

DPMI+ Deliverables

Spring 2012

Elizabeth Edouard

ABSTRACT

Elizabeth Edouard conducted her Development Project Management Practicum (DPMI+) in the Spring 2012 semester while on a Boren Fellowship in Tanzania. She interned for the Jhpiego Tanzania Volunteer Medical Male Circumcision (VMMC) program from January 2012 to May 2012. She was based at the country head office in Dar Es Salaam. Her internship involved significant fieldwork, for which she was based at the regional offices of Jhpiego Tanzania in Iringa, Njombe and Tabora. Her DPMI+ deliverables reflect the work that she undertook during the period of her internship.

GLOSSARY OF ACRONYMS

VMMC: Voluntary Medical Male Circumcision

GoT: Government of Tanzania

MC: Male Circumcision

MCHIP: Maternal and Child Health Integrated Program

EIC: Early Infant Male Circumcision

SNA: Social Network Analysis

GIS: Geographic Information Systems

DPMI: Development Project Management Institute

DPMI+: Development Project Management Institute Practicum

USAID: United States Agency for International Development

WHO: World Health Organization

MIIS: Monterey Institute of International Studies

SCMS: Supply Chain Management System

FSW: Female Sex Worker

MARPS: Most at Risk Populations

MCP: Multiple Concurrent Partners

CAT: Community Action Teams

BCC: Behavior Change Communications

Table of Contents

Glossary of Acronyms	2
Deliverable 1: Problem Tree	4
Figure 1: Problem Tree.....	6
Deliverable 2: Core Competency Map	7
Figure 2: Core Competency Map.....	10
Deliverable 3: Strategy Canvas	11
Figure 3: Strategy Canvas.....	13
Deliverable 4: Social Network Analysis	14
Figure 4: SNA Degree.....	16
Figure 5: SNA Betweenness.....	17
Deliverable 5: Partnership Strategy Matrix	18
Figure 6: Partnership Strategy Matrix	21
Deliverable 6: Introduction of collaborative technologies	22
Figure 7: Inflow Presentation	24
Deliverable 7: GIS Mapping	26
Figure 8: Map for site selection 2012	28
Case Study: Scale-Up	29
References	36

Deliverable 1: Problem Tree of the HIV context in Iringa

Module 1: Problem Tree

[The problem tree outlines the decision to scale-up VMMC in Iringa Region as part of HIV prevention and possible challenges in its adoption]

Background

Based on three randomized control trials in South Africa, Uganda and Zambia, medical male circumcision is proven to protect men by up to 60 percent in sex with female partners (Auvert et al, 2005; Bailey et al, 2007; and Gray et al., 2007). To reduce HIV prevalence in Eastern and Southern Africa, a scale up of volunteer medical male circumcision (VMMC) is occurring in Lesotho, Zambia, Swaziland, South Africa, Zimbabwe, Botswana, Kenya, Uganda and Tanzania in areas with high HIV prevalence and low prevalence of male circumcision. Based on modeling, circumcision coverage of 80% of the population in these areas will avert four million new cases of HIV. Therefore, the goal is to circumcise a total of 20.3 million men in these countries by 2015.

The Government of Tanzania (GoT) based on the recommendation of WHO and UNAIDS has scaled up circumcision in eight areas, which have a high prevalence of HIV and low prevalence of male circumcision (MC). In the Iringa Region, in South Western Tanzania, the HIV prevalence is 15.7 percent, the highest in the country, and the male circumcision rate is the second lowest in the country, qualifying Iringa as a priority region for the implementation of VMMC services.

Rationale and Explanation of Problem Tree

To better understand the literature on male circumcision and the HIV epidemic in the Iringa Region, I developed a problem tree that illustrates the situation. The nature of the HIV epidemic in the Iringa Region is attributable to a number of factors, of which some are depicted on the problem tree, as seen in Figure 1. Specifically, the peak in HIV infection is from 35-39 years old in men and 30-34 years old in women.

Cultural factors contributing to the high rate of HIV transmission include multiple partners, sexual intercourse without protection, and a low prevalence of male circumcision. Within marriage, condom use is virtually non-existent. Given the culture of having multiple concurrent partners (MCP) before and during marriage, the lack of condom use tangent to MCPs is a large risk factor for HIV transmission. Furthermore, structural factors include the influx of a migratory population given the position of Iringa on the TanZam highway and an economy dependent on seasonal laborers. The number of female sex workers (FSWs) is high in Iringa region due to the demand for their services in large towns along the TanZam highway. FSWs along with other Most-At-Risk-Populations (MARPS) such as truck drivers and migrant laborers have driven the HIV epidemic in Iringa.

