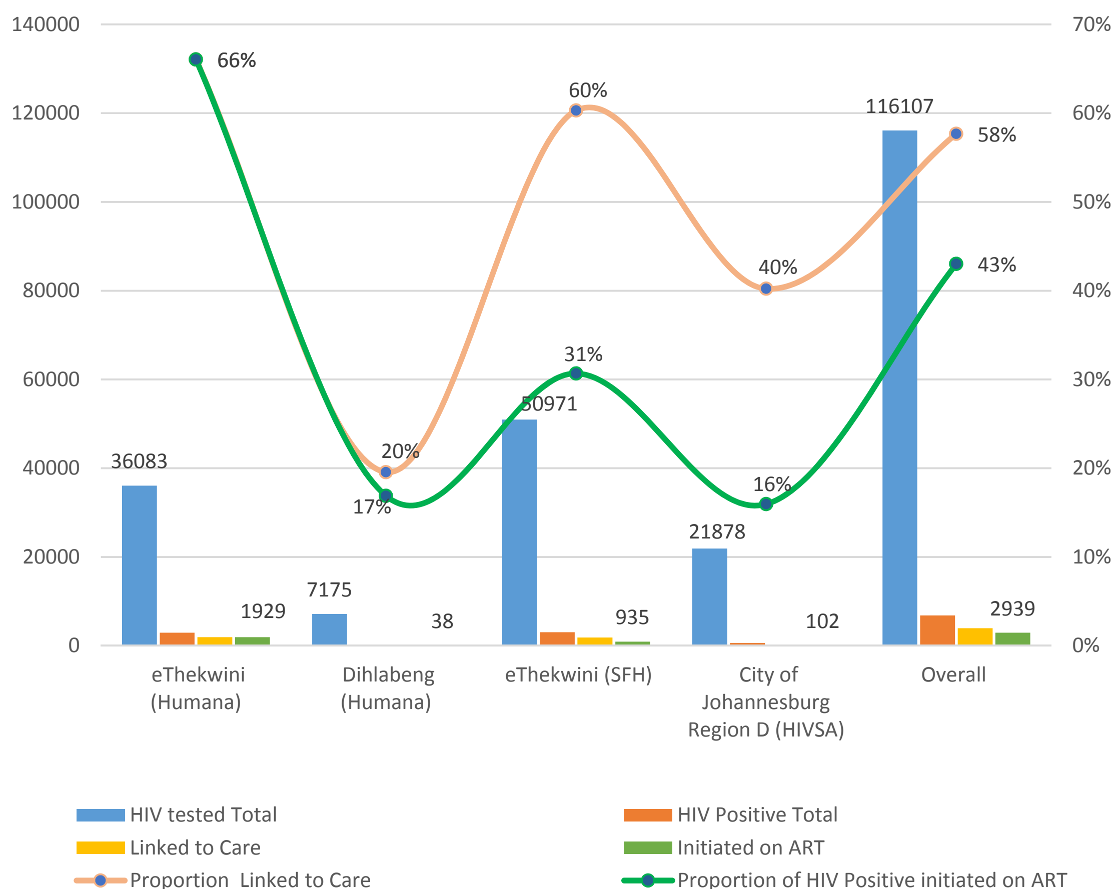


The most commonly used modality was home-based testing, with 81,960 individuals (71%) tested using this modality. Mobile testing accounted for 28% of those tested, and workplace and index case testing combined accounted for 1% of those tested. In the City of Johannesburg, mobile testing has been used as the primary modality, as the DOH has not permitted home-based testing in the area. HIVSA is however implementing testing in homes on a smaller scale using an appointment basis rather than systematic home testing.

Index testing yielded the highest positivity rate in the City of Johannesburg (22%), followed by all testing modalities used in eThekwini: mobile (7%), home-based (6%) and workplace testing (6%). In quarter four, CDS will support its sub-awardees to use index testing in all sub-districts to improve their yield. Implementation of this modality will follow the protocols of the 2016 HTS guidelines to ensure that confidentiality is maintained and no stigma is introduced in the homes of the index clients.

Linkages to Care and Treatment

Linkages to care and treatment by sub-district in quarter three



The highest proportion of clients linked to care was achieved in eThekwini (Humana), at 66%, followed by eThekwini (Society for Family Health), at 60%. The lowest proportion of clients linked to care was in Dihlabeng, at 20%, and Region D in the City of Johannesburg, at 40%. Overall, the proportion of clients linked to care was 58%.

Cumulatively, females have a substantially higher linkage rate (63%) than males (52%) across the sub-districts, which is consistent with existing findings regarding the health-seeking behaviour of men, who tend to present at health facilities for care at later stages of HIV infection. Similarly, women have a higher ART initiation rate at 48%, compared to 36% among males.

The highest proportion of newly diagnosed clients initiated on treatment was achieved in eThekwini (Humana) at 66%, followed by eThekwini (Society for Family Health) at 31%. The lowest ART initiation rate was in Dihlabeng, at 16%, and Region D in the City of Johannesburg, at 16%. Overall, the proportion of those tested HIV-positive who were initiated on ART was 43%.

Linkages by District and sex: cumulative

District	Achieved	Total positive		Total arrived at health facility		Total initiated on ART	
		Males	Females	Males	Females	Males	Females
eThekwini (Humana)	36,083	590	2330	383	1546	383	1546
Dihlabeng (Humana)	7,175	76	149	8	36	8	30
eThekwini (Society for Family Health)	50,971	1,374	1,674	691	1138	403	532
City of Johannesburg (HIVSA)	21,878	284	355	129	128	44	58
Total	116,107	2,324	4,508	1,211	2,848	838	2,166
% of HIV-positive				52%	63%	36%	48%

The data show gaps between the number of individuals who test HIV-positive and who arrive at the health facility, indicating challenges with sub-awardees' referral systems. It also shows gaps between the number of individuals who arrive at the health facility and those who are initiated on treatment, indicating challenges with the health system, particularly related to inconsistent implementation of the country's policy of universal treatment for all HIV-positive individuals. In quarter four, CDS will support its sub-awardees to identify strategies for each of these observed gaps.

CDS, with consortium partner FPD, provided technical assistance to its sub-awardees operating in eThekwini (Humana and Society for Family Health) in May 2017 to improve their capacity to link clients to care. This included on-site support and standardization of the data capturing and disaggregation tools. CDS provided input on the processes of each sub-awardee's Referral and Linkages SOP. In quarter four, CDS will provide similar technical assistance to its sub-awardees in Region D, City of Johannesburg, and Dihlabeng sub-district (HIVSA and Humana) to ensure that they improve the entire HIV cascade, particularly where linkage and initiation rates are currently poor. HIVSA has a good electronic system for recording client data, but more attention is required in identifying and mitigating factors that are contributing to low linkage rates.

A key aspect of CDS' approach to linkages has been to ensure that each sub-awardee has a master register containing all HIV-positive and referred clients, which captures all the required data such as dates of arrival at the health facility, services received (such as CD4 counts and blood taken), each follow-up with clients, and the date of ART initiation.

Strategies used to improve the process for linking clients to care in eThekwini included:

- Allocate dedicated people to support linkages to care
- Strengthen relationships with the District Support Partner
- Compile a spreadsheet of all referred clients which is updated as linkages to care are confirmed
- Conduct telephone follow-up of all previously tested clients
- Negotiate access to the Tier.Net system at health facilities
- Each field worker to track and follow up on his/her referred clients

These best practices will be replicated across Region D in the City of Johannesburg and Dihlabeng in quarter four.

Condom Distribution

In addition to providing HTS, the ATC-HTS sub-awardees distribute condoms wherever testing services are provided. The condoms are provided together with screening services for STIs and TB. They provide male and female condom demonstrations as well as promotion messaging to encourage correct and consistent condom use for HIV prevention. More male condoms are typically distributed due to the greater popularity and availability of the male condom across the country. A total of 91,857 male condoms and 59,523 female condoms were distributed by the three sub-awardees in quarter three.

HTS Quality Assurance

CDS conducted ongoing site support in quarter three, identifying gaps in program quality and developing action plans to facilitate improvement in quality service provision. This included application of the SPI-RT Checklist to audit the quality, efficiency and effectiveness of HTS among the sub-awardees. SPI-RT uses a scoring system of level 0 (a score of less than 40%) to level 4 (a score of 90% or above).

HIVSA scored 88% on the SPI-RT assessment. CDS also conducted a baseline SIMS assessment with the organization. The following were noted as best practices:

- Bi-directional meetings with stakeholders, especially on processes for referral and linkages of clients (with deployment of linkages officers within DOH facilities) and layering of services with DSPs such as Anova Health Institute.

- HIVSA has a well-staffed QI/health systems strengthening team that meets regularly, and there are quality assurance systems in place.

Society for Family Health scored 48% on the assessment. CDS provided technical assistance on the gaps identified, including an inadequate management of the HTS system, the lack of a procurement system, and poor waste management system. CDS supported the organization's linkages to care, identifying gaps with the current tracing system and introducing new tools and strategies.

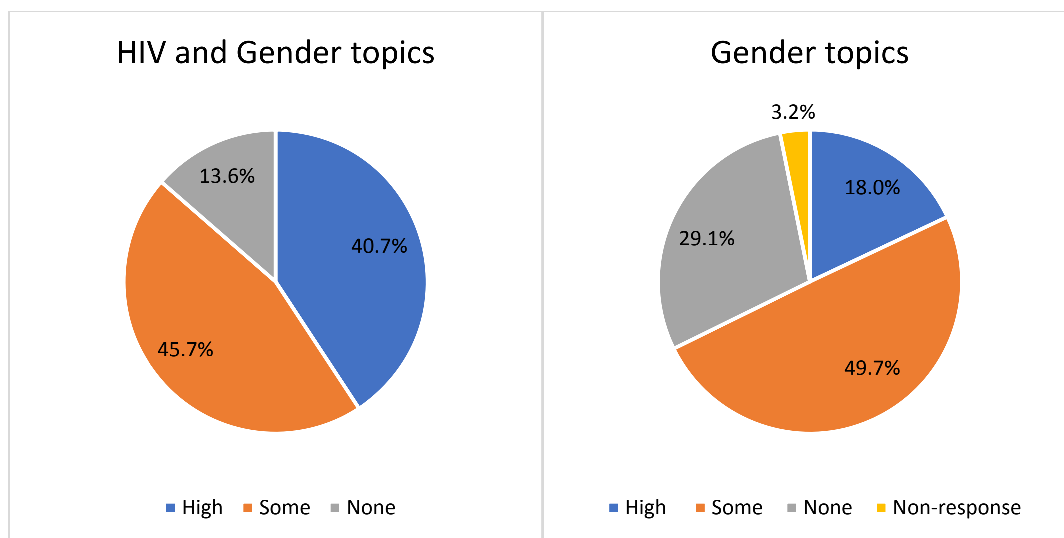
Site providing HTS

Gender Mainstreaming

CDS conducted a three-day GBV training for 28 of HOPE worldwide's home visitors from May 17-19, 2017. The training built the capacity participants to address GBV and child abuse as part of the organization's ECHS program interventions. The training covered:

- HIV and AIDS and gender terminology, concepts and definitions
- Domestic violence and child abuse as forms of GBV
- Formulation of gender messaging to be delivered at household level

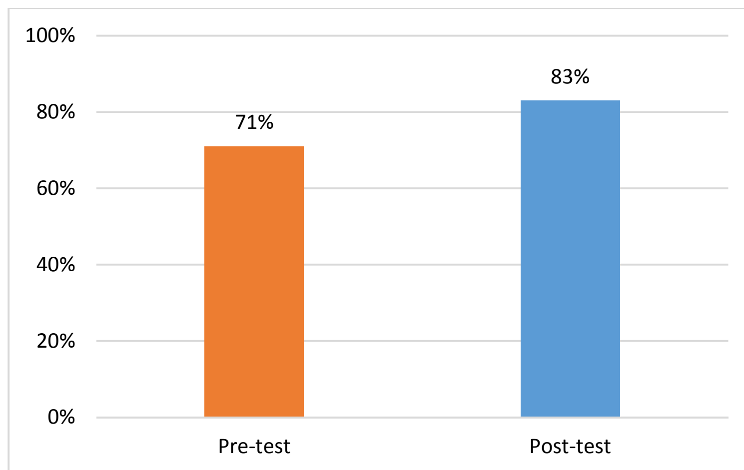
CDS conducted a training needs analysis to identify and assess the participants' knowledge, understanding and skill levels in gender mainstreaming, using the findings to customize the material to address the needs of participants. Most the participants who attended the workshop indicated that they had not received introductory training on gender or gender training in the last two years.[36] The majority of participants indicated that they had some knowledge about HIV (46% of participants) and gender topics (50% of participants). However, knowledge of LGBTI issues was particularly low, with 72% of the participants indicating that they had no knowledge in this area.



[36] Those who had received gender training were part of Sonke Gender Justice's GBV/Victim Empowerment training offered by the Department of Social Development or had received introductory gender information through undergraduate studies.

Pre- and post-test assessments were administered to determine the participants' knowledge of gender concepts, including the linkages between gender and HIV, and their relevance for HIV programming. There was an overall increase of 12 percentage points between the average pre- and post-test assessment scores. In the post-test assessment, participants scored well on questions related to sex and gender, suggesting basic knowledge and better understanding of the difference between sex and gender, as well as gender concepts and definitions. Questions that the participants did not answer correctly were those related to sexual orientation. While participants demonstrated satisfactory knowledge and understanding of gender concepts and GBV, which will assist in identification and referral of child abuse cases in households, these results indicate the need for ongoing support in gender mainstreaming.

Pre- and post-test assessment results: GBV training in quarter three



More than 90% of participants rated the training facilitator, content and presentation as "good" or "excellent." Participants commented positively on the facilitator's knowledge on the subject matter and level of engagement. However, they also indicated there was inadequate time for reflection and discussion of case studies and fieldwork experiences.

Participants engage in discussion at the GBV training

Participants committed to use the knowledge acquired during the training to enhance the ECHS program through mainstreaming norms change, identifying child abuse cases in households and referral of those cases to relevant service providers for PVC and PSS. *"I will help the Diepsloot community to break their silence about gender-based violence in households,"* one participant stated.

Follow-up training on Thogomelo child protection skills is scheduled to take place with all ECHS sub-awardees in quarter four.

HIV Prevention Education: Vhutshilo 1, 2 and 3, and Let's Talk

The Vhutshilo program is an evidence-based developmental curricula that focuses on risk reduction and development of healthy behaviors for adolescents aged 10-18 years. It empowers young people with SRH education as a strategy to prevent HIV, STIs, substance abuse and GBV, as well as strengthen referral and linkages to youth-friendly services. CDS held two partner kick-off meetings with Vhutshilo training provider, HETTAS, and OVCY partners to discuss the roll out and implementation of Vhutshilo 1, 2 and 3 training in quarter four. Planned dates for Vhutshilo training in quarter four include:

- SAfAIDS
  - Vhutshilo 2: July 10-21, 2017
  - Vhutshilo 1: August 21-25, 2017
  - Vhutshilo 3: September 18-22, 2017
- HIVSA: Vhutshilo 2 from August 21-September 1, 2017
- Future Families: Vhutshilo 2 from September 4-15, 2017

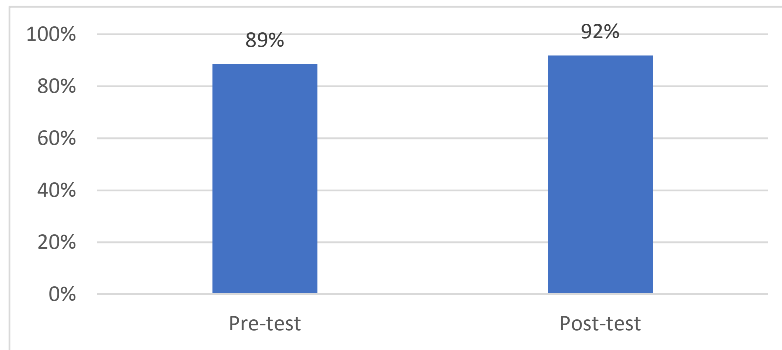
Let's Talk is a weekly support group for adults and the adolescents aged 13-19 years under their care. Let's Talk, an evidence-based program, addresses key issues facing adolescents affected by HIV and AIDS, including elevated risk for poor psychological health, sexual risk behavior and HIV infection. These efforts are accentuated by parallel support for caregivers, addressing their personal challenges and working to build skills for effective emotional coping and parenting.

CDS Master Trainers began the rollout of Let's Talk Phase 1 in June 2017. Phase 1, "Family and Emotional Strengthening," focuses on effective communication, coping with sadness/anger, strengths and goals, and positive family relationships. CDS trained 21 SAfAIDS facilitators and two managers in Let's Talk in Klerksdorp in Dr. Kenneth Kaunda District, North West province from June 26-July 1, 2017.

Participants achieved high scores in both the pre- and post-test questionnaires, with a slight average knowledge increase of three percentage points. This may be a result of participants giving socially acceptable responses regarding their behavior prior to the training. For

example, one question relates to solving a problem with a 15-year-old, and options include finding out what the problem is and finding a solution, as well as telling an adolescent what to do, slapping her, or chasing her away from home. Administration of the assessment questionnaire during the Let's Talk program implementation with adolescents and caregivers will measure actual behavior.

Pre- and post-test assessment results: Let's Talk facilitator training in quarter three



"Let's Talk showed me that talking helps. I used to bottle up things, but when I opened up about my situation, I got relieved and became a brand-new person."

"I feel very empowered and I can't wait to do Let's Talk with caregivers and adolescents: it will change their lives."

"I was sad and unhappy before yesterday, but now I'm good because I expressed my emotions and changed my negative thoughts to positive and helpful thoughts."

CDS learned several lessons from the first Let's Talk training. These include:

- It is advisable to have a counsellor or social worker present to assist with emotional support for participants. Several participants became emotional during the training and required individual attention.
- There is a large volume of training material to cover, with 40 minute videos shown before discussions. CDS will seek to combine or shorten the content to allow adequate time for participant engagement.

Additional training at SAfAIDS for 18 facilitators and five managers will be held from July 3-8, 2017, in Tzaneen, Limpopo province. A supportive mentorship site visit by CDS Master Trainers is scheduled for August 7-8, 2017.

Component 3: Capacity Building Assistance to SAG

The activities of Component Three are responsive to CDS strategic objectives three and four, and are divided into two parts. The first focuses on the recruitment, placement, monitoring, and support of Technical Advisors (TAs) to SAG departments (3a), and the second focuses on strengthening capacity to deliver a comprehensive set of nutrition interventions (3b).

Component 3a: Technical assistance to SAG

Recruitment and Placement of SAG TAs

Consultant on Integrated Clinical Services Management (ICSM): National Department of Health (NDOH)

CDS conducted a kick-off meeting on April 6, 2017, and a technical orientation meeting on April 25, 2017, with the ICSM consultant, Dr. A. Nkhi. The kick-off meeting provided the consultant with an understanding of the CDS contract and performance management processes. The technical orientation meeting was facilitated by the DOH (Dr. Shaidah Asmall) and attended by USAID (Mr. Alfeous Rundare), the consultant and CDS. A follow-up technical orientation session was conducted on May 29, 2017, where the consultant conducted a dry-run to rehearse the critical workshop topics and ensure common understanding of the ICSM training model, methodology and materials.

After a brief implementation period, the consultant tendered notification of termination of the contract due to erratic cancellation of workshop sessions, causing disruptions to work planning and cash flow. In consultation with USAID and NDOH, the contract is being renegotiated.

Consultant on Department of Basic Education (DBE) HIV Policy Implementation Plan

On March 30, 2017, CDS received a request from USAID to second a consultant to develop the national DBE HIV Policy Implementation Plan. CDS drafted the terms of reference in collaboration with DBE officials and requested USAID approval on April 12, 2017. CDS advertised the position on May 4, 2017, after receiving conditional approval from USAID on April 20, 2017. Two candidates were shortlisted in consultation with DBE on May 23, 2017. CDS is still awaiting approval of the shortlisted candidates from the DBE principal.

