

UNITED REPUBLIC OF TANZANIA



MINISTRY OF HEALTH AND SOCIAL WELFARE

NATIONAL STRATEGY FOR SCALING UP MALE CIRCUMCISION FOR HIV PREVENTION

2010 - 2015

Enhancing Men's Role in HIV Prevention



NATIONAL AIDS CONTROL PROGRAMME

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ABBREVIATIONS and ACRONYMS

| | |
|---------|--|
| AIDS | Acquired Immuno-Deficiency Syndrome |
| CMC | Clinical male circumcision |
| ESRF | Economic and Social Research Foundation |
| FBO | Faith-Based Organization |
| FGM | Female Genital Mutilation |
| HBCT | Home-Based Counseling and Testing |
| HTC | HIV Testing and Counseling |
| HIV | Human Immunodeficiency Virus |
| ICAP | International Centre for AIDS Programmes |
| IDU | Injecting Drug Users |
| Jhpiego | Johns Hopkins Program for International Education in Gynecology and Obstetrics |
| MC | Male Circumcision |
| MoHSW | Ministry of Health and Social Welfare |
| MSM | Men having Sex with Men |
| NACP | National AIDS Control Programme |
| NBS | National Bureau of Statistics |
| NGO | Non-Governmental Organization |
| NMSF | National Multi-Sectoral Framework |
| PEP | Post Exposure Prophylaxis |
| PLWHA | People Living With HIV and AIDS |
| PMTCT | Prevention of Mother-to-Child Transmission |
| PPP | Public- Private-Partnership |
| REPOA | Research on Poverty Alleviation |
| STI | Sexually Transmitted Infection |
| TACAIDS | Tanzania Commission for AIDS |
| THMIS | Tanzania HIV and Malaria Indicator Survey |
| TMARC | Tanzania Marketing and Communication |
| TWG | Technical Working Group |
| UNAIDS | United Nations Programme on HIV/AIDS |
| VCT | Voluntary Counseling and Testing |
| WHO | World Health Organization |

ACKNOWLEDGEMENT

Male circumcision services are routinely provided as part of minor surgery activities in the health care delivery system, as well as in communities by traditional circumcisers. The need to scale up this service became necessary following the results of randomized controlled trials for medical male circumcision that took place in three African countries of South Africa, Kenya and Uganda during 2005 and 2006. These results showed that medical male circumcision can prevent HIV infection by about 60%.

Following these results, the Ministry of Health and Social Welfare, in collaboration with its partners, formed a National Technical Working Group on male circumcision to advise on how these services can be rolled-out quickly to reach all those in need. The Working Group has among other things, coordinated the implementation of a situation analysis on male circumcision in Tanzania, which was immediately followed by the development of this Male Circumcision Strategy.

The Ministry of Health and Social Welfare, is grateful to the Technical Working Group for its leadership in the development of the National Strategy for scaling up medical male circumcision in Tanzania. The composition of the Technical Working Group on male circumcision included representatives of collaborating partners from the UN-Family and Development Partners – especially from the United States Government implementing agencies. The following organizations and agencies provided invaluable input for this strategy; TACAIDS, this and the UN Joint on HIV/AIDS. Similarly, a number of USG agencies and partners led by USAID and CDC played a key role in this process. The USG partners included Jhpiego, DOD, ICAP, Engender health/Champion Project, T-MARC and FHI. We also wish to acknowledge the Christian Social Services Commission and PharmAccess for their involvement in the process.

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Dr. Deo M. Mtasiwa
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August 2010

FOREWORD

Since the emergency of the HIV and AIDS epidemic in Tanzania over 25 years ago, the country has implemented various national strategies and interventions to address the epidemic. To start with, and for almost a decade, the only interventions for HIV and AIDS prevention and control that were implemented included the creation of public awareness on HIV and AIDS and promotion of condom use in risky sexual encounters.

In mid 1990, a national programme for prevention and control of Sexually Transmitted Infections was introduced. This decision was taken as a result of a community intervention trial for treatment of Sexually Transmitted Infections that was conducted in Mwanza in the early 1990's. The results of the study showed that treatment of Sexually Transmitted Infections could prevent Sexual Transmission of HIV by about 40%. Another intervention for Prevention of HIV Transmission from Mother to her Child (PMTCT), during pregnancy, delivery and through lactation was introduced in 2002. This intervention has been shown to prevent paediatric HIV infection by about 30%.

The results of recent controlled trials on medical male circumcision in South Africa, Kenya and Uganda have confirmed that male circumcision reduces HIV infection from female to male by about 60%. Following these studies, many countries - especially from Sub-Saharan Africa, where the HIV prevalence rates are much higher than other parts of the world, have started to initiate or scale up male circumcision services.

In Tanzania, introduction of medical male circumcision was preceded by conducting a situational analysis to determine current male circumcision practices in the country; who is doing male circumcision; the magnitude of the practice, and how is it being reported or recorded. From these studies, and other sources, it is now established that the prevalence rate of male circumcision in the country is about 70%; ranging from below 40% in 5 regions, Kagera, Shinyanga, Rukwa, Mbeya and Iringa to over 90% in Eastern part of the country.

It is important to note that, medical male circumcision will not replace other known and effective HIV prevention methods such as condom use; rather it will complement, and be part of, the comprehensive HIV prevention package. In addition, male circumcision has several other medical benefits, including reduction in infections with Human Papilloma Virus, the agent that causes penile cancer in men and cervical cancer in women. Also, male circumcision has protective impact on genital ulcer disease, and other Sexually Transmitted Infections. Through this strategy, male circumcision will be promoted not only as a beneficial intervention for men, but it will also directly or indirectly give a number of benefits to women as well. The strategy is intended to serve as the main guiding document for male circumcision practices and services at all levels of the health delivery system in Tanzania.



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EXECUTIVE SUMMARY

In March 2007, the World Health Organization (WHO) and UNAIDS issued recommendations on male circumcision and HIV prevention, not only affirming the efficacy of male circumcision in reducing female to male HIV transmission, but advising that the procedure should be considered as part of a comprehensive HIV prevention package¹. The overall prevalence of male circumcision in Tanzania is estimated at 70% (TACAIDS, 2009) with regional variations from 26.4%² in Kagera to 97.9% in Dar es Salaam (Wambura, 2009) while in 4 out of the 5 regions with HIV prevalence rate above 6%, MC prevalence rate is below 43%.

In line with the above, Tanzania has identified the limited coverage of male circumcision as one of the underlying factors influencing the spread of HIV and AIDS in Mainland Tanzania. Key national policy documents such as the NMSF II (2008-2012), the National Multi-sectoral HIV Prevention Strategy, 2009-2012 and Health Sector HIV and AIDS Strategic Plan II (2008-2012), recommend safe male circumcision should be promoted and scaled-up as one of the new prevention interventions. Recent studies indicate that scaling up male circumcision for HIV prevention in the country will require:

1. *Investment in health facilities, human resources, equipment and supply of materials* to cope with demand for the service.
2. *Information, Education and Communication* about the role of clinical male circumcision in HIV prevention to dispel potential misinformation arising from misconceptions.
3. *Development of policies and guidelines* to ensure voluntary accessibility, acceptability, quality and safety for all that who need this service.

To Scale up Male Circumcision for HIV prevention a package of strategic actions need to be undertaken by government and other key stakeholders that include the following:

- (a) *Increasing access*: Increasing access to Male Circumcision services will require:
 - i. Enhancing the capacity of the regional health management teams and regional hospitals to carry out capacity building and provide support supervision for lower level facilities
 - ii. Renovating and equipping district hospitals and lower health facilities
 - iii. Enlisting private sector facilities and satellite clinics to be supervised by Regional and district hospitals
 - iv. Setting up Male Circumcision camps in areas far from static health services or where demand is high.
 - v. Mobilizing communities, schools, community gate-keepers to support MC for HIV prevention.

- (a) *Integrating MC in existing health care delivery system*:

Male Circumcision for HIV prevention should be integrated in the existing health care delivery system particularly the hospital services, RCH and HIV prevention services. Male circumcision will not replace other known effective HIV prevention methods and MC is part of a comprehensive HIV prevention package. It will complement and be part of HIV prevention, reproductive health and other primary health care services.

¹WHO/UNAIDS Technical Consultation on Male Circumcision and HIV Prevention: Research Implications for Policy and Programming, Montreaux, Switzerland, March 2007

²This is the estimate from the Situational Analysis. The THMIS states that MC prevalence in Kagera is 38%. Since the THMIS is the only source that provides MC prevalence for all regions, it's better to use data from the THMIS or at least state the range found from both of the sources

- (b) *Volunteerism, cultural sensitivity and respect for Human Rights:*
While promotion of male circumcision for HIV prevention will be undertaken for the targeted sexually active age group of 10-24 year old males, clinical male circumcision services are the right of all males and will be provided to all without discrimination after appropriate counselling.
- (c) *Information, Communication and Advocacy:*
As a new preventive approach male circumcision is likely to be accompanied by misconceptions. While the Situational Analysis (Wambura et. al., 2009) showed great acceptance of MC services, the advocacy strategy should aim at providing correct information on MC for HIV prevention. Thus key messages to prevent anticipated myths and misconceptions need to be developed as the program scale-up is launched. Key issues to address include (i) the degree of protection offered by male circumcision against HIV infection where MC significantly reduces transmission of HIV among males but offers only partial protection and hence the need to use in conjunction with other known prevention methods such as abstinence, proper use of condoms, partner reduction and voluntary counselling and testing for HIV, (ii) the duration necessary to allow for healing and the protection required for beneficiary clients of Male Circumcision and (iii) the need for clarity in separating male circumcision from Female Genital Mutilation (FGM), sometimes called female circumcision.
- (d) *Participatory role of women in promoting male circumcision:*
This should be guided by:
- i. Design and dissemination of advocacy messages, community mobilization and engaging women leaders in discussions about what having a circumcised partner will mean for their sexual lives, pre and post-circumcision counseling and follow-up. To minimize the risk of infection and the need for use of condom protection in the first six months after healing.
 - ii. Giving education to partners of circumcised men about the need to support the man during the period of abstinence that is necessary for post-circumcision healing.
 - iii. Providing education to women about the partial protection of male circumcision for men and no protection for women with regard to hetero-sexual infection with HIV where unprotected sexual contact is concerned.
- (f) *Policy Development, Legal and regulatory mechanism:*
Although there are several policies on HIV prevention, there remains lack of clarity on laws that will ensure clinical male circumcision services are accessible and provided safely and with sufficient safeguards for all stakeholders. All other medical ethics and conduct should be adhered to as per code of conduct.
- (g) *Coordination, Leadership and Management:*
Male circumcision scale-up involves different stakeholders at national, regional, district and community levels. This calls for clarity of leadership and partnerships to ensure success and sustainability of the programme from National to Local councils.
- (h) *Monitoring and Evaluation:*
Considering that Male Circumcision activities will be carried out at different levels from the health units to the Ministry of Health and Social Welfare, it will be necessary to have in place accurate, timely and comprehensive data and information for planning purposes and ensuring quality of services.
- (i) *Operational Research:*
Operational research should be carried out to strengthen male circumcision services and to implement effective, comprehensive HIV prevention programmes in the context of sexual and reproductive health.

Table 1 shows a summary of key actors and the roles they are to play in implementing the strategy to address the issues raised above towards scaling-up male circumcision for HIV prevention.

Table 1: Summary of Key Roles and Key Actors in the Male Circumcision Action Plan

| Roles in the MC strategic plan | Key actors |
|--|--|
| Organize and carry out sensitization workshop for Regional Level management | NACP/ TACAIDS/development partners, MoHSW line Departments, TWG |
| Carry out a Health Facility Audit | DHMT and Consultants - Funding support partners - Implementing Partners -Service Providers TWG, MoHSW, RHMT |
| MoHSW/ MoF, TACAIDS | Resource mobilization |
| Developing male circumcision guidelines | MoHSW (NACP), Implementing partners |
| Building/ renovation at regional Level | MoHSW -Board of Procurement, RHMT and Funding partners -Contractors |
| Identify and prepare satellite clinics for MC services around the regional hospitals | TWG, MoHSW and RHMTs DHMT for districts where the Regional Hospital is located and other partners |
| Procurement and supply of equipment and materials for all levels and satellite sites. | MoHSW, MSD, RHMT -Private Companies -Funding and implementing partners. |
| Incorporating MC into existing HMIS | MoHSW, RHMT, DHMT, local and international NGO partners |
| Training of trainers of MC for HIV prevention (Counsellors, surgeons, nurses, programme managers). | TWG NACP and other training institutions. |
| Training of service providers | TWG, NACP and other training institutions, MoHSW Participating NGOs & Regional Teams. |
| Mobilization and preparation of District Hospitals for scale-up of MC for HIV prevention | MoHSW, RHMT, DHMT Other implementing partners (NGOs, private health facility management) |
| Training of Service Providers and teams at district level | TWG, MoHSW /NACP, RHMT, DHMT - Other training partners (NGOs, private training institutions). |
| Supply of equipment and materials to district hospitals and outreach services | MoHSW, MSD, RHMT, DHMT, Private sector , Procurement Board NGOs and other implementing partners |
| Starting and operating district MC services for HIV prevention at district hospitals | DHMT - District hospital management - MoHSW RHMT And other partners |
| Launching and sustaining MC for HIV prevention Campaign | MoHSW, TWG, RHMT, DHMT, Service providers -Community mobilisers -NGOs -Community leadership and mobilisers -Central and local government leaders Political Leaders And other implementing partners |

| Roles in the MC strategic plan | Key actors |
|--|--|
| Provide monthly support supervision. | MoHSW, RHMT, DHMT Funding and implementing partners. -Supervisors at different levels |
| Reviewing and improving HMIS to include MC for HIV prevention services | MOHSW, Consultants & Implementing Partners |
| Developing guidelines for integrating MC into HIV prevention, RCHC and other regular health services | NACP, TWG, WHO and other technical partners |
| Review the pre and in-service curricula for training HIV/AIDS and RCHC service providers to integrate MC services | NACP/MOHSW, WHO and other technical partners - Health training institutions |
| Carry out in-service training of existing RCHC, VCT and PITC service providers | MOHSW, RHMT, DHMT & implementing partners |
| Develop guidelines for integrating traditional/cultural circumcision services into health unit-based MC for HIV prevention | MOHSW, Implementing partners |
| Sensitization activities (meetings, seminars, group discussions, joint planning sessions) between health unit providers and cultural circumcision key stakeholders | NACP/TACAIDS, Implementation Partners, Community leaders, Political Leadership |
| Developing of Advocacy Strategy of MC for HIV prevention. | MoHSW, RHMT DHMT & implementing partners |
| Mounting media campaign to obtain support of key groups especially cultural/religious leaders, | MoHSW, RHMT, DHMT & implementing partners, TAMWA Ministry of Gender & Ministry of Sports and Youth Development |
| Reviewing legal, regulatory and policy framework for Male Circumcision | MoHSW, Ministry of Justice and Constitutional Affairs, The Parliament of the United Republic of Tanzania; Ministry of Sports and Culture |
| Developing and Pre-test M & E toolkit | MoHSW, Implementing Partners |
| Putting in place an effective support supervision | RHMT, DHMT, TWG, Higher level MoHSW officers |
| Carrying out Operations Research | TWG, Consultants/Researchers, Implementing partners |