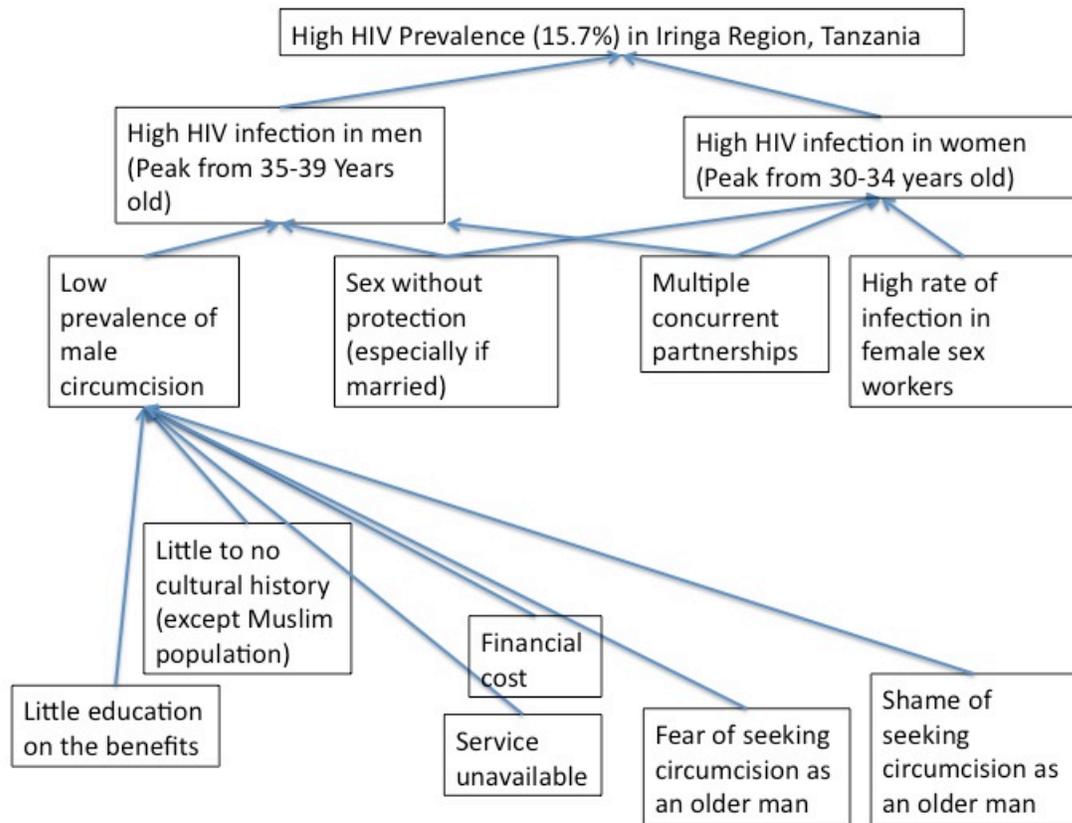
In the problem tree, the focus is on male circumcision as it is my scope of work and it is a relevant prevention method, in Tanzania as almost 85% of HIV transmission in Tanzania occurs through heterosexual contact. In the Iringa region, the low prevalence of male circumcision stems from the traditional beliefs of the population who are mainly Christian, a non-circumcising community. In Tanzania, men in urban areas are more likely to be circumcised than men in rural areas, 88 and 60 percent respectively. One of the reasons for the limited adoption of circumcision in rural areas is a result of little education in rural communities on the benefits of circumcision and inavailability of the service. Another barrier for seeking service in the past, as reported by current VMMC clients, was the financial cost—at present, through USAID funding, the service is free. Research from Iringa (Plotkin et al, 2011) has shown that fear and shame are barriers to seeking circumcision for older men.

Use of Tool in Project Management Cycle

The problem tree depicts the various factors that have led to a high HIV prevalence. While there are many other factors attributable to the high HIV prevalence, I selected to focus on the current challenge for our organization, the low circumcision rate. Specifically, as the work of the VMMC program in Tanzania is becoming more focused on strategies to target older men for VMMC, I wanted to prioritize this area of the problem tree.

While the problem tree does not offer new information, given the research that has already been conducted, it provides a way to illustrate the current situation. It also outlines a path for developing specific activities. This problem tree will provide insight to me in the future when drafting concept notes or other scale-up plans. For example, as shame is a barrier to seeking MC, the next MC implementation research project should focus on ways to reduce the shame of seeking circumcision as an older man.

Figure 1: Problem Tree



Deliverable 2: Core Competency Map of MCHIP program in Tanzania
Module 3: Core Competency Map
[The core competency map identified the value-creating activities of MCHIP in Tanzania]

Background

Jhpiego, was initially founded in 1974 as the Johns Hopkins Program for International Education in Gynecology and Obstetrics. Based in Baltimore, it continues to work as a public health NGO affiliated with Johns Hopkins University; however, its programmatic scope has expanded from maternal health to HIV/AIDS, and cervical cancer. As always, Jhpiego emphasized practical solutions for low-resource settings.

