AIDSFree

The Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Cooperative Agreement AID-OAA-A-14-00046. AIDSFree is implemented by JSI Research & Training Institute, Inc. with partners Abt Associates Inc., Elizabeth Glaser Pediatric AIDS Foundation, EnCompass LLC, IMA World Health, the International HIV/AIDS Alliance, Jhpiego Corporation, and PATH. AIDSFree supports and advances implementation of the U.S. President’s Emergency Plan for AIDS Relief by providing capacity development and technical support to USAID missions, host-country governments, and HIV implementers at the local, regional, and national level.

Recommended Citation


JSI Research & Training Institute, Inc.
1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Email: info@aids-free.org
Web: aidsfree.usaid.gov

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### ACRONYMS

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<th>Acronym</th>
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<tr>
<td>AIDSFree</td>
<td>Strengthening High Impact Interventions for an AIDS-free Generation</td>
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<tr>
<td>C&amp;T</td>
<td>care and treatment</td>
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<tr>
<td>CHMT</td>
<td>Council Health Management Team</td>
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<tr>
<td>CHW</td>
<td>community health worker</td>
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<tr>
<td>CQI</td>
<td>continuous quality improvement</td>
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<tr>
<td>DACC</td>
<td>district AIDS control coordinator</td>
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<tr>
<td>DQA</td>
<td>data quality assessment</td>
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<tr>
<td>EA</td>
<td>early adolescents</td>
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<tr>
<td>EAMC</td>
<td>early adolescent male circumcision</td>
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<tr>
<td>EQA</td>
<td>external quality assessment</td>
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<tr>
<td>IP</td>
<td>implementing partner</td>
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<td>LGA</td>
<td>local government authority</td>
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<tr>
<td>M&amp;E</td>
<td>monitoring and evaluation</td>
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<tr>
<td>MC</td>
<td>male circumcision</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health, Community, Development, Gender, Elderly and</td>
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<tr>
<td></td>
<td>Children</td>
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<tr>
<td>MSD</td>
<td>medical stores department</td>
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<td>NACP</td>
<td>Tanzania National AIDS Control Programme</td>
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<td>PEPFAR</td>
<td>U.S. President's Emergency Plan for AIDS Relief</td>
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<td>RACC</td>
<td>regional AIDS control coordinator</td>
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<td>RHMT</td>
<td>regional health management team</td>
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<tr>
<td>SCMS/PSM</td>
<td>Supply Chain Management System/Procurement and Supply Management</td>
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<td>SID</td>
<td>Sustainability Index and Dashboard Tool</td>
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<tr>
<td>TWG</td>
<td>technical working group</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>Acronym</td>
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<tr>
<td>VCA</td>
<td>volunteer community advocate</td>
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<td>VMMC</td>
<td>voluntary medical male circumcision</td>
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<td>WIT</td>
<td>workplace improvement team</td>
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AIM AND OBJECTIVES

The purpose of this report is to provide an accurate snapshot of Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project fiscal year (FY) 2017 sustainability work; describe the current state of voluntary medical male circumcision (VMMC) services in Iringa, Njombe, and Tabora regions; highlight transition-specific challenges; and provide a clear pathway with concrete sustainability milestones to ensure district-led, sustainable VMMC implementation.

Report objectives include:

- Communicate the current state of VMMC integration to stakeholders
- Define methods to assess and measure progress toward project sustainability
- Describe current approaches used to support sustainability transition
- Recommend next steps for the continued transition of VMMC activities
- Identify barriers and successes to achieving sustainability
- Create guidance to document the process of country-owned VMMC programming.
BACKGROUND

The Tanzania VMMC Country Operational Plan (2014–2017) describes the sustainability phase of the national VMMC program as “the implementation of VMMC services at the majority of hospitals and health centers to be able to serve the remaining (after scale-up is completed) older clients and early adolescents (EA) (boys turning 10 years old). In addition, EIMC services are launched and scaled up during the sustainability phase.” The AIDSFree Project, through support from the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID), has been supporting VMMC in two regions in Tanzania (Iringa and Njombe) since 2009 and in Tabora region since 2013. Iringa and Njombe have reached male circumcision saturation, which is defined as 80 percent circumcision prevalence for 10–34-year-old males, thus averting an estimated 7,000 HIV infections by 2025.\(^1\) An early infant male circumcision (EIMC) pilot program was introduced in 2013 in Iringa region and has since been expanded to Njombe region with 8,000 EIMCs performed to September 2017. Now that saturation has been reached within specific age groups (see Figure 1), Iringa and Njombe are working to integrate EIMC and EAMC (early adolescent male circumcision) services within the existing health care infrastructure and transfer ownership of services and operations to the regions.