TA on Adolescent Girls and Young Women (AGYW)

On March 30, 2017, CDS received a request to second a TA to coordinate and manage the AGYW project at the KwaZulu-Natal provincial DBE. CDS drafted the terms of reference in collaboration with KwaZulu-Natal DBE officials. On June 23, 2017, Mr. Zabalaza Mahlase from KwaZulu-Natal DBE forwarded approval to commence the advertisement of the position. The position will be advertised in quarter four.

TA on Nutrition

CDS received a request to second a TA on nutrition from USAID on April 6, 2017. CDS drafted the terms of reference in consultation with USAID and DOH. The terms of reference are being reviewed by Dr. Tim Quick from USAID (Washington, D.C.) to strengthen HIV integration and PEPFAR priorities into the TA's activities.

Manage and Support TAs Seconded to SAG

CDS has recruited and seconded eight TAs to provide technical assistance to SAG across three national departments: National Department of Social Development (NDSD), NDOH and National Treasury. Their key achievements in quarter three are listed below.

TA on the Isibindi Project in the NDSD

The TA for the Isibindi Project supports the NDSD to strengthen processes, systems and management efficiency, as well as service delivery of the Isibindi model. This technical support benefits the provincial support partner NACCW and local implementing organizations throughout their service delivery sites. CDS has reached a total of 12,836 individuals towards the overall OVC_SERV TA target of 23,250, which constitutes a 55% achievement.

In quarter three, the TA refined the national package of services to ensure standardized service delivery to OVC. The package includes practical assistance, therapeutic support, household economic strengthening, child and social protection, support and linkages, educational support through the learning and development program. It also includes youth-friendly SRH care (including linkages to health services and provision of HTS) and interventions that empower children, strengthen families and mobilize communities. These services are provided by CYCWs in the life space of children and families, and through safe parks.[37]

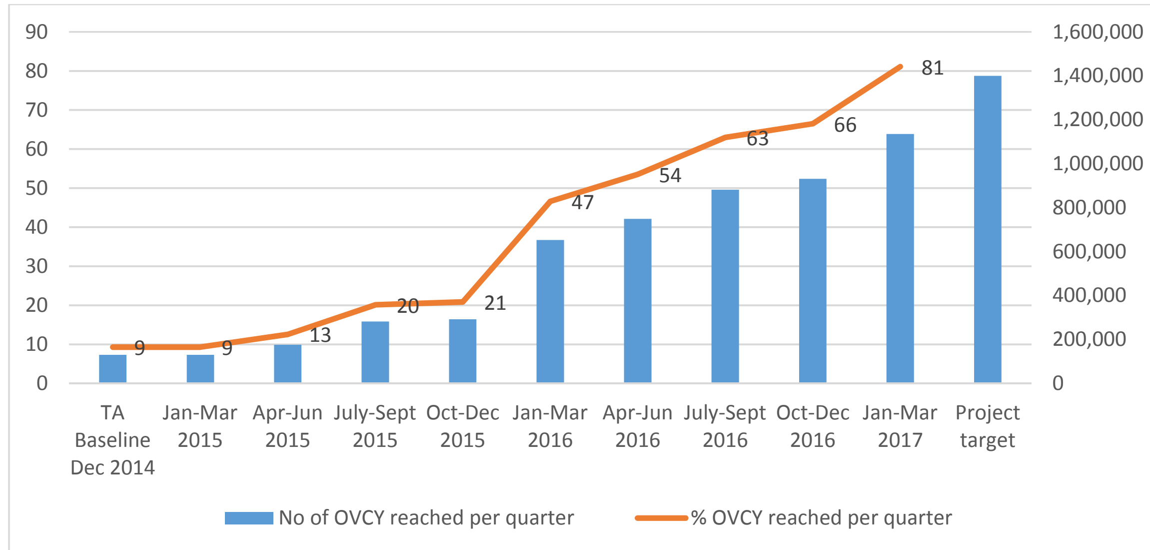
The TA has significantly contributed towards the management of the project by facilitating the finalization of the comprehensive status report to inform NDSD of the progress made in the national roll out of the community child and youth care services through the Isibindi model. The report will inform the implementation strategy after the end of the contract between NDSD and NACCW in March 2018.

The TA has continued to strengthen data collection and improved reporting on the key indicators, including the number of OVCY reached. The graphs below depict an overall increase of 772.15% of OVC reached from the inception of her technical assistance to date. Of the target of 1.4 million, 81% (1,135,387) have been reached from January-March 2017,

[37] A safe park is a safe place for children to play where they have access to adult supervision under the Isibindi model.

which is an increase of 15 percentage points from the proportion of the target reached at the end of the previous quarter.[38]

OVCY reached by quarter against the Isibindi target: December 2014-March 2017



The TA facilitated the successful screening of 4,687 CYCWs against the National Child Protection Register in partnership with the Child Protection Unit. The TA also supported NACCW to comply to Health and Welfare Sector Education Training Authority requirements. Consequently, the number of CYCWs trained increased from 2,273 CYCWs certified in quarter two to 3,000 CYCWs certificated in quarter three. Of the 7,3952 CYCWs who are in training or have completed training, 4,687 have been screened (63.4%), 3,450 are still in training (46.7%), and 3,000 have been certificated (40.6%).

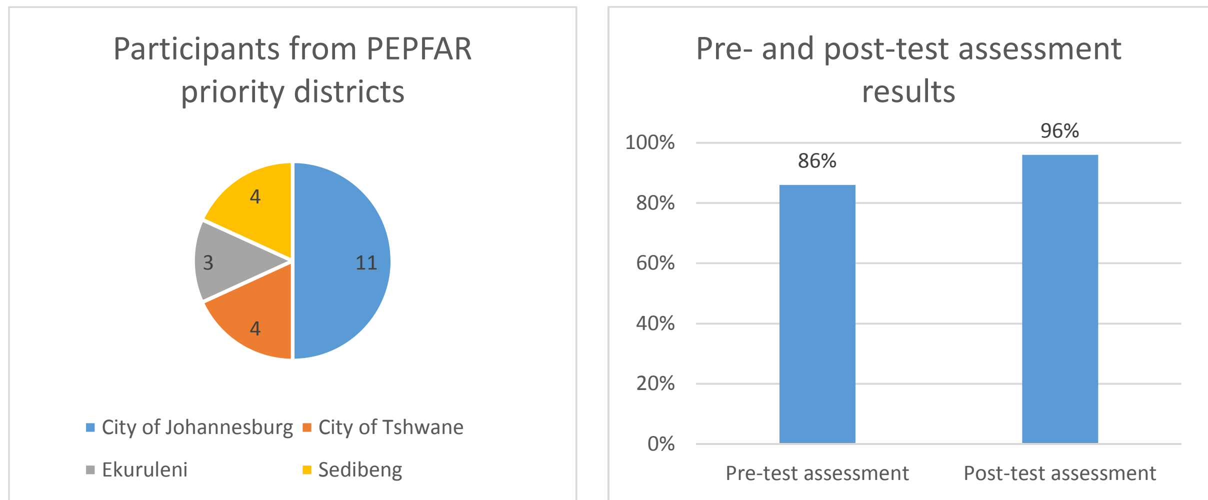
TA on ECD in NDSD

Parental/Primary Caregiver Capacity Building Package

The TA co-facilitated one capacity building workshop on the Parental/Primary Caregiver Capacity Building Package in Pretoria, Gauteng province from May 22-26, 2017. The 29 participants were comprised of 25 social workers, two home visitors from ECHS sub-awardee HOPE worldwide and representatives from DBE and the National Development Agency. The majority (22 participants) were from four PEPFAR priority districts. Participants' knowledge

[38] The SAG reporting timelines run a quarter behind USAID's timelines. Therefore, SAG data for January-March 2017 is reported in some cases.

increased an average of 10 percentage points following the training. Each participant is now considered a master trainer and expected to conduct sessions with 25 other individuals.



Cumulatively, 147 social service professionals have been trained on the Parental Program in six provinces (Eastern Cape, North West, Northern Cape, Free State, Western Cape and Gauteng), of a target of 210 individuals (70% achievement). The Parental/Primary Caregiver Program Training Package has a comprehensive program which include children's rights and responsibilities; health and nutrition (with a strong emphasis on HIV prevention, care and treatment); play and creativity; physical, social, emotional development and confidence building; intellectual and language stimulation; child safety and protection; healthy family relationships; positive discipline; and grief and bereavement. Training will be continued in quarter four and involve Isibindi sites.

Piloting of the ECD skills audit tool

A tool to determine the capacity building needs of the national, provincial and local staff in the DSD was tested by administering it to officials who attended the parenting workshop. The questionnaire and results were submitted to the Chief Director: ECD for final approval before proceeding with data collection. The results of the audit will inform the development of the training program for the ECD unit at DSD.

Compilation of the ECD research agenda

In June 2017, the TA solicited input from experts based in the Children's Institute in Cape Town, Advocacy Aid and CUSTODA Trust for the ECD research agenda. Emerging themes indicate research needs in:

- **Finances:** especially research on public-private arrangements for ECD and the public flow of funding towards ECD

- **Policy:** review of the entire regulatory system for ECD to ensure a seamless registration process for all models of ECD service provision, including center-based and non-center-based ECD programs
- **Home visiting program:** assessment of the human resource and training requirements to ensure adequate and quality service delivery
- **Day mothers:** assessment of their circumstances, challenges and training needs

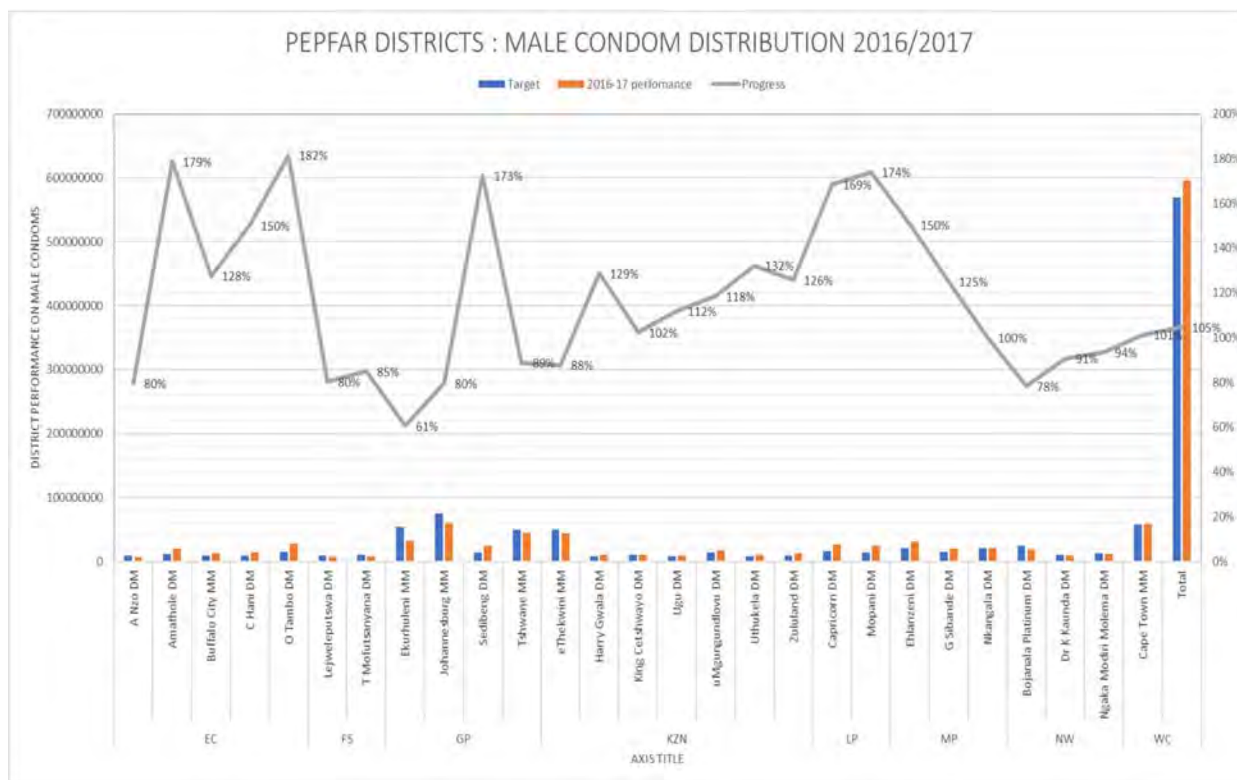
TA on the Condom Program in NDOH

Assessment of condom manufacturing readiness

The TA conducted five site visits to Gauteng and KwaZulu-Natal provinces between May and June 2017 with National Treasury and NDOH Condom Program team to assess warehouse readiness for the local manufacturing of condoms. The TA advised the NDOH to consider the climatic and environmental factors that could affect condom processing and warehouse management. She also encouraged the manufacturers to comply with the storage standard operating procedure developed by NDOH. The site visits revealed that the condom suppliers are not yet ready to produce condoms locally until recommendations made by the assessment team are addressed. NDOH and National Treasury will meet to fast-track the start-up process of condom manufacturing.

Support to condom distribution

Condom distribution occurs through 263 primary distribution sites. The TA facilitated condom distribution through the development and implementation of district condom distribution plans, condom program participant's manual, condom logistic management SOPs, job aids, posters and condom messaging. The development and implementation of these technical resources have improved condom distribution nationally by an estimated 80%. A total of 19 (70%) of the primary distribution sites located in the 27 PEPFAR priority districts exceeded their targets. However, in some provinces, distribution of condoms is still hampered by limited storage facilities, inadequate staffing and transportation problems between primary and secondary distribution sites. These issues can be addressed by applying the SOPs and adequate budgeting by provinces.



Improving branding of condoms

Compliance with South African Bureau of Standard (SABS) marking guidelines for condom branding is mandatory. The TA contributed to the correct branding of MAX brand condoms by ensuring that condom suppliers have the correct brand name, which will assist the NDOH in the social marketing of MAX condoms to increase acceptability among the public.

TA on DREAMS coordination in the NDOH

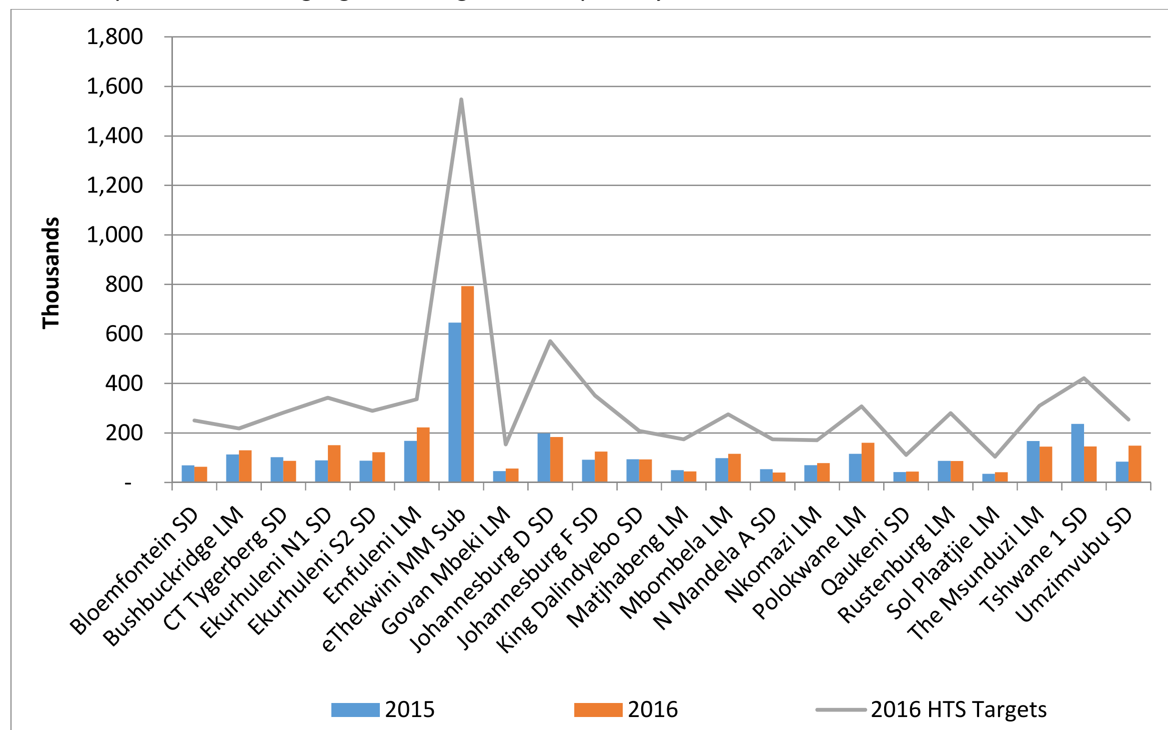
***She Conquers* campaign focusing on AGYW**

In quarter three, the TA consolidated the results and lessons learned from the first year of implementation of the national *She Conquers* campaign for AGYW to inform year two implementation. In year one, the campaign focused on 22 sub-districts identified as being areas of highest priority, 17 of which are PEPFAR priority districts. These sub-districts were chosen as focal areas for phase one of implementation as they had the highest number of 15-24-year-olds (approximately 2.9 million) and highest number of new HIV infections, teenage pregnancies, school dropouts and unemployed youth. The campaign programs seek to address a range of focus areas such as HIV prevention, teenage pregnancy, keeping girls in school, GBV, economic empowerment, sexuality education, safe sex practices, HIV testing services, linkage to treatment, and treatment adherence support. The TA played a significant role in mobilizing government departments (such as DOH, DBE, DSD, Department of Planning,

Monitoring and Evaluation, Department of Higher Education, South African Police Service and Provincial Councils on AIDS), international donors (such as PEPFAR, USAID, Centers Disease Control and Prevention, and The Global Fund to Fight AIDS, TB and Malaria), private sector partners (such as Transnet) and civil society organizations (such as the South African National AIDS Council) to collaborate in reaching young people in the identified sub-districts with key services.

In the first year of implementation, more than 230,000 AGYW in the 22 sub-districts received an HIV test through PEPFAR and Global Fund implementing partners. Of these, 18,000 (8%) were HIV-positive and linked to care.

She Conquers HIV testing against targets in 22 priority sub-districts



Additional results include:

- Over 60,000 adolescent girls received life skills and sexuality education
- More than 30,000 adolescent girls received support to remain in school
- Over 2,600 completed a parenting program (including teen parents)
- 15,000 AGYW received PVC
- More than 4,000 AGYW attended economic strengthening programs

As part of *She Conquers*, young people are engaged in a range of ways, including: community dialogues, social media (Facebook and Twitter), the B-Wise mobi-site, *She Conquers* website, Shuga TV series on SABC 2 and DSTV channels, CHOMA magazine, and Rise TV talk show.

The TA also facilitated the development of roadmaps that will guide young people on services they may require. These roadmaps were printed as a booklet and will be available on the *She Conquers* website. They are currently being tested in a variety of contexts before they are finalized and disseminated.