The Maternal and Child Integrated Program (MCHIP), a USAID-funded program, is managed by Jhpiego along with John Snow International (JSI), Save the Children, PATH, JHU/IIP, Broad Brance, PSI, and Macro International and is active in the 30 USAID priority countries where it intends to accelerate the reduction of maternal, newborn and child mortality (MCHIP 2012). With experience in VMMC from its work on male circumcision for HIV prevention in Zambia, Jhpiego won awards in several countries to implement VMMC through MCHIP.

MCHIP in Tanzania: Core Competencies

In Tanzania, through MCHIP, Jhpiego is currently responsible for a majority of VMMC activities given its technical expertise and history with implementation in the country. Jhpiego was awarded funds for VMMC from MCHIP in 2009 and has been active in service delivery, monitoring and evaluation, training and behavior change communication for VMMC.

While Jhpiego remains uniquely responsible for national M & E related to MC and training of providers, there are now several organizations implementing VMMC in Tanzania through non-USAID funded grants. Therefore, it is important for Jhpiego in its management of MCHIP to identify its core competencies as it continues to work in a changing environment, as illustrated in Figure 2.

Stakeholders in VMMC through Jhpiego in Tanzania include the national and local government, other NGOs providing VMMC services, MC providers including doctors, clinical officers, nurses and counselors, VMMC clients and the community. From the perspective of these stakeholders, MCHIP in Tanzania would be identified as a program that provides at its core: the implementation of VMMC service delivery in Iringa, Njombe and Tabora through government providers, the training of VMMC service providers, the development of a national VMMC monitoring and evaluation system and demand creation in the respective communities in which it provides service delivery. Additionally, the successful work of Jhpiego in Tanzania has been recognized in the rapid scale up of VMMC services internationally; therefore, technical assistance is often sought

from Jhpiego's staff in Tanzania for countries in the region. These activities represent the core competencies of the Jhpiego managed MCHIP program.

The MCHIP team of Jhpiego in Tanzania operates smoothly and successfully in its role given the technical and managerial experience of the staff, the planning with regard to behavior change communication, and the supportive relationship from the government. The tangible and intangible resources for VMMC are extensive ranging from VMMC service delivery commodities, to overtime from service providers, and support from the local government and community for VMMC services; however, they are all essential in the success of the program.

While other funders are supporting organizations to implement VMMC services in low circumcising regions outside of Iringa, Njombe and Tabora, Jhpiego continues its work in its regions as well as at the national level with regard to the training of providers and the establishment of a national monitoring and evaluation system. In all regions where VMMC services are being implemented, service providers were trained by the staff of Jhpiego. Furthermore, the VMMC monitoring and evaluation system, which is based on the work of Jhpiego, is nationalized; therefore, Jhpiego supports the government in the implementation of its VMMC monitoring and evaluation system.

MCHIP in Tanzania: Adjacent Competencies

While the work of Jhpiego through its VMMC program as led to the circumcision of over 70,000 adolescents and men from 2010 to date, the focus of VMMC service implementation is shifting due to the maturity of the program and the demands of funders. To see the impact of a reduction in HIV transmission, it is essential for sexually active males, specifically before the age when there is a peak in HIV prevalence, to become circumcised. In the VMMC service delivery in Iringa and Njombe, a majority of clients are aged 10-18 years old. Reaching older men proves to be a challenge in the current implementation of VMMC services. Research has and continues to be conducted to determine methods in which to change supply and demand of services to better attract older men clients. While Jhpiego has not yet found a niche in this area, it remains an adjacent competency that will prove to be essential in its program life cycle.

A second adjacency to its core competencies will be the development of skills in the implementation of Early Infant Male Circumcision (EIC). Based on recommendations by the WHO and UNAIDS, EIC programs are only to begin once the regular VMMC program has reached maturity determined based on the level of saturation of clients in the region. The government, in the Iringa Region in Tanzania, where Jhpiego has been implementing VMMC for 3 years, requested and was granted EIC services in the year 2012. This program will be a pilot in the year 2012 and will expand over the next 5 years as the regular VMMC service reaches complete saturation of 80% of males between the ages of 10-49, as per government targets. As Jhpiego is the first organization in Tanzania to pilot and initiate an EIC program, it has taken the lead in getting government support and it will become the leader with regard to technical experience in the field of EIC. Finally, Jhpiego has only recently in 2011 expanded its VMMC services to Tabora. Prior, Iringa and Njombe were the only two areas providing a scale-up of VMMC activities.