**Figure 1. Male Circumcision Prevalence before Start of VMMC Program (“Base”) and Modeled Estimates of Coverage in Iringa, Njombe, and Tabora**

![Figure 1. Male Circumcision Prevalence before Start of VMMC Program (“Base”) and Modeled Estimates of Coverage in Iringa, Njombe, and Tabora](image)

\(^3\) Avenir, internal documents.
Globally, “a sustainable VMMC program is one whose stakeholders maintain high circumcision prevalence after the initial scale-up—generally by incorporating EIMC, EAMC, or both, into routine newborn and adolescent service delivery systems.”

AIDSFree, working with the Government of Tanzania, is using a mixed modality to maintain 80 percent circumcision coverage by scaling up EIMC while simultaneously focusing on EAMC. In addition, AIDSFree is actively working with facilities, districts, and regions both to build capacity and to create ownership of these services so that each program has the capacity and management capabilities for long-term, sustainable VMMC implementation.

AIDSFree directly supports the five regions at different stages of VMMC implementation, building capacity for VMMC, EAMC, and EIMC programming and working hand-in-hand with districts during this transition period to support district-led VMMC implementation. To date, health facilities that offer integrated VMMC services (static sites) have begun to conduct their own facility-led outreach services, ensuring that EA boys that live far from facilities are still able to access services. In Iringa and Njombe, and in FY 2018 in Tabora, AIDSFree has supported the integration of EIMC services into reproductive health services by offering EIMC alongside other well-baby and postnatal care services.

The “sustainability phase” of the VMMC project is a three-pronged approach focusing on capacity—building and developing a sustainable model of service provision—a mix of EAMC and EIMC (Figure 2).

**Figure 2. AIDSFree’s Three-Pronged Approach to Sustainable VMMC Implementation**

<table>
<thead>
<tr>
<th>PRONG 1</th>
<th>PRONG 2</th>
<th>PRONG 3</th>
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<tr>
<td>Integrate VMMC service delivery into existing health services</td>
<td>Focus on adolescent campaigns/outreaches to ‘catch’ clients aging into services (10 years and above)</td>
<td>Scaling up early infant male circumcision in the next 2–3 years</td>
</tr>
<tr>
<td>Continue to build region and district capacity and expand number of static sites</td>
<td>Partner and build capacity of CSOs within the regions</td>
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Using a VMMC-specific site- and district-level tool modified from the PEPFAR Sustainability Index and Dashboard Tool, AIDSFree used four domains of VMMC sustainability with three cross-cutting areas as shown in Figure 3.

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Figure 3. AIDSFree Domains of VMMC Sustainability
METHODS

A baseline sustainability assessment using the site-level VMMC Sustainability Index and Dashboard (SID) Tool was conducted in April and May 2017 in Iringa and Njombe and in June 2017 in Tabora. The assessment covered all 36 health facilities that offer VMMC services in the AIDSFree-supported regions. Fifty-seven individuals (3 regional management officers, 18 district management officers/medical officers in charge, and 36 site managers) were interviewed using the tool, which includes 67 yes or no questions covering four domains.

In addition, three qualitative interviews were conducted with: Paul Luvanda, MD, Iringa Regional AIDS Control Coordinator (RACC); Eusibio Kessy, MD, Njombe RACC; and Rosaria Mkolomi, MD, Tosamaganga Iringa VMMC service provider. Additionally, interviews were conducted with AIDSFree technical advisors with extensive knowledge of VMMC and EIMC implementation in the regions.
CURRENT STATE OF VMMC SERVICES

AIDSFree is committed to the sustainable implementation of EAMC/EIMC activities in Iringa, Njombe, and Tabora, as shown in Figure 4. In FY 2017, AIDSFree support moved away from VMMC scale-up approaches, such as campaigns and outreaches, to focus on improving the integration of VMMC and EIMC services at existing health facilities and using facility-led outreaches, which meant health facilities offering VMMC services during outreaches in their catchment area, ensuring clients do not have to travel long distances to receive VMMC.

While many operational changes are still required at the facility level for truly sustainable VMMC implementation, it will be impossible to achieve VMMC sustainability without addressing the overall perception of ownership of the VMMC program and appropriately planning for methods to bridge funding gaps. Ownership at the region, district, and facility levels remains critical: while there has been progress in this area, the program is still donor-funded, which drives the perception that it is a vertical silo program rather than an integrated service belonging within the health facilities’ package of services.

Figure 4. Tanzania’s VMMC Country Operational Plan 2014–2017: Phases of VMMC Implementation
FINDINGS

Crosscutting

Findings on the current state of VMMC services by domain are based on the baseline assessment and interviews; however, they do not necessarily apply to every health facility that was assessed.

A. Perception and Accountability

In Tanzania, VMMC is still largely viewed as a stand-alone, donor-funded package, separate from standard primary care HIV prevention services, with the implementing partner (IP) accountable for activities and results. This viewpoint permeates all levels, from local government authorities (LGAs), facility management, service providers, to the community:

- **Ministry of Health, Community, Development, Gender, Elderly, and Children (MOH)/Regional Health Management Team (RHMT):** Views IP in leadership role, with MOHCDGEC and RHMT having responsibility for coordination and collaboration. Typically the team appreciates the importance of VMMC, but this does not always transfer to planning and decision-making.