The key lessons learned from the implementation of the *She Conquers* campaign are that the campaign requires:

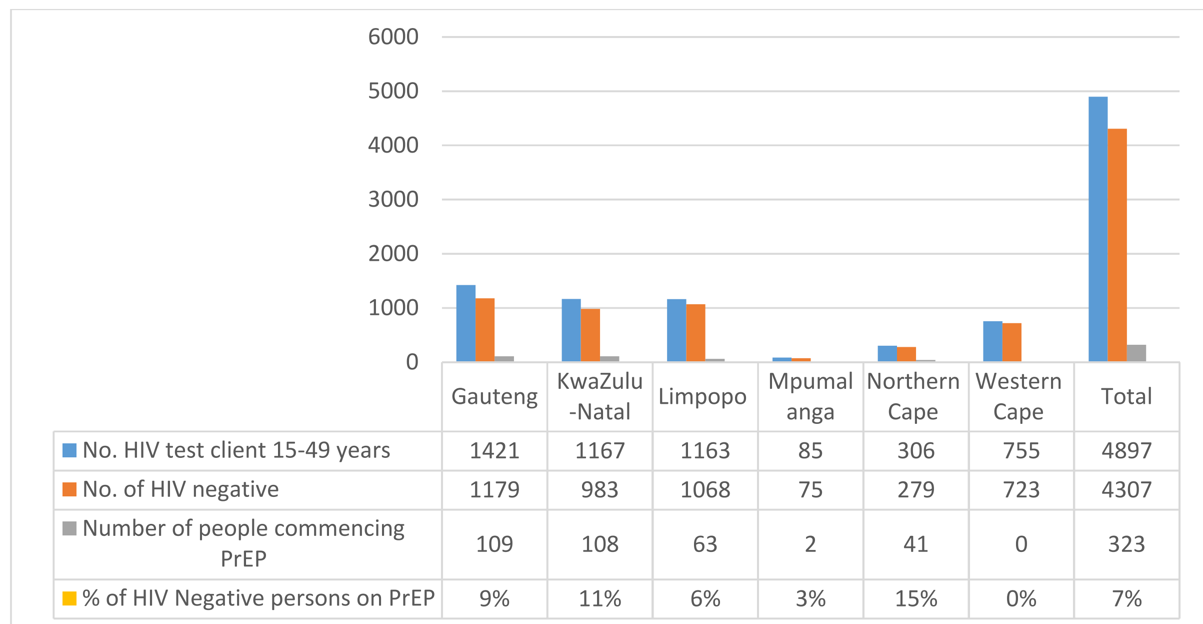
- Support and commitment from all relevant partners to facilitate a unified approach to implementation at every level
- Consultation and participation of stakeholders at all levels
- Utilization of existing structures for coordination to promote the campaign's effectiveness and sustainability
- A formal registration process for all service providers working with AGYW
- Promotion of adolescent and youth friendly services
- A standardized and integrated reporting system and a mechanism to track individuals

The TA will support the development of a clear plan of action incorporating these lessons learned in quarter four.

Pre-exposure Prophylaxis (PrEP) and Test and Treat for KP

The TA facilitated the provision of PrEP in 14 sites that provide health services to sex workers across six provinces. The TA supported a new site offering health services, including PrEP, to sex workers to acquire implementation authorization from the provincial DOH, and the site was launched by the Member of Executive Committee (MEC) of Health in the Western Cape on May 25, 2017. Since April 1, 2017, PrEP was also expanded to men who have sex with men (MSM) in three sites located in PEPFAR priority districts: Woodstock, Cape Town (City of Cape Town district), and Yeoville (City of Johannesburg district), under Anova Health Institute, and Pretoria (City of Tshwane district) under Out, funded by the Global Fund through Right to Care. The TA supported the established sites through facilitation of training, on-site support, and provision of information, education and communication (IEC) materials and pharmaceuticals. As of May 31, 2017, a total of 1,676 persons had begun PrEP. In addition, 2,349 newly diagnosed HIV-positive members of key populations were initiated on treatment across the country's PrEP sites, in alignment with the Test and Treat Policy.

Clients initiated on PrEP: quarter three



	Gauteng	KwaZulu -Natal	Limpopo	Mpumal anga	Northern Cape	Western Cape	Total
No. HIV test client 15-49 years	1421	1167	1163	85	306	755	4897
No. of HIV negative	1179	983	1068	75	279	723	4307
Number of people commencing PrEP	109	108	63	2	41	0	323
% of HIV Negative persons on PrEP	9%	11%	6%	3%	15%	0%	7%

In preparation for expanded ART and PrEP implementation, the TA has conducted site assessments of 25 potential sites to identify gaps, and provided technical assistance to address them. The TA linked the sites to available resources that will capacitate them to address their training, human resources, logistical and contractual requirements in order to provide high-quality services to key populations. In addition, the TA convened consultations with key stakeholders and meetings with technical experts discuss expanding PrEP to other high-risk populations, including pregnant and breastfeeding women and AGYW.

The TA continued to provide ongoing support for DREAMS PrEP implementation, including distribution of IEC materials and job aids. In addition, the first consignment of pharmaceuticals from the DREAMS funding mechanism was delivered to DREAMS sites.

TA on High Transmission Areas and Key Populations (HTA/KP) in the DOH

Finalization of strategic documents

The TA on High Transmission Areas and Key Populations (HTA/KP) contributed to the finalization of the STI Strategy and Comprehensive Clinical Guidelines for the Management of STIs between April and May 2017 by:

- Reviewing and aligning the graphical STI prevention and management related messages with the content
- Developing a presentation for the dissemination of the two documents

The TA's contribution ensured the inclusion of KP as a high priority in the management of STIs, including HIV, as per the National Strategic Plan (NSP) 2017-2022 and the PEPFAR Country Operational Plan 2017 (COP17), which emphasizes intensifying outreach to KP and increasing linkage to prevention and care.

Training and capacity building

As part of the nationwide RTQII training conducted in collaboration with the TA on HTS, the TA introduced the HTA/KP program and facilitated a KP sensitization training. The participants included 31 health facility nurses and HTS trainers in East London, Eastern Cape province on April 12, 2017. The KP sensitization explained the alignment of the HIV testing procedures with the risk assessment of KP at health facilities, informed by the health care providers' understanding of the specific needs of KP. The sensitization provided the health care workers with a better understanding of key population groups, their sexual behaviors and gender dynamics, paving a foundation for non-discriminatory health care service provision. The participants will engage KPs in dialogues to inform improvements in service delivery.

In May 2017, the TA also co-facilitated five dissemination workshops on the National STI Strategy and Comprehensive Clinical Guidelines for Management of STIs. These focused on the management of STIs among priority populations, the key "game changers" in the strategy, such as sexual history taking and risk assessment of MSM, STI management in specific KP, point of care STI screening for KP, and drug management of sexually transmitted pharyngitis. The TA also emphasized inclusion of KP in integrated health care programs. The workshop participants were provincial and district HIV managers, STI managers and facility operational managers in Northern Cape, Eastern Cape, KwaZulu-Natal, Mpumalanga and North West provinces. The provinces have drafted their operational plans based on the strategy and clinical guidelines for STI management, including plans for dissemination of the strategy to districts.

Date	Province	Number of participants
May 9, 2017	Northern Cape	44
May 16, 2017	Eastern Cape	53
May 17, 2017	KwaZulu-Natal	55
May 24, 2017	Mpumalanga	56
May 30, 2017	North West	53

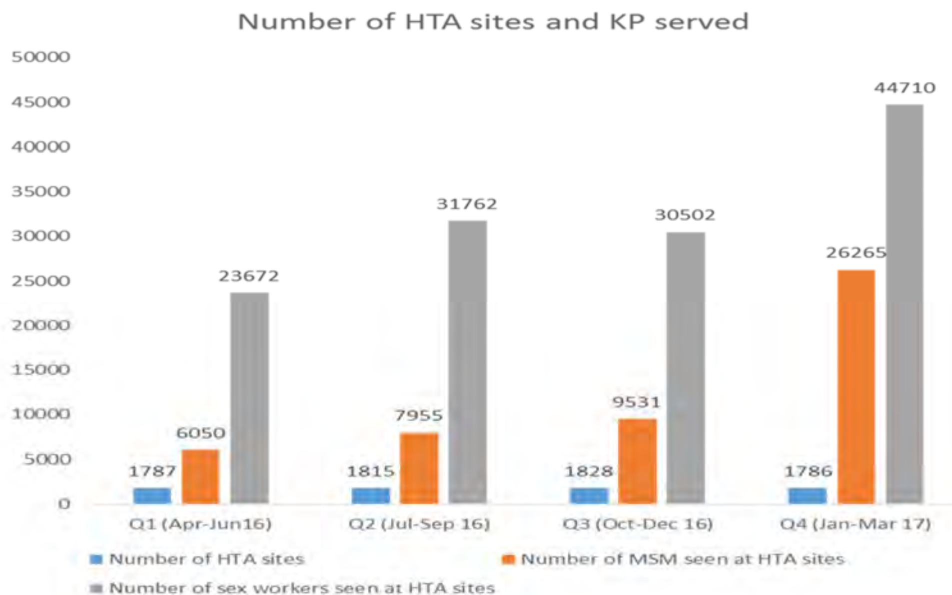
Strengthened monitoring and evaluation systems and quality assurance

The TA contributed to strengthening the M&E system of the HTA program by:

- Developing a concept note on the development of an M&E framework for the HTA program to strengthen reporting by districts and provinces, and revising the HTA indicators and to align them to the 90-90-90 targets. The concept paper was accepted by the TA's Technical Supervisor within NDOH.
- Developing a draft M&E framework document, which proposes the steps to be taken to strengthen the M&E of the HTA program, including revision of the program indicators and clarifying channels of reporting, reporting timelines and consolidation of partners' reports. When the framework is finalized, it will guide provinces and supporting partners to improve the accuracy of program reporting and strengthen the M&E system.

Collation and analysis of the provincial HTA reports

The TA collated and analyzed the annual performance report to monitor the HTA program's progress and identify areas of improvement on June 25, 2017. Continuous support to provinces has resulted in an improvement in reporting. The number of HTA intervention sites is slowly dropping as provinces exclude hotspots which have been reported in previous quarters, improving the accuracy of their reporting. The number of sex workers and MSM seen at HTA intervention sites increased substantially in the January-March 2017 period.



TA on HTS in the NDOH

Strategic document review

In quarter three, the TA reviewed and revised three strategic documents - the Health Sector HIV Treatment Strategy and HIV Testing Participant and Facilitator Manuals - to better align them to HTS policy and HIV prevention strategy. New content incorporated into the documents included the HTS algorithm, updated HIV and AIDS data, and updated information on PrEP, STIs, condoms and HIV treatment.

Quality assurance training for outreach activities in communities

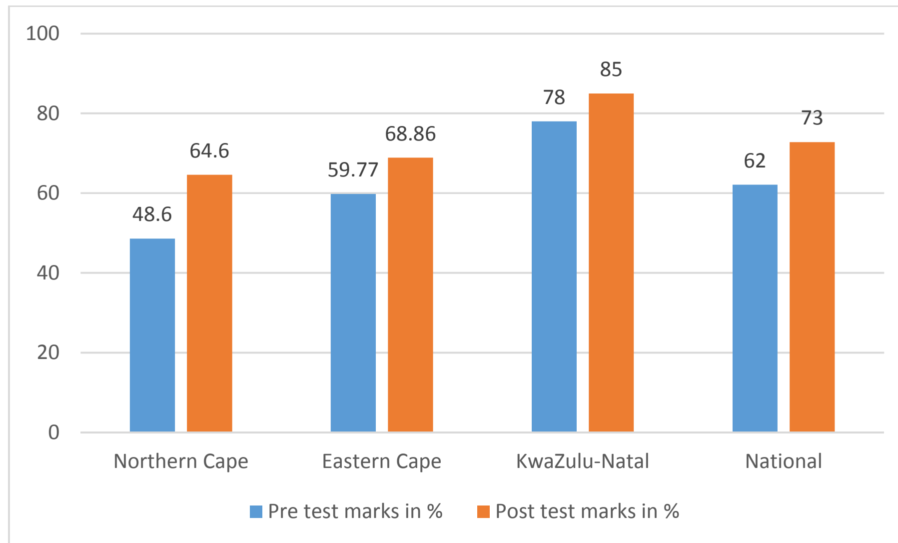
The TA co-facilitated four trainings on RTQII in three provinces, attended by a total of 161 participants, exceeding the target of 120 participants. They included HTS counsellors and managers, mentors and clinic and laboratory personnel. The majority of participants (61.5%) were drawn from nine PEPFAR districts as tabulated below.

RTQII trainings held in quarter three

Province	Districts	Training dates	# of participants
Northern Cape (Upington)	• Francis Baardt • Namakwa • John Taole Gaetsewe • Prixley Ka Seme • ZF Mgcawu	May 17-19, 2017	39
Eastern Cape (Umtata and East London)	• OR Tambo	June 20-22, 2017	41
	• Buffalo City	April 10-12, 2017	7
	• Sara Baartman		3
	• Amathole		24
KwaZulu-Natal (Durban)	• Uthugela	May 30-June 1, 2017	3
	• Umgungundlovhu		4
	• Zululand		7
	• Harry Gcwala		4
	• Ugu		4
	• Amajuba		4
	• King Cetshwayo		4
	• Ilembe		4
	• eThekwini		5
	• Mzinyathi		5
	• Mkhayakude		3

The participants were engaged in practical HIV testing and recording to demonstrate quality assurance in HTS. In addition, the training program defined the activities that mid- to high-level professionals must perform to monitor the accuracy and reliability of HIV results using tools and job aids. The trainings empowered the participants on finger pricking and interpretation of the results.

Pre- and post-test scores: RTQII trainings in quarter three



Based on the pre- and post-tests the knowledge increase among participants from the Northern Cape was higher than those from the Eastern Cape and KwaZulu-Natal provinces, but Northern Cape participants had the lowest baseline knowledge. Participants from KwaZulu-Natal had the highest baseline and post-test results. Northern Cape province had not previously held training on RTQII, while the training was a refresher for many participants from Eastern Cape and KwaZulu-Natal provinces. Additional RTQII trainings will be held in the Northern Cape in the future.

Following the training, the TA supported the provinces to implement the RTQII program. She also participated in the RTQII partners' meeting held on May 22, 2017, to review the implementation of RTQII program. The meeting was attended by more than 50 HTS quality assurance stakeholders, including development and implementing partners, regional training centers and provincial officials. Participants noted improvements in the RTQII program implementation, such as increases in trained staff and improved program reporting. These were noted particularly in Northern Cape, Eastern Cape, North West, Free State and Mpumalanga provinces.

TA on Health Financing in the National Treasury

Analysis of conditional grant reports

The TA analyzed conditional grant reports (financial and non-financial performance) for the HIV/TB, National Tertiary Services Grant and Health Practitioners Contracting (including Central Chronic Medicine Dispensing and Distribution) for the period January to March 2017. He also coordinated and developed a consolidated document with queries on the performance of the other conditional grants, which informed National Treasury of challenges faced by the conditional grants which resulted in over- or under-performance in the last quarter. Subsequently, the National Treasury requested additional data around these challenges to conduct a robust analysis. For example, the National Treasury requested development of a detailed report on the underperformance of the VMMC program of the HIV grant to better understand, and be able to address, the gaps identified.

Revision and prioritization of DOH indicator list

The TA, in collaboration with the USAID-funded National Health Insurance consultant Tihomir Strizrep, researched Global Fund indicators and developed additional HIV/TB conditional grant indicators to facilitate comparison with NDOH HIV Unit indicators. The indicator list developed informed the revision and prioritization of the NDOH indicator list with the NDOH HIV team on June 19, 2017. The NDOH will use the newly-developed list to report to the National Treasury during 2017/18. This will also allow for more robust analysis of the HIV/TB grant performance and financial reporting by NDOH.

Establishment of South African Health Products Regulatory Authority

Based on the legal and financial advice received from the National Treasury team, the TA, in collaboration with the Director: Health, developed a memo and letter advising the NDOH to carry the financial obligation of the South African Health Products Regulatory Authority (SAHPRA) until its full promulgation as a public entity. After promulgation, SAHPRA will reimburse NDOH upon receipt of its financial allocation through the re-appropriation budget process in the 2017/18 financial year. SAHPRA was promulgated on June 2, 2017, but remains within the NDOH until the Board is established. Once the Board is established, SAHPRA can hire the required staff to carry out its mandate and move out of the NDOH.

The TA analyzed and provided input into the following SAHPRA documentation:

- SAHPRA update presentation to executive management
- SAHPRA implementation plan
- Memorandum of understanding between the SAHPRA and the NDOH
- Final SAHPRA business case

The SAHPRA business case was presented to the National Treasury, with emphasis on selected areas (such as governance, expenditure, and revenue), on May 21, 2017. The presentation informed National Treasury of its role in these key areas once SAHPRA is established. In addition, the business case and other documentation analyzed were used by the TA to suggest next steps for the National Treasury to advise on the SAHPRA establishment process.

TA on Primary Health Care (PHC) in the NDOH

National Specifications and Catalogue Workshop

Through USAID support, the TA on Primary Health Care (PHC) facilitated a workshop from May 30-31, 2017, on the National Specifications and Catalogue. The workshop oriented provinces on the ideal clinic specification and catalogue and the transversal contracts[39], developed to facilitate smoother and improved turnaround times for procurement of essential equipment. The workshop was attended by 68 representatives from seven provinces, comprised of medical and nursing specialists, health technology managers, and infrastructure and supply chain practitioners. The TA secured the buy-in of participants regarding transversal contract procurement rather than the existing quotation procurement process. He also facilitated the adoption of the ideal clinic catalogue (with amendments) as a tool to be used to facilitate procurement nationally. The TA then facilitated the production of ideal clinic procurement plans for Eastern Cape, Free State and KwaZulu-Natal provinces.

Participants at the Specification and Catalogue workshop

Compilation of the essential equipment list for procurement

The TA compiled the essential equipment list for procurement to assist health facilities in the 27 PEPFAR districts achieve ideal clinic status.

[39] Transversal contracts are national-level contracts which can be used to procure items by provinces, promoting efficiency and cost-effectiveness.

Essential equipment list

Item	Clinical indication
Diagnostic set with ophthalmic piece	Ear, nose and throat assessment and detection of treatment-related complications
Turning fork	Assessment of TB drug-induced deafness
Non-invasive blood pressure machine with three cuff sizes	Vital signs monitoring
Peak flow meter	Airway-related disorder identification and management
Pulse oximeter	Monitor oxygen saturation levels
Patella hammer	Neurological assessment of patients
Wall mounted and clinical thermometer	Temperature monitoring
Stethoscopes	Physical examination
Urine specimen jar	Assessment of renal function
Adult scale with height measure	Monitor treatment impact and dosing of patients
Paediatric scale with height measure	Monitor treatment impact and dosing of patients
Haemoglobin meter	Early detection of anaemia
Glucometer	Diagnosis and management of co-morbidities
Maternity delivery pack	Obstetric emergencies management
Emergency trolley with accessories	Resuscitation of patients

Mobilization of funding for procurement of ideal clinic essential equipment

The TA, through engagement with strategic units, secured funding commitments dedicated to the ideal clinic program to the estimated value of R118 million. Of this amount, R106 million is from provincial allocations:

- Eastern Cape: R23 million
- Free State: R12.5 million
- KwaZulu-Natal: R58.6 million
- Mpumalanga: R12.2 million

The remainder of R12 million is from the ideal clinic indirect grant funding, which increased from R3 million in the 2016/2017 budget allocation. This demonstrates recent improvements in prioritizing the procurement of essential equipment for primary health care from the previous focus on hospital health technology investment.

Ideal clinic status determination and baseline assessment

In quarter three, the TA analyzed the status determination baseline assessment reports for the period of April to June 2017. By June 30, 2017, there were 1,139 ideal clinics compared to 140 ideal clinics at the commencement of the technical support in August 2016. The TA conducted assessments in all provinces to identify health facility readiness for the peer review assessments planned for September 2017. Out of the 27 PEPFAR priority districts, only nine achieved ideal clinic status in at least 50% of the total district facilities.[40] This achievement is a result of the investment and support from NDOH and partner organizations. However, in 18 of the 27 PEPFAR priority districts, performance is unsatisfactory, as less than 50% of their facilities achieved ideal clinic status. This is due to challenges relating to inconsistent availability of supplies and equipment, and human resource shortages. It is recommended that these districts be supported with operations management capacity building and essential health commodities procurement towards achieving ideal clinic status, as availability of health commodities and skilled personnel is related to achievement of the 90-90-90 targets.

Overall, the facilities that progressed satisfactorily have challenges in maintaining their performance due to limited operations management skills of facility managers and sustainability of compliance with standards. These needs must be addressed to maintain ideal clinic achievements, and the TA will refer them to the relevant departments for resolution.