Therefore, the organization in 2012 is scaling up services through the training of providers in Tabora, a mini-campaign and outreach activities to reach a target of ## clients in the area. The provision of services in a new region is viewed as an adjacent competency given the new landscape and potential for challenges with regard to demand of VMMC by clients.

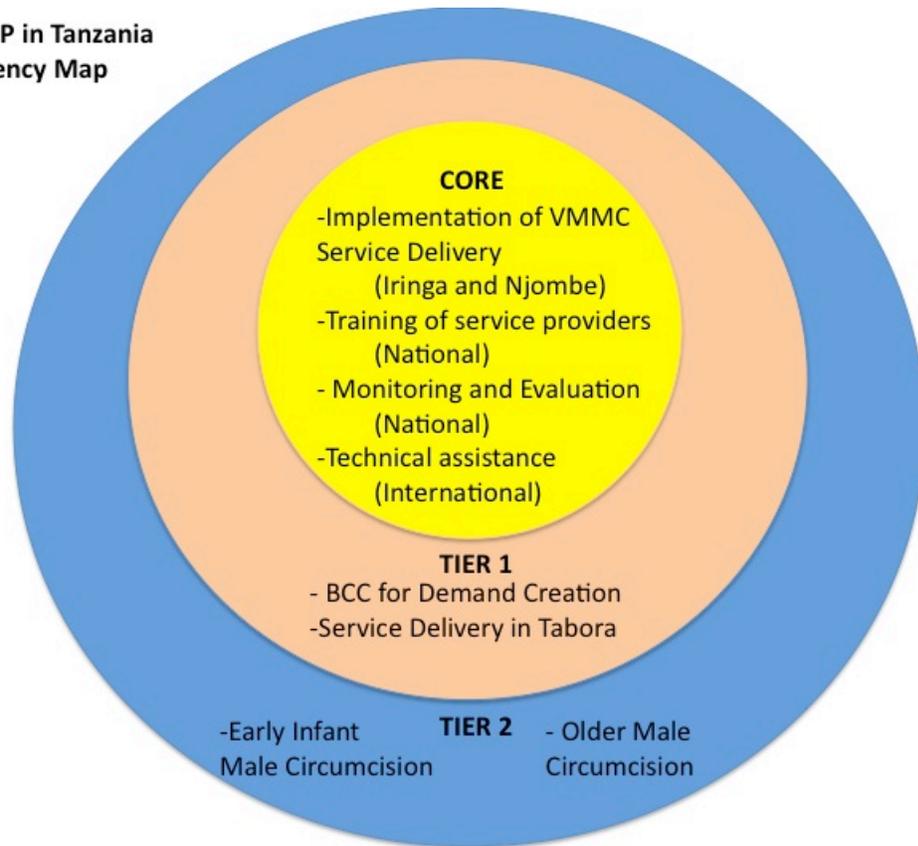
Use of Core Competency Map in the Project Cycle

This core competency map of the MCHIP program managed by Jhpiego in Tanzania outlines the unique set of skills and capabilities of Jhpiego in the current context of VMMC in Tanzania. It identifies the strengths and value-creating activities that differentiate Jhpiego in its provision of VMMC services, specifically monitoring and evaluation as well as the training of providers at the national level. With this knowledge, Jhpiego management should concentrate on ensuring that these activities continue to be prioritized and highlighted in its work. Furthermore, looking at its adjacencies, Jhpiego management is able to identify new areas for growth and challenges that lie ahead. By putting resources into these adjacent areas, Jhpiego may develop new core competencies that set it apart from other organizations implementing VMMC. Jhpiego should focus on achieving greater impact specifically by reaching older men in VMMC service delivery.

As the MCHIP managed Jhpiego program continues to grow, it will develop new adjacencies that will sometimes require work with a partner organization. It is valuable for an organization to know its skills and the boundaries in which it works, in order to best identify how to work in its current context. For example, Jhpiego currently depends significantly on an internal demand creation team with the help of a hired demand creation company; however, partnering with another organization in the region that has experience working with our target population could be an alternative, and maybe cheaper solution. Overall, the core competency map serves to guide Jhpiego in its management of MCHIP to ensure that it remains mission-oriented while pushing the limits to which it can provide scaled-up VMMC service delivery in Tanzania.

Figure 2: Core Competency Map

**Jhpiego MCHIP in Tanzania
Core Competency Map**



Deliverable 3: Strategy Canvas for Jhpiego

Module 3: Strategy Canvas

[This strategy canvas is a planning tool for the Jhpiego VMMC program in FY 2013 and beyond]

Background

As illustrated in the core competency map, the Jhpiego male circumcision (MC) program has greatly expanded its scope of work since 2009. It has gained fame in Tanzania -- and internationally -- for its success in scaling-up VMMC. This fame has earned the Jhpiego MC program approval for a significant increase in funding for the financial year (FY) 2013. This funding will enable the program to make more progress in reaching the USAID established target of 2.8 million circumcisions by 2015; more funding also translates to more pressure to fulfill targets and goals. Within this context, the Jhpiego MC team spent two days in January 2012 developing a five-year vision and a two-year strategic plan to determine the funding needed to implement a scale-up in VMMC services.