- **Facility Management:** Critical for integration at the facility level, they are often champions for VMMC, but this leadership is often lost with staff turnover.

- **Service Providers:** View VMMC as an add-on to regular service provision, not part of normal care, so don’t always feel obligated to provide; some even feel it is not necessary medical care as it is an elective procedure.

- **Facility Staff:** Charges, matrons, secretaries, and other staff often aren’t informed or engaged.

- **Community:** VMMC services will not be performed if the community is not engaged and interested in receiving them.

Box 1. Sustainability in Action: Provider Ownership of Services

**Sustainability Challenge:** With the phase-out of financial incentives to VMMC providers at facilities offering VMMC services after scale-up, there was a noticeable drop-off of number of clients served.

**Sustainable Solution:** AIDSFree introduced a non-monetary reward system at health facilities offering VMMC and EIMC services to reward providers for achieving specific benchmarks. This approach was developed to assist in phasing out monetary stipends with a focus on integrating VMMC/EIMC into routine services. Rewards included providing celebratory parties, provider uniforms, and facility equipment when benchmarks were met, creating both motivation and ownership of the services.
Changing the perception of all VMMC stakeholders and beneficiaries is a tall order, but critical to program sustainability.

**AIDSFree-supported activities contributing to improved perception and accountability:**

- Provide subawards to regions and districts to take a leadership role in VMMC implementation with the appropriate budget. This should enable a transition where regions and districts are both planning and making the decisions around VMMC implementation.
- Advocate for discussions on sustainability to be integrated into every stakeholder meeting.
- Provide key sustainability milestones to regions and districts to achieve in FY 2018.
- Continue advocacy at the facility level for integration of VMMC services, involving key personnel at the facility level in VMMC planning.
- Provide subawards to CSOs to ensure community engagement.
- Train RHMT, council health management team (CHMT), and CSO representatives in project management of subawards to increase capacity for local planning and accountability.
- Prioritize recruitment of local volunteer community advocates (VCA) from among existing community resource persons including community health workers (CHWs).

**Next Steps**

- Top-down advocacy starting at the government level and defining, sensitizing, and engaging stakeholders at all levels.
- Continue demand creation and outreach activities to engage the communities with appropriate subawards to CSOs.
- Involve and sensitize the LGAs to take a leadership role in the implementation of the transition to sustainability.
- Conduct continued sustainability assessments in collaboration with facilities so they are able to identify gaps and make progress towards ownership.
- Expand engagement with local leaders and influencers at the community level to advocate for VMMC and promote it as a primary care service.
- Mobilize local groups, institutions, and agencies to incorporate advocacy for VMMC among their constituencies and via their social networks.
B. Funding

All aspects of VMMC—including commodities in the supply chain, monitoring and evaluation (M&E), supportive supervision and mentorship, training, demand creation, and service provision—require funding to implement. VMMC is currently embedded in the HIV prevention package budget but it is not prioritized, and no government funding has been allocated in Iringa, Njombe, or Tabora to date, with the exception of Mafinga Town Council. The majority of funding is currently coming from the AIDSFree program through USAID and PEPFAR support, with some support from districts in the form of provider time, facility space, and vehicle usage. HIV test kits used in the VMMC program are now coming through the national supply chain. In FY 2017, AIDSFree advocated for the allocation of VMMC funds in the CHMT budgets, but this was not successful. No known plans are in place to supplement VMMC funding using either public or private funds.

**AIDSFree-supported activities contributing to improved sustainable VMMC funding**

- Working with regions and districts to ensure that a portion of VMMC funding is requested in the CHMT budgets for FY 2018.
- Building capacity at the district level for VMMC budgeting by supporting districts to develop their subaward budgets.
- AIDSFree has had conversations with the National AIDS Control Programme (NACP) to start to work with IPs to pull VMMC commodities from national supply chain.

**Next Steps**

- Continue advocacy at the national level for VMMC funding.
- Build facility, district, and regional capacity for VMMC budgeting.
- Conduct private sector mapping and exploring insurance co-pay system.
- Conduct a study exploring perceptions of parents and their willingness to pay for EIMC and VMMC services.
- Develop demand creation messages framing paying for VMMC services as a small investment now for a lifelong prevention benefit.

C. Data Access and Use

VMMC performance data is recorded through DHIS2 and the LGAs. IPs and facilities have access to VMMC data. Facilities use data to inform the scheduling of outreaches, but typically MOHCDGEC/RHMT use of data for decision making is minimal. Communities are unable to access and use data for program decision making.
AIDSFree-supported activities contributing to sustainable data access and use

- Build capacity at the district level to ensure VMMC data entry into DHIS2.
- Collaboratively conduct data quality assurance exercises with district teams, building their capacity and ownership of EIMC and VMMC data.
- Provide and train providers on data dashboards at each facility that records VMMC and EIMC data with the goal of using this data for decision making.
- Roll out tablets at facilities offering VMMC and EIMC services for facility level data entry linked to DHIS2.
- Collaborate with NACP on VMMC indicators in DHIS2.
- Conduct district-level data summits to examine data and build ownership and capacity at the facility and district levels.