Results of status determination on ideal clinics achieved in the 27 PEPFAR priority Districts and Metros

District/ Metro	Total Facilities	Status determination on Version17	Platinum	Gold	Silver	Not achieved	Number of ideal clinics	% ideal clinics
1. A Nzo DM	75	74	2	3	17	52	22	30%
2. Amathole DM	157	156	3	15	19	119	37	24%
3. Buffalo City MM	77	74	0	0	4	70	4	5%
4. C Hani DM	154	153	1	3	18	131	22	14%
5. OR Tambo DM	145	130	13	7	26	84	46	35%
6. Lejweleputswa DM	44	44	0	0	4	40	4	9%

[40] These include Tshwane, Thabo Mofutsanyana, Dr. Kenneth Kaunda, Gert Sibande, uMgungundlovu and Zululand (which are also pilot sites for the National Health Insurance), as well as Ekuruleni, City of Johannesburg and Uthungulu.

District/ Metro	Total Facilities	Status determination on Version17	Platinum	Gold	Silver	Not achieved	Number of ideal clinics	% ideal clinics
7. Thabo Mofutsanyane DM	74	73	0	10	31	32	41	56%
8. Ekurhuleni MM	93	92	10	34	40	8	84	91%
9. Johannesburg MM	117	109	4	24	36	45	64	59%
10. Sedibeng DM	39	38	0	2	8	28	10	26%
11. Tshwane MM	73	73	2	25	39	7	66	90%
12. eThekwini MM	113	104	0	11	26	67	37	36%
13. Harry Gwala DM	40	40	3	1	14	22	18	45%
14. Ugu DM	56	55	0	9	9	37	18	33%
15. uMgungundlovu DM	52	51	8	22	17	4	47	92%
16. Uthukela DM	37	37	1	7	15	14	23	62%
17. Uthungulu DM	62	62	0	7	18	37	25	40%
18. Zululand DM	71	71	16	24	4	27	44	62%
19. Mopani DM	105	44	0	0	0	44	0	0%
20. Vhembe DM	124	123	2	6	23	92	31	25%
21. Ehlanzeni DM	122	115	0	3	3	109	6	5%
22. G Sibande DM	77	70	3	10	23	34	36	51%
23. Nkangala DM	89	52	0	1	4	47	5	10%
24. Bojanala Platinum DM	119	117	1	5	12	99	18	15%
25. Dr K Kaunda DM	40	40	0	6	16	18	22	55%
26. Ngaka Modiri Molema DM	92	87	1	7	13	66	21	24%
27. Cape Town MM	127	122	3	4	22	93	29	24%

Consultant on ICSM in the NDOH

The consultant facilitated 11 two-day workshops to facilitate the implementation of ICSM for facility and district managers. A total of 472 provincial, district, sub-district and facility staff, including implementing partners, attended the workshops. Six of these workshops were in PEPFAR priority districts and were attended by 272 individuals (58% of all participants). The workshops:

- Provided participants with the knowledge and skills to effectively manage the implementation of ICSM at facility level
- Familiarized participants with the rationale for ICSM, its benefits and components
- Supported participants to prepare for ICSM implementation
- Supported participants to implement ICSM and monitor implementation progress

The training was delivered through a combination of didactic training, facilitated through presentations, practical group exercises, individual exercises and group discussions. It was interactive, with sharing of best practices and working through challenges as a team. Participants prepared data from their respective facilities and brought sketches of their facilities for practical application of learning.

ICSM training held in quarter three

Number	Date	Province	District	Number of participants
PEPFAR priority districts				
1.	12-13 June 2017	Mpumalanga	Nkangala	39
2.	14-15 June 2017	Mpumalanga	Gert Sibande	49
3.	22 – 23 June 2017	Gauteng	City of Johannesburg	52
4.	27-28 June 2017	Gauteng	Sedibeng	53
5.	29-30 June 2017	Gauteng	Ekurhuleni	39
6.	29-30 June 2017	Free State	Thabo Mofutsanyane	40
			Sub-total	**272**
Non-PEPFAR districts				
7.	01-02 June 2017	Free State	Mangaung	43
8.	01-02 June 2017	Northern Cape	JTG	42
9.	12-13 June 2017	Northern Cape	ZFM	41
10.	20-21 June 2017	Northern Cape	Namakwa	35
11.	20-21 June 2017	Free State	Fezile Dabi	39

Number	Date	Province	District	Number of participants
			Sub-total	**200**
			Overall total	**472**

Preliminary analysis of the pre- and post-workshop results for the first five workshops reflect improvement in the overall knowledge of participants, although the analysis also reflected ongoing areas of weakness. The findings will inform adaptations to the workshop content to spend more time on specific aspects found to be weak. Participant evaluation of the facilitators' skills and knowledge was positive.

TA Management and Support

The TAs are managed through the implementation of the Performance Management Framework (PMF).

Management and support meetings

Two of the key PMF activities are the monthly management meetings CDS holds with SAG technical supervisors and the TAs, and support meetings with the TAs. The meetings facilitate monitoring of the progress of the technical assistance provided to SAG and create an enabling environment for implementation. In quarter three, 17 management meetings were held with SAG technical supervisors, including:

- Two meetings with each technical supervisor for ECD, HTS, Condom Program, HTA/KP, Health Financing, PHC and ICSM
- One meeting with the technical supervisor for Isibindi

There were no meetings with the technical supervisors for DREAMS. During the management meetings, performance appraisals were finalized and the technical supervisors verbalized their satisfaction with the quality of technical assistance provided by TAs. These meetings are complemented by the fortnightly support meetings with the TAs and monthly all-TA meetings which contribute to the quality of technical assistance and strengthen synergies among the work of the TAs.

PMF review and modification

CDS began a review of the PMF to strengthen and improve the quality and efficiency of the TA management systems, applying both qualitative and quantitative methods. Data collection progressed slowly with the technical supervisors, and only five technical supervisors completed the on-line questionnaire during the quarter. Data analysis will commence and report-writing will be concluded in quarter four.

Cost-benefit analysis

A final draft report on the cost-benefit analysis of the technical assistance provided by the Isibindi project TA was compiled. The methodology included outcome monitoring and cost analysis through document study and key informant interviews. The outcome monitoring tool compared the status of the project at the inception of the technical assistance with the results and outcomes achieved from December 2014 through December 2016, during the TA's support. The key documents reviewed were the inception reports, monthly and quarterly progress reports, and the results framework. The cost analysis compared the cost of the TA against the cost of a consultant that could have been contracted by the department in the place of the TA.

The analysis demonstrated that the TA mechanism was cost effective: the TA started showing results six months earlier than the consultant would have, and the costs of using the TA mechanism were almost half the cost of using the consultant mechanism.

Component 3b: Nutrition Assessment, Counselling and Support

The activities of Component 3b are intended to strengthen the capacity of OVCY partners and PEPFAR implementing partners supporting SAG/DOH health facilities to deliver NACS, which is a comprehensive set of nutrition interventions to improve health outcomes of vulnerable populations.

Support to DSPs

DSPs are funded by USAID/PEPFAR to provide direct technical and financial support for clinical services, including human resources, equipment, supplies, training, mentoring and coaching, community programs and M&E at district level. CDS is partnering with seven DSPs, two Innovation Partners and one Community Care Partner.[41]

Knowledge and Skills Building

CDS conducted knowledge and skills development in NACS and breastfeeding with two DSPs in quarter three as shown below.

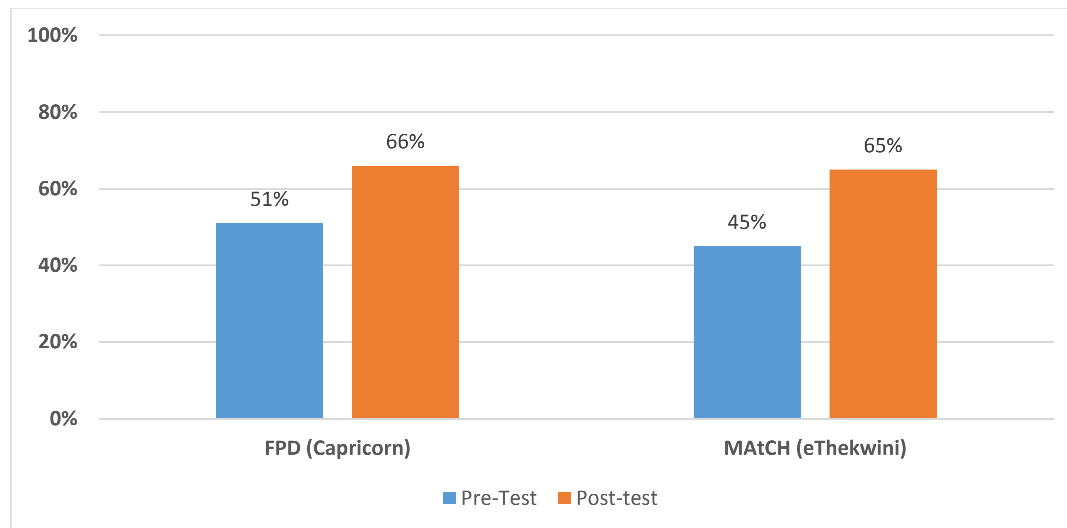
DSP NACS training in quarter three[42]

DSP and location	Training dates (2017)	# of participants
FPD Capricorn, Limpopo	April 19-21 (3 days)	24
MatCH eThekwini, KwaZulu-Natal	May 29-June 2 (5 days)	21

[41] These partners include: Anova Health Institute, Right to Care, Wits Reproductive Health and HIV Institute, MatCH, BroadReach, FPD, Kheth'Impilo, mothers2mothers, Witkoppen Health and Welfare Center, and Hospice Palliative Care Association.

[42] Training duration was based primarily on partner availability and request.

FPD and MatCH pre- and post-test assessment results



The DSPs made the following commitments after the training sessions:

- Continue to do in-service training at facility level, and conduct continuous mentoring to ensure NACS integration into routine services
- Conduct audits of patients' files in their facilities using NACS tools
- Ensure that staff are able to use NACS tools appropriately for patients' assessments including the body mass index (BMI) wheel, MUAC tapes and job aids provided during training
- Ensure that all clients are nutritionally assessed and correctly classified
- Implement referral systems and nutrition support systems for all clients
- Actively participate in mentoring and coaching visits from CDS to pilot sites and further cascade similar activities to all the sites supported

Integration of NACS into Nurse-Initiated Management of Anti-Retroviral Therapy

CDS provided orientation to 36 participants from MatCH on how to integrate NACS into Nurse-Initiated Management of Anti-Retroviral Therapy. This session was attended by professional nurses providing clinical services, specifically those initiating clients onto ART in facilities in eThekwini District, KwaZulu-Natal province. The three-hour session covered nutritional assessment, classification, counselling and support (supplementation and referral) in the context of the 90-90-90 targets. The importance of recording NACS services into the health facility forms was emphasized. These nurses will now assess patients nutritionally as they initiate patients onto treatment, addressing both HIV and nutritional status simultaneously and promoting better clinical management and patient outcomes.

Mentoring and Coaching

The NACS technical model includes mentoring and coaching to support the application of theory into practice and build confidence of participants. These visits incorporate observations, clinical audits, on-site capacity building, quality improvement plans and journal, which further capacitate the sites for SIMS assessments. CDS conducted mentoring and coaching visits to DSP clinical staff at 31 health facility sites under six DSPs in quarter three. CDS provided the DSPs and their sites with nutrition tools such as BMI wheels, child and MUAC tapes, and job aids for nutrition classification and counselling. The NACS training addressed the use of these tools, and CDS reinforces their usage during mentoring and coaching sessions.

CDS mentoring and coaching process

While CDS has observed progress through its mentoring and coaching in quarter three, some sites have shown regression between the mentoring visits due to challenges such as high staff turnover. Some of the sites, for example in the City of Tshwane in Gauteng province, depend on “Agency Nurses” to provide services. This practice impacts negatively on implementing NACS, as these nurses have not been oriented or trained on nutrition and they rotate based on three-month contracts. Implementation of nutrition activities is still not seen as core in most facilities, reinforced by the fact that district health nutrition information systems do not have sufficient nutrition indicators.

Some of the facilities were not visited on the scheduled dates because they had not been informed by the DSP with sufficient time and could not accommodate the visit due to competing priorities. Similarly, when the DSP was not available to accompany CDS to the site, visits were re-scheduled. CDS and the relevant DSP conduct a record review of 10 client files at each site, scoring on a 100-point system: 0-49 is poor (red), 50-70 points is good (yellow) and 71-100 points is excellent (green).

Anova Health Institute (Anova)

In the City of Johannesburg, nutrition assessment is comprehensively done by all the selected sites. Nutrition classification has been partly done by all sites except for Edenvale Hospital, which has regressed in this dimension. Nutrition counselling and nutrition support is a challenge for the selected sites, but there is notable improvement at Alexandra Community Health Center (CHC) in recording nutrition counselling.

The DSP's progress in Mopani, Limpopo province, is partly a result of having a nutrition focal person who is able to ensure ongoing implementation of NACS in the sites and facilitate timely acquisition of nutrition activity reports. A nutrition dashboard has been developed in Mopani District to monitor progress in integration of NACS into treatment and care. The model employed by Anova, where management is supportive and provides leadership for NACS implementation, promotes ongoing progress and sustainability of the results.

Nutrition assessment and classification are comprehensively done by all the selected sites in Mopani, except for Mapayeni Clinic. Nutrition counselling and nutrition support are a challenge for the selected sites. One of the reasons for the recent regression in the sites may be attributed to the fact that Anova is expanding its technical support to 10 other sites.

Anova: City of Johannesburg, Gauteng province

Sites	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
Edenvale Hospital	10 May 2017					
	29-30 June 2017					
Alexandra CHC	10 May 2017					
	29-30 June 2017					
East Bank Clinic	10 May 2017	**Site not visited**				
	29-30 June 2017					

Anova: Mopani, Limpopo province

Sites	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
Nkhensani Hospital	4-6 April 2017					
	16-18 May 2017					
	7-8 June 2017					
Dzumeri CHC	4-6 April 2017					
	16-18 May 2017					
	7-8 June 2017					
Mapayeni Clinic	4-6 April 2017					
	16-18 May 2017					
	7-8 June 2017					

Wits Reproductive Health and HIV Institute (WRHI)

The sites under WRHI were doing relatively well in April. In May, the site visits did not take place as the DSP did not arrange these visits in time. In June, it is noted that sites had regressed in integrating NACS into services. While South Rand, Hillbrow and Malvern continued to do nutrition assessments, they did not do nutrition classification, and therefore the rest of the cascade could not be followed. While, Esselen Clinic (which provides services for sex workers) has attempted to integrate NACS, it failed to consistently assess all clients comprehensively. Nutrition supplementation systems are in place at both South Rand Hospital and Hillbrow CHC.

In Dr. Kenneth Kaunda District, WRHI sites have all improved in doing nutrition assessment and classification. Nutrition counselling is not done in all the selected sites, and nutrition support and the existence and functionality of referral systems varies by site.

WRHI: City of Johannesburg, Gauteng province

Sites	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
South Rand Hospital	2 April 2017					
	24-26 April 2017					
	7-8 June 2017					
Hillbrow CHC	24-26 April 2017					
Esselen Clinic	7-8 June 2017					
Malvern Clinic	24-26 April 2017					
	7-8 June 2017					

WRHI: Dr. Kenneth Kaunda, North West province

Sites	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
Steve Tshwete Hospital	4-5 April 2017					
	6-8 June 2017					
Nic Bodenstein Hospital	4-5 April 2017					
	6-8 June 2017					
Botshabelo Clinic	4-5 April 2017					
	6-8 June 2017					

BroadReach

BroadReach sites in Sedibeng District were identified as priority sites for CDS technical support. However, getting buy-in from DOH was a challenge which made it difficult to access the health facilities. Despite the technical assistance provided, only nutrition assessment is done in these sites. CDS has planned meetings with the DSPs and DOH to find solutions to improve services in the sites.

BroadReach requested CDS to provide extra technical assistance in Ugu, where nutrition assessment is now comprehensively done. Nutrition classification is comprehensively done by selected sites, except for KwaJali Clinic, where the practice is inconsistent. Similarly, nutrition counselling and nutrition support are comprehensively done by the other two sites, and KwaJali Clinic is scored moderately on its counselling practices.

BroadReach in Gert Sibande has been successful in conducting nutrition assessments in the selected sites. However, nutrition classification is not done by all sites, and nutrition counselling and support are persistent challenges for the selected sites. BroadReach in King Cetshwayo is integrating NACS into routine health care services. This success may be

attributed to existing district support structures that support program implementation at site level. The structure has ongoing meetings, which includes DSPs, and CDS had presented on NACS at one of these regular meetings. Due to the success of the sites to date, CDS has recommended that BroadReach expand NACS services to all the sites within its districts.

BroadReach: Sedibeng, Gauteng province

Sites	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
Bophelong clinic	24-25 May 2017					
Heidelburg Hospital	24-25 May 2017					
Ratanda Clinic	24-25 May 2017	**Site not visited**				

BroadReach: Ugu, KwaZulu-Natal province

Sites	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
St. Andrews Hospital	17-18 May 2017					
	13-15 June 2017					
Thembalesizwe Clinic	17-18 May 2017					
	13-15 June 2017					
KwaJali Clinic	17-18 May 2017	**Site not visited**				
	13-15 June 2017					

BroadReach: Gert Sibande, Mpumalanga province

Sites	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
Nhlazatshe 4 Clinic	15-17 May 2017					
	14-15 June 2017					
Embhuleni Hospital	15-17 May 2017					
	14-15 June 2017	**Site not visited**				
Badplaas Clinic	15-17 May 2017					
	14-15 June 2017					

BroadReach: King Cetshwayo, KwaZulu-Natal province

Sites:	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
Nkandla Hospital	April 2017					
	12-15 June 2017					
Empandleni Clinic	April 2017					
	12-15 June 2017					
Vumanhlamvu Clinic	April 2017					
	12-15 June 2017					
Chwezi clinic	April 2017	**Site not visited**				
	12-15 June 2017					

FPD

In Tshwane, nutrition assessment is comprehensively done by Stanza CHC, but nutrition classification and counselling have not been consistently done for all clients. FPD is exiting the other two sites, so no site visits were conducted by CDS this quarter.

In Capricorn, nutrition assessment and classification have improved in both sites. Nutrition counselling and nutrition support in the first visit had not been done in the sites, but there was notable improvement at Zebediela Hospital. However, Mogoto Clinic has regressed in these dimensions.

FPD sites in Nkangala were only visited once in this quarter due to failure by the partner to set up timely appointments with the sites. Nutrition assessment is done, but not consistently for all clients in the sites. At Poly Clinic, the nutrition equipment is not adequate. Nutrition classification is not done by all selected sites. Nutrition counselling and nutrition support are challenges for the selected sites, but there is a nutrition support system at Middleburg Hospital.

FPD: Tshwane, Gauteng province

Sites	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
Stanza Bopape CHC	20 June 2017					
Mamelodi Hospital		Site not visited				
Refilwe Clinic		Site not visited				

FPD: Capricorn, Limpopo province

Sites	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
Zebediela Hospital	23-24 May 2017					
	20-22 June 2017					
Mogoto Clinic	23-24 May 2017					
	20-22 June 2017					

FPD: Nkangala, Mpumalanga province

Sites	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
Middleburg Hospital	20-23 June 2017					
KwaMhlanga CHC	20-23 June 2017					
Poly Clinic	20-23 June 2017					

Right to Care

In Right to Care sites in the City of Johannesburg, nutrition assessment and classification are done, but not consistently for all clients by the selected sites, though there was some improvement in NACS integration after each support visit. Like many other sites, nutrition counselling and nutrition support are challenging for the selected sites. In Right to Care sites in Thabo Mofotsanyana, nutrition assessment is comprehensively done and nutrition classification has been partly done. Nutrition counselling and nutrition support are comprehensively done by both sites, except for the Bethlehem Hospital, where the nutrition support systems are not well established. In Right to Care sites in Ehlanzeni, nutrition assessment has improved and is now comprehensively done by all the selected sites. Nutrition classification is also comprehensively done by selected sites, except Louw's Clinic, where this dimension is only partly covered. Nutrition counselling is inconsistently done in all the selected sites, and nutrition support is well established at Barberton Hospital, and fairly established at the other two selected sites.