Rationale

A strategy canvas can be used in planning to visualize differentiation and innovation opportunities. A strategy canvas complements a core competency map, as it goes a step further with the competencies and adjacencies of an organization by providing a visualization of next steps. While the development of strategy canvas was not included in planning activities at this meeting, I have made a strategy canvas to reflect the discussion from the meeting and as a visual for future planning, as seen in Figure 3.

Explanation

My strategy canvas depicts the priorities of the three main stakeholders in the Jhpiego MC program: USAID, Government of Tanzania and Jhpiego. The dashed line represents the current strategic plan for 2013, which reflects the current environment and satisfies the requirements of the funder and government demands.

As all stakeholders have similar targets for the number of men to reach as well as expectations with respect to quality standards, VMMC service delivery is a priority for all stakeholders, and is given utmost importance in the strategy plan for 2013.

Training is a necessary component of current VMMC service delivery; however, it also is crucial to the sustainability of VMMC programming. As all providers of VMMC are part of the government of Tanzania, if they are properly trained, the government in 2015 will smoothly be able to take over the Jhpiego managed VMMC program.

Jhpiego has focused a lot of time and effort to nationalized the monitoring and evaluation tools. The work that they have completed to date in the integration of VMMC data with

government-collected data at district level is groundbreaking. While the work is notable, it represents a priority of Jhpiego, but not one of the government of Tanzania or USAID at present.

International technical assistance is provided by Jhpiego staff about three times annually in Eastern and Southern African countries. While it is an opportunity for lesson sharing and appreciated by USAID, it is not feasible if the Jhpiego MC team expects to be conducting over 20 weeks of MC intense activities such as campaign and outreach each year.

To scale-up VMMC service delivery, behavior change communication (BCC) is an essential stepping stone. All stakeholders prioritize investment of efforts and resources in BCC because of its growing importance, as the Jhpiego MC team starts to target higher hanging fruit.

Early infant circumcision (EIC) is the next phase of VMMC scale-up, which normally begins when a country has reached a certain threshold of MCs completed. While Tanzania has not yet reached this number, USAID has put pressure on the Jhpiego MC team to initiate EIC in FY 2012. Depending on the support of the government, the Jhpiego MC team will be expected to make EIC an integral of its strategic plan in 2013.

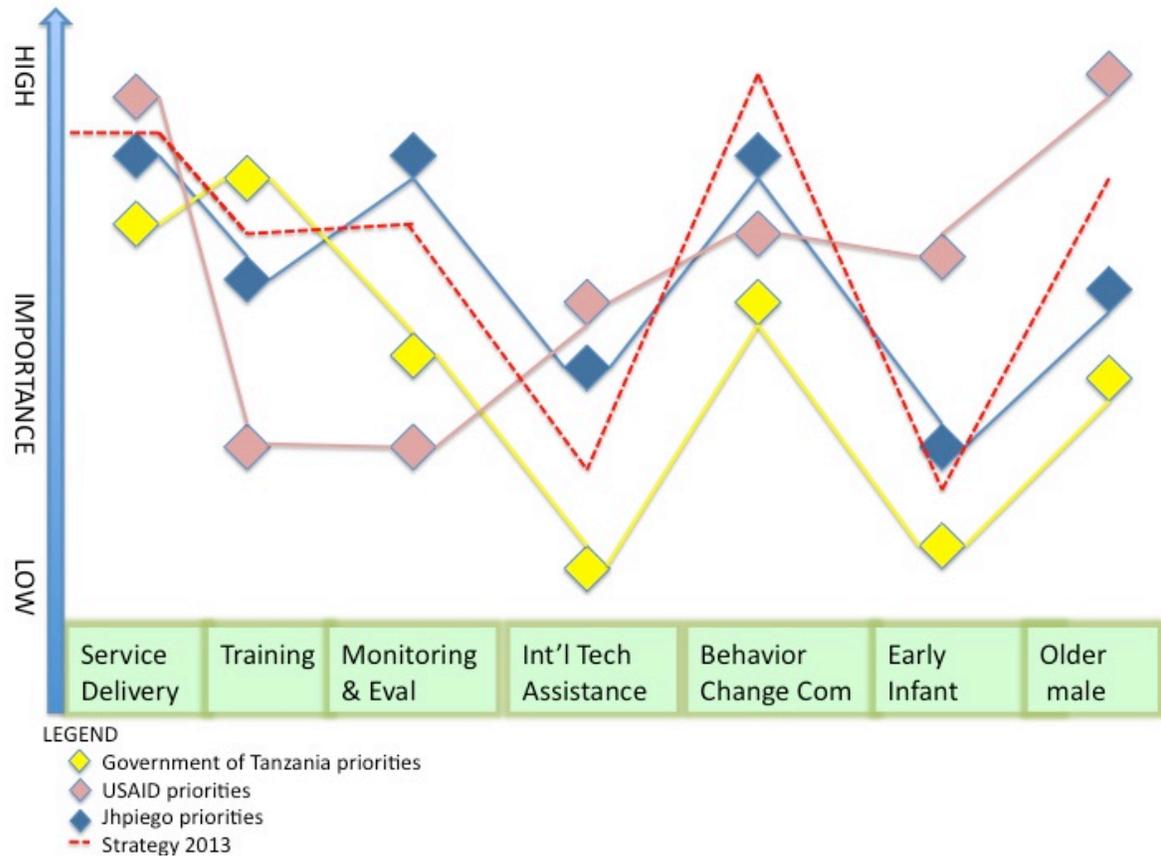
USAID has made it clear that in their programming, older men are the target population of VMMC. The Tanzania national government in their vision have young men between the ages of 10-18 as the first priority followed by men between the ages of 18-25. The Jhpiego MC program remains focused on meeting targets determined in each funding year, for which the indicators are number of males circumcised. At this point, target numbers have not had to be disaggregated by age. However, a large scale research project funded by USAID has set targets for reaching older men and is providing funding to Jhpiego in FY 2013 to achieve these targets.