1. Governance

A. Strategic Planning

VMMC is discussed at the regional level, and all stakeholders at this level attend district planning meetings, but no regular VMMC-focused forum or planning session is held. A regional five-year plan for HIV prevention, which includes VMMC, is implemented and monitored. Annual PEPFAR VMMC targets for facilities are aligned with regional and national targets, and facilities plan outreach activities to meet these PEPFAR targets.

AIDSFree-supported activities contributing to site and district level strategic planning

- Supported Iringa HIV strategic planning meeting to ensure VMMC was incorporated into the strategic plan.
- Supported joint stakeholders planning meetings in each region in FY 2017.
- Supported project management training of RHMT and CHMT representatives.
- Supported CSOs to incorporate local leaders and influencers in decision-making and advocacy.

Next Steps

- Establish sustainability task forces at national and regional government levels.
- Support sustainability task force meetings at national and regional levels.
- Work with stakeholders to identify sustainability successes and challenges, and to identify follow-up activities based on sustainability assessment findings.
- Advocate for regular networking forums at all levels, from providers to facility managers, in the form of WhatsApp groups or other social media, which could facilitate sharing of best practices.
B. Civil Society Organization Engagement

Six civil society organizations (CSOs) communicate directly with AIDSFree and are funded through AIDSFree, but there remains limited engagement between CSOs and facilities at the district and regional levels. Most CSO capacity is limited to VMMC/EIMC advocacy and demand creation. CSO engagement could be especially helpful in adolescent-centered outreach.

**FY 2017 AIDSFree-supported activities contributing to CSO engagement**

- Support six subawards to CSOs for VMMC advocacy and demand creation.
- Ensure that CSOs, as well as district and regional stakeholders, interact and collaborate in AIDSFree-supported forums.
- Incorporate LGA approval of each activity implemented by CSOs in their jurisdiction as part of supporting documentation for activity completion.

**Next Steps**

- Assess CSO capacity in the regions and identify areas of support needed by facilities.
- Build direct communication between CSOs and facilities into contract structure.
- Reach out to vibrant local groups, institutions, and agencies beyond subawards mechanism.

C. Private Sector Engagement

Currently no private sector engagement on VMMC. There has been some discussion with companies, but the appropriate decision makers within the private companies weren't involved.

**AIDSFree-supported activities contributing to private sector engagement**

- AIDSFree met with UNICEF to discuss their task of conducting private sector mapping of VMMC services in some regions.
- Privately run Lugoda hospital collaborates with the government to ensure that guidelines, policies, and supervision are provided by CHMTs and RHMTs.

**Next Steps**

- Use lessons learned from engagement in other regions and programs to engage private sector partners, including media partnerships.
D. Coordination between Programs at Regional and District Levels

Other programs implementing similar or complementary activities, such as HIV prevention, don’t always coordinate planning to avoid duplicate work or account for government participants’ schedules. This can be problematic for outreaches and trainings.

FY 2017 AIDSFree-supported activities contributing to coordination between programs

- Present annual VMMC workplan to key stakeholders.
- Support semiannual stakeholder and joint planning meetings in each region where key stakeholders and implementing partners come together to discuss the AIDSFree workplan, VMMC implementation, and collaboration.
- Support district-level data summits that review the VMMC data for the previous years with key stakeholders.

Next Steps

- Advocate with regions to establish a forum, such as a sustainability task force, for joint planning or coordination of activities after they are planned.
- Support CSOs to use AIDSFree subawards to leverage community health and development projects supported by other funders to create synergies.

E. Policy

National VMMC policies are in place and are followed, and there is a national VMMC Country Operational Plan (2014–2017). AIDSFree created a standard operating procedure that includes all aspects of VMMC service and MOH has a standardized curriculum. The challenge is to ensure the link between policy and action is monitored.

FY 2017 AIDSFree-supported activities contributing to VMMC policy development

- Provide technical assistance and printing of the VMMC and EIMC National Guidelines.
- Provide technical assistance to and support of the development of the EIMC and VMMC national training package.
- Provide printing and dissemination support for the VMMC Country Operational Plan.
Next Steps
• Support MOH to develop a VMMC/EIMC National Sustainability Roadmap to guide stakeholders on sustainability milestones and create a harmonized guide for the sustainability transition.

F. Human Resources: Hiring and Retention
The government is aware of human resource shortages and is trying to fill them, but funding is a limitation. Staff transition is problematic, as staff are often transferred to new facilities without regard to specialty, resulting in the loss of skilled staff. LGAs are in control of staff salary and benefits, and some staff retention incentives are in place, including hiring late-career staff on a contractual basis and offering job security after leave without pay.