Right to Care: City of Johannesburg, Gauteng province

Sites	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
Thuthukani Clinic	4-5 April 2017					
	6-8 June 2017					
Diepsloot Clinic	4-5 April 2017					
	6-8 June 2017					
Randburg Clinic	4-5 April 2017					
	6-8 June 2017					

Right to Care: Thabo Mofutsanyana, Free State province

Sites	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
Bethlehem Clinic	8-11 May 2017					
	7-8 June 2017					
Bohlokong CHC	8-11 May 2017					
	7-8 June 2017					

Right to Care: Ehlanzeni, Mpumalanga province

Sites	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
Barberton Hospital	19-21 April 2017					
	10-12 May 2017					
	13-15 June 2017					
M'Afrika CHC	19-21 April 2017					
	10-12 May 2017					
	13-15 June 2017					
Louw's Creek Clinic	19-21 April 2017					
	10-12 May 2017					
	13-15 June 2017					

MatCH

In MatCH sites in uMkhanyakude, nutrition assessment is comprehensively done by some sites and partially done by others. Nutrition classification is done by all sites except for Somkhele Clinic, where classification is partly done regardless of the availability of equipment for assessment. Nutrition counselling and nutrition support are partially done, except for the recording of counselling at Somkhele Clinic that has regressed following the resignation of the nutrition advisor at that site.

MatCH: Umkhanyakude, KwaZulu-Natal province

Sites	Dates	Nutritional Assessment	Nutritional Classification	Nutritional Counselling	Referral Systems	Nutritional Support
Hlabisa Hospital	10-11 April 2017					
	15-18 May 2017					
	12-15 June 2017					
Hlabisa Gateway	10-11 April 2017					
	15-18 May 2017					
	12-15 June 2017					
Inhlwathi Clinic	10-11 April 2017	**Site not visited**				
	15-18 May 2017					
	12-15 June 2017					
KwaMsane	10-11 April 2017					
	15-18 May 2017					
	12-15 June 2017					
Somkhele	10-11 April 2017					
	15-18 May 2017					
	12-15 June 2017					

Collaborative Strengthening Arrangements

In quarter three, CDS participated in three meetings with DSPs and the DOH to promote integration of NACS into routine health care services and address persistent gaps highlighted from the site assessments.

PEPFAR-funded DSPs

CDS held a meeting with the DSPs on May 31, 2017, to discuss progress on NACS integration. This included a CDS presentation of support provided and challenges experienced, and presentations from each DSP on their progress. USAID shared its expectations, and the DSPs committed to the following actions:

- Each organization to appoint a focal person (point of contact) for nutrition to work with CDS and selected sites on NACS
- DSPs to form a nutrition task team to discuss the core interventions and improvement plans by June 2017
- DSPs to conduct SIMS assessments to diagnose the problems regarding nutrition integration into care and treatment at their supported health facilities
- Each DSP to develop a specific strategy on nutrition as part of their work plans to USAID, with core interventions agreed on by the task team; activities should be framed based on the 90-90-90 targets
- Each DSP should have a professional development plan to ensure that staff have a minimum skill set which includes nutrition
- DSPs to have a district dashboard indicating NACS site performance

CDS will follow up on these actions at the DSP Nutrition Task Team meeting in July 2017.

Right to Care: Ehlanzeni Health District in Mpumalanga province

CDS held a meeting on April 21, 2017, with Right to Care in Mpumalanga to discuss status updates on NACS integration in Ehlanzeni Health District and clarify roles and responsibilities. Participants agreed on the importance of integrating NACS within the Universal Test and Treat program and discussed the potential placement of a Peace Corps volunteer at Right to Care to provide nutrition support for the organization starting in August 2017.

Anova: Mopani District in Limpopo province

CDS held a meeting on June 6, 2017, to discuss Anova's progress on NACS integration in Mopani Health district, outline CDS support to the organization and the DOH, and discuss Anova's participation in the establishment of a national nutrition task team. Anova is currently a member of the Mopani District Nutrition Forum, which was established to strengthen collaboration between the district DOH and supportive partners. The participants clarified the roles and responsibilities of the DOH Dietetics personnel and the Anova dietitian, and agreed on a referral system. The District Nutrition Forum will address nutrition priorities in the district, including finalizing data collection tools with support from CDS, and roll out the tools in all health facilities. Anova will work with the DOH to roll out NACS training to all health facility staff.

Support to OVCY Partners

Most OVCY programs in South Africa do not adequately integrate nutrition as a standard of care, as evidenced by poor performance on nutrition-related core essential elements on the SIMS assessments at organizational level. CDS is supporting the five ECHS partners and three ReACH partners to integrate nutrition into their programming in six provinces.

Readiness Assessments of OVCY Partners

In quarter three, CDS assessed ReACH sub-awardee NACOSA to determine its level of readiness to provide nutrition services.[43] It is critical for partners to achieve level 3 or 4 across all six dimensions to fully implement NACS. The assessment findings revealed significant gaps in the overall provision of nutrition services, as depicted in the table below.

[43] The nutrition assessment forms part of CDS' overall organizational capacity assessment

NACOSA's site readiness assessment: baseline findings in quarter three

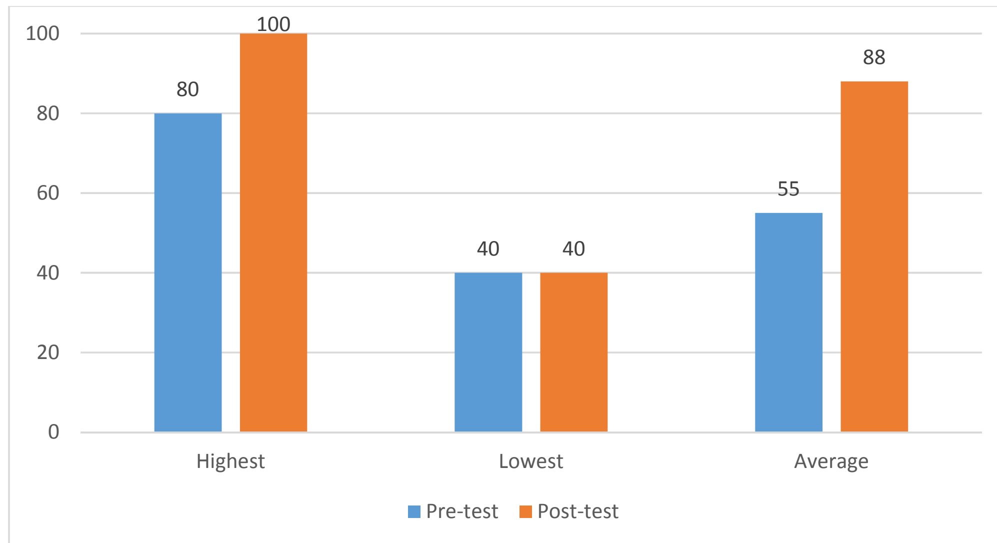
Key: Level of Readiness		1	Limited capacity
		2	Moderate capacity
		3	Strong capacity
		4	Excellent capacity
Domain	**NACOSA**	**Key gaps identified**	
Organizational knowledge and skills		No staff have been trained in a comprehensive NACS package, resulting in inadequate knowledge and skills among program and implementing staff	
Essential supplies		There is a lack of nutrition essential supplies (MUAC tapes and NACS implementation tools), and unfamiliarity with nutrition policies and guidelines	
Assessment skills and practice		No nutrition assessment and classification services are provided to clients	
Counseling skills and practice		No nutrition counseling is done	
Referral systems		No nutrition support referrals are done	
Recording and documenting of information		Organizational data recording tools do not make allowance for nutrition data to be collected	

NACOSA verbalized the need for intensive support on nutrition during the assessment. CDS began its response to the findings by providing customized training to address organizational skills and knowledge gaps in quarter three. CDS also provided NACOSA with a NACS starter pack consisting of nutrition essential supplies such as copies of key nutrition policies, MUAC tapes and job aids. CDS will provide mentoring and coaching through site visits, meetings and conference calls to support the roll out of NACS activities at the organization in quarter four.

Knowledge and Skills Building

To address gaps identified during NACOSA's baseline assessment, CDS conducted a three-day NACS training from May 30 to June 1, 2017, as part of the PEPFAR Annual Training Plan. The training was attended by 29 participants from NACOSA and ECHS partners Kheth'Impilo and The Valley Trust. The training targeted technical specialists involved in nutrition as well as program and M&E staff who will assist the organizations in rolling out nutrition implementation. The training equipped participants with the knowledge and skills to cascade information to implementing staff, including how to nutritionally assess, classify and support clients based on their age group. The training also emphasized nutrition as a core activity within the 90-90-90 approach and covered compliance in relation to SIMS.

Pre- and post-test assessment results: OVCY partner training in May 2017



Participants achieved an average increase in knowledge of 60%. Analysis of the pre- and post-tests revealed that participants scored better on key questions related to nutrition assessment and support in the post-test, which are crucial in the continuum of NACS activities. Participants developed action plans based on the knowledge and skills gained at the training, which CDS will support during its mentoring and coaching in quarter four. Examples of key activities in the action plans include:

- Cascade training on how to do MUAC and nutrition classification to key organizational staff, especially implementers at community level
- Integrate nutrition into the supportive supervision schedule
- Improve the referral system to be inclusive of nutrition services
- Review data collection tools to incorporate nutrition elements

These activities will strengthen the case management of OVCY clients in recognition of the synergistic nature of HIV and nutrition, as well as the key role that nutrition plays in ECD, health and wellbeing.

OVCY partner training participants

Mentoring and Coaching

CDS conducted mentoring and coaching visits to three OVCY partners in quarter three, including technical assistance for cascade training at HOPE worldwide, and site visits at Woz'obona and SAfAIDS.

HOPE worldwide

In the quarters one and two, CDS trained HOPE worldwide's home visitors and program staff on nutrition. However, the organization's program manager and supervisory staff identified a need to provide refresher training to the home visitors. Consequently, CDS provided technical support at two nutrition refresher trainings hosted by HOPE worldwide in quarter three. The two-day trainings were conducted with 20 home visitors from Zandspruit, and 21 home visitors from Diepsloot. The home visitors showed a high level of skill in taking nutrition assessments at household level, but need to improve on explaining the reasons of taking MUAC and interpretation of results to the caregivers. Generally, HOPE worldwide's facilitators demonstrated skill and confidence in their facilitation of the trainings. CDS provided detailed feedback to HOPE worldwide on the training content, facilitation skills and training outcomes after each training session.

CDS further encouraged HOPE worldwide to link its HIV testing of clients with nutrition assessment during their program management meeting conference calls in quarter three.

Woz'obona

CDS conducted a NACS mentoring and coaching visit to Woz'obona on April 5, 2017. During the visit, CDS audited client files to assess NACS service delivery. Out of 23 files randomly selected and audited, four were found to be compliant with NACS. These four files had the MUAC recorded, however, the measurements were questionable as the readings do not

coincide with MAUC tape calibrations. One major gap identified was that home visitors were not consistently measuring, classifying and recording MUAC measurements for each client at least once a quarter. CDS supported Woz'obona to update its action plan for NACS implementation. Additions include:

- Woz'obona training officer to arrange training with home visitors, to be conducted with CDS technical assistance
- Woz'obona to include NACS when doing data verification at its weekly meetings
- Woz'obona to provide NACS job aids to home visitors

SAfAIDS

CDS conducted a visit to SAfAIDS in Mopani District, Limpopo province, on May 16, 2017. The client file audit revealed that the several data collection forms need to be updated to include comprehensive nutrition information. In addition, home visitors do not record the MUAC measurement and nutrition classification on the screening tool to allow for data verification on the service provision tool. CDS provided input on revisions to the tools and recording process.

CDS also conducted a home visit to observe nutrition service provision by SAfAIDS staff. The home visitor was confident in explaining and conducting the MUAC measurement, but was not sure how to complete the screening tool to capture the information. According to feedback received from SAfAIDS, not all home visitors have been trained on NACS.

At the close of the mentoring and coaching visit, SAfAIDS made the following commitments to improve the delivery of NACS services:

- Address the findings from the file audit and home visit
- Incorporate nutrition indicators on daily assessment forms and ensure nutrition data is collected
- Cascade home visitors' training to cover all implementation areas and home visitors

Knowledge and Skills Building in NACS Implementation

Mother, Child Health and Nutrition flipchart and poster

In quarter one, CDS developed a job aid to facilitate communication between community health workers and community members, particularly pregnant women and mothers, based on the Mother, Child Health and Nutrition booklet previously developed by FHI 360 and the NDOH.[44] In quarter two, the job aid was approved by the NDOH and USAID. CDS translated the job aids into five languages in quarter three: IsiZulu, IsiXhosa, Sepedi, Setswana and Sesotho. The flipcharts will be printed for distribution in quarter four.

Poster promoting child nutrition

A poster based on the Mother, Child Health and Nutrition flipchart was developed for use by ECHS partners, ECD centers and potentially health facilities. The poster's key messages include exclusive and sustained breastfeeding, and timely introduction of appropriate complementary feeding for infants and young children. The poster was finalized with input from the NDOH and USAID and printed for distribution in quarter three.

NACS curriculum and job aids

In quarter two, the NACS curriculum was finalized with input from the National Child Health Department, and CDS is still awaiting approval from the National Nutrition Directorate. CDS printed the NACS job aids and began distribution to the DSPs and OVCY partners in quarter three.

Nutrition Essential Supplies

In quarter three, CDS distributed the following nutrition essential supplies to DSPs, OVCY partners, the DOH and participants at the South African AIDS Conference 2017:

- 1,420 BMI wheels
- 3,852 adult MUAC tapes
- 3,738 child MUAC tapes
- 67 flipcharts
- 50 job aids

[44] The booklet was created under the NACSCAP project, which has since been integrated into CDS.

Support at the National Level

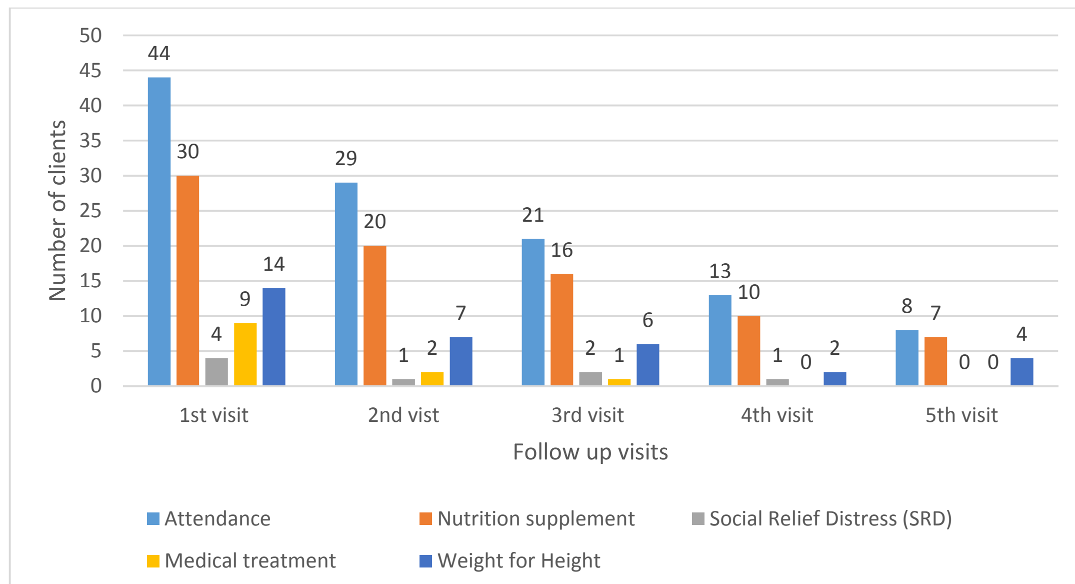
In quarter three, CDS participated in several meetings addressing strategic issues related to scaling up the provision of nutrition services. These included advocacy at the national level and participation in technical working groups, and participation in the provincial quarterly meeting between the KwaZulu-Natal DOH and PEPFAR treatment partners. CDS also participated in provincial meetings to introduce the new USAID Activity Manager and discuss revised roles and responsibilities in NACS implementation in KwaZulu-Natal and Mpumalanga.

SAM Rapid Assessment

In quarter two, CDS and the DOH conducted a rapid assessment on SAM implementation in Gert Sibande district in Mpumalanga province. The aim of the assessment was to describe the characteristics and outcomes of a cohort of SAM cases (children under the age of 18 years) admitted to hospital in Gert Sibande district during the 2014/2015 and 2016/2017 financial years, and understand the quality of medical, nutritional and social interventions provided. Key results included:

- SAM and HIV co-exist: at least 30% of in-patient SAM cases were HIV infected
- TB and HIV co-infection rates were high: approximately 50% of HIV-infected SAM cases also had TB
- Although the rates of diarrhea and pneumonia were high among SAM cases, there was no link between these diseases and HIV infection
- Both client attendance and service provision decreased over subsequent follow-up visits

Number of clients provided with recommended services at follow-up visits



- There was a lack of integration between DSD and DOH: many more children received clinical nutritional supplements compared to Social Relief of Distress vouchers to support nutrition at home.
- There are inadequate referral systems and linkages with community support structures: the outcome of most SAM cases after discharge from the health facility was unknown.

Recommendations include:

- There is an urgent need to integrate nutrition into both PMTCT and ART treatment programs.
- All children under five years old diagnosed with malnutrition should be tested for HIV routinely, and all HIV-infected children should be nutritionally assessed and classified.
- Linkages between health facilities and communities should be strengthened to promote ongoing support and full recovery of SAM cases.
- The quality of inpatient care can be improved by consistent application of the standard treatment guidelines for both HIV and malnutrition.

CDS is revising the rapid assessment report based on feedback from the Mpumalanga DOH.

Peace Corps Volunteers

CDS attended the swearing-in ceremony for 33 new Peace Corps volunteers on April 7, 2017, three of whom have experience in nutrition work. CDS is working to place one of these volunteers at Right to Care in Mpumalanga to support NACS integration at the organization. CDS oriented the Peace Corps volunteer on NACS, and the volunteer will be included in the NACS training in Mpumalanga province in quarter four. The Peace Corps Program Manager is willing to support an application for additional nutritionists for NACS technical assistance, which CDS will purse to build support for the program in the districts.

Implementation of Nutrition Services in ECD Programs

CDS and other development partners attended a meeting with the national DOH on June 28, 2017, to discuss the implementation of nutrition in ECD programs. CDS staff shared their work in this area since 2014, and the national DOH Nutrition Directorate presented the *Nutrition Guidelines for ECD Programmes* outlining the knowledge and skills required by ECD caregivers and staff. These guidelines are a subset of the overarching National Integrated ECD Policy. Participants were requested to participate in drafting an implementation plan for the nutrition guidelines, and CDS is responsible for the resource mobilization section. The draft Implementation Plan for Nutrition Guidelines will be submitted to the ECD policy sub-committee for health and nutrition on July 5, 2017. CDS will continue to support activities related to the finalization and implementation of the plan in quarter four.

TechLab Closeout

CDS presented the final TechLab closeout report for uMkhanyakude in a meeting from June 5-6, 2017. The project was designed to identify children at risk of malnutrition in Hlabisa sub-district, within the catchment area for Hlabisa Hospital and its feeder clinics. Participants at the closeout meeting included the Provincial Director: Mother, Child and Women's Health (MCWH) and Nutrition; Assistant Director: Nutrition; the District Nutrition Assistant Director; PHC Manager; Phila Mntwana facilitators and coordinators; and Hlabisa hospital management. The project found that an average of 9% of children under five years old who were assessed using MUAC were exposed to HIV, and there were mixed feeding practices among more than 70% of infants under six months old. Also identified was the potential for stunting, which affects about 18% of the children over 18 months in KwaZulu-Natal province. Only four of the Phila Mntwana Centers in the area had scales, resulting in inadequate numbers of children receiving regular growth monitoring as recommended by the DOH. The province and the district will work to strengthen the Phila Mntwana Centers' nutrition work in the future.