Use of Tool in the Project Cycle

The topics that were included in the strategic canvas were taken from the core competency map. I chose to develop the strategy canvas using the priorities from the three main stakeholders to illustrate their impact on the work of Jhpiego. There are other stakeholders that influence the strategy of the Jhpiego MC program that were not included such as other funders and individuals, specifically government officials, with other demands.

The strategy canvas illustrates the areas that will need to be scaled up in other years in order to satisfy individuals such as an early infant circumcision program and further targeting to older male clients. However, the Jhpiego MC program has successfully managed expectations of funders and government officials, which has enabled the program to remain mission focused and accommodate the needs of all stakeholders.

Figure 3: Strategy Canvas



Deliverable 4: SNA Mapping Exercise for Strategic Planning

Module 3: Social Network Analysis

[A visualization of partnerships in Iringa region was developed to generate discussion on opportunities for further collaborations between USAID-funded partners]

Background on SNA

Analysis of social network structures provides a lens, in which to understand the dynamics and interactions of relevant stakeholders, and a means through which an organization can develop better relationships and improve communication with constituents. SNA provides a quantitative method of assessing an aspect of social science, relationships, that in the past has been qualitative only. By emphasizing the structure of the networks, rather than the simple attributes of the actors in the network, new information emerges that can be used in a variety of ways. Through network analysis, it is possible to understand patterns of relationships that can improve the ability to make other predictions.

Methodology for collecting data on USAID partners in Iringa

The prioritization on partnering and the need for partnership in scaling up Volunteer Medical Male Circumcision (VMMC) has already been explained. To provide further insight on the current situation of partnerships in Iringa, I mapped relationships of USAID funded NGOs in Iringa during financial year (FY) 2010 and 2011.

The data were constituted using USAID partners' strategic plans, evaluations, presentations and annual reports that were uploaded to the Knowledge4Health internal database. This database was developed by researchers to access information on NGOs in the area as part of the HIV/AIDS combination prevention study. Unfortunately, many USAID partners did not upload their information to the database. Therefore, a limitation of this methodology for data collection on partnerships was gaps in information. Additionally, the quality of these partnerships, with regard to frequency of collaboration and length of time, is unknown. As a result, the analysis of the map should be regarded as limited and it may not accurately reflect partnerships on the ground.

Description/Findings from SNA

Each node in the network analysis map represents an organization that was listed in data collection by a USAID-funded partner. As USAID holds a central position in the network analysis map, due its relationship with all organizations as a funder, I have removed it in my analysis. The relationships reflect the collaborations of these organizations in Iringa.

Using degree centrality, which identifies the number of ties that each node has to another node, I determined the organizations in Iringa that had listed the most partners, as seen in Figure 4. For example, FHI and Jhpiego, which have many partners exemplify organizations that collaborate in the field with other organizations. In the context of

strengthening VMMC programming and reaching more of the population, the Jhpiego MC program is looking for organizations with a high degree centrality. These organizations with high degree centrality are key information sources because of their relationship with diverse actors.