AIDSFree-supported activities contributing to hiring and retention
• Capacitate staff in provision of VMMC and EIMC services and provides emergency refresher training to providers.
• Provide to providers non-monetary incentives and motivate providers in VMMC/EIMC service delivery (see Box 1).
• Support health facilities to develop duty rosters to ensure the providers are available for VMMC/EIMC service delivery.

Next Steps
• Map current state of VMMC trained providers at facilities.
• Advocate for consideration of provider specialty when districts/regions are deciding on staff transfers, and explore additional monetary, benefit, and recognition incentives for VMMC/EIMC providers.

2. Supply Chain

A. Commodities Sourced through Medical Stores Department
VMMC commodities are currently sourced through Supply Chain Management System/Procurement and Supply Management (SCMS/PSM) and/or AIDSFree in a parallel system from the national supply chain. However, commodity sourcing will need to transition to the national system medical stores department (MSD) procurement for a fully sustainable system. Except for Morgen clamps and bupivacaine, all items needed for VMMC and EIMC are also needed for other routine services, so they are already in the MSD system and provided as line items in facility budgets. Yet, there are no VMMC or EIMC “packaged” kits in the current MSD system. In addition, the various implementing partners use
different items for VMMC programs, so there is no single set of procurements for VMMC programming needs. The significant increase in volume of procurements may be a challenge, and the funding for additional quantities will need to be incorporated into the appropriate CHMT budgets and ultimately approved at the national level.

**AIDSFree-supported activities contributing to a sustainable supply chain**

- Presented steps for integration of VMMC and EIMC supplies at the MC technical working group (TWG) with a goal of getting 50 percent of supplies/commodities sourced through the national supply chain.
- Advocated for VMMC and EIMC commodities integration into the national supply chain with NACP and other IPs during VMMC TWG meetings.

**Next Steps**

- Perform quantification exercises for each AIDSFree-supported VMMC/EIMC facility and each district to determine overall quantities of VMMC/EIMC commodities needed per region.
- Work with other IPs and NACP to identify the equipment and commodities needed for VMMC implementation, and work through the VMMC TWG and MSD to ensure they are available through the national supply chain.
- Advocate for funding of equipment and supplies at the CHMT level and for funding approval at the national level.

**B. Inventory Management**

AIDSFree uses an in-house inventory management system for VMMC equipment and commodities. Item quantities are tracked with ledgers quarterly (monthly for disposables) at the facility level and used to inform order amounts. This inventory management is not conducted through the national supply chain, given that a parallel supply chain is used in VMMC implementation. Inventory is not regularly tracked at the district level for VMMC, but is tracked for HIV prevention and care and treatment (C&T) commodities.

**AIDSFree-supported activities contributing to sustainable supply chain**

- Advocated for integration of VMMC and EIMC supplies into existing systems during stakeholder meetings

**Next Steps**

- Merge implementing partner VMMC inventory needs with the government system and donor-supported system.
C. Equipment Management

An AIDSFree equipment management system is in place and regional biomedical technicians are in place to assist in maintenance and upkeep of generators and autoclaves used by VMMC and EIMC programs. AIDSFree provides most autoclaves, generators, and other equipment, but there is some confusion regarding who should cover the cost of repairs and maintenance for donor-provided items. The government provides vehicles for outreach activities, but they are not always sufficient or available when needed.

AIDSFree-supported activities contributing to sustainable equipment management

- AIDSFree has connected with the various biomedical technicians in each of the regions to make them aware of the equipment at each facility. AIDSFree also supports autoclave training using national trainers.

Next Steps

- Map out equipment (autoclaves and generators) with districts and ensure they are registered with the districts and regions.
- Per facility, define plan for maintenance, repair, and replacement of equipment originally provided by AIDSFree.

D. Lab Supply Management

MOH laboratories are located within the public health facilities and are run by the MOH. Facilities fill out and submit request forms on a quarterly basis for HIV test kits for both facility usage and VMMC campaigns and outreaches. Provision of HIV testing kits for VMMC services is sourced from the national supply chain. A system for lab supply management is in place and run by the ministry. Commodities are typically available, and facilities notify labs of low quantities of HIV tests on a quarterly basis.

AIDSFree-supported activities contributing to lab supply management

- Met with the district and regional AIDS control coordinators to discuss HIV test kit forecasting plans as AIDSFree received all test kits through the government system.
- Works with facilities, districts, and regions to integrate VMMC testing targets into the HIV test kit forecasts.

Next Steps

- Strengthen proper and timely facility-level quarterly report and reorder form filling to ensure HIV test kits for VMMC programming are available through on the job training for service providers.
3. Service Delivery

A. Facility Workplan

AIDSFree shares its VMMC workplan with facilities, and the facilities integrate the work into their plan. The cadence of work planning varies from facility to facility. In FY 2017 AIDSFree made a concerted effort to collaborate with key stakeholders in VMMC and EIMC implementation planning.