Participation in the SA AIDS Conference

CDS delivered a nutrition presentation, *Strengthening the Capacity of Health Facilities to Integrate Nutrition into HIV Care and Treatment Services: Promising results from South Africa*, at the South African AIDS Conference in June 2017.[45] The nutrition materials, including the BMI wheels and MUAC tapes, were popular items at the FHI 360 exhibition booth, and CDS is following up on requests for additional materials. Representatives from the WRHI sex workers' program expressed interest in building the capacity of its mentors in NACS, and CDS will follow up this request from the organization. The DBE and DSD also indicated interest in collaborating to integrate nutrition into their programs. A meeting with DSD is planned for July 2017 to discuss how best to proceed with building this capacity within the department.

National Technical Working Groups

CDS attended the Breastfeeding Technical Working Group meeting and South African Civil Society for Women's, Adolescents', and Children's Health (SACSoWACH) annual meeting in order to contribute to policy development and stay informed regarding national-level decisions and directives in infant and young child feeding. For example, the DOH clarified its position regarding the revised World Health Organization (WHO)/United Nations Children's Fund (UNICEF) Infant and Young Child Feeding Guidelines to align its NACS training to national policy. While South Africa has not adopted the entire WHO guidance, it has adopted the recommendation that HIV-infected women who are breastfeeding should be supported to adhere to ART, and should be counselled and supported to exclusively breastfeed their infants for the first six months of life. Thereafter, women should introduce

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[45] Read more about CDS' presentations at the South African AIDS Conference in the Knowledge Management and Communication section of this report.

complementary foods and continue breastfeeding for at least two years. CDS will incorporate this information into its training.

National Food and Nutrition Security Coordinating Committee

CDS attended a meeting on April 19, 2017, to discuss proposed models for costing the National Food and Nutrition Security Plan from DNA Cornerstone Consultants. The Coordinating Committee, led by the Department of Planning, Monitoring and Evaluation, visited the Eastern Cape, Gauteng and Limpopo provinces in May 2017. Departments responsible for coordinating the plan's strategic objectives 1-6, support departments and support partners sent representatives to attend provincial sessions.

District Quarterly Performance Review meetings

CDS participated in the Uthungulu District Quarterly Performance Review for all the DOH programs and supporting partners on May 22, 2017, to share the progress among various programs within the district such as MCWH and Nutrition, HIV and AIDS, and TB and PHC. DSP BroadReach and CDS will present the progress on support provided by partners to the district in quarter four. There was a decision to include nutrition on the PHC supervisors' checklist.

Component 4: Monitoring, Evaluation and Reporting

The activities of Component 4 are cross-cutting, responding to all four CDS strategic objectives.

MER Implementation

Results Reporting: DATIM and DIMES

CDS remains responsive to Data for Accountability, Transparency and Impact (DATIM) reporting requirements. Following the realignment of South Africa's DATIM reporting calendar with PEPFAR real-time reporting timelines, CDS reported its performance results for HTS_TST for quarters two (January-March 2017) and three (April-June 2017). The HTS results were drawn from the DREAMS, SRI and ATC-HTS programs. This shift in reporting will enable CDS to utilize DATIM results more effectively to support programmatic needs.

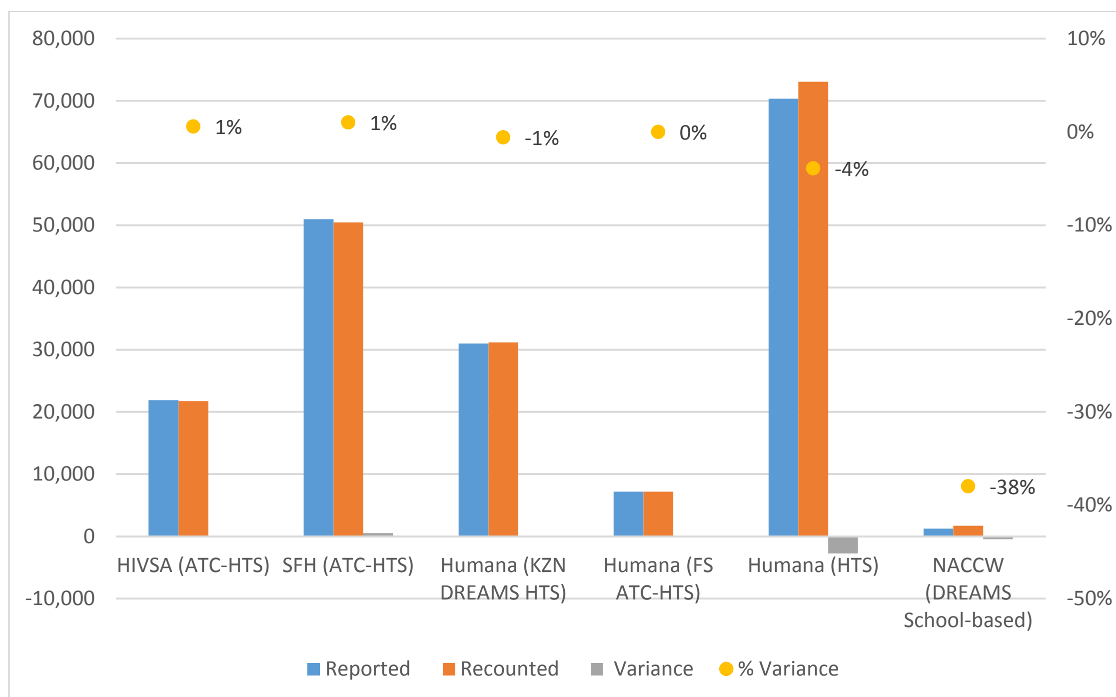
Results for DREAMS continued to be reported in the DREAMS DIMES monthly during the quarter, including results for PP_PREV, GEND_GBV and HTS_TST. Results for PP_PREV and GEND_GBV will be reported as semi-annual and annual indicators, respectively, in DATIM in quarter four.

Rapid Data Quality Assessments (RDQAs) and Technical Assistance to CDS Sub-awardees

CDS conducted several RDQAs and provided data quality-related technical assistance throughout the quarter to improve the reliability of the program data reported from sub-awardees to CDS. As part of measuring the effectiveness of data quality capacity building at partner level, which is part of the RDQA process, CDS staff monitor and measure error rates for each sub-awardee.

All five ECHS sub-awardees have institutionalized the CBIMS database as a repository for all OVCY program indicator data. This has enabled CDS to minimize the number of site-based RDQA visits. Monthly telephonic discussions after review of CBIMS data are used to provide feedback to the sub-awardees, provide technical assistance and follow up on action plans for improvement. Uptake of the CBIMS database among ReACH partners is good despite a few systemic and capacity-related challenges. Consequently, CDS continued to conduct site-level RDQAs for these sub-awardees in quarter three.

CDS RDQA findings for selected sub-awardees across three programs: quarter three



CDS is finding that the percentage of variance (the difference between data reported by sub-awardees from data verified by CDS) is decreasing over time as it conducts RDQAs and provides support to the sub-awardees, and they implement internal verification to reduce discrepancies between reported and verified data. Common data quality challenges include:

- Incomplete client records, such as information on age and Ward of residence
- Lags in data capturing from service provision forms to databases or collation data sheets, resulting in irreconcilable data differences between the two sources

CDS sub-awardees' RDQA findings and recommendations

Program	Sub-awardee/s	Findings	Recommendations
ATC_HTS	HIVSA Humana Society for Family Health	Highlights include: • HIVSA has a good data management system in place. • The average variance among sub-awardees has improved from approximately 35% to less than 5%.	• Appointment of additional staff in line with the budget review, which will improve timely submission of data. • Society for Family Health to revise its filing system to simplify location of data for verification purposes.

Program	Sub-awardee/s	Findings	Recommendations
ECHS	Kheth'Impilo, HOPE worldwide, mothers2 mothers, The Valley Trust, Woz'obona	• Quarter three data reports were generated including all ECHS services provided to clients. CBIMS is now being used as the ultimate data source for OVC _SERV by all sub-awardees. • Reporting of OVC_HIVSTAT has improved among all ECHS sub-awardees.	No specific recommendations due to strong performance; CBIMS serving as a valuable system for verification.
DREAMS HTS and Condom Promotion and Provision	Humana	• The variance between reported and recounted HTS data has improved. However, there is underreporting of data. Specifically, the data quality criteria of validity still needs improvement as key data elements are missing from the consent forms, which results in underreporting.	• Internal quality control measures to be instituted at data collection level (field level) before completed forms are sent to Humana's office.
ReACH	NACCW SAfAIDS NACOSA	• SAfAIDS and NACOSA are in the process of capturing data into CBIMS to generate reports. • NACCW is currently using its own database and it is not able to generate the required data for reporting to USAID.	• NACCW to ensure that it can generate reports without compromising the quality of data.
DREAMS Community Mobilization	Project Empower Hope Africa NICDAM	• Filing of data and data clean-up still need improvement.	• Staff need training on data quality management systems.
DREAMS School-based HIV and Violence Prevention	NACCW	• NACCW uses a paper-based system as its data source, and this is collated in their internal electronic database. • Hard copies had some data elements missing. • Transcription errors (from hard copies to electronic database) were noted.	• NACCW to strengthen its data quality control measures to ensure quality data is produced.

CDS has developed and implemented a data quality SOP for its sub-awardees to regulate routine data activities and enhance the quality of data generated through their MER systems. The SOP covers key essentials of data quality and that include data quality management criteria and processes, data quality assessment, data quality improvement plan (DQIP), data storage, security, and data access and availability. The SOP can be used by all individuals performing a data management function, such as managers, volunteers, MER officers, data capturers, information officers and program staff. The SOP seeks to:

- Improve the quality of data as measured by criteria such as: accuracy, integrity, precision, reliability, timeliness and completeness
- Introduce a uniform benchmark that ensures a consistent and standardized data management processes to promote and maintain high-quality data

External OVCY and PP_PREV DQA implementation

CDS developed, awarded and managed a contract with Khulisa Management Services (Khulisa) in response to a request by USAID for a large-scale, comprehensive DQA of 11 PEPFAR-funded partners and six sub-partners implementing OVC, HIV prevention, and/or gender programs during the period from July 1, 2015 to June 30, 2016. The contract, which began March 13, 2017, has been extended to July 31, 2017, to allow Khulisa to finalize the DQA report. The purpose of the DQAs was to:

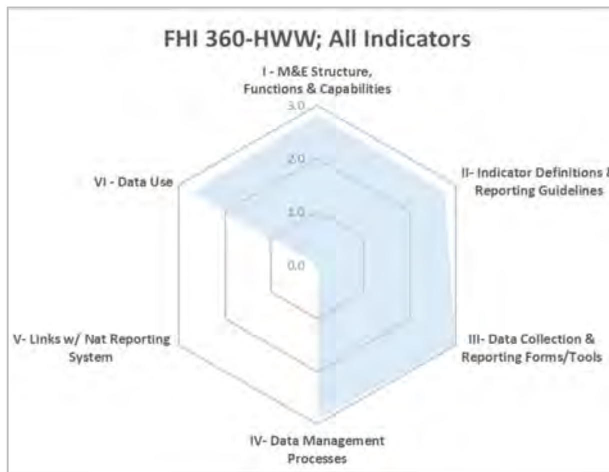
- Identify the strengths and weaknesses of the routinely-collected and -reported indicator data under PEPFAR's MER 1.0 indicator set
- Assess the appropriateness of the existing data management systems to collect and accurately report selected PEPFAR MER 2.0 OVC and HIV prevention indicators

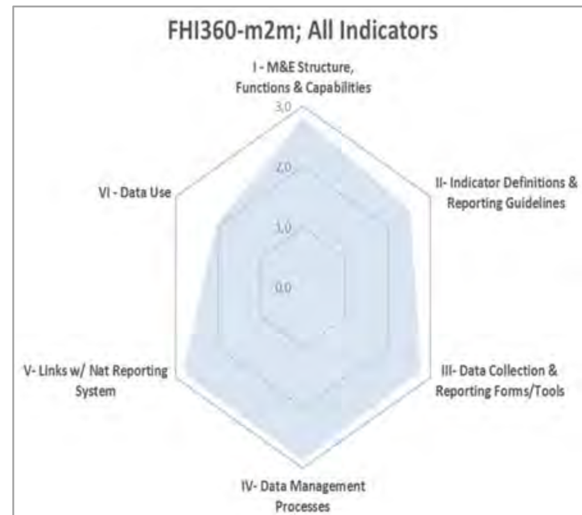
Summary DQA results

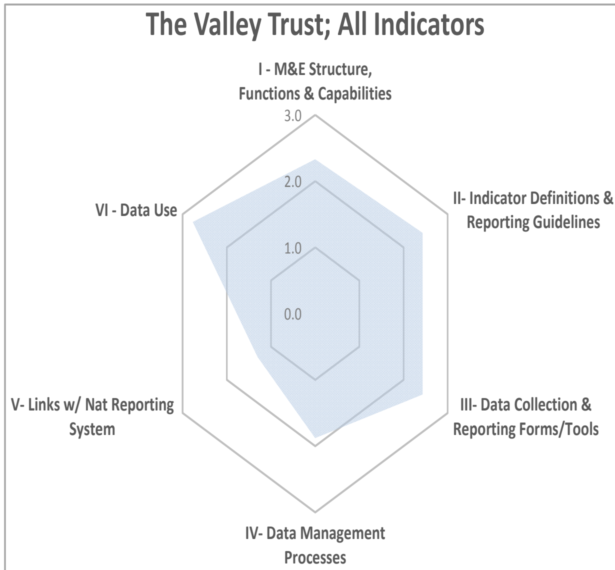
Strengths	Weaknesses
Indicator: OVC_SERV	
• Capturing of client level data directly into database creates greater accuracy • Partners with daily service forms have greater accuracy • Internal data audits to verify numbers are important	• Data collection forms/tools do not clearly capture the indicator • Multiple partners implementing different programs are contributing to the indicator, but with dissimilar understandings of aggregation
Indicator: OVC_HIVSTAT	
• Partners have mostly created systems to measure disclosure	• Some partners not tracking disclosure by clients • Referral tracking systems are weak or immature • Few data management systems allow for full disaggregation of the indicator per MER guidance
Indicator: PP_PREV	
• Session registration forms help identify participation	• Many partners have inadequate systems for tracking the total number of sessions that a client attends – especially in schools • The minimum number of sessions is not always clearly defined to implementers • Lack of data collection and reporting forms/tools usage guidance, resulting in poor practices in data recording

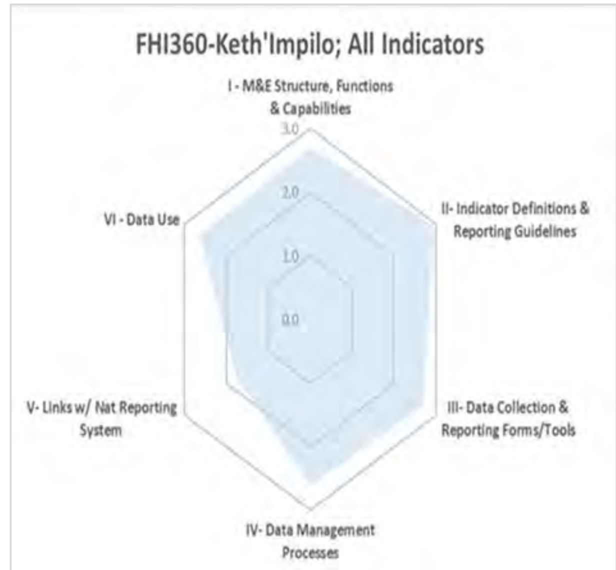
Among the ECHS sub-awardees, the DQA found strong data management processes, data collection and reporting guidelines and tools, and M&E structures and functions. Common gaps were noted in linking with national reporting systems and in data use. CDS will support its sub-awardees to implement the recommendations during its monthly RDQAs and PMMs.

DQA scoring among ECHS sub-awardees: 0 (lowest) to 3 (highest) over six domains









CDS Database

In quarter three, CDS continued its development of a CDS central database with data analytics and data visualization capabilities, which will improve access to its data, support effective communication of key results and support analysis across programs and levels. In response to growing USG reporting requirements, the CDS central database will allow for data exchange with existing databases, including CBIMS for OVCY data and DIMES for DREAMS data. With the central DHIS2 component of the database functional, CDS focused on completing the Power BI Dashboard for analytics. This is ongoing given the number of variables across the CDS programs. The bulk of service delivery data extracted from the central database into Power BI enabled preliminary set up of DREAMS, ATC-HTS, ECHS and

ReACH dashboards. While significant progress was made in the development of financial dashboards for visualization and analytics, CDS is still in the process of linking this with service delivery data. CDS will finalize the service delivery data dashboards in quarter four.

Service delivery dashboard example: ATC-HTS program

The next steps in finalizing the CDS central database include:

- Complete data entry and data exchange
- Conduct a test run on the data analytics and visualization
- Develop operational procedures for database management
- Train MER staff and assign specific roles

CBIMS Support

In quarter three, CDS achieved the following related to CBIMS support to PEPFAR partners:

- Updated OVC and CBIMS database and developed a short technical report to include additional information for ECHS and Vhutshilo programs. This included the integration of workshop attendance into the PEPFAR report, and modification of CBIMS desktop functions that generate XML files, updates, merges, and aggregates to handle the new workshop tables and fields. A DREAMS report was developed to allow for grouping by ward (as exported to DIMES) or by household, personnel, organization, USAID funding stream, province, district, municipality, or sub-district.

- Onsite and virtual support to OVCY partners on CBIMS desktop and OVC database: CDS held onsite training with ReACH sub-awardees NACOSA and SAfAIDS in quarter three.[46] A total of 12 staff from NACOSA and its sub-awardees attended the training from April 24-26, 2017. A total of nine SAfAIDS staff attended the training from May 8-10, 2017, including two staff members from the organization's Zimbabwe office. The total time spent on virtual support was 49.076 hours. The majority of assistance was given to NACOSA and its sub-awardees (MIET, Thandolwethu and Umbumbano), followed by CINDI, SAfAIDS, and The Valley Trust. Other partners (Childline Mpumalanga, Kheth'Impilo, mothers2mothers and Woz'obona) accounted for less than one hour each.
- Development of MS Excel, CSV and XML files that can be imported directly to DIMES with John Snow International (JSI). This entailed developing a special CSV file that can be generated by the database and tested against specifications provided by JSI. The reporting period, ward numbers, age category and service type had to be recoded to match the DIMES codes. The database generated file has been tested successfully by JSI.
- Updated the OVC and CBIMS desktop database for ReACH: This work entailed developing a report as designed by CDS to capture data on client enrollment, current participation or graduation from a ReACH intensive program in a particular month. Other counts, including OVC_SERV, OVC_HIVSTAT and individual services are also performed. The results are generated monthly and disaggregated by sub-district.
- Identification of measures to improve the accuracy of data submitted to DATIM: Measures identified included providing a clearer understanding of partners' responsibilities to administer the database, tighter version control, distribution of the algorithm over and above the documentation in the MER guidelines, and improving partner understanding of the services they provided and whether they could record incomplete referrals.

[46] NACCW has declined to use the CBIMS database, preferring to use its own database.