Betweenness measures how often ties go through a certain node, which in this context, refers to the organizations that would be able to broker relationships with other organizations. As seen in Figure 5, the Jhpiego VMMC program is currently one of the organizations with the highest betweenness because of its collaborations with radio stations, counseling and testing programs and other private organizations. As a result, many other organizations see value in partnering with Jhpiego because through the relationship they can become more connected with activities in the community. The Jhpiego MC program is also interested in partnering with other organizations who have a high betweenness because they are a source of information. For example, AFRICARE-Pamoja Tuwalee has high betweenness, yet is not connected at present to Jhpiego. A relationship with this organization could generate many new relationships as well as extend the reach of the MC program.

Recommendations and Use of Tool in the Project Cycle

This tool is to provide a visual analysis of relationships between USAID partners to encourage discussion at the next Iringa partners meeting. Within the context of increasing collaboration between USAID funded partners in Iringa as well as scaling up VMMC, the following are my recommendations:

- **Jhpiego MC should partner with EngenderHealth in order to reach older male clients**

EngenderHealth- Champion and EngenderHealth ACQUIRE are not partners of the Jhpiego MC program. Champion has indicated past partnerships with Tanwat, a tea plantation where the MC program hopes to start providing VMMC for workers. Furthermore, Champion and ACQUIRE are both positioned in the map, with a high betweenness and partners that are outside of Jhpiego's primary or secondary relationships. A partnership with EngenderHealth would introduce the Jhpiego MC program to new communities.

- **Jhpiego MC should assess its current partnership with radio stations to determine the value added from partnering with TCCP**

From the network analysis map, it appears that Jhpiego has established a direct partnership with radio stations as well as a secondary partnership through TCCP. While USAID encourages partnership, the scope of the partnership should be defined to avoid unnecessary overhead expenses or communication.

- **USAID funded partners should communicate current collaborations with other USAID funded partners to optimize opportunities for collaboration in Iringa**

Four organizations are not connected to the rest of map without the presence of USAID: JHU evaluation, Tunajali, Technoserve and Abt Associates. These organizations should start their collaboration with other organizations by uploading their information to the partners server. In the case of the JHU evaluation, which is the HIV combination prevention evaluation, it is important for the staff to develop relationships and understand the function of each organization prior to starting their large evaluation.

Figure 4: Organizations by degree

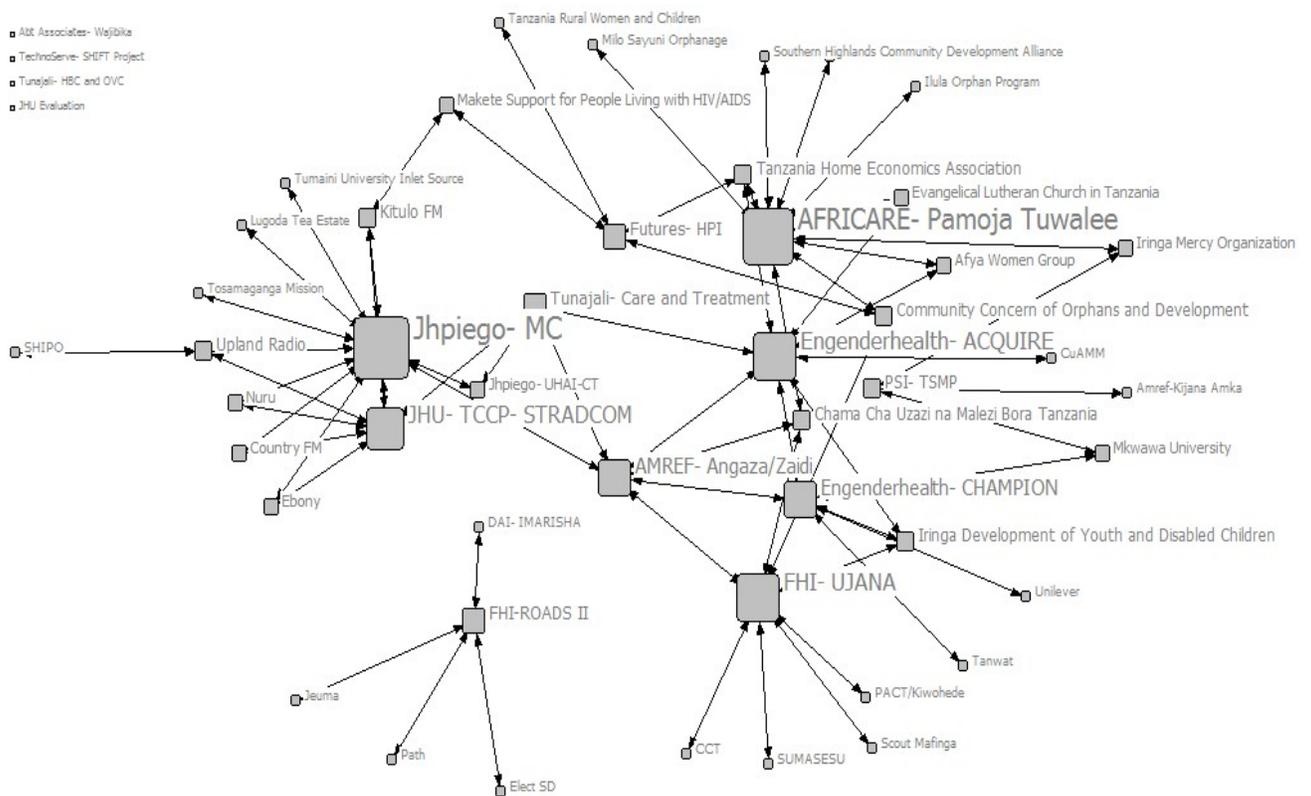
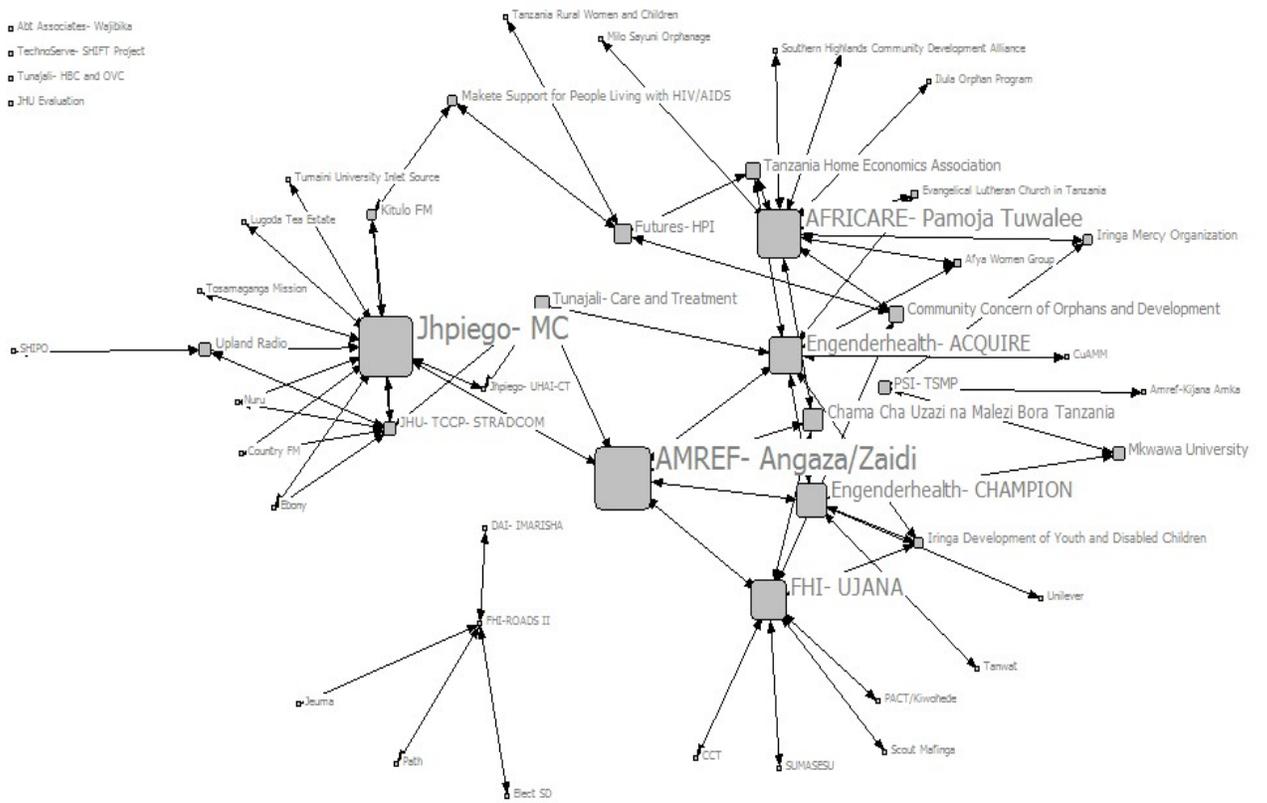


Figure 5: Organizations by betweenness



Deliverable 5: Strategic Partnership between Jhpiego and EngenderHealth

Module 3: Strategic Partnership Matrix

[The strategic partnership matrix outlines the value added of a partnership between Jhpiego and EngenderHealth in Iringa]

Background

USAID has selected Iringa Region in Tanzania as a priority area for funding and activities. Currently, there are over 8 USAID funded partners working in this region; however, there is little communication between these respective organizations. As a result, USAID