FY 2017 AIDSFree-supported activities contributing to facility workplans

- Subawards provided to districts in Iringa and Njombe for government-led VMMC implementation.
- Sustainability action plans developed at the facility level highlighting the need for facility workplans.
- Program management training provided to district and regional government staff.

Next Steps

- Incorporate facility representatives into work planning processes for VMMC.
- Monitor and learn from facility-owned outreach in FY 2018 to improve the process.
- Support program management training for facility staff that will review all aspects of workplan development and implementation.
- Develop a forum for facility managers to meet before annual planning is finalized to discuss best practices.

Box 2. Sustainability in Action: Community-Led Demand Creation

**Sustainability Challenge:** Demand creation has not been able to remain static over the life of the VMMC program, as client numbers were dwindling. AIDSFree had to shift demand creation activities to address the various phases of VMMC implementation using sustainable methods.

**Sustainable Solution:** AIDSFree currently focuses on building on existing networks, using local knowledge and champions, as well as building capacity of CSOs for sustainable demand creation. The current demand creation strategy uses volunteer community advocates, local leaders, and local institutions, building their capacity to create demand for EAMC/EIMC. AIDSFree also supports CSOs to undertake advocacy and demand creation work by developing their financial, management, and implementation skills. By using local CSOs and champions in existing networks, the demand for EAMC/EIMC services is driven from within the communities, so demand for services will continue over time.
B. Demand Creation and Outreach

While AIDSFree supports VCAs who are linked to health facilities, the facilities do not have an active role in planning or implementing demand creation activities. Demand creation materials are produced and printed by AIDSFree. However, in future subawards to districts and facilities, districts will be training existing CHWs who are working within the district, and who can incorporate EAMC/EIMC demand creation into their scope. AIDSFree also uses a holistic community-based approach for sustainable demand creation to build local community capacity, capitalizing on existing networks (see Figure 5 and Box 2).

**Figure 5. Community-Based Approach for Sustainable Demand Creation**

AIDSFree-supported activities contributing to sustainable demand creation and outreach

- AIDSFree supported six CSOs to conduct advocacy and demand creation activities. Support included a subgrant, program management training, and financial management support.
- Facilities now own community-level demand creation activities using existing networks.
• AIDSFree shifted to the use of local volunteer community advocates, many of whom have connections with existing CHWs or home-based care worker networks.

Next Steps

• Monitor and learn from facility-owned outreach in FY 2018 to improve on the process. Begin discussions with RHMT/CHMT/LGA on logistics for using CHWs for demand creation and potential private sector media partnerships.

• Mentor providers and facility and district stakeholders to start incorporating VMMC promotion techniques in their planning and approach to service delivery.

• Support monthly planning meetings between providers and demand creation agents assigned to a particular facility to plan demand creation activities collaboratively.

• Develop nationally approved demand creation materials.

C. Service Delivery and Provider Scheduling

Health facilities that offer VMMC and EIMC services have shifted to conducting their own outreach to early adolescent boys, a significant transition to facility ownership. For health facility outreach, AIDSFree provides financial support through per diem and fuel payments, and the government provides vehicles and service providers. AIDSFree has moved away from AIDSFree-led outreaches and campaigns and is advocating for the majority of service delivery to be within health facilities with integrated VMMC and EIMC services. AIDSFree is also supporting facility-led outreach and subawards to regions and districts for government-led planning and implementation of activities. Facility outreaches are initiated and led by the facility-based team. These outreach activities are focused on early infants and early adolescents in line with the sustainability plan for maintaining 80 percent coverage.

AIDSFree also continues to motivate providers at health facilities through non-monetary incentives to ensure that clients are seen and attended to when coming to facilities for VMMC services. When AIDSFree phased out stipends to providers, it was

Box 3. Sustainability in Action: Tablets at Facilities for Sustainable Data Collection

Sustainability Challenge: It became apparent that when relying on the national data system in Tanzania, there were large data discrepancies between implementing partner data and the national DHIS2 database. This was due to a backlog of VMMC data at district level that was not being entered.

Sustainable Solution: To develop a sustainable way to collect data and ensure the DHIS2 database remains up to date, AIDSFree supported the purchase and the facility level rollout of tablets that collect and upload data to the national database. AIDSFree has trained three to four workers at each health facility that enter client-level VMMC and EIMC data into tablets. Tablet data is then uploaded directly to both the AIDSFree and national databases, preventing a backlog of data and ensuring sustainable data collection for EIMC and VMMC.
noted that VMMC numbers at health facilities dropped drastically. AIDSFree used non-monetary incentives (see Box 1) to motivate and recognize facilities that were integrating services into their routine platforms.

Service providers are scheduled to provide services on a part-time basis during specific VMMC days (usually two to three afternoons or mornings per week). VMMC services are provided separately from other services, and often providers are pulled into other urgent priorities and are unable to provide services when scheduled. Integrated services would allow providers to conduct VMMC as part of their regular routine, instead of needing to carve out separate time.