MER Capacity Development

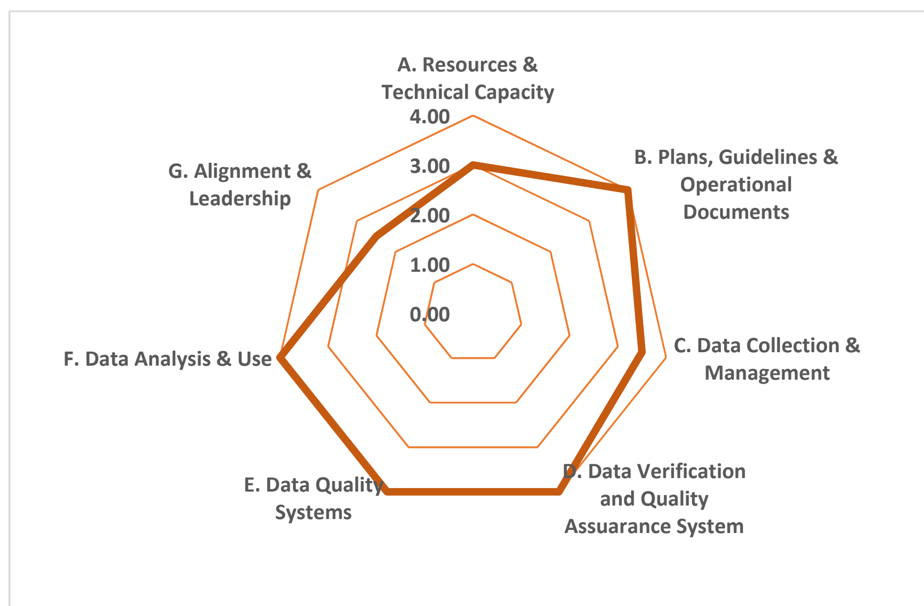
In quarter three, CDS conducted M&E baseline capacity assessments with DREAMS sub-awardees NICDAM and Hope Africa, and a re-assessment with ECHS sub-awardee Kheth'Impilo.

NICDAM

CDS conducted an M&E baseline capacity assessment with NICDAM on May 4, 2017, to assess the organization's M&E systems and identify key areas that require technical assistance to enhance data quality. Key findings included:

- M&E staff have been trained on data quality and data analysis processes.
- The organization has an approved, comprehensive M&E plan that includes project-specific M&E reporting requirements.
- The organization has data collection tools and collation and reporting templates, but there is not written guidance on how to complete the tools.
- NICDAM keeps records of data verified and data quality assessments, but does not use longitudinal results.
- NICDAM holds regular data review meetings to analyze its results and improve performance.
- The organization reports to various government departments, including the DOH at provincial and district level, DSD and the City of Johannesburg Metropolitan Municipality.

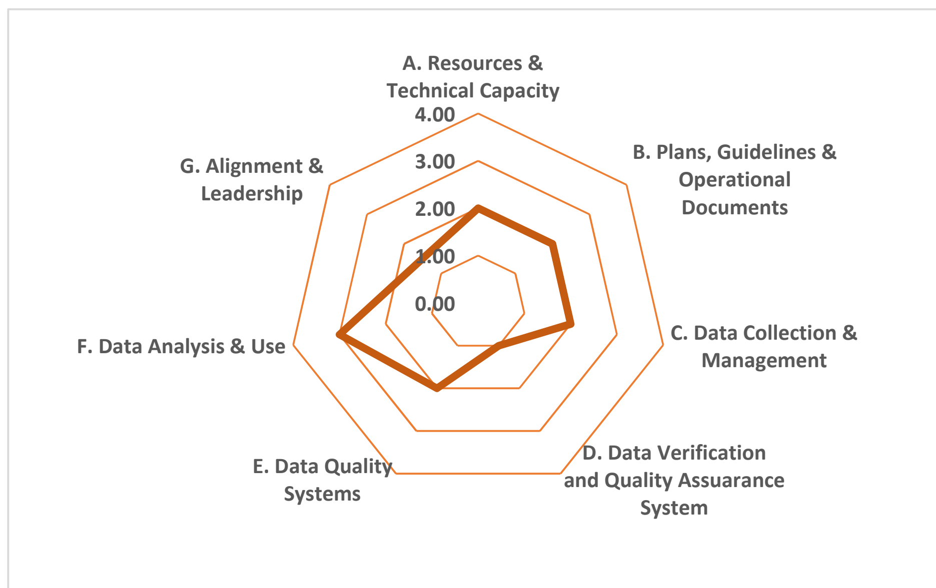
NICDAM assessment results



Hope Africa

CDS conducted a baseline capacity assessment with Hope Africa from May 1-3, 2017. The M&E score of 1.7 out of four indicates a weak M&E system requiring immediate capacity development. Priorities identified include training on MER data quality and completion of indicator definitions of key project indicators. To address the identified gaps, the organization's MER plan will include M&E supervision procedures, data flow chart, graphic results framework, indicator definition sheets, and roles and responsibilities. M&E strengths identified at Hope Africa included adequate data management tools and templates which match the scope of the program, and quarterly data review meetings with M&E, program and technical staff.

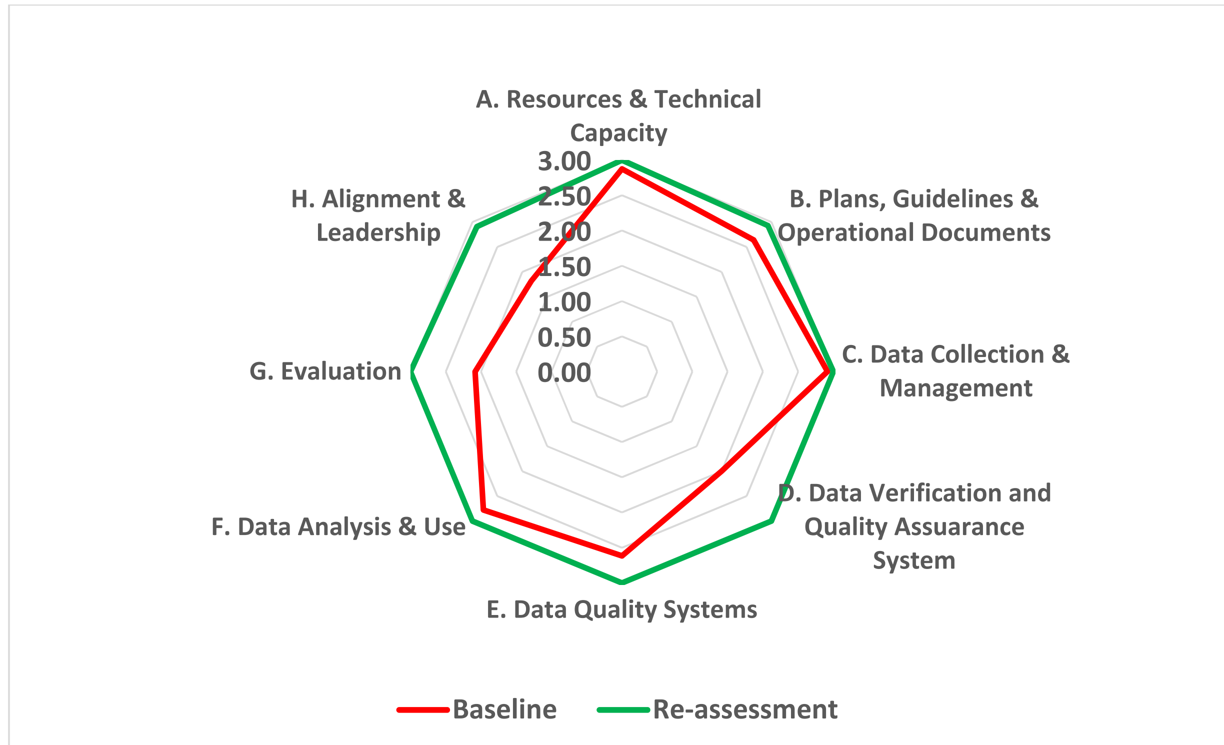
Hope Africa assessment results



Kheth'Impilo

CDS conducted a capacity re-assessment of Kheth'Impilo on May 12, 2017, which demonstrated significant M&E capacity improvement from the baseline assessment conducted in August 2015.

Re-assessment findings: Kheth'Impilo



Key findings included:

- Kheth'Impilo has data management guidelines and M&E supervision procedures, which are followed by all employees to improve data quality and reporting.
- An M&E specialist and data capturers have been employed. There is an employee of the month certificate to recognize excellence and commitment of the staff, and community caregivers are recognized for their key role as custodians of data at the source level.
- Kheth'Impilo consistently uses CBIMS, which assists to identify data errors, double counting and missing data, and supports tracking of longitudinal results. Data collection tools are completed accurately.

OVC and DREAMS summary reports are now able to generate service reports in CBIMS as reflected in the table below.

Example of CBIMS service summary support: Education support provided by SAfAIDS

OVC Clients Service Summary Report								
Grouping	Ba-Phalaborwa LM		Period	01 Jul 2016-30 Jun 2017				
Date Generated	30-Jun-17		Filter	[Organisation] = "SAfAIDS"			Version	4.04
Education Support								
Female	0-10years	10-14years	15-17years	18-24years	25+ years	Unknown Age		
	54	33	3	0	0	0	90	
Male	0-10years	10-14years	15-17years	18-24years	25+ years	Unknown Age		
	46	20	3	0	0	0	69	
		Sub-total	159					

M&E 101 Training

CDS conducted M&E 101 training from June 5-8, 2017, with 27 participants from nine USAID-supported organizations. The participants included data capturers, M&E officers, project managers and coordinators, M&E managers, office administrators and quality assurance specialists. The pre- and post-test results for the training yielded an 18% increase in knowledge.

Participants at the M&E 101 training in Pretoria in June 2017

The M&E 101 training introduced participants to the fundamentals of M&E concepts, applications and processes, providing insights and step-by-step guidance needed to develop good M&E systems that use evidence at every stage of the project life cycle to promote informed decision making and support the achievement of significant, sustainable change attributable to the organization's programming.

Participants identified three main outcomes for action:

- Review of indicators
- Log frame development for the CBOs
- Development of a Performance Management Plan

CDS plans to follow up with participants in six months to assess the completion of the action plans.

Development of M&E Plans with Sub-awardees

CDS provided technical assistance to ReACH sub-awardees to develop project-specific M&E plans in quarter three, including provision of an M&E template with clear guidance to develop the plan. All three sub-awardees completed the M&E plans on time. CDS also facilitated the updating of all five ECHS sub-awardees' M&E plans to accommodate indicator changes as required by new PEPFAR guidance, and in preparation for the external DQA by Khulisa Management Services. The M&E plan development and updating process served a capacity development function by informing incumbent M&E officers (some of them newly hired) of the key components of a good M&E plan, and deepening their understanding of how indicators are calculated and measured.

The Khulisa DQA findings noted that the ECHS sub-awardees' M&E plans were comprehensive and complete with the latest indicator updates.

Research and Evaluation

ReACH Program Implementation Outcome Monitoring

The original planned implementation of the ReACH program baseline study was called off by USAID in May 2017, with a revision of the concept taking financial and ethics process implications into consideration. The revised strategy will involve routinely collected data by the sub-awardees in the three provinces served by ReACH. Data will be collected during client recruitment, assessing their knowledge of HIV risk and sexual reproductive health practices to monitor both changes in knowledge and behavior in randomly-selected cohorts over a period of six months. This modification calls for efficient electronic data collection and collation methods to reduce data entry and verification costs. Consequently, an EpiInfo™ cloud-based data collection application has been set up on MS Azure. A backup system has been set up on SurveyMonkey, where all the relevant forms have been coded. The Risk and Vulnerability Assessment Tool test data from Mopani district (from SAfAIDS) has been entered, and the identified issues are currently being analyzed.

The approach includes the following steps:

1. The Risk and Vulnerability Assessment Tool is administered at recruitment.
2. The client begins an intervention, either Let's Talk or Vhutshilo.
3. A cohort is randomly selected from the clients of each intervention. These clients are given unique identifiers for easy identification.
4. CDS administers the Risk and Vulnerability Assessment Tool again at six months with the cohort to assess whether any changes have occurred in the risk profiles of the adolescents.

Components of ReACH intervention for evaluation

The adolescents chosen to be part of the cohort will be counselled and tested for HIV at time T_0 (the moment they are co-opted into the cohort) and tested again at time T_6 (six months later). All those testing HIV-positive will be linked to treatment, and CDS will assess retention in care at six months. This approach will seek to demonstrate what proportion of HIV-negative adolescents maintain their status and what proportion of HIV-positive adolescents are on treatment and staying on treatment.

The major challenge has been the inconsistency of application of the Risk and Vulnerability Assessment Tool in the field. CDS will reinforce and closely monitor the sub-awardees' use of the tool in quarter four.

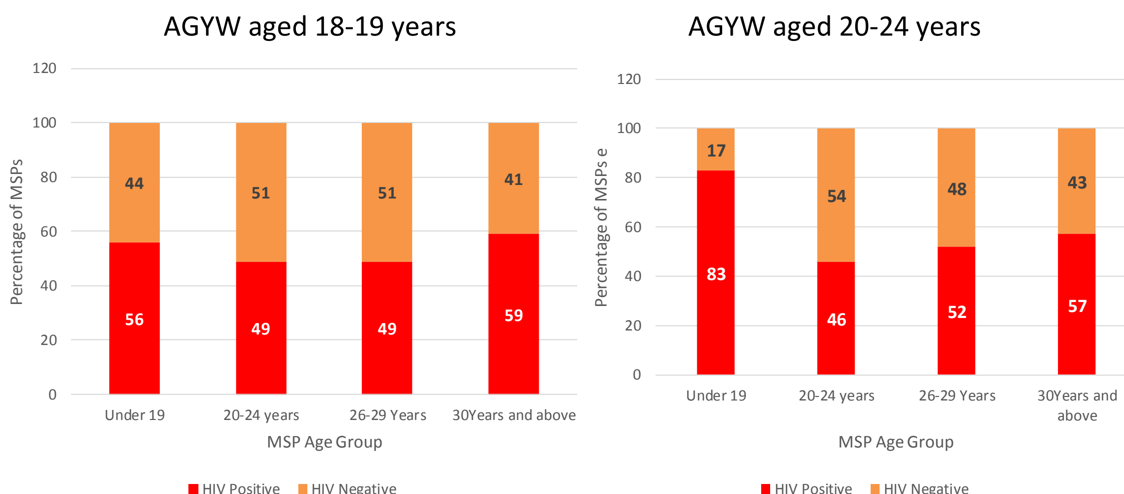
Male Characterization Study

HSRC completed the research for the DREAMS Male Characterization Study in KwaZulu-Natal province and presented the preliminary results to CDS. The first draft of the final report is ready, and comprehensive results from the study will be presented to the DREAMS National Committee on July 21, 2017.

The study found that there is no significant difference in the age categories of the male sex partners of HIV-positive and HIV-negative AGYW in either of the two age groups (18-19 years

and 20-24 years). A striking preliminary finding warranting further research is that 83% of the partners of AGYW aged 20-24 years are under 19 years of age and are HIV-positive.

Age differences between AGYW and their male sex partners



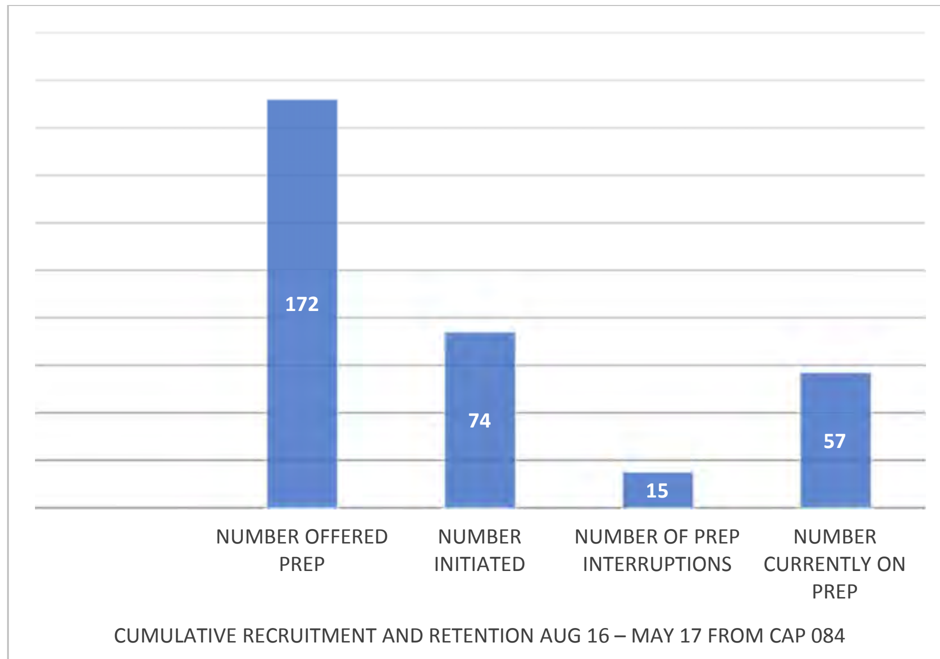
These findings imply a greater amount of sexual activity with male sex partners of similar or younger age than previously thought, pointing towards the need for more prevention and treatment interventions targeted toward males between the ages of 18-30 years.

CDS is exploring options related to the Gauteng province portion of the study due to the amount of time lapsed and the existence of similar DREAMS initiatives in the province that may provide similar insights to those initially sought by the study.

CAPRISA Update

CDS continued to oversee the DREAMS PrEP demonstration study implemented as CAPRISA 084, which is testing the efficacy of Truvada, a daily oral pill for the prevention of HIV infection, in young women at high risk of infection in KwaZulu-Natal province. The ancillary study protocol (CAPRISA 019) was submitted for Biomedical Research Ethics Council review on June 12, 2017. The additional research seeks to validate the findings that vaginal health impacts on oral PrEP efficacy and that treating bacterial vaginosis can enhance PrEP efficacy. Of the 172 women offered PrEP, 43% were initiated on treatment. Of those initiated, 77% have remained on PrEP, demonstrating an emerging need for a targeted systematic review of the reasons for interruption and patterns of retention in the PrEP study areas.

Oral PrEP recruitment and retention on CAPRISA 084 study: August 2016-May 2017



The CDS Research Agenda

CDS is realigning its research agenda after USAID highlighted key priorities for the future during the AOR meeting on June 29, 2017. This includes studies that shed more light on location and avoidance strategies in high-risk target areas across the age spectrum. A draft of the document is being finalized for circulation.

Component 5: Knowledge Management and Communication

The activities of Component 5 are cross-cutting, responding to all four CDS strategic objectives. In quarter three, CDS delivered nine presentations at the 2017 South African AIDS Conference, including four oral presentations and five poster presentations.

CDS presentations at the South African AIDS Conference

Presentation title	Presenter	Number of participants	Questions/interest from participants
Alcohol-related Gender-Based Violence and Increased Vulnerability to HIV in the Northern Cape, South Africa	Esther Maluleke	60-70	• Alignment with DSD policies • Strategies to strengthen alcohol interventions among children • Consensus on the linkages between HIV, GBV and alcohol use
Strengthening the capacity of health facilities to integrate nutrition into HIV care and treatment services: Promising results from South Africa	Phyllis Baxen and Nokuzola Mamabolo	80-90	• Interest in support to DBE • What supplements were provided • Community referral systems • Site readiness assessment tool for different target groups
An effective peer education intervention for HIV prevention, sexual reproductive health and psychosocial support for orphans, vulnerable children and youth	Barbara Michel (HETTAS)	30-40	• How others can benefit from Vhutshilo curricula • How Vhutshilo 3 fits with the other two curricula (1 and 2)
Applying a comprehensive, evidence-based model for building early childhood and household resilience in high HIV prevalence urban communities	Marc Aguirre (HOPE worldwide)	20-30	• Curricula used for men's forums • How efforts fit within the country's ECD focus, including the new ECD policy
Investing in Early Childhood Household Stimulation: Responsive programming for orphans and vulnerable children living in communities with high rates of HIV and AIDS	Nokuzola Mamabolo	25	• How to access the educational toys displayed • Where ECHS operates to link programs/clients • Use of the Ages and Stages Questionnaire
Using SIMS as a quality improvement tool among community-based organizations in South Africa	Coceka Nogoduka	20	• Understanding the SIMS process and CDS' role in improving outcomes • Interest from other prime partners to replicate the process
Capacitating indigenous organizations for high-quality service delivery in South Africa	Zanele Kunene	15	• How CDS' capacity development methodologies are unique • Training materials • Interest in benefiting from capacity development

Presentation title	Presenter	Number of participants	Questions/interest from participants
			• Which organizations are currently receiving capacity development
Scaling up HTS among OVCY and their families: enhancing the quantity and quality of HIV testing and linkages to care services	Nonsikelelo Nyoni	10	• Testing modalities used • Linkage to care • Purpose of GIS mapping
Role of sustainability capacity development and planning in building the resilience and longevity of HIV prevention organizations	Karen Krakowitzer	10	• 3 serious queries regarding sustainability support to CBOs, including from a network organization of 200 CBOs

Success Story: Changing gender norms and building the resilience of adolescent girls and young women in the City of Johannesburg, South Africa

Stepping Stones participants with staff from NICDAM and CDS in Lawley, Johannesburg, in May 2017

In the community of Lawley south of Johannesburg, South Africa, a group of women gather to discuss their lives and relationships. However, this is no ordinary meeting. These women are participating in Stepping Stones, an evidence-based training which applies participatory learning approaches to guide participants through a series of topics including gender, sexuality, HIV, GBV, communication and relationship skills[47].