SECTION 1: INTRODUCTION

1.1 Background

Since 1983, when the first cases of AIDS were diagnosed in Tanzania, the country has progressively sought mechanisms for HIV infection prevention. Key among these have been enhancing national blood safety, prevention of mother-to-child transmission, HIV testing and counseling, control of STIs, and promotion of abstinence, faithfulness and using condoms. The country's efforts to become innovative, through adoption of international standards and search for solutions have increased and paid off with reduction in new infections, increased life expectancy for PLWHA, and reduction in orphanhood.

Likewise, national tracking of the epidemic and understanding of the virus has progressively improved. As we approach the end of the third-decade of AIDS in Tanzania, it is imperative that new mechanisms for reducing HIV infection and changing its endemic state to a manageable disease be undertaken. It is in this regard that the male circumcision in the context of HIV prevention scale-up has been prepared.

Male Circumcision is the surgical removal of the foreskin of the penis. It is one of the oldest and most common surgical procedures worldwide, undertaken for religious, cultural, social, and medical reasons. Approximately, 30% of adult men worldwide are circumcised. In sub-Saharan Africa, about two-thirds of men are circumcised.

The quest for the inter-linkage between male circumcision and HIV, date back to the late 1980s³. Over 45 observational studies, and recently three randomized controlled trials in South Africa⁴, Kenya⁵ and Uganda,⁶ have demonstrated that male circumcision reduces men's risk of heterosexual HIV infection by approximately 60%. Patterson et. al. (2002)⁷ and Donoval et. al. (2006)⁸ concluded that circumcision reduces the risk of male HIV infection due to the fact that the foreskin is rich in HIV target cells (Langerhans' and dendritic cells, CD4+ T-cells, and macrophages), and the inner surface of the foreskin is less keratinized, making it vulnerable to HIV infection, . The foreskin is retracted over the shaft during intercourse, hence exposing the inner mucosa to vaginal and cervical fluids. Also, abrasions in the mucosa can occur during intercourse, especially at the frenulum, and uncircumcised men are more susceptible to genital ulcer disease, which could increase HIV entry⁹.

³Reining, P., Way, P., and Conant, F. (1989) "The relationship between male circumcision and HIV infection in African populations," *AIDS* 3, no. 6: 373–377.

⁴ Auvert B, Taljaard D, Lagard E, Sobingwi-Tambekou J, Sitta R, Puren A. (2005). Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. *PLoS Med* 2005:e298. Epub 2005.

⁵ Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN, Williams CFM, Campbell RT, Ndinya-Achola JO. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. *Lancet* 2007; 369:643-56.

⁶ Gray RH, Kigozi G, Serwadda D, Makumbi F, Watya S, et al. Male circumcision for HIV prevention in Rakai, Uganda: a randomized trial. *Lancet* 2007; 369:657-66.

⁷ Patterson, B.K., Landay, A., Siegel, J.N., Flener, Z., Pessis, D., Chaviano, A. & Bailey, R.C. (2002) Susceptibility to Human Immunodeficiency Virus-1 infection of human foreskin and cervical tissue grown in explant culture. *American Journal of Pathology* 161(3): 867–873.

⁸ Donoval, B.A., Landay, A.L., Moses, S., Agot, K., Ndinya-Achola, J.O., Nyagaya, E.A., MacLean, I. & Bailey, R.C. (2006) HIV-1 target cells in foreskins of African men with varying histories of sexually transmitted infections. *American Journal of Clinical Pathology*, 125, 386-391.

⁹ Weiss, H.A., Thomas, S.L., Munabi, S.K. & Hayes, R.J. (2006) Male circumcision and risk of syphilis, chancroid, and genital herpes: a systematic review and meta-analysis. *Sexually Transmitted Infections* 82, 101-110.

Besides prevention of HIV, male circumcision has several other medical benefits including reduction in infection with human papilloma virus, the agent that causes penile cancer in men and cervical cancer in female partners of uncircumcised men, genital ulcer disease, and Chlamydia infection¹⁰, which can cause infertility.

In March 2007, the World Health Organization (WHO) and UNAIDS issued recommendations on male circumcision and HIV prevention, not only affirming the efficacy of male circumcision in reducing female to male HIV transmission, but advising that the procedure should be considered as part of a comprehensive HIV prevention package¹¹.

In Tanzania, in 4 out of the 5 regions with HIV prevalence rate above 6%, MC prevalence rate is at or below 43%, the national MC average estimated at 70%. Given this fact and in the light of increasing international epidemiological evidence linking reduction in HIV prevalence with male circumcision, Tanzania, has adopted as one of the prevention strategies objectives, the “promotion and scale-up of safe male circumcision as a preventive measure in appropriately selected regions in Tanzania, after careful study of policy, cultural, human rights, ethical and operational aspects and while safeguarding against adverse effects”¹².

1.2 National HIV Prevalence

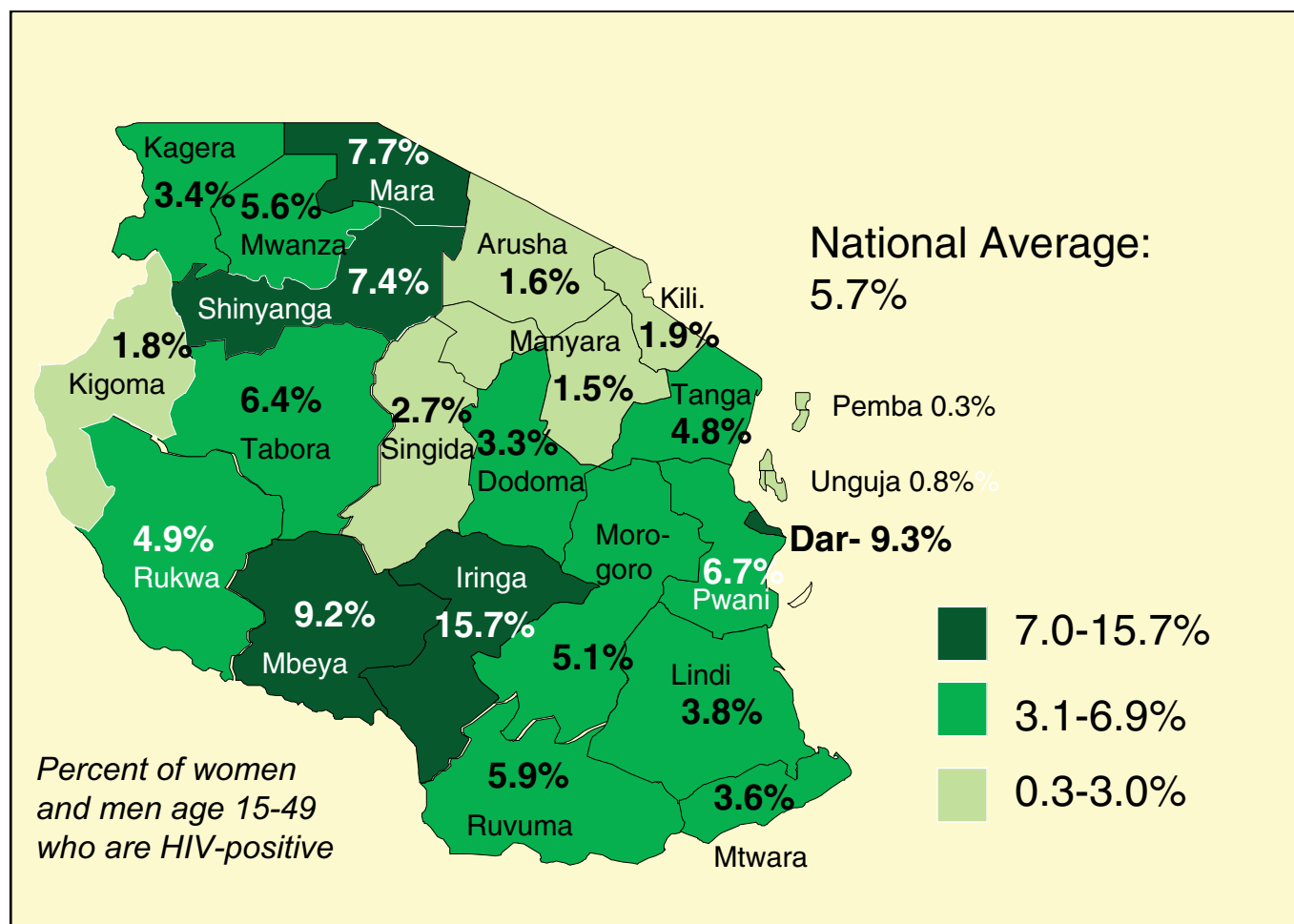
Tanzania is one of the most severely HIV and AIDS-affected countries in the world. The country is ranked among the top ten hardest hit. An estimated 1.4 million Tanzanians were living with HIV as of the end of 2007. For nearly a decade and a half, AIDS has remained one of the leading causes of death in adults, and is the major contributor to infant and under-five mortality. In 2005, AIDS accounted for 140,000 deaths among both adults and children. There is a difference in HIV prevalence rates across the regions (Figure 1). Over the last 15 years, there has been a shift in the national epidemic distribution trajectory. Kagera, which used to have the highest prevalence rate a decade and a half ago, currently has a prevalence rate of 3.4% and therefore has of the least affected region in the country. Iringa, Dar es Salaam and Mbeya regions have the highest prevalence rates ranging from 15.7%, 9.3% and 9.2% percent respectively. Other regions with prevalence rates higher than the national average include Mara and Shinyanga.

¹⁰ Castellsague, X., Peeling, R.W., Franceschi, S., de Sanjose, S., Smith, J.S., Albero, G., Diaz, M., Herrero, R., Munoz, N., and Bosch, F.X., Chlamydia trachomatis infection in female partners of circumcised and uncircumcised adult men. *Am J Epidemiol*, 2005. 162(9): p. 907-16.

¹¹ WHO/UNAIDS Technical Consultation on Male Circumcision and HIV Prevention: Research Implications for Policy and Programming, Montreaux, Switzerland. March 2007

¹² TACAIDS, 2009. The Second National Multi – Sectoral Strategic Framework on HIV and AIDS(2008 –2012) 2nd Edition, October 2007

Figure 1: HIV prevalence (%) by Region



Source: 2007-08 THMIS: NBS, TACAIDS, and Macro International, Inc.

Tanzania13 has identified the absence of Male Circumcision as one of the underlying factors influencing the spread of HIV and AIDS in Mainland Tanzania.

1.3 National HIV Prevention Strategy and Male Circumcision

Tanzania is classified into two broad male circumcision zones: the Eastern and the Western. The Eastern half of the country (Figure 2) constitutes regions where traditional male circumcision is practiced and the Western half is occupied largely by ethno-religious groups that traditionally did not practice cultural male circumcision. Within this broad classification, there are some intra-regional differences in regions like Mara, where some districts, such as Rorya, occupied by mainly the Luos, an ethnic group that does not exercise cultural male circumcision. In the west and south, cultural male circumcision is carried out by members of the Muslim faith and not so widely by other faith groups. Thus, the large presence of Muslims in Kigoma and Ruvuma ensures a relatively high prevalence of the practice, against a background of ethnic groups that did not practice male circumcision. Spreading across most of North Eastern and Central Tanzania, the Maasai strictly observe cultural circumcision even in areas where they have migrated as a distinct minority group.

Beyond the ethno-religious distinction, there has been the infusion of modern health facility based male circumcision. Findings of the Situational Analysis (Wambura et. al., 2009) indicate that even in traditional cultural circumcising communities, such as Tarime District, more than one-third of the circumcised males (38%) had been circumcised in health facilities.

¹³ <http://www.tacaids.go.tz/index.php/what-we-do/-/provide-basic-hivaids-information.html> accessed June 2009

Currently from the NMSF, male circumcision is one of the new prevention interventions that should be introduced. The strategy will be to promote and scale-up safe male circumcision as a preventive measure in appropriately selected regions in Tanzania, after careful study of policy, cultural, human rights, ethical and operational aspects and while safeguarding against adverse effects. The National Multi-sectoral HIV Prevention Strategy, 2009-2012¹⁴ within its Strategic priorities for promotion of safer sexual behaviors and reduction in risk taking behaviors prescribes the introduction and targeted scale up of male circumcision through:

- Development and dissemination of policies and guidelines for male circumcision
- Phased introduction of adult and neonatal male circumcision services in public health facilities in the eight regions with the highest HIV prevalence through appropriate capacity building (skills, infrastructure, and equipment)
- Finalization and dissemination of national plan for male circumcision, prioritizing regions with low male circumcision and high HIV prevalence.
- Increased collaboration and referrals between HTC and male circumcision services
- Determine the appropriate role of traditional male circumcisers, and strengthen their capacity to contribute to adult male circumcision activities
- Carry out additional studies on policy, cultural, and operational aspects of medical circumcision in eight regions with low prevalence of circumcision but high HIV prevalence.
- Public education campaigns on male circumcision through TV, radios, leaflets, brochures etc with emphasis on guarding against behavioural disinhibition, norms and dynamics as well as gender concerns.

The Health Sector HIV and AIDS Strategic Plan II (2008-2012)¹⁵ notes that Male circumcision has not been integrated in current HIV prevention services and has as one of the strategic objectives the promotion of medically safe accepted male circumcision for health benefits and as a preventive measure against HIV transmission. The plan notes however the barriers as:

Availability

- Male circumcision has not been institutionalized as a routine service for health benefits and now HIV prevention
- Health services are already overburdened and scaling up of male circumcision needs to consider improvement of health systems

Equitable access

- Prevalence, determinants, acceptability and practices of male circumcision vary across regions and districts but has not been well documented
- Costs incurred to access MC may become a barrier to scaling up the service for poor people who need the service

Quality

Substantial male circumcision is done by traditional practitioners where complete removal of prepuce and safety may not be ensured.

¹⁴ The United Republic of Tanzania, Prime Minister's Office, National Multi-sectoral HIV Prevention Strategy, 2009-2012 'Towards achieving Tanzania without HIV', Dar es Salaam, 2009

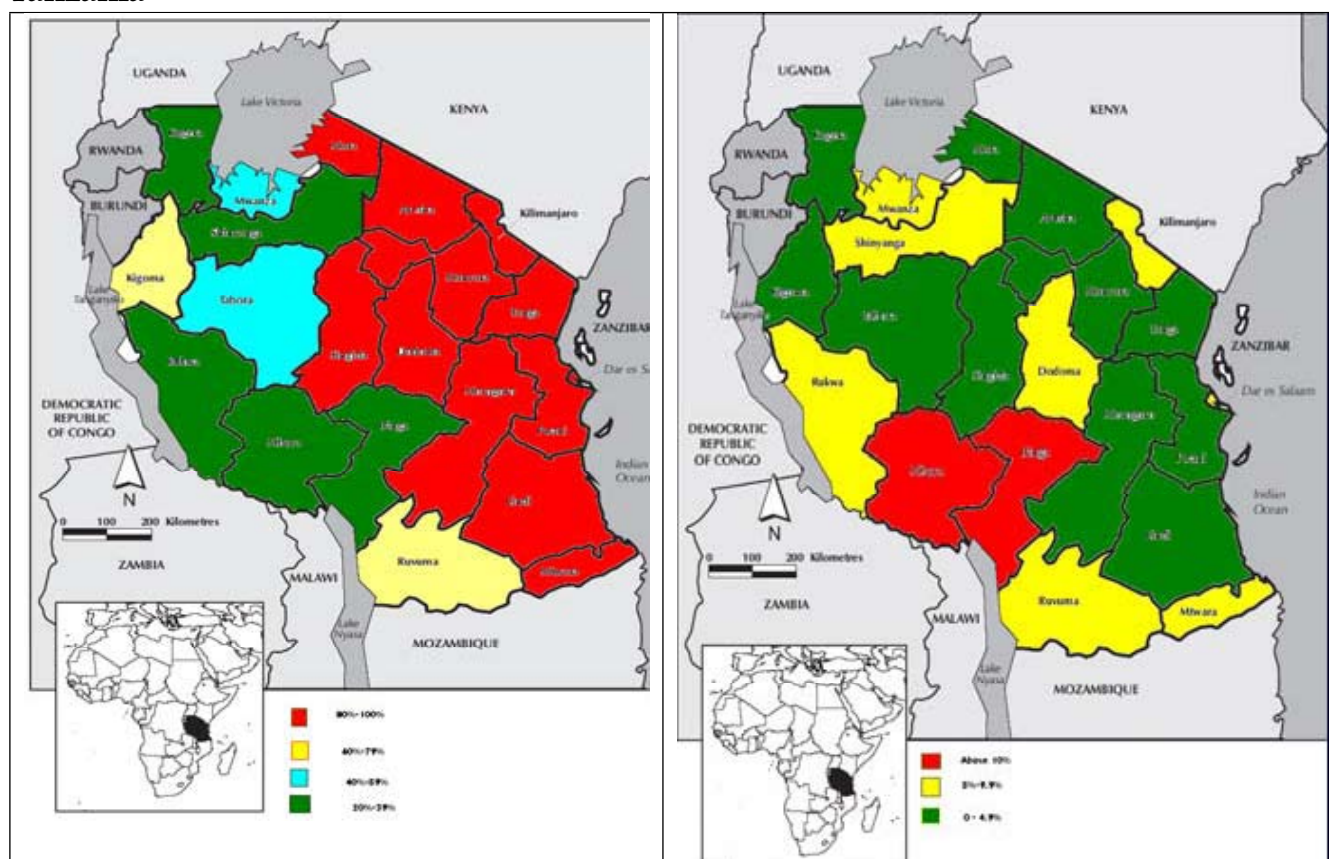
¹⁵ Ministry Of Health and Social Welfare, Tanzania Mainland (2009), Health Sector HIV and AIDS, Strategic Plan –II, (HSHSP) 2008-2012

1.4 Situational Analysis

1.4.1 National Male Circumcision Prevalence

The overall prevalence of male circumcision in Tanzania is estimated at 70% (TACAIDS, 2009). However, rates vary across geographical areas and range from 26.4%¹⁶ in Kagera to 97.9% in Dar es Salaam (Wambura, 2009). There is also a pattern in regional HIV prevalence variation that is generally inversely related with the prevalence of male circumcision. As shown in Figure 1 and 2, among the five regions with an HIV prevalence higher than the national average of (6.6%), four have low rate of male circumcision (26.5- 42.8).

Figure 2: Male circumcision and HIV prevalence among males aged 15-49 years in Tanzania



Source: Tanzania Male Circumcision and HIV Prevention Country Stakeholder Consultation Meeting Report held at Courtyard Protea Hotel, 14 -16 September, 2006, Dar es Salaam

¹⁶ This is the estimate from the Situational Analysis. The THMIS states that MC prevalence in Kagera is 38%. Since the THMIS is the only source that provides MC prevalence for all regions, it's better to use data from the THMIS or at least state the range found from both sources

Table 2: Male HIV prevalence and Male circumcision prevalence in regions of Tanzania

| Region | HIV prevalence Rate | MC prevalence rate |
|---------------|---------------------|--------------------|
| Iringa | 15.7 | 37.7 |
| Dar es Salaam | 9.3 | 97.9 |
| Mbeya | 9.2 | 34.4 |
| Shinyanga | 7.4 | 26.5 |
| Tabora | 6.4 | 42.8 |
| Ruvuma | 5.9 | 68.9 |
| Pwani | 6.7 | 96.9 |
| Mara | 7.7 | 89.0 |
| Mwanza | 5.5 | 54.1 |
| Rukwa | 4.9 | 31.4 |
| Morogoro | 5.1 | 93.1 |
| Lindi | 3.8 | 93.3 |
| Tanga | 4.8 | 95.0 |
| Kagera | 3.4 | 26.4 |
| Dodoma | 3.3 | 96.9 |
| Mtwara | 3.6 | 93.1 |
| Singida | 2.7 | 90.9 |
| Kilimanjaro | 1.9 | 97.0 |
| Manyara | 1.5 | 97.3 |
| Arusha | 1.6 | 96.2 |
| Kigoma | 1.8 | 68.4 |

Source: Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and Macro International Inc. 2008. Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and Macro International Inc.

A study by the National Institute for Medical Research carried out in Mkuranga, Bahi and Monduli¹⁷ found the preference for traditional male circumcision (TMC) as part of the culture of societies that practice it. In the three ethno-religious groups, as regarded as a rite of passage from childhood to manhood. Rather than outright rejection, the study found lack of understanding of the advantages of clinical male circumcision. Less than half (42%) of the respondents knew at least one advantage of clinical male circumcision (CMC). Among those that knew the advantages of CMC, more than three quarters (76%) reported that it was hygienic, safe and the wound heals fast. Only 39% reported the lowering of the risk of HIV transmission as an advantage of CMC over TMC.

Other findings of the study include:

- A significant proportion of the respondents (38%) were aware of the occurrence of adverse events associated with TMC that included severe bleeding, amputation of the penis and wound infection.
- While about one third (12/38) of health workers admitted there was some kind of informal collaboration between traditional and conventional practitioners, the population were not aware and reported no formal collaboration between traditional practitioners and conventional health workers. However, two-thirds of the respondents (67%) noted there was a need to establish a formal linkage between traditional and conventional practitioners.
- Lack of collaboration between traditional and conventional practitioners was attributed to fear that CMC would erode traditional values.
- Provision of education on HIV prevention; safety of male circumcision; use of local anaesthesia; care of wounds; and use of modern equipment, was mentioned as the best strategy that could be used to strengthen linkages between traditional and conventional health practitioners.

¹⁷ Mboera et al., (2009) Challenges and Opportunities for the involvement of Traditional Practitioners in Scaling up Safe Male Circumcision in the Context of HIV Prevention in Tanzania, NIMR, Dar es Salaam, Tanzania

- The costs for the circumcision differed from one practitioner to another within the district, but most of the traditional practitioners charged TShs 5,000-10,000 per client.

1.5 Current Situation, Acceptability and Service readiness for MC Scale-up

Another NIMR study, the Situational analysis for Male Circumcision in Tanzania (Wambura et. al., 2009) carried out in Tarime, Bukoba Rural and Ileje districts found the following:

- Overall, 55% of the males reported they were circumcised and 48% of the males were assessed by the clinician as being fully circumcised.
- Circumcision is highly acceptable among men and women in both traditionally circumcising and non-circumcising populations. Almost 76% of the non-circumcised males would like to be circumcised if the services were provided. About 93% and 98% of non-circumcised and circumcised males, respectively, would like their sons to be circumcised. Similarly, 89% of women supported their sons to be circumcised and a similar proportion preferred sex with a circumcised man.
- The level of education had an effect on whether one was circumcised or not, indicating that men with above primary level of education were more likely to be circumcised compared to those that had not completed primary.
- Almost 90% and 60% of the males in the traditionally non-circumcising and circumcising populations, respectively, indicated preference of circumcision of their male children at a health facility. In the traditional cultural circumcision district of Tarime, 38% of those circumcised had been circumcised in health facilities.
- Overall, 80% of the non-circumcised males reported that there was no problem or consequence following circumcision. The rest reported side effects of delayed intercourse for weeks while nursing the wound, penile dysfunctions, excessive bleeding, fear of pain and infections from contaminated circumcision instruments.
- The majority of participants preferred child circumcision (those aged less than 10 years) compared to adult circumcision (above 10 years of age).
- There were age and gender differences in the willingness to pay for MC services. Among those who agreed it should be charged, the preferred fee ranged from Shs. 2000-5000.
- Most of the Health Facilities (84%) suggested that MC should be included into the National Insurance Fund.
- Of the 69 facilities studied, 59% provided MC services. More facilities in Tarime District (82%) provided the services compared to facilities in Bukoba Rural (36%) and Ileje (55%) District.
- Less than one-third of the facilities providing circumcision services documented circumcision procedures.
- Less than one in ten (9%) of the facilities had an operating main theatre, 64% had an operating outpatient minor theatre, 91% had operating essential surgical equipment and only 22% had functioning emergency equipment available. Less than one-third facilities had sterilizing equipment (15% autoclave, 23% pressure cooker); most facilities (>90%) were supplied with facilities needed for basic infection prevention.
- Only one-third of the facilities (38%) had reliable electrical power, 48.5% had adequate water supply and 96% provided STIs and VCT services.

Regarding Practitioners and their training needs the study found the following:

- In Bukoba Rural and Ileje districts, MC was mainly done by MO, AMO, COs and nurses. In Tarime, circumcision was done by all health practitioners including medical attendants, Lab technicians and nurse anesthiologists most of whom had no formal training but learned through observations.

- Of the 203 (53 males, 150 females) practitioners interviewed, Tarime practitioners had significantly performed more circumcisions than those in Ileje and Bukoba Rural. A quarter (50/203) have been trained on circumcision surgical procedures 41 of these were from Tarime District. Of the 50 trained 22 (45%) had got pre-service training and 55% received in-service training by observing other practitioners. Overall, 94% of all the practitioners interviewed reported that they will benefit from additional circumcision training.
- Complications which have been observed by health practitioners were: excessive bleeding, infections, disfigurement and impotence. Complications reported in clinical based circumcision were very few.
- Almost all practitioners interviewed supported clinical and medical officers to circumcise. Almost 90% of all practitioners interviewed were not in favour of allowing traditional circumcisers and other cadres to perform circumcision procedures.
- Most practitioners interviewed preferred children aged between 5 and 10 to be circumcised. The age preference was similar to the preference of male and female in the community.

The study participants recommended:

- Improvement of the health systems in order to meet the demand for circumcision services.
- The need to involve all stakeholders including traditional leaders and circumcisers in the community sensitization and mobilization campaigns.
- Reliable electrical power, medicines, recruitment and training of staff, surgical protective gears, procedure room, sterilizer, surgical bed and adequate water supply.

1.6 Summary of special needs to Scaling up Male Circumcision in Tanzania

From the above findings, scaling up male circumcision for HIV prevention in Tanzania is likely to require special arrangements, notably:

1. *Health Facilities, human resources, equipment and supply of materials:* Inadequate health infrastructure and human resources scarcity will require substantial investment to cope with the potential demand for the service.
2. *The need for Information, Education and Communication:* Despite the high level of acceptability for male circumcision among both men and women in both traditionally circumcising and non-circumcising populations (Wambura, et al. 2009)¹⁸, the low levels of knowledge of the role of clinical male circumcision in HIV prevention and the potential for behavioural misinformation arising from misconceptions and false sense of security afforded by circumcision will need to be addressed. There is also the risk of mistaking male circumcision with FGM, especially in communities that traditionally practiced the latter that will arise when the scale up starts. These issues will require intensive educational interventions. The acceptability of male circumcision might also vary across regions in the country.
3. *Development of policies and guidelines:* Although it has been some years since the protective effect of male circumcision was confirmed, relevant technical policies and guidelines need to be formulated including a legal, regulatory and policy frameworks to ensure voluntary accessibility, acceptability, quality and safety for all that who need this service.

¹⁸ Wambura M. W., Mwangi J., Moshia J., Mshana G., Moshia F., and Changalucha J. , 2009. Situational Analysis for Male Circumcision in Tanzania, Final Report, National Medical Research Institute , and MoHSW

SECTION II:

MALE CIRCUMCISION STRATEGY AND ITS IMPLEMENTATION

2.0 Introduction

This strategy identifies the broad goal, objectives and guiding principles for scaling-up of Male Circumcision for HIV prevention programme in Tanzania. While it does not, serve as a specific guideline for each of the necessary interventions in Male Circumcision scale-up, the strategy summarizes critical elements for Male Circumcision in the context of HIV prevention. The strategy provides a quick platform for policy makers, programme managers, implementing partners, public and private health units as well as programme support partners to identify entry points into the Male Circumcision scale-up. The implementation of the strategy is designed to meet each of the outlined guiding principles.

The strategy also broadly outlines mechanisms for community and different population group engagement to ensure the smooth planning and implementation of the MC scale up for HIV prevention. In addition, the strategy provides for the monitoring and evaluation of the MC scale-up programme, as well as identifying some key operational research areas.

2.1 Goal, Objectives and Guiding Principles

The goal of the National Strategy for scaling up Male Circumcision in Tanzania is to contribute to the reduction of new HIV infection among males and indirectly among females. The national target is to increase the prevalence of male circumcision to 80% in the regions identified as public health priorities for MC for HIV prevention.

To attain this goal, greater emphasis will be directed towards areas with lowest prevalence of male circumcision and highest prevalence of HIV, as recommended by WHO/UNAIDS in “*New Data on MC and HIV Prevention: Policy and Programme Implications*” recommends MC in areas where HIV prevalence is 15% or higher and MC prevalence is less than 20%. Where there is lower HIV prevalence and/or higher MC prevalence, the target for male circumcision should be towards higher risk male populations within regions.

The Tanzania Health Sector HIV/AIDS Strategic Plan, HSHP II recommends MC for HIV prevention services first to be targeted to adolescent and adult males aged 10 to 24 years old. This age range was chosen, as boys and men who are 10 to 24 are either already sexually active or soon will become sexually active, and HIV incidence increases from 0.5% among 15-24 year old males to 4.6% among 15-49 year old males, indicating a high number of infections occur in this age range.

2.1.1 The purpose

To provide program and operational guidance to policy-makers and implementers, technical support organizations and their staff, and funding partners, to scale up male circumcision services as an integral component of the HIV prevention strategy in Tanzania.

2.1.2 Specific Objectives

More specifically, the strategy seeks to:

1. Strengthen the environment for the scale-up of well coordinated, safe, accessible and affordable male circumcision services in Tanzania Mainland.
2. Increase the capacity of Tanzania health system to offer safe male circumcision services.
3. Promote comprehensive male circumcision for HIV prevention in addition to other preventive measures.

2.1.3 Guiding Principles

1. *Universal access:*

Subject to the capacity of the health service system to deliver, a comprehensive, integrated, high quality male circumcision package to be accessible to all males for protection against HIV infection provided by trained practitioners in male circumcision in aseptic settings and applying high safety standards. It is important to note however that universal access, does not imply one-universal approach for scaling up male circumcision, but different approaches will be followed taking into consideration cultural/traditional settings of the concerned communities.

2. *Integration:*

- a. The scaling up of male circumcision will not replace other known effective HIV prevention methods hence MC is part of a comprehensive prevention package
- b. Existing traditional male circumcision practitioners will be assisted and sensitized to refer male circumcision procedures to health units for safety and effective integration of HIV prevention
- c. Male circumcision programmes will reinforce delivery of other HIV prevention, reproductive health and other primary health care services.

3. *Information and Communication:* Community /individual education and counseling programs will accompany service provision to ensure the benefits of MC for HIV prevention are properly and accurately explained. For this purpose a subcommittee on communications on the national Task force is recommended to handle IEC/BCC/media and draft a communications strategy on MC for HIV prevention.¹⁹

4. *Cultural Sensitivity, voluntarism and respect for Human rights:* Male circumcision will be provided in respect of people's cultural background in an environment that ensures the minimum package for MC for HIV prevention is adhered to and it will be voluntary, under conditions of informed consent, confidentiality and risk reduction counseling.²⁰

5. *Gender sensitivity:* Male circumcision and related interventions will be carried out with consideration to (a) minimizing stigma and discrimination and (b) recognizing and ensuring the co-operation, understanding and protection of male circumcision clients and their partners²¹

6. *Leadership and Partnership:* A National Male Circumcision policy will be developed and spell out issues of coordination, advocacy, quality assurance, resource mobilization, monitoring and evaluation, operational research and advise on the role of other different sectors.

¹⁹ UNAIDS "Communications Guidance: MC& HIV Prevention in Eastern and Southern Africa".

²⁰ UNAIDS "Safe, Voluntary, Informed MC and Comprehensive HIV Prevention Programming: Guidance for Decision Makers for Human Rights, Ethical and Legal Considerations". In addition the "UNAIDS Legal and Regulatory Self Assessment Tool for MC in sub-Saharan Africa", is an exercise that Tanzania should complete.

²¹ WHO, Consultation on gender in the context of MC for HIV prevention 2008.

7. *Policy Development, Legal and regulatory mechanism:* Appropriate by laws and regulations will be developed so that male circumcision services are accessible and provided safely without discrimination and different stakeholders are guided and protected by law.²²
8. *Monitoring and Evaluation:* There will be a monitoring and evaluation framework for male circumcision services for quality control and planning purposes.²³
9. *Operational Research:* This will be carried out to strengthen male circumcision services and to implement effective, comprehensive HIV prevention programs in the context of sexual and reproductive health.²⁴

2.2 Strategies for Scaling up Male Circumcision for HIV Prevention

2.2.1 Universal access

Strategic Objective: To enhance access to a comprehensive package of male circumcision services for HIV prevention for the male population in Tanzania.

The existing public and private health delivery system consisting of referral hospitals, specialized hospitals, regional hospitals, district hospitals, health centers, and dispensaries will form the base for integrating male circumcision services²⁵. Both the situational analysis²⁶ and the ongoing demonstrations in Kagera, Mbeya and Iringa have revealed that the existing health care delivery system can, with moderate renovations and improvement in supply of equipment and materials, be improved to deliver an effective male circumcision service. Beyond demonstration phase, however there will be a need to determine the actual Male population aged 10 – 24 years. The data from demonstration sites will be able to show the number that is within the target age group for scaling up that fall out and the implication of this for the ability of the service to effectively deliver MC to all that demand it.

On-going health sector reforms and capacity building towards the scale-up in HIV and AIDS prevention, care, treatment, support and impact mitigation, will provide yet another opportunity for enhancing the scale-up on male circumcision in the context of HIV infection prevention.

The USAID Health Policy Initiative (September 2009)²⁷ results indicate that:

- If no MC scaling up occurs in Tanzania, the number of MCs that would maintain the current level of MC (70% of adult males) is about 320,000 per year.
- A rapid scale-up to meet a National target of 80% by 2015 would result in a large increase in the number of new MCs required per year in the short term, peaking at more than 1.3 million in 2012 before reaching a new equilibrium of about 650,000 annually.
- The level would represent approximately 80% of newborn males in 2030, as all adults and adolescents requiring circumcision would have received it by that time.
- Scaling up Medical MC Services to reach 80% of all adult and newborn males by 2015 would reduce the number of new adult HIV infections by more than 16% by the end of 2025.

²² “UNAIDS Legal and Regulatory Self Assessment Tool for MC in sub-Saharan Africa”, is an exercise that Tanzania should complete.

²³ WHO/UNAIDS “A Guide to Indicators for MC Programmes in the Formal Health Care Sector”.

²⁴ WHO “MC and HIV Prevention: Operations Research Implications”.

²⁵ According to the Ministry of Health and Social Welfare statistical report for 2005, the government owned 87 (39%) of the 219 hospitals. Two of the four referral hospitals are owned and operated by faithbased organizations.

²⁶ Wambura M., et. Al. op. cit.

²⁷ The potential Cost and Impact of expanding Male Circumcision in Tanzania.

- Over the time period 2009 – 2025, the total number of annual new infections would decline from about 148,000 to about 124,000, and the cumulative number of adult HIV infections averted would be more than 225,000 or 9% of all new adult infections that would have otherwise occurred in the Base scenario.
- Scaling up only newborn MCs would not result in adult infections being averted until after the newborn have grown up and become sexually active. As a result, most infections would not begin to be averted until after 2025.
- Over the time period 2009 – 2025, the cumulative net cost savings increase rapidly, reaching more than \$966 million by 2025.

Different Approaches for scaling up

Given the above projections, Tanzania needs different models/approach within the 8 regions of initial scale-up of Male circumcision for HIV prevention (Iringa, Kagera, Mara, Mbeya, Mwanza, Rukwa, Shinyanga and Tabora) based on service capacity and demographic differences as follows:

1. A Short term-adult Male circumcision program lasting five years (catch-up period) which should involve Public, Private, NGO, Static and mobile clinics. This will be a rapid scale up to attain the necessary numbers critical for cost effective HIV prevention. This will target 10-24 years males.
2. Medium term- adolescent MC program for 10-15years targeting those who were too young for the initial scale up approach in the first five years.
3. Long Term-Neonatal MC Program targeting the neonates and being fully integrated in the existing Health services and recognized as means for long life HIV prevention for the beneficiaries.

So in the two years of the roll out plan, the main aim will be to have male circumcision in all communities undertaken under conditions meeting the minimum standards of MC for HIV prevention. In areas with tradition cultural male circumcision, the scale-up approach goal will be to promote safe male circumcision services conducted under medical facilities or in circumcision camps organized jointly by the cultural leaders and trained medical staff. Other innovative methods include:

- (i) Promotion of health facility-based male circumcision, supervised or carried out by ethnically or religiously acceptable individuals;
- (ii) Sensitization and advocacy approaches that recognize the authority of cultural leaders but seeking to explain the need for health facility or trained medical practitioner to perform the male circumcision procedure and counseling;
- (iii) Identification of the role and means of introducing the family life education programme into the cultural rites of passage which normally accompanies traditional cultural circumcision;
- (iv) Widening the role of traditional leaders and women in mobilizing for male circumcision, HIV/AIDS positive prevention and positive living, home-based counseling and testing and referral for health facility-based male circumcision; and
- (v) Identification of other suitable compensatory approaches for traditional male circumcisers and the cultural leaders, if and when cultural male circumcision gets phased out.

In regions where cultural male circumcision is not common, the main approach will be to promote and scale-up static facility services in regional and district hospitals, outreach services to health centers and dispensaries, and mobile service delivery for hard to reach populations. It will require (a) the improvement and accessibility of quality counseling and surgical services (b) an advocacy strategy to promote male circumcision for adolescents and males in the reproductive age-group.

Where there has been facility- based male circumcision already in practice, the approach will be to enhance accessibility, and ensure a minimum package of male circumcision for HIV prevention is provided.

Roll-out plan for scaling-up MC

The roll-out plan for male circumcision will be guided by three factors:

1. Findings of the Situational analysis report (Wambura et. al., 2009) the Challenges and Opportunities for the involvement of Traditional Practitioners in Scaling up Male Circumcision in Context of HIV Prevention in Tanzania (Mboera et. al., 2009) findings.
2. The critical numbers of MC to be attained in order to reduce HIV infection and the need for different levels of aggressiveness in scaling-up MC services depending on existing regional differentials in prevalence of MC.
3. Quality of health facilities and their ability to meet minimum standards of MC for HIV prevention.
4. On-going demonstrations in Iringa, Mbeya and Kagera show that the establishment of MC services for male circumcision in different sites requires about four months as indicated in the operational guide for establishing male circumcision services (Figure 3).

Figure 3: Illustrative Timeline for initiating MC services.

| Activity | Month | | | | | | | | | | | |
|---|-------|---|---|---|----|---|---|---|---|----|----|----|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| Site Selection (Initial assessment of the facility) | | | | | | | | | | | | |
| Site Preparation (includes Renovation if necessary) | | | | | | | | | | | | |
| Site Strengthening (Procurement and supply of equipment and materials) | | | | | | | | | | | | |
| Community sensitization/Mobilization | | | | | | | | | | | | |
| MC Counseling Training | | | | | | | | | | | | |
| MC clinical skills Orientation/Training | | | | | | | | | | | | |
| Support for initiation of MC services | | | | | | | | | | | | |
| Training of MC supervisors* | | | | | or | | | | | | | |
| Supportive Supervision Visits | | | | | | | | | | | | |
| Routine M&E | | | | | | | | | | | | |
| Periodic M&E / Special Studies | | | | | | | | | | | | |
| <p>Notes:</p> <p>*If MC supervisors will assure the support for initiation of MC services, they should be trained prior to training the MC providers; if not, they can be trained closer to beginning their role in supervision.</p> <p>Estimate about four months to initiation of MC services at a brand new site (depending on how Long it takes to complete site Strengthening)</p> | | | | | | | | | | | | |
| <p><i>Adapted from JHPIEGO: Operational guide for Establishing MC services at a new site, December 2009</i></p> | | | | | | | | | | | | |

Considering that the country's health services are provided in a hierarchical form, from the dispensaries to health centres, district hospitals, regional hospitals and referral hospitals, the same structure will be used to roll out male circumcision, while taking into consideration the need for innovative approaches in the initial five year roll out plan suggested above. The regional hospital will form the node for introduction of standard male circumcision services for HIV prevention in the region by providing:

- (a) Standard MC services for HIV prevention.
- (b) Teams to carry out orientation, or where necessary training of staff in the region.
- (c) Supportive supervision to the district hospitals, health centers and dispensaries run by government, NGO/FBO and private practitioners.

In traditionally non-circumcising regions, after establishing MC services at the regional hospitals, satellite sites, within easy reach of the hospitals, should be identified and prepared to establish MC services. Preparation will be premised on ensuring that the recommended WHO and nationally approved standards are met by each of the facilities so identified. Where necessary, mobile sites will need to exist that are actually not close to hospitals because they will need to reach remote populations.

Initially, a Regional Hospital MC team should start providing MC services at these newly established sites together with the oriented staff on outreach basis. With time, the staff at the sites will be able to provide MC services their own on, at a regular basis.

In addition, selected district hospitals will be identified and initial contacts with the management of these hospitals established, needs of each of the district hospitals' capacity assessed on the basis of the minimum standards, and preparation for the scale-up will be effected. Each district hospital will identify suitable established sites at lower level facilities, and prepare them to provide and scale-up male circumcision. Some of these lower level facilities will work either as outreach sites or camps. With time, some of these outreach sites will, depending on the demand, act as fully-fledged male circumcision centers, offering permanent regular services.

Gaps in the health system delivery mechanism

The above notwithstanding, gaps remain that will need addressing before quality male circumcision services can be effectively integrated in the existing health delivery system, in general, and HIV preventive services in particular. Areas of improvement will include:

- (d) Renovation of existing facilities to provide rooms for counselling services and minor surgery.
- (e) Need for improvement of supply of equipment, supplies and materials necessary for scaling-up male circumcision.
- (f) Sustaining the supply of infection prevention materials in the context of the scale-up.
- (g) Improvement in the purchase and supply of medicines.
- (h) Innovative approaches to ensuring adequate availability of water and electricity to health facilities in both rural and urban areas.

Factors for Site Selection:

This involves working with the appropriate authorities to identify sites that would be appropriate for developing MC services.

Considerations should include:

- Prevalence of HIV and MC in the area
- Expected demand for facility based MC services
- The type/level of facility
- Existing infrastructure and equipment
- Availability of skilled manpower
- Adequacy of emergency services in case severe adverse events
- Level of interest of the concerned managers and services providers.

- (i) New investments in behaviour change communication materials and delivery systems, to take into consideration the need to scale-up male circumcision among the existing HIV preventive and reproductive IEC services.
- (j) Abstinence from all sexual activity is required for 6 weeks and condom use indefinitely thereafter. Monogamous couples may make their own modifications, but the recommendations are more broadly for risk reduction.
- (k) Improvements in the management information systems to ensure appropriate monitoring and evaluation activities and greater general coverage and specific documentation related to male circumcision.
- (l) Human resources will be critical to scaling up Male Circumcision.

Human Resources

The health sector has a shortage of human resources. The health workforce has been declining over the years by 28% from 67,600 in 1994/95 to 48,500 in 2001/2002 and by a further 10% to 43,650 in 2005/2006²⁸. In 2002, the key cadre of health care workers including nurses, clinical officers, and laboratory technicians was reported to be at 50% or less of the agreed staffing norms in 1999, although the level was slightly above 60% among the doctors²⁹.

The situation had not improved much by 2008. A training needs assessment in the Context of HIV and AIDS programmes (Msuya and Tumushabe, 2008) noted the health system was overstretched especially in the rural areas with a client load of 1(one) health practitioner per 1,525 people. The same assessment found a large disparity in the distribution of health practitioners between rural and urban areas with most health practitioners concentrated in Dar es Salaam (1:589) while Shinyanga, had the worst ratio of 1:3,284. It is against this background that the scale-up of male circumcision in Tanzania will be provided.

When the additional burden for HIV and AIDS prevention, care, treatment and support are factored into the demand on the health care workforce, the human resource base upon which the male circumcision scale-up will rely, will be over-stretched further in the short run and additional staff recruitment and task shifting with accompanying in-service training will be required (Wambura et.al. 2009, p.80).

It should be noted that considerable capacity has been built over the last five years in the wake of scaling-up on HIV and AIDS responses. Although less than 40% of the service providers in urban based health units and about 30% of their rural counterparts have undergone AIDS training, in all districts, capacity is progressively being built. This is a consequence of the scale-up in PMTCT, VCT, HBCT and care and treatment. In addition the situational analysis for male Circumcision in Tanzania (Wambura et. al. p. 78) found that nearly 60% of the health facilities surveyed provided male circumcision including between one-third and 55% of the facilities in traditionally non-circumcising regions. It is this existing capacity that will form the base for enhancing male circumcision services including community and facility based mobilization, counseling, nursing, surgery and post operation procedures and follow-up.

The proposals for human resources under this strategy are guided by:

- (a) The above existing conditions of health sector workforce and their needs;
- (b) The existing knowledge base and wide practices of male circumcision in Tanzania that has been on-going and can/should be capitalised on;
- (c) The minimum package of services defined for male circumcision for HIV prevention;

²⁸ NMSF Human and Financial Assessment Report. AM Kireria & D Ngowi. TACAIDS. March 2007.

²⁹ Wyss, K. (2004), Human Resources for Health Development for Scaling up ARVs in Tanzania. WHO/Swiss Tropical Institute

- (d) The need for male circumcision to reach a wide segment of the sexually active males fairly quickly for it to have an impact on prevention; and,
- (e) Recommendations of a cross-section of key stakeholders interviewed in preparation of this strategy.

It is difficult to determine the human resources needs before projecting the estimated number of males that will require circumcision in the short, medium and the long term. The human resources can be determined by the Decision Makers Programme Planning Tool (DMPPT). It is however recommended even before using DMPPT to project the regional demand for MC:

1. The regional break down of the number of men and neonates who will need services is established at the start so as to forecast the supply of service teams that will be needed. Doing so will help quantify the capacity of the existing health system and identify gaps that exist and how they may be addressed. Care should also be taken to incorporate efficiency suggestions outlined in the WHO Models for Optimizing the Volume and Efficiency of MC services “MOVE” document to make the most efficient use of staff.
2. At national, regional and council levels the existing gaps in human resources should be filled-up immediately through recruitment and/or in-service training and re-training particularly in regions undertaking scaling-up of male circumcision. During this capacity building areas of management such as Procurement and Supply Chain Management as well as overall programme management should not be ignored. It should be noted that filling up the gaps in the health care system does not necessarily mean hiring all staff for MC as employees of public hospitals because the system won’t have the absorptive capacity to utilize them after the campaign and donor funds for adult MC will be time-limited.
3. Alternative mechanisms for filling up human resource gaps for MC include task shifting, task sharing and extra duty allocations and overtime allocations.
4. Male circumcision:
 - i. Should be delivered by a multi-disciplinary team of trained and certified providers drawn from available service providers in health facilities. The recommended team of providers should include a “surgeon” (medical officer, assistant medical officer, clinical officer, or trained nurse), surgical assistant and a trained counsellor. Additional staff may be incorporated into the team for special initiative like community mobilization.
 - ii. Considering the shortage of surgeons especially in the district hospitals and health centres, task shifting will be required in which nurses and other health care cadres will be trained and allowed to carry out male circumcision, as was done recently in Kisumu Western Kenya. Under this arrangement accreditation for this cadre of workers will be necessary. Like all other services close supervision by surgeons will be necessary, especially in the initial stages.
 - iii. Where a particular male circumcision clinic lacks the necessary staff, recruitment and training or pairing up with other teams should be organized.
 - iv. The WHO recommends 10 MC per a standard team per day. However, innovative approaches such as ‘MOVE’ and the surgical technique of Forceps guided used by MC teams have indicated that teams of highly motivated staff can perform well over 30 MCs per day if required.
 - v. For each of the component services (community mobilisation, counselling, surgical provision and nursing) adequate training, mentorship and supervision should be provided to ensure adherence to the required policies and standards³⁰.

³⁰ The Performance Standards for Male Circumcision in Tanzania is currently in draft form.

- vi. Training should be arranged by training teams based at the regional hospitals. These teams will have undergone training of trainers' course in all aspects of the minimum package for male circumcision and will be organizing the training at the district hospitals, health centres and dispensaries. This training will need to take into consideration the existing knowledge and practice of male circumcision among different cadres of health workers in Tanzania as indicated in the Situational Analysis (Wambura et. al., 2009).
- vii. While currently pre-service training for different cadres of medical workers includes the male circumcision procedure, the minimum package for male circumcision and HIV prevention services is not part of this training and should be included.
- viii. Surgeons at all levels will provide oversight of male circumcision scale-up activities. They will participate actively in site selection, accreditation, training, mentorship, supervision, and evaluation of male circumcision services.
- ix. There is a need to use existing staff rather than to have dedicated staff due to this shortage of human resources. After the MC center is established it will be wastage of resources if it will work only few days within the week. So each surgeon will have a day for MC services while others are doing the other surgery.

The above recommended strategies will be informed by experience and demands in the field once the roll out plan has been put in place. The TWG through appraisal of data from the various tools (see annexes attached) will from time to time give guidance on changes in the strategy.

2.2 Integration

Strategic Objective: To integrate male circumcision for HIV prevention in the existing HIV preventive, reproductive health and other regular health services.

Tanzania has been implementing HIV prevention programmes since the 1980s with strategies for delaying sexual debut, mutual faithfulness to partners of known HIV status, reduction of sexual partners and correct consistent use of condoms, especially with casual partners or partners of unknown HIV status as well as promotion of utilization of HIV prevention services. Currently, the main HIV prevention interventions in the country comprise of behavioural prevention initiatives that focus on the general population, young people, vulnerable and high-risk population groups, condom promotion, prevention of mother-to-child transmission (PMTCT), HIV Counseling and Testing (HCT), blood transfusion safety, medical infection control (including injection safety and post-exposure prophylaxis (PEP)).

The scaling up of male circumcision will not replace the above known effective HIV prevention methods but rather complement them. Male circumcision is thus going to be part of a comprehensive prevention package utilizing and promoting such elements as safe sex and engaging young people in promotion of safe sex behaviour towards more reduction of HIV infection.

The success of male circumcision for HIV prevention depends a lot on the effectiveness of the Directorate of Hospital Services and overall coordination by the MoHSW. The directorate should coordinate the line departments, in particular, prevention and treatment of sexually transmitted infections (STI), reproductive health services, surgery, laboratory and HIV and AIDS prevention. In addition the department is well placed to coordinate with sister departments in the ministry such as community health. This strategy paper recommends that male circumcision for HIV prevention services not only be an integral part of the hospital services but any up-scaling should be towards improving of the quality and access to these services, in particular for adolescents and young adult males. In effect, rather than diverting attention and resources from other preventive and support services, the scale-up of male

circumcision for HIV prevention seeks to reinforce and draw attention to and improve the quality and accessibility of existing health unit-based and community-based health services for a hitherto difficult to reach vulnerable groups especially reproductive age males.

The role of traditional cultural institutions in male circumcision cannot be avoided. Not only do these institutions carry out massive circumcision, but even in traditional non-circumcising regions, there is a sizeable Muslim population that carries out male circumcision. In the medium and long term, appropriate anthropological approaches will need to be adopted to explore mechanisms for co-existence and referral mechanisms to make the traditional cultural male circumcision not only safe, but able to deliver optimum benefits for HIV prevention. One approach suggested in the course of designing this strategy paper was the use of medical workers hailing from these communities to carry out male circumcision. In the short run, operational research in this area is recommended.

2.3 Information, Communication and Advocacy

Strategic Objective: To have in place an effective service-guided male circumcision for HIV prevention advocacy strategy.

The main aim of the communication strategy is to enable the potential clients for male circumcision make informed decision and sustain behaviour that will reduce the risk of HIV infection. The strategy takes into consideration the fact that (a) male circumcision is already widely accepted as established in the Situational Analysis (Wambura, et. al. 2009); and (b) there is need to match advocacy with service provision, demand and acceptability of services;

The male circumcision for HIV prevention communication strategy should ensure the support of leadership, parents, adolescents and youth community mobilisers, well as health facility based male circumcision and HIV prevention staff.

The Male circumcision for HIV prevention communication strategy should have a feedback mechanism from the message receivers that shall be applied to ensure the efficacy of the channels and messages sent. This will lead to refining and redefining messages as necessary.

The IEC unit of the MoHSW shall coordinate the male circumcision communication strategy. The unit in collaboration with key stakeholders should adhere to the steps to development of effective Communication strategy on MC (see Box). The unit shall develop a strategy that combines the different platforms as follows:

- (a) *Mass media* – messages should be integrated into mass media formats for television and radio, print and advertising.
- (b) *Interpersonal Communication* – through door-to-door outreach, churches, schools, government and NGOs facilitated discussions, counselling sessions and community events, focus group discussions with cultural gate keepers, women and youth groups.
- (c) *Health care setting* – sensitization of healthcare providers about male circumcision and its relationship to HIV and to advocate the procedure to all un-circumcised clients.

Eight Steps to Effective Communication on MC

- (i) Conduct a situation Analysis
- (ii) Set goals and objectives
- (iii) Segment key audiences
- (iv) Develop key messages
- (v) Identify appropriate communication channels
- (vi) Identify key partners for collaboration
- (vii) Develop and Pre-test tools and materials
- (viii) Monitor and evaluate on progress.

Source: **WHO Operational Guidance for scaling up male circumcision services for HIV Prevention, 2008, p.48**

(d) Social-cultural elements such as initiation groups should be identified and used as a vehicle for community mobilization for clinical male circumcision and HIV prevention. This also includes use of community leadership and existing groups and structures to promote male circumcision for HIV prevention.

(e) Use of key messages (see Box) and other specialised messages and translating these into socially acceptable packages for promoting male circumcision for HIV prevention. In the national context, appropriate messages for different community and group settings will be necessary as follows:

(i) In the traditionally non-circumcising communities the communication strategy will be used to educate the population, about the significance of Male Circumcision for HIV prevention as well as address fears and misconceptions about the procedure and its outcomes.

(ii) In the traditional circumcising communities, the strategy will aim at ensuring safety of procedures, strengthening the HIV prevention messages through cultural circumcision channels and referral for the procedure of circumcision to established national health facilities.

(iii) In areas where there has been traditional Female Genital Mutilation, ((FGM) there will be a need to clarify the difference between the two and ensure understanding that what is being promoted for HIV prevention is male circumcision and not FGM.

(iv) In circumstances where there is a danger circumcised men may be perceived as free from HIV and potential increase of unprotected sex with them, the strategy will need to address this specific aspect.

(v) Where social exclusion is likely to occur or detected, the advocacy strategy will target traditionally disadvantaged and excluded groups such as adolescents and the youth and women with sensitisation to increase their knowledge of the service and access to its advantages

(vi) It is recommended that male circumcision not be promoted for men who are already infected with HIV, but it should not be denied unless medically contraindicated. For HIV-positive men there is no demonstrated public health benefit of reduced HIV transmission to their partners, and men with severe immunodeficiency are at an increased risk of complications following surgery. However, HIV-positive men who become circumcised do benefit directly from reduced genital ulcer disease and the counselling provided alongside MC.

Key messages of the Male Circumcision for HIV prevention Strategy

- Male circumcision significantly reduces heterosexual transmission of HIV but offers only partial protection. To achieve greater protection male circumcision must be used in conjunction with other known prevention methods such as abstinence, condoms, partner reduction and undergoing voluntary counselling and testing for HIV.
- Newly circumcised males should abstain from sex for at least six weeks to ensure the penis is fully healed, as they could be at an even higher risk of infection during this time.
- Male circumcision has other health benefits which include reduced risk of some sexually transmitted infections (STIs), especially ulcerative diseases, such as chancroid and syphilis.
- Male circumcision carried out under local anaesthesia by well trained, adequately equipped, experienced health care personnel rarely leads to complications and if any occurs, they are easily and rapidly resolved.

The following critical actors should be brought on board at the different levels to participate in the advocacy for male circumcision:

- (i) Education sector – most of the books used in Tanzania education system (HIV and AIDS) do not have the aspect of Male Circumcision as one of the preventive methods. But this aspect can be included through the education system and if students are taught they will easily demand. Their numbers will ensure quick scale-up success.
- (ii) Community development organs should be brought on board including the extension staff in community development and agriculture offices.
- (iii) Political leaders have to date proved to be effective. The use of youth organizations within political parties to spread the message and sensitization is one channel that will prove useful.
- (iv) The Tanzania Bureau of Statistics (TBS) other research bodies such as REPOA and ESRF need to be sensitized to add male circumcision within the national data base for HIV and AIDS prevention. TBS should also utilize the scaling up to track the changes in HIV infection trends in population sub-groups by including age disaggregated MC data in regular national surveys.
- (v) Religious leaders (Christians, Islam and others) should be recognized, respected, sensitized and brought on board to support male circumcision for HIV prevention.
- (vi) The armed services including the army, police and prisons services require high levels of advocacy and service expansion. There is much fear about control and much emphasis will be required with regard to human observance of the rights of the rank and file of the members of the armed forces.
- (vii) According to the situational analysis for Male Circumcision for HIV prevention (Wambura et. al., 2009) most parents have been found not to object the process of Male Circumcision for their children. The advocacy strategy will therefore seek to address parents to translate this support into actual demand for MC for their children in this scale-up.

2.4 Cultural Sensitivity, voluntarism and respect for human rights

Strategic Objective: To ensure cultural sensitivity, respect for human rights that all male circumcision for HIV prevention services in Tanzania are voluntary.

In both the cultural circumcising and non-cultural circumcising communities there are strong held views, myths and misinformation surrounding the practice. Individuals wishing to undertake Male Circumcision for HIV prevention or any other reason or intending not to have circumcision are often influenced by social sanctions as indicated in Situational Analysis for Male Circumcision in Tanzania (Wambura M. et. al., 2009). Even in traditionally circumcising communities, seeking of Male Circumcision in health settings is sometimes ridiculed and results in social sanctions.

Where circumcision services are provided in a traditional cultural setting or through the health system, it is important to know who seeks the services (age, ethnic or religious group, etc.), why they seek them, the clinical methods, who the providers are, what training they have had, the context (camp setting, at home individually, at a clinic, etc.), the costs and fees, what additional services may be incorporated (education, counseling, STI diagnosis and treatment, etc.), and the outcomes (frequency of adverse events, etc.)³¹.

Male circumcision should be delivered to all communities with awareness of cultural sensitivity. The participatory approach, as detailed hereunder, should be encouraged in communities that exhibit resistance to clinical male circumcision. Elsewhere social mobilization using behavioural change communication strategies should be undertaken aimed at reducing stigma and discrimination circumcision status under medical conditions.

³¹ WHO, 2008. Operational guidance for scaling up male circumcision services for HIV prevention.

The principles of community empowerment should be encouraged with particular focus on (a) adapting male circumcision activities to the time and schedule of the community programmes (b) flexibility in aspects such as appointing culturally acceptable medical staff to handle the circumcision procedures (c) Focusing on the long-term sustainability and impact of the operation.

The Brazzaville Commitment on scaling up towards Universal access to HIV and AIDS prevention, treatment, care and support in Africa, recognizes that the expansion of health, social and development programmes and services has to be underpinned by among others the respect for human rights, especially with regard to the fight against stigma and discrimination and to advance equity.

With regard to the above issues, this strategy recommends that:

- (a) Any person wishing to undergo male circumcision should first be offered counselling for surgery and HIV infection risk reduction behaviour. Counselling and testing should be undertaken for all the MC clients under conditions and guidelines of the Provider Initiated Testing and Counselling.
- (b) Informed consent must be sought by the service provider and this should be signed where the client is of age and by the parent/legal guardian in case of minors and children less than 18 years.
- (c) The highest level of confidentiality should be maintained by all providers and disclosure of such facts will depend on consent of the clients or only under legal prescription.
- (d) While promotion of male circumcision for HIV prevention will be undertaken for the targeted sexually active age group, clinical male circumcision services are the right of all males and will be provided to all without discrimination after appropriate counselling.

2.5 Gender Sensitivity in promoting male circumcision

Strategic Objective: To promote and consider the needs of women and their responsibilities in the scale-up of male circumcision for HIV prevention and enhance the participation of men in sexual and reproductive health.

Although existing evidence suggests that women are not directly (in the short run) protected against HIV infection from circumcised men³², women will benefit indirectly from male circumcision. First, as a result of being exposed to less HIV infected men (in the medium and long run) and secondly, many will benefit from less exposure to other sexually transmitted infections including HPV which causes cervical cancer. This benefit will increase over time as more men seek additional protection against HIV by becoming circumcised. In the scale-up of male circumcision in the country, programme managers and service providers should monitor and minimize potentially harmful outcomes such as unsafe sex, sexual violence, or confusion of male circumcision with female genital mutilation. Thus women and girls have to be included and indeed have a role to play for the following reasons:

- (a) *Potential for risk compensation:* Circumcised men and their female partners may be put at increased risk of HIV infection. This is where women are exposed to false beliefs towards being protected from infection if they have unprotected sex with circumcised men. Men may use their circumcision status as a reason for not using condoms, while women may be less inclined to insist on condom use if their male partners are circumcised.
- (b) *Mistaking FGM for male circumcision:* There is a danger of mistaking female genital mutilation (FGM) as being part of the advanced HIV prevention strategy, yet the reality is that FGM actually increases the risk of infection and is a globally condemned practice.
- (c) *Increasing male participation in reproductive health including HIV and AIDS prevention:* The expansion of safe male circumcision services provides an opportunity to strengthen and expand HIV prevention and sexual health programmes for men. It is also a means to reach a population

³² Male circumcision and women's risk of HIV, and Male circumcision provides no direct benefit to women, Quoting *Lancet* 17th July 2009, http://www.malecircumcision.org/publications/male_circumcision_news.html#news37 viewed 23rd December, 2009

that is not normally addressed by existing services. For instance while women's participation in HIV prevention has in recent years been boosted by the scaling-up of PMTCT³³ men have not. Policy-makers and programme managers should maximize the opportunity that male circumcision programmes afford for education and behaviour-change communication, the promotion of shared sexual decision-making, gender equality, and improvements in the health of both women and men. Male circumcision service provision should also be used as an opportunity to address the sexual health needs of men. Such services should actively counsel and promote safer and responsible sexual behaviour.

- (d) *Safe sex negotiation:* Although sex decision is a joint responsibility between men and women, many studies indicate there is limited decision making by women in sex. Since the state has the duty to make sure every woman is protected against HIV infection, it is imperative that a preventive mechanism with 60% efficacy against HIV infection, should be enforced for the sake of ensuring current and subsequent generations of young men are not infected and indirectly will not infect women with HIV. Making sex as safe as is humanly possible, should also be the duty and right expected of both women and men and hence women should be sensitised to promote male circumcision as a right of protection against HIV infection for both men and women.
- (e) *Stigmatising attitudes:* The HIV/AIDS-old stigma laden belief of attributing HIV infection to women is likely to be resurrected, if male circumcision is promoted as a means to protecting men from being infected "by women". Women need to be given adequate information about the rationale for male circumcision and provide sufficient response to any stigmatising attitudes.

Given the above, women are an important constituency who will need to be targeted in all efforts to scale-up male circumcision. It is recommended that each unit of operation provides for:

- i. Education to both men and women on gender equity and shared sexual decision making. This will be at each stage of operation including design and dissemination of key messages, community mobilization and engaging women leaders in discussions about what having a circumcised partner will mean for their sexual lives. At the individual couple level women should be invited to participate in pre and post-circumcision counselling and follow-up to ensure mutual commitment to the avoidance of sex until healing is complete.
- ii. The need to fully understand risks around male circumcision and HIV prevention.
- iii. The need for partner reduction to minimize the risk of infection with HIV and other STIs.
- iv. Discussion fora for young boys and girls in-school and community youth clubs about their sexuality, sex behaviour, STI and HIV prevention and the need for male circumcision as well as where to access services.

2.6 Leadership and partnerships

Strategic Objective: To have in place a well coordinated male circumcision for HIV prevention programme from national to service unit levels.

Male circumcision scale-up involves different stakeholders at national, regional, district and community levels. This calls for clarity of leadership and partnerships to ensure success of the programme.

National Level Leadership

Since male circumcision is primarily a health service, the programme should be led by the Ministry of Health and Social Welfare (MoHSW) and have the full collaboration and support of the National AIDS Control Programme (NACP) and Tanzania Commission for AIDS (TACAIDS). This provides legitimacy and helps to ensure the quality of services and long – term sustainability. MoHSW leadership and support are necessary not only where the public sector is involved but also where the private and

33 a factor that has led to a significantly higher proportion of women accessing HIV and STI prevention programmes than men of the same age-group

NGO sectors provide and expand Male Circumcision services. This will ensure the quality of services and long-term sustainability since it will have full ownership by the government. A national Technical Working Group (TWG) for male circumcision which already exists will have the following roles:

- i. Lead and coordinate the scale – up of male circumcision activities.
- ii. An advisory role to the Ministry and her partners.
- iii. It will offer the necessary technical guidance to the process of planning for scale-up and overseeing the implementation of a national male circumcision programme.

The TWG should be comprising a broad range of representatives from government departments at national, regional and district levels, donor organizations and cooperating partners, together with key civil society, NGO, religious and traditional sectors, and networks of people living with HIV. A focal person in the MoHSW should be designated to lead the National TWG.

Regional Level Leadership

At the regional level, the Regional Medical Officer will oversee all activities of male circumcision for HIV prevention. In a situation where there are multiple stakeholders in the region, working on the male circumcision scale-up, it will be necessary for the Regional Medical Officer to form a regional task force which will be the technical working group that assists in organizing service delivery in the region.

The Regional AIDS Control Coordinator assisted by the regional MC Task force, will coordinate all male circumcision activities for HIV prevention in the region. It will carry out the tasks similar to those of the national body with an emphasis on service delivery. Specific responsibilities of the Regional MC Task Force will be to:

- i. Plan for establishing MC services for HIV prevention in their region, including advocacy, site identification and assessment, community mobilization, mobilization of resources, site orientation/training of providers, service delivery, supervision, monitoring and evaluation and quality assurance.
- ii. Facilitate the integration of Male Circumcision into existing health systems
- iii. Coordinating the activities of various partners in their area of jurisdiction to ensure accessibility of male circumcision services
- iv. Assessing site level and regional resources and advice on the best option of efficient utilization of its resources
- v. Be responsible for accreditation of male circumcision sites that are offering male circumcision services
- vi. Will develop and implement the regional support supervision programme.
- vii. Play an active representation role on the National Male Circumcision Committee.

Council Level Leadership

At the district level, the District Medical Officer with assistance of the District AIDS Control Coordinator will:

- i. Oversee all male circumcision services for HIV prevention in the district.
- ii. Be responsible for ensuring quality services in the district.
- iii. Facilitate integration of MC services into existing health systems including human resource arrangements, budgeting, planning and procurement functions.
- iv. Provide support supervision for all health units and for the unit Male Circumcision teams.

- v. Identify gaps in implementation and mechanisms for their bridging.
- vi. Ensure the set-up and reporting of MC in the health management information systems and prepare progress reports.

Service Delivery Point Leadership

The service delivery points (hospitals, health centres and dispensaries) play the critical role of integrating male circumcision for HIV prevention. Service delivery point management will therefore:

- i. Ensure there is a minimum package for safe delivery of MC services for HIV prevention.
- ii. Put in place mechanisms to use the available facilities, equipment, human and material resources for the integrated MC for HIV prevention together with existing health services.
- iii. Ensure scale-up of the MC services within the health unit does not compromise but complements other health unit services.
- iv. Put in place a mechanism for ensuring existing male circumcision services adhere to the minimum package for HIV prevention and are regularised within health management system.
- v. Allocate enough staff for orientation and/or training to carry out MC for HIV prevention including performance of additional services as are necessary to attain optimum levels for HIV prevention within the catchment area of the health unit.
- vi. Ensure timely delivery and availability of equipment and supplies as are necessary for MC for HIV prevention in the health unit.
- vii. Suggest to the MC TWG best ways to improve the scaling up of MC services pertaining to their health unit and the hinterland it serves.
- viii. Appoint a focal person responsible for MC for HIV prevention services within the health unit.

Partnerships

Partnerships facilitate advocacy for the scale-up of male circumcision and bringing resources, knowledge and experience from other programme areas. At national level the work of partnerships will be realized in the working of the multi-stakeholders on the Male Circumcision National Technical working committee. Here partners that have indicated desire or willingness to participate in the scale-up of male circumcision include bilateral agencies, international and national NGOs, the private health-care providers, and professional bodies.

At regional and local government level other partners relevant for advocacy, political support and ensuring an equitable male circumcision programme include civil society groups, primary and secondary schools, youth-groups, women's groups and organizations, human rights advocates, HIV prevention advocates, women's health advocates and the cultural gate-keepers (traditional health-care providers, healers and circumcisers).

Different partners will need to address different aspects of the essential components based on their respective mandates and strengths. For partnerships to attain optimum programme benefits it will be necessary to clarify each partner's role.

All opportunities for partnerships to expand male circumcision services should be utilized. Among the critical actors are community and cultural gate-keepers responsible for encouraging and/or discouraging male circumcision. Efforts will be put in, to ensure community participation from the traditional, cultural, as well as the new development agenda perspectives. With the latter, being public- private-partnership (PPP) led. Towards the modern community development programming, partnerships, to encourage male circumcision and foster HIV prevention behaviours, should be developed with key stakeholders, including community leaders, women's and young people's groups.

The nature of the partnerships will depend on local contexts and needs, and will differ from region to region and district to district. In traditional cultural circumcision areas and groups, traditional practitioners are vital stakeholders who have attained a significant proportion of the estimated 70% circumcisions that constitute the estimated total males circumcised in Tanzania. Therefore their role in programme scale-up should be carefully considered, particularly in areas where cultural circumcision

is the established norm, and HIV prevention programmes for adolescents and young adults remain weak. Furthermore traditional circumciser's involvement would bridge the gaps and potential conflict between the health unit-based and traditional circumcisions.

Clear plans will need to be designed to reach in and out of school, orphans and other vulnerable children such as street kids. Women in particular will need specific strategies to access them to ensure their involvement as leaders, cultural gate-keepers, partners and parents.

2.7 Policy Development, Legal and regulatory mechanism

The protection and promotion of human rights is integral to all aspects of HIV prevention, treatment, care and support. Expansion and initiation of male circumcision services must ensure that the procedure is carried out safely, under conditions of informed consent and without discrimination. However, the legal, regulatory and policy framework governing MC in Tanzania is weak and there is no specific law dealing specifically with male circumcision. Male Circumcision, as one of the HIV-risk reduction strategies, is governed by general laws that regulate the medical profession and the provision of medical services in medical settings by health professionals.

In the absence of such a specific legal and regulatory framework on MC, there is need to:

- a) Guide the Tanzania Medical Council to develop specific ethical guidelines to assist health workers to understand their duties in relation to male circumcision.
- b) Review the existing legal and regulatory framework, including relevant customary laws, action plans and strategy papers, and practices.
- c) Convene community consultations with a broad range of relevant stakeholders, including technical experts from NACP, traditional providers of male circumcision (in regions where male circumcision is an existing practice), representatives of the national human rights institutions/organisations, women's groups, human rights and legal groups, groups of men working towards gender equality, youth groups and other civil society groups.
- d) Develop specific policies and laws relating to male circumcision so that male circumcision services are accessible and provided safely and with sufficient safeguards for all stakeholders. The legal regulatory framework will, among other, ensure that
 - The laws, regulations or policies require health facilities to adopt and comply with safety and quality standards of services including human resources, sterility of equipment, universal precautions, in the delivery of safe and voluntary male circumcision services;
 - There is adequate safety and ethics training of all health practitioners, including traditional cultural circumcisers where appropriate.
 - The law provides for a grievance redress mechanism to address violations of patients' rights to safe and ethical medical procedures, for example through a Medical and Dental Council, Human Rights Commission, or Public Protector.
 - Health care providers supply all individuals seeking male circumcision services with accurate and adequate information necessary to secure consent (including information about the risks, benefits, and methods of male circumcision; and the right to refuse the procedure without risk of reprisal or other adverse consequences).
 - Ensure that consent is obtained in a culturally appropriate manner, with due consideration for individuals' literacy, linguistic, and educational levels.
 - Individuals are able to make free and informed decisions without undue influence from peers, sexual partners, or health providers.
 - People with mental disability or persons in institutional settings such as prisons and jails or the military who may be unable to provide free and informed consent are not coerced to undergo circumcision.

- There is prohibition of disclosure of any health information, including information about the HIV status of individuals seeking male circumcision. Health care providers trained on the importance of protecting the privacy of vulnerable persons from discrimination based on their circumcision status through keeping personal health information confidential, recalling that unauthorized disclosure of medical information is unethical and can cause stigma.

2.8 Quality assurance through Monitoring and Evaluation

Considering that Male Circumcision activities will be carried out at different levels from the health units to the Ministry of Health and Social Welfare, it will be necessary to have in place accurate, timely and comprehensive data and information for planning purposes and ensuring quality of services. This also calls for identifying the key input, process, outcome, output and impact indicators which will assist programme managers at all levels to oversee the quality of the services and provide targets for supervisory activities. The formulation of the Monitoring and Evaluation Framework of male circumcision for HIV prevention in Tanzania should be guided by the following:

1. The Objectives of Monitoring and Evaluation framework should be to ensure the quality of Male circumcision services by collecting, analyzing and utilizing routine data as well as periodic and special studies concerning the programme.
2. Routine data should be collected at each Male Circumcision site, in the client records which should then be entered into the Male circumcision client register. Wherever feasible, this data should be computerized at the source. Facilities (and supervisors) should be empowered to collate, analyze and utilize their own data for monitoring and quality improvement purposes. Districts, regions and the National level should likewise have the capacity to analyse the data and feedback responses down to each of the lower levels.
3. Routine summary data should be compiled in monthly reports that should be submitted to the district level and upward following the usual circuit of HMIS reporting.
4. The collection of routine data should be guided by the needs of key stakeholders, the capacity of the data collectors to provide it alongside service delivery and the needs of the planning and quality assurance needs of the programme.
5. Supportive supervision should be provided for to ensure that sites are adequately collecting and reporting on their data as expected.
6. Routine data will help to monitor some aspects of male circumcision services; however, there are aspects of quality care which are not well suited to monitoring through routine data collection. Among these are client perspectives on quality of services and reporting. There are special aspects of male circumcision services that may warrant periodic in-depth studies, such as changes in sexual risk behaviours or community perceptions of health unit-based male circumcision. Periodic or special studies can help the program to monitor and improve the quality of services offered.

2.9 Operations Research

Operational research should be carried out to strengthen male circumcision services and to implement effective, comprehensive HIV prevention programs in the context of sexual and reproductive health. The National Technical Working Group (NTWG) should:

- (a) Identify and prioritize the areas for research
- (b) Facilitate its implementation and ensure ethical conduct of the research and that minimum quality standards are reached and maintained.
- (c) Expedite the process for operations research to minimize the negative effect of bureaucracy and ensure Operational Research is commissioned in a timely manner for it to deliver benefits that will feed into the planning and implementation process of the programme.

- (d) The following areas require research and even others will crop up during implementation of the project:
- i. A comprehensive health unit assessment to be carried out in every health facility to identify its specific needs to carry out quality male circumcision services for HIV prevention.
 - ii. A study of the potential mechanisms for bridging the gaps between Cultural Male circumcision and health facility-based services. This study will also examine in addition the role of cultural institutions in male circumcision scale-up for HIV prevention.
 - iii. In-depth analysis of the methods used by traditional cultural circumcisers, risks perceived, and how they are mitigated, including referral system if any existing.
 - iv. A rites of passage study of the male circumcision scale-up that would seek to unite the traditional cultural elements of rites of passage to imparting responsible sexual behavioural messages and practices among newly circumcised males under the scale-up programme³⁴.
 - v. Two longitudinal behavioural surveys of those circumcised in the roll-up; one examining the behaviour aspects, and, the other, a clinical assessment of their pre and post –circumcision lives against their different environmental settings (e.g. Truck and taxi drivers, farmers, workers in roads constructions areas, armed service personnel, clients of commercial sex workers, MSM etc).
 - vi. Knowledge, practices and attitudes, as well as behaviour on condom use should be assessed.
 - vii. Attitude of the society towards the circumcised men including attitudes of men, boys and girls and women towards circumcised men including those circumcised under cultural versus health facility based clientele.
 - viii. Exploring the possibility of bringing in the neonates in the scale-up of male circumcision to avoid late catch.
 - ix. Studies on dealing with the costs and using male circumcision for reaping optimum benefits for prevention of HIV and other STIs. It should be noted that since the earliest days of HIV diagnosis, besides condom use there has not been any other wide-scale prevention strategy to address in particular young unmarried males protected sexual needs. Thus while there is near universal health-based Provider Initiated Testing and Counselling and the PMTCT programme for women for the young males their participation in reproductive health has been limited. There is thus a need to assess in what manner the scale-up of male circumcision services can be used to enhance men's access and participation in reproductive health including HIV and STI prevention.
 - x. An assessment of different types of advocacy to be carried out for different age-sex groups for the scale-up of male circumcision in both cultural circumcision communities and in non-cultural circumcision community, and how can this be embarked upon, monitored and improved?
 - xi. Studies need to be carried out to assess the outcome of various techniques of Male circumcision used among Dorsal slit, Clamp and Shield.
 - xii. Finally we need mechanism for improving HMIS database.

³⁴ This study would seek to answer the question: “Under the scale-up of Male circumcision, is there a way in which we can use the male circumcision as a rite of passage, predominantly aimed at preparing young men for mature responsible sex lives in which they will be protected from infection with HIV and equipped with skills to lead stable relationship in marriage”.

3.0 MALE CIRCUMCISION ACTION PLAN 2010-2012

| Goal: To increase the prevalence of male circumcision to 80% in the regions identified as public health priorities for MC for HIV prevention. | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|---------|---|---|---|---------|---|---|---|--|--|--|--|--|--|--|
| Strategic Objective 1: To enhance access to a comprehensive package of male circumcision services for HIV prevention to the male population aged 10 – 24 years in 7 traditionally non-circumcising regions by 2012/2013. | | | | | | | | | | | | | | | | | | | |
| Activity description | Responsible/lead organization/ agency or division/unit | Indicator (s) | Resources required | Participating partners for implementation | 2010/11 | | | | 2011/12 | | | | | | | | | | |
| | | | | | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | | | | | | | |
| 1. Organize and carry out sensitization workshop for Regional Level management | TWG | # No. of RHMTs accepting and ready to initiate MC for HIV prevention services | -Workshop facilitator -TWG -Travel support - Workshop materials | NACP/ TACAIDS/ development partners MoHSW line Departments | | | | | | | | | | | | | | | |
| 2. Carry out a Health Facility Audit | TWG MoHSW RHMT | -Facility readiness -Equipment available -human resource -Integration of service -Advocacy -Client seeking and obtaining MC service | -Fund -Consultants - | -DHMT and Consultants - Funding support partners - Implementing Partners -Service Providers | | | | | | | | | | | | | | | |
| 3. Mobilize funds | MoHSW/ MoF TACAIDS | # Funding commitment to support scale-up of MC services. | -Costed Budget | Funding support partners | | | | | | | | | | | | | | | |
| 4. Developing of male circumcision guidelines | MoHSW (NACP) | Guidelines for Male Circumcision (Advocacy and Mobilization; Setting-up clinical services; Quality Assurance; Counseling for MC; Working with cultural male circumcisers etc) | - Consultant | Implementing partners | | | | | | | | | | | | | | | |
| 5. Building/ renovation at regional Level | -MoHSW -Board of Procurement | # of health facilities with adequate capacity to perform MC according to national guidelines # average km needed to access MC services | - Budgeted plan -Contractors - | RHMT and Funding partners -Contractors | | | | | | | | | | | | | | | |

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| 6. Identify and prepare satellite clinics for MC services around the regional hospitals | TWG, MoHSW and RHMTs | # of satellite MC clinics identified at each region and ready for providing MC services -Report of identified sites available. # of male circumcision kits purchased and distributed # of health facilities carrying out male circumcision -O/S reports in a month # of community outreach services with sufficient capacity | -Guidelines for preparing MC for HIV prevention services | DHMT for districts where the Regional Hospital is located and other partners | | | | | | | |
| 7. Procurement and supply of equipment and materials for all levels and satellite sites. | MoHSW MSD RHMT | | -Budgeted plan | -Private Companies - MSD - MoHSW -Funding and implementing partners. | | | | | | | |
| 8. Incorporating MC into existing HMIS | MoHSW RHMT DHMT | -Monitoring reports compiled -Routine data and report prepared and available in a timely manner about sites and quality of services. # of Facilities receiving feedback reports #of data collectors and managers trained to incorporate MC #of health facilities utilizing their own MC and other data for planning and reporting purposes -Training Reports available | - HMIS trainers -training guidelines -Computer hardware and software | MoHSW RHMT local and international NGO partners | | | | | | | |

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| 9. Training of trainers of MC for HIV prevention (Counselors, surgeons, nurses, programme managers). | TWG NACP and other training institutions. | # of Trainers per category available. -Training reports | -Trainers -Funds for Training -Training materials | TWG MoHSW NACP | | | | | | | | | | | | | | | |
| 10. Training of service providers | TWG NACP and other training institutions. | #of Service providers trained and available for service provision. # of facilities with sufficient and trained providers -Training reports | -Trainers -Funds for training -Materials -Committed trainees | TWG MoHSW NACP Participating NGOs | | | | | | | | | | | | | | | |
| 11. Mobilization and preparation of District Hospitals for scale-up of MC for HIV prevention | MoHSW RHMT and other partners | # & % of districts assessed for scale-up . # &% of trained providers available # & % of district hospitals with sufficient equipment and supplies for MC service provision. # &% hospitals of facilities available for MC provision | -Funds -Contractors -Supplies and Material -Available trained staff | MoHSW RHMT DHMT Other implementing partners (NGOs, private health facility management) | | | | | | | | | | | | | | | |
| 12. Training of Service Providers and teams at district level | MoHSW RHMT and training teams based at Regional level | # Service providers trained and available for service provision. # and % of facilities with sufficient and trained providers -Training reports | -Trainers -Funds for training -Materials -Committed trainees -Training guidelines | TWG MoHSW RHMT DHMT NACP - Other training partners (NGOs, private training institutions). | | | | | | | | | | | | | | | |

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| 13. Supply of equipment and materials to district hospitals and outreach services | MoHSW MSD RHMT DHMT | # of male circumcision kits purchased and distributed # of health facilities carrying out male circumcision #Health facilities reporting adequate materials and equipment for MC # of community outreach services with sufficient capacity to carry out MC for HIV prevention -O/S reports in a month | Budgeted plan | Private sector Procurement Board NGOs and other implementing partners | | | | |
| 14. Starting and operating district MC services for HIV prevention at district hospitals | - DHMT - District hospital management - MoHSW | #of health facilities accepting and with ability to implement MC scale up #of health facilities carrying out MC for HIV prevention services # males 10-49 years seeking counseling for MC services # males 10-24 getting comprehensive package of MC for HIV prevention services. | - Available and assigned staff -Materials and supplies - Community mobilizers | RHMT MoHSW And other partners | | | | |

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| 15. Launching and sustaining MC for HIV prevention Campaign | MoHSW TWG RHMT DHMT And other implementing partners | # meetings/discussions held # of participants # Radio and TV spots on MC for HIV prevention # Posters distributed % of clients reporting access to Campaign material # health facilities properly displaying MC for HIV prevention materials. # Billboards on MC circumcision mounted % general population know and accept MC for HIV prevention | -Key messages -Community mobilizes - Communication media | -Service providers -Community mobilisers -NGOs -Community leadership and mobilisers -Central and local government leaders -Political Leaders | | | | | | |
| 16. # Provide monthly support supervision. | MoHSW RHMT DHMT | #of support supervision conducted -Reports -Proportion of gaps identified and addressed. % Client satisfied with Quality of services # of complications reported | -Supervision toolkit -Transport -support Supervisors at different levels -Speed of Response mechanism in place | -Funding and implementing partners. -Supervisors at different levels | | | | | | |
| 17. Reviewing and improving HMIS to include MC for HIV prevention services | MoHSW | # Indicators for MC for HIV prevention included in HMIS # Data on MC for HIV prevention available # MC for HIV prevention indicators of progress available in routine reports of Health units and at all levels | - Material and supplies (computers and accessories) -Trained personnel | Consultants & Implementing Partners | | | | | | |

Goal: To increase the prevalence of male circumcision to 80% in the regions identified as public health priorities for MC for HIV prevention.
Strategic Objective 2: To integrate male circumcision for HIV prevention in the existing HIV preventive, reproductive health and other regular health services.

| Activity description | Responsible/ lead organization/ agency or division/unit | Indicator (s) | Resources required | Participating partners for implementation | 2010/11 | | | | 2011/12 | | | | | |
|--|---|---|---|--|---------|---|---|---|---------|---|---|---|--|--|
| | | | | | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | | |
| 18. Developing guidelines for integrating MC into HIV prevention, RCHC and other regular health services | NACP/TWG | # Guidelines available at all service units | - Consultant - Funds for guideline development process, reproduction and dissemination | WHO and other technical partners | | | | | | | | | | |
| 19. Review the pre and in-service curricular for training HIV/AIDS and RCHC service providers to integrate MC services | NACP/ MoHSW | # Revised curriculum available at training institutions | - Consultant - Funds for curriculum development, reproduction and trainer orientation | - WHO and other technical partners - Health training institutions | | | | | | | | | | |
| 20. Carry out in-service training of existing RCHC, VCT and PITC service providers | MoHSW RHMT DHMT | - Proportion of gaps identified and addressed | - Training kits available. -# of Staff to be available | RHMT DHMT & implementing partners | | | | | | | | | | |

| Goal: To increase the prevalence of male circumcision to 80% in the regions identified as public health priorities for MC for HIV prevention. | | | | | | | | | | | | | |
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| Strategic Objective 3: To set-up an effective referral system between cultural male circumcision and health unit-based circumcision services. | | | | | | | | | | | | | |
| Activity description | Responsible/lead organization/agency or division/unit | Indicator (s) | Resources required | Participating partners for implementation | 2010/11 | | | | 2011/12 | | | | |
| | | | | | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | |
| 21. Develop guidelines for integrating traditional/cultural circumcision services into health unit-based MC for HIV prevention | MoHSW | -Guidelines for integrating traditional/cultural circumcision services into health unit based services available and disseminated | - Consultants - Funds for guideline development process, reproduction and dissemination | Implementing partners | | | | | | | | | |
| 22. sensitization activities (meetings, seminars, group discussions, joint planning sessions) between health unit providers and cultural circumcision key stakeholders | NACP/TACAIDS | # Participants in seminars # Reports of Seminars with recommendations | # Facilitators Funds | -Implementation Partners -Community leaders - Political Leadership | | | | | | | | | |

Goal: To increase the prevalence of male circumcision to 80% in the regions identified as public health priorities for MC for HIV prevention.
Strategic Objective 4: To have in place an effective service-guided Male Circumcision for HIV prevention advocacy strategy by the year 2011.

| Activity description | Responsible/ lead organization/ agency or division/unit | Indicator (s) | Resources required | Participating partners for implementation | 2010/11 | | | | 2011/12 | | | | | |
|--|---|---|--|---|---------|---|---|---|---------|---|---|---|--|--|
| | | | | | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | | |
| 23. Developing of Advocacy Strategy of MC for HIV prevention. | MoHSW | - Major gaps identified and addressed - Advocacy strategy developed | -Well trained personnel -MC guidelines | RHMT DHMT & implementing partners | | | | | | | | | | |
| 24. Mounting media campaign to obtain support of key groups especially cultural/religious leaders, | MoHSW | -Role of women in health services participation -Role of women at the household level -Role played by women Media -Women leaders | -IEC tool kits -Logistics for outreach services (cars, staff, testing kits, consumables and other logistics | RHMT DHMT & implementing partners TAMWA Ministry of Gender &Ministry of Sports and Youth Development | | | | | | | | | | |

Goal: To increase the prevalence of male circumcision to 80% in the regions identified as public health priorities for MC for HIV prevention.

Strategic Objective 5: To establish a legal and regulatory framework to guide male circumcision for HIV prevention

| Activity description | Responsible/ lead organization/ agency or division/unit | Indicator (s) | Resources required | Participating partners for implementation | 2010/11 | | | | 2011/2012 | | | | | |
|--|--|---|-------------------------------|---|---------|---|---|---|-----------|---|---|---|--|--|
| | | | | | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | | |
| 25. Reviewing legal, regulatory and policy framework for Male Circumcision | MoHSW, Ministry of Justice and Constitutional Affairs | Report on the legal and regulatory framework. Changes in the Laws | - Legal Consultant - Funds | The Parliament of the United Republic of Tanzania; Ministry of Sports and Culture | | | | | | | | | | |
| 26. Drafting National Policy on Male Circumcision | Ministry of Justice and Constitutional Affairs, MoHSW (NACP) | Policy on Male Circumcision in place | - Consultant - Funds | The Parliament of the United Republic of Tanzania; Ministry of Sports and Culture | | | | | | | | | | |

Goal: To increase the prevalence of male circumcision to 80% in the regions identified as public health priorities for MC for HIV prevention.

Strategic Objective 6: To ensure the highest quality of male circumcision services through effective support supervision, monitoring, evaluation and operations research

| Activity description | Responsible/ lead organization/ agency or division/ unit | Indicator (s) | Resources required | Participating partners for implementation | 2010/11 | | | | 2011/2012 | | | | | |
|---|--|---|--|--|---------|---|---|---|-----------|---|---|---|--|--|
| | | | | | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | | |
| 27. Developing and Pre-test M&E toolkit | MoHSW (NACP) | -Proportion of gaps identified and addressed. | -Human resources -Consultants -Funds -Material and supplies -Transport logistics | MoHSW, Implementing Partners | | | | | | | | | | |
| 28. Putting in place an effective support supervision | MoHSW RHMT DHMT | # Support supervision visits that included MC # Number of referrals # support supervision reports | - Guidelines for support supervision - Transport support | TWG Higher level MoHSW officers | | | | | | | | | | |
| Carrying out Operations Research | TWG | # Number of studies carried out and # Changes effected in programme | #Consultants/ Researchers | Consultants, Researchers Implementing. partners | | | | | | | | | | |