**AIDSFree-supported activities contributing to sustainable service delivery**

- AIDSFree has shifted to facility-led outreach and phased out AIDSFree-led outreach and campaigns in Iringa and Njombe regions.
- AIDSFree mediates client appointments and develop collaboration between demand creation agents and VMMC providers to better manage facility workloads.

**Next Steps**

- Continue to phase out campaigns in all three regions, with a goal of a majority of circumcisions coming from health facilities providing EAMC/EIMC through routine service delivery and facility-led outreach.
- Further explore which facilities are scheduling VMMC and provider time successfully and which are struggling, and identify ideal state for scheduling as well as challenges to share with other facilities.

**D. Service Provider Retention**

There is a need to change the outlook of providers to view VMMC as part of normal care that salaried staff are obligated to provide as their duty to patients. At a government level, it is important that skilled VMMC staff are not rotated to other facilities, which then requires new staff not only to be re-trained but also to buy-in to VMMC. Providers initially received a monetary incentive from donors, and are not motivated to continue providing services without these incentives.

**AIDSFree-supported activities contributing to service provider retention**

- Sensitized facility staff on non-monetary incentives to encourage an increase in VMMCs and high quality services at facilities.
- Developed and deployed motivation thermometers at each health facility (See Box 1).
Next Steps

- Expand non-monetary incentives for providers, including recognition, and non-donor funded incentives such as allocating a portion of insurance payments.
- Meet with stakeholders that influence staffing at health facilities to advocate for limited movement of VMMC and EIMC staffing away from key facilities.

E. Provider and Leadership Capacity Building

Provider trainings on emergency management, continuous quality improvement, and VMMC technical updates are conducted annually, but these trainings depend on AIDSFree funding. VMMC training is not included in the regular staff orientation, so new staff may miss the information. While clinical training is not needed at a leadership level, it is important that facility management understand the importance of VMMC in HIV prevention and how it is operationalized so that their staff can serve as champions and advocates.

AIDSFree-supported activities contributing to provider and leadership capacity

- Conducted program management training to district and regional stakeholders in conjunction with the subawards to build capacity in VMMC implementation.

Next Steps

- Include VMMC clinical and on-the-job training as part of staff orientation, and discuss gaps and successes regularly at staff meetings.
- Include VMMC provider and emergency refresher training in district and regional subawards.
- Ensure budgets for regional and district training are incorporated in CHMT budgets.

F. Laboratory Operations

Laboratories are government facilities led by a lab technician in charge at each lab, and each operates independently. Personnel, operations, and policy are already established and are being implemented.

*No next steps on this domain related to VMMC programming.*
G. Integration into Existing Structures

VMMC is provided in a separate room in almost all facilities. This poses a risk, especially after the program closes, that the dedicated space might be used for other competing priorities.

**AIDSFree-supported activity contributing to integration of VMMC/EIMC services**

- Sustainability site assessments using the VMMC SID were conducted at all health facilities offering VMMC and EIMC services in the three regions with conversations regarding integration held with key facility stakeholders.

**Next Steps**

- Integrate VMMC rooms into facility operations, possibly using a little used minor theater or other similar room. Combine group counseling into routine health education, individual counseling into routine HIV testing and counseling, and infection prevention and control (IPC) into minor or main theater IPC.

H. Quality Improvement

All facilities have quality improvement plans, but the extent to which they are regulated and implemented varies. An internal workplace improvement Team (WIT) assesses VMMC and EIMC services; external quality assessments (EQAs) are also conducted by the district, AIDSFree, MOH, or USAID.

**AIDSFree-supported activities contributing to sustainable quality improvement**

- Supported the development of national VMMC and EIMC quality improvement tools.
- Conducted continuous quality improvement (CQI) assessments and coaching for all health facilities.
- Quality improvement initiatives are currently led by districts.
- AIDSFree staff trained in CQI techniques.

**Next Steps**

- Develop standard process to report on quality and check up on compliance on a regular basis.
- Sensitize RHMTs and stakeholders to CQI processes.
- Check in with districts on CQI assessments and coaching.

I. Facility Leadership

Facility management plays a large role in stressing the importance of VMMC, making it a priority for staff and institutionalizing it at the facility level by serving as champions. VMMC site managers also
need to provide leadership in advocating for the integration of these services. There is currently a WhatsApp group for site managers to raise questions that is linked to AIDSFree technical advisors, but no formal leadership development.

**AIDSFree-supported activities contributing to facility leadership**

- Engage with medical officers in charge during site-level meetings.
- Conduct CQI assessments and coaching for all health facilities.
- Quality improvement initiatives are currently led by districts.
- Train AIDSFree staff in CQI techniques.

**Next Steps**

- Further use the WhatsApp forum to prompt questions and sharing of best practices, and document recommendations.
- Introduce a method to engage facility leadership, such as participating in VMMC stakeholder meetings.

### 4. Strategic Information

**A. Epidemiologic and Health Data**

Regional and district data are recorded in DHIS2, but not broken down to the facility level. Facilities have the ability to access data but do not access data regularly. A DHIS2 focal person is in place at every district to ensure the collection of facility-level monthly VMMC data; that person is responsible for collecting and verifying VMMC data before submission into the DHIS2.

**AIDSFree-supported activities contributing to sustainable data collection**

- Tablets rolled out to facilities and linked to the DHIS2 for data input (See Box 3).
- Providers trained on tablet data collection.
- Held district level data summits to engage stakeholders.
Next Steps

- Meet quarterly with DHIS focal person to review data collection status and quality.
- Support data visualization tools to engage stakeholders in data reviews.
- Host district level data summits.
- Continue to reinforce site-level data collection.
- Conduct DQA exercises at site level.

B. Financial and Expenditure Data

VMMC expenditure data are tracked as part of the AIDSFree budget, but are not tracked by facilities or LGAs. This makes it difficult for the regions to accurately know the amount needed to budget for these activities.

Next Steps

- Develop mechanism to track and report out on funding needed per activity and overall amount by funding source.

AIDSFree-supported activities for expenditure data

- Site and districts are now developing VMMC and EIMC implementation budgets as part of their subawards so that there are known funding amounts for district-level VMMC implementation.

C. Performance Data

Processes are in place to collect performance data, but there is no incentive to collect and report regularly without targets as incentives. All facilities offering VMMC and EIMC services have tablets to track performance—including patient satisfaction, services, VMMC acceptability, and loss to follow up—and these measures are regularly collected and linked to DHIS2. Tablets are currently owned by AIDSFree, but ownership is in the process of being transferred to the facility. Facility...
staff have the opportunity to become more involved with this process, as AIDSFree staff currently enter the data, which are routed directly to DHIS. One challenge is that there are separate registers for VMMC and EIMC, which need to be addressed.

AIDSFree-supported activities for performance data

- Tablets are supplied at each facility and staff are trained.
- Data dashboards are installed at each facility.

Next Steps
- Review and harmonize VMMC and EIMC registers.
- Continue to engage providers in data for decision-making.

D. Data Quality

Data discrepancies are regularly reviewed and investigated at the national level, but not regularly at the district level. Facilities do not have a standard data entry process, and data are often not entered in a timely manner or by skilled personnel.

AIDSFree-supported activities for performance data

- Supported district-level data summits for each district.
- Collaborates with stakeholders to conduct data quality assessment (DQA) exercises in all AIDSFree-supported districts.

Next Steps
- Continue to support MOH in data quality improvement.

E. Data Dissemination

Not everyone has access to the data they need and it isn’t always in a usable form. DHIS outputs a dashboard to view trends that could be adapted to all data sources.

AIDSFree-supported activities for data dissemination

- Tablets at each site have the capability to provide data dashboards to improve data for decision making.
- Each site also has a data dashboard to aid facility-level data analysis (see Box 4).

Next Steps
- Continue to support providers district and regional AIDS control coordinators (DACCs and RACCs) on the use of tablets for data dissemination.
- Establish forums at district, regional, and national levels for data dissemination.
RECOMMENDATIONS AND SUSTAINABILITY MILESTONES

In addition to the detailed next steps outlined in this report, the baseline sustainability assessment resulted in key overarching recommendations for AIDSFree to accomplish in FY 2018:

1. Continue to shift the perception of VMMC as a vertical program to an integrated element of primary care through the use of national and regional taskforces and engagement of key stakeholders.
2. Develop a national sustainability roadmap to provide clear steps for a sustainable national VMMC program.
3. Strengthen leadership, management, and implementation capacity at the regional, district, and health facility levels.
4. Develop regular forums for stakeholders and IPs to meet and share best practices.
5. Work with donor and IPs to integrated VMMC commodities into the national supply chain.
6. Shift service delivery to be integrated into routine services with limited facility-led outreach.
7. Continue to expand demand creation to local networks and develop national demand creation materials.
8. Assess gaps in each MOH/LGA health management team/council health management team, and facility; develop customized plans to address these gaps with relevant technical support.

AIDSFree has set the following milestone targets to progress toward sustainability in FY18:

1. Increased ownership of VMMC and EIMC programming at the health facility and district levels measured by the site level sustainability index and dashboard tool.
2. Supportive supervision and management of VMMC is conducted by relevant RHMT and CHMT through milestones designated in their subawards
3. VMMC activities are budgeted during the FY 2018 CHMT budgeting process and incorporated into the subaward milestones.
4. VMMC and EIMC training is integrated into the regional training plans
5. VMMC and EIMC supplies are incorporated into the MSD national supply chain.
6. A portion of VMMC and EIMC commodities are ordered through the national supply chain.
7. Fifty percent of VMMC clients are coming from routine services and/or facility-led outreach in Iringa, Njombe, and Tabora.