The 19 participants spoke positively about their experience with Stepping Stones. "Now we understand each other and get along better as women – we are empowering ourselves and growing," said one participant. Another participant noted that her involvement has helped her deal with her emotions and communicate better: "I had a lot of anger and it was getting out of hand. Now I know how to calm myself down, think about what made me angry and address it with others."

Together the women have developed a trusting and supportive environment where they are able to share their experiences and challenges: "It has taught me to be open and share who I am, and has built my self-esteem," one woman noted. This has translated into better relationships with partners as well as improved self-care: "I put my health first and know I have the right to protect myself…I went to test for HIV after one session and felt free to share my status with my friend," another participant shared.

South African civil society organization National Institute Community Development and Management (NICDAM) is implementing the *Community Gender-Based Violence and HIV Prevention Initiative for Adolescent Girls and Young Women* under the USAID-funded Capacity

[47] Read more about Stepping Stones and access the curricula at: www.mrc.ac.za/gender/stepping.htm

Development and Support (CDS) program from July 2016 to July 2018. The goal of the project is to improve existing services to address GBV and the risk of HIV through community mobilization and norms change activities, as well as provision of post-violence care and psychosocial support to those affected by GBV.

Ntombi's story

Ntombifuthi (Ntombi) Ndungwana is 23 years old has lived in Lawley for most of her life. She and her two-year-old daughter live with her mother and several other family members. She completed secondary school and wanted to become a teacher, but did not have money to study further.

Ntombi began attending Stepping Stones due to her friendship with one of the facilitators. "Usually I am shy, but I am able to be open with the other women because we can relate to each other's experiences," she said. "I see it as a support group." The sessions are held once a week for 2-3 hours. Ntombi attends the group regularly because of the bond she has formed with other women. She has learned more about her own body and how to protect herself. "I didn't know much about my reproductive cycle, but now I understand how my body works, and I am confident to use contraceptives and condoms," she stated.

Ntombi's involvement with Stepping Stones has improved her relationship with her boyfriend. "When we fought before, he would sometimes hit me and I would hit him back. After learning about dealing with anger in one of the sessions, I sat down with him and explained that fighting doesn't resolve anything and destroys relationships. We agreed that when we are angry, we will separate and discuss the issue after we have taken some time to think about it."

Stepping Stones has also prompted Ntombi to be more intentional in her parenting. "I want to be a good mother and want us to have a close relationship," she said. "I want my daughter to feel comfortable to tell me anything when she is a teenager. I have learned I need to build that open communication even now – I listen to her and ask her what she needs. I read her bedtime stories to make her eager to learn."

Ntombi is using what she has learned at Stepping Stones to support her family and friends. "My 15-year-old niece is using the information I shared with her on reproduction and hygiene, and I am thinking about volunteering at my church to teach the children about handwashing and other basic health lessons."

Ntombi Ndungwana (center) with two friends from the Stepping Stones group

While Ntombi has experienced challenges in her life, she looks forward to new opportunities: she has a sponsor from her church to continue her education, and has new confidence and skills to protect and support herself and her family.

CDS is implementing the *Community Gender-Based Violence and HIV Prevention Initiative for Adolescent Girls and Young Women* in collaboration with three partners in Gauteng and KwaZulu-Natal provinces in South Africa. As of June 2017, these partners have reached more than 11,500 people with services. The project is part of the DREAMS initiative, which is being implemented in 10 sub-Saharan African countries to help adolescent girls and young women become **D**etermined, **R**esilient, **E**mpowered, **A**IDS-free, **M**entored and **S**afe.

Activities Planned for the Next Quarter

Activities planned for quarter four (July to September 2017)

Project Component	Activities	Timelines (2017)
Component 1: Award and Management	• Finalize grant agreements for the Bridge Project	• July-September
	• Issue Accelerated Targeted Community-based HIV Testing Services (ATC-HTS) Initiative II APS and select implementing partners	• July-September
	• Process ECHS, ReACH and DREAMS incremental modifications for COP17 in line with new target allocation	• August-September
	• Close out the SRI grants (NICDAM and Humana)	• July-August
	• Conduct close out for Woz'obona (ECHS) and Humana (DREAMS)	• August-September

Project Component	Activities	Timelines (2017)
Component 2: Institutional Capacity Development of Indigenous Organizations	**Program Management**	
	• Coordinate CDS sub-awardees' activities to ensure they reach 100% of their targets by September 2017	• July - September
	• Coordinate weekly sub-awardees' data tracking meetings	• July - September
	• Coordinate and provide orientation to new Bridge Project sub-awardees	• July - September
	• Facilitate program management meetings and progress reviews with all sub-awardees	• July - September
	• Coordinate the SRI close-out process	• July - September
	• Represent CDS in all Provincial and District stakeholder meetings	• July - September
	Organizational Development	
	• Implement ECHS and CEGAA capacity development plans after their re-assessments	• July
	• Implement capacity development plans for ReACH and DREAMS sub-awardees	• July – September
	• Finalize a technical assistance report for ECHS sub-awardees to assess the level of effort required against achievements	• July
	Training	
	• Coordinate CDS PEPFAR Annual Training Plan	• July – September
	• Orient the NACS team on TraiNet system	• July
	• Coordinate and update TraiNet training information for 2017 trainings	• July – September
	Sustainability	

Project Component	Activities	Timelines (2017)
	• Facilitate private sector linkages for ECHS sub-awardees through disseminating the updated database of potential funders	• July
	• Finalize the transition planning tool for use by CDS sub-awardees	• July
	• Implement planned sustainability capacity development for assessed sub-awardees	• July – September
	• Deliver Gauteng-based Sustainability training as part of the CDS PEPFAR Annual Training Plan	• July
	• Design and conduct a Social Enterprise workshop for CDS sub-awardees	• July – September

Project Component	Activities	Timelines (2017)
Component 2b: Institutional Capacity Development of Indigenous Organizations - Technical	**ECHS**	
	• Strengthen sub-awardees' use of the HIV risk assessment tool and demonstration of the OVC HIV cascade	• August- September
	• Strengthen linkage to care and treatment for HIV-positive OVC and caregivers	• August – September
	• Develop linkage systems for HIV-negative males to VMMC	• August- September
	• Conduct a five-day Thogomelo child protection training for home visitors	• July- August
	• Strengthen layering and case management systems through engaging home visitors and supervisors	• August – September
	• Distribute job aids to all ECHS sub-awardees	• August
	ReACH	
	• Conduct Let's talk training for master trainers, home visitors and project staff	• July- August
	• Conduct Vhutshilo training for master trainers	• July- September
	• Strengthen sub-awardees' use of the HIV risk assessment tool and demonstration of the OVC HIV cascade	• August- September
	• Strengthen linkage to care and treatment for HIV-positive OVC and caregivers	• August- September
	• Develop linkage systems for HIV-negative males to VMMC	• August- September
	• Conduct a five-day Thogomelo child protection training for home visitors	• August- September
	• Strengthen layering and case management systems through engaging home visitors and supervisors	• August- September
	• Conduct technical site visits for quality improvement	• August- September
	DREAMS: School-based HIV and Violence Prevention	
	• Submit revised implementation work plan and catch-up strategy to USAID	• July

Project Component	Activities	Timelines (2017)
	• Provide oversight technical assistance to NACCW to monitor quality of implementation and meeting of targets	• July- September
	• Conduct technical site visits to NACCW and its CBOs to address programmatic weaknesses	• August- September
	• Participate in the bi-monthly DBE/NACCW meetings and other stakeholder's meetings	• August- September
	• Conduct a consultative meeting with GDE/NACCW to address school enrolment and ward allocation	• August
	• Provide technical assistance to strengthen the implementation approach and layering and case management processes	• August
	Sexual and Reproductive Health (SRH)	
	• Finalize the SRH checklist and administer it to all sub-awardees	• July- August
	• Review existing training curricula to identify SRH gaps	• August
	• Develop a SRH strategy and SOP for sub-awardees	• August- September
	• Provide technical assistance to sub-awardees to integrate SRH into programs, with targeted interventions for: ✓ risk avoidance for 10 -14 year-olds ✓ improved access to SRH for 15-17 year-olds	• August- September
	DREAMS: Community Mobilization & Gender Mainstreaming	
	• Attend DREAMS Community Mobilization sub-awardee PSS meetings and workshops	• July-August
	• Review and revise implementation strategies for the DREAMS Community Mobilization sub-awardees to align with USAID's focus	• July-August
	• Conduct gender mainstreaming training for PEPFAR partners	• August
	• Conduct technical oversight and support meetings with DREAMS Community Mobilization sub-awardees	• August-September
	• Conduct gender-based violence trainings with home visitors under the ECHS and DREAMS Community Mobilization programs	• August-September
	• Conduct gender mainstreaming brown bags with FHI 360 staff	• August-September
	• Plan and technically support the implementation of the OVC-Plus Up initiative	• August - September
	Quality Assurance/Quality Improvement	
	• Support quality improvement activities through mentoring of sub-awardees' Quality Improvement teams	• August - September
	• Conduct SIMS assessments for ReACH, HTS and DREAMS sub-awardees	• August - September
	• Conduct SIMS re-assessments for ECHS sub-awardees	• August - September

Project Component	Activities	Timelines (2017)
	DREAMS: HTS	
	• Strengthen linkage to care and treatment for HIV-positive clients	• July-September
	• Facilitate quality improvement activities for HTS at site level, and conduct in-service training to address gaps	• July-September
	• Coordinate HTS consumables for the sub-awardees in their operational districts	• July-September
	• Provide technical assistance to Humana to improve HTS delivery in Hlabisa, Mtubatuba and eThekwini North	• July-September
	ATC-HTS	
	• Strengthen linkage to care and treatment for HIV-positive clients	• July-September
	• Finalize the ATC-HTS APS for Mpumalanga and Free State provinces and support the selection of implementing partners	• July-September
	• Provide technical assistance to sub-awardees toward improving positivity rates by: ✓ Increasing numbers tested through the index patient modality ✓ Improving targeting of high-yield communities/locations ✓ Piloting a partner notification model with sub-awardees	• July-September
	• Conduct support visits to ensure provision of high-quality HTS	• July-September
	• Support Linkage Tracers in terms of strengthening relationships with the DOH and municipality sectors	• July-September
	• Convene an HTS sub-awardee meeting to communicate USAID priorities for COP17	• August
	HIV Prevention	
	• Facilitate Vhutshilo training for CDS staff	• July-September
	• Conduct Vhutshilo 1, 2 and 3; Let's Talk and Impumelelo Financial Literacy training for all ReACH sub-awardees	• July-September
	• Facilitate and support implementing partners with the roll out of Vhutshilo and Let's Talk training	• July-September
	• Finalize the CDS HIV prevention Strategy and circulate it to sub-awardees	• July-September
	• Provide HIV prevention technical assistance to sub-awardees	• July-September
	• Support strengthening of the layering, referrals and linkages strategies by all sub-awardees	• July-September

Project Component	Activities	Timelines (2017)
Component 3(a): SAG Support	**Recruitment and Management of TAs**	
	• Finalize the recruitment of a consultant for the development of the DBE HIV Policy, TA for the AGYW project in KwaZulu-Natal's DBE and TA on Nutrition for the NDOH	• July-September
	• Finalize the review of the performance management framework	• July-September
	• Conduct monthly management meetings with the Technical Supervisors	• July-September
	TA (Isibindi Project)	
	• Strengthen the collection and quality of data reported on the key project deliverables	• July-September
	• Develop SOPs and minimum standards for the implementation of the community-based child and youth care services	• July-September
	• Coordinate and strengthen the functioning of multi-stakeholder forums that support the implementation of the Isibindi project	• July-September
	• Coordinate the implementation of the learning and development program activities	• July-September
	TA (ECD)	
	• Conduct an assessment of the capacity building needs of the DSD officials involved in ECD services	• July-September
	• Expand the ECD research agenda, particularly providing a focus on HIV and AIDS	• July-September
	• Support the finalization of the implementation plan and development of an M&E framework for the ECD Policy	• July-September
	• Support the rollout of the Parental/Primary Caregiver Capacity Building program with provincial DSDs, UNICEF and National ECD Alliance	• July-September
	• Support the compilation of the chapter on ECD for the Child Protection Policy	• July-September
	TA (Condom Program)	
	• Facilitate condom SOP training and condom curriculum training in Western Cape, Gauteng and North West provinces	• July - September
	• Support provinces to plan and develop provincial and district condom SOPs in Ekurhuleni District	• August
	• Coordinate data management flow between primary distribution sites and the DHIS on a monthly basis	• July-September
	• Monitor all batch tested results with compliance certificates from SABS by analyzing the reports	• July-September
	• Coordinate the performance of suppliers by liaising with provincial HIV program managers to ensure no condom stock outs	• July-September

Project Component	Activities	Timelines (2017)
	TA (HTS)	
	• Provide support to provinces to develop and implement HTS and other health campaigns	• July-September
	• Facilitate the development of at least two IEC materials on HTS	• July-September
	• Co-facilitate three provincial RTQII trainings to assist National Institute for Communicable Diseases to enroll facilities in proficiency testing and Internal Quality Control	• July-September
	• Support Regional Training Centers to organize three trainings to capacitate healthcare workers on HIV rapid testing	• July-September
	• Review the progress on implementation of RTQII through the HTS revitalization meeting	• July-September
	• Facilitate the linkage of PEPFAR partners to health facilities to access HIV test kits	• July-September
	TA (DREAMS)	
	• Support the implementation of *She Conquers* in the 53 priority sub-districts	• July-September
	• Mobilize resources for implementation of the *She Conquers* campaign	• July-September
	• Support the capacitation of *She Conquers* coordination structures in all nine provinces	• July-September
	• Support and monitor the 17 sites implementing PrEP and Test and Treat with sex workers	• July-September
	• Prepare potential sites to commence implementation of PrEP and Test and Treat for MSM, AGYW and sex workers	• July- September
	• Support national, provincial, district and sub-district implementation of DREAMS activities	• July- September
	TA (HTA/KP)	
	• Coordinate, fast-track and co-facilitate the KP sensitization training of trainers in four provinces	• July - September
	• Coordinate input of HTA stakeholders into the draft M&E Framework	• July - September
	• Analyze and consolidate the quarterly and annual HTA performance reports	• September
	• Finalize the HTA assessment tool field testing report	• September
	TA (Health Financing)	
	• Analyze and produce written comments on HIV/TB, National Tertiary Services Grant, Health Practitioners Contracting Conditional Grants reports for April-June 2017	• July-September
	• Compile Conditional Grant data request sheets for National Tertiary Services Grant, Health Practitioners	• July-September

Project Component	Activities	Timelines (2017)
	Contracting Conditional Grants contracting conditional grants	
	• Complete analysis of the earmarked budgets related to HIV	• July-September
	• Facilitate meetings with SAHPRA to monitor progress and support the process of establishing the entity	• July-September
	TA (PHC)	
	• Conduct provincial support visits to assess progress towards investment in PHC equipment	• July-September
	• Procure the essential equipment for the identified health facilities utilizing the ideal clinic in kind grant	• July-September
	• Follow up on the potential project for procurement of equipment by USAID and CDC for the 27 priority districts	• July-September
	• Host Bids Specification and Evaluations Committee meetings for new tenders	• July-September
	Consultant (ICSM)	
	• Roll out ICSM training in 24 districts	• July-September

Project Component	Activities	Timelines (2017)
Component 3b: NACS	**Support to OVCY partners**	
	• Meet with ReACH sub-awardee NACCW to plan strategies to integrate NACS into programming, including action plans and terms of reference	• July-August
	• Conduct NACS trainings with ReACH sub-awardee NACCW	• July-August
	• Provide onsite mentoring and coaching for all OVCY sub-awardees	• July-August
	• Distribute key nutrition essential supplies (MUAC tapes, job aids and counselling aids) to ReACH sub-awardees	• July-August
	• Facilitate the linkage of OVCY partners to DSPs	• July-August
	Support to DSP partners	
	• Convene a one-day workshop for the DSPs to establish a Nutrition Task Team and hold monthly meetings with the team	• July-September
	• Build the capacity of the Nutrition Task Team on core essential elements to integrate NACS into services through a one-day workshop	• July
	• Conduct a decision-makers' course for the DOH and DSPs in Tshwane District to support NACS	• July

Project Component	Activities	Timelines (2017)
	• Develop plans with the DSPs to improve nutrition counselling	• August
	• Review the draft DSP implementation plans, including for alignment to the 90-90-90 strategy	• July
	• Support the DSPs to identify the nutrition gaps in their districts through conducting diagnosis analyses	• July-August
	• Support the creation of professional development plans by DSPs	• July-September
	• Meet with Hospice Palliative Care Association to plan for required technical assistance to integrate NACS into programming and health services in the districts supported	• July
	• Conduct knowledge and skills development for MatCH	• July
	• Conduct repeat site assessment at DSP-supported health facilities	• August-September
	Support to National level	
	• Attend national-level meetings including the Food and Nutrition Security Coordinating Committee, MCWH & Nutrition Think Tank and Breastfeeding technical working group	• July-September
	• Attend the Community and Nutrition and Development Center provincial meeting	• July
	• Attend provincial quarterly progress meetings in Free State, Mpumalanga, KwaZulu-Natal, Gauteng and Limpopo provinces	• July-September
	• Present the SAM assessment findings to USAID and the DOH	• July

Project Component	Activities	Timelines (2017)
Component 4: Monitoring, Evaluation and Reporting	• Finalize and implement the ReACH evaluation platform	• July-September
	• Finalize and implement the CDS research agenda	• July-September
	• Develop the ECHS cost-benefit analysis strategy	• July-September
	• Finalize the Male Characterization study's KwaZulu-Natal report and related documentation	• July-September
	• Develop a database and data analysis plan for Vhutshilo and Let's Talk pre- and post-test activities	• July-September
	• Conduct M&E capacity assessments with the remaining ECHS, ReACH and DREAMS sub-awardees	• July-September
	• Provide CBIMS training for ReACH sub-awardees	• July
	• Provide M&E support to the OVC-Plus Up project	• August

	• Address Khulisa's DQA recommendations to CDS and support the sub-awardees to implement their recommendations	• July - August
	• Conduct environmental compliance inspection visits to testing partners and CAPRISA 084 study sites	• July -September
	• Support new sub-awardees in the development of M&E plans	• July -September
	• Operationalize the CDS central database and systematize the data analytics	• July
	• Update the CDS Data Management System SOP	• July
	• Conduct RDQAs with all CDS sub-awardees	• July -September

Project Component	Activities	Timelines (2017)
Component 5: Knowledge Management and Communication	• Conduct follow-up from the SA AIDS Conference, including programming contacts and discussion on incorporating lessons learned and good practice	• July
	• Develop products from each program area conveying both quantitative and qualitative results	• August-September
	• Develop and implement a capacity development strategy for partners related to documentation of ECHS and other programs	• July -September
	• Maintain the CDS website with current results and information, and use the site for dissemination of approved documentation	• July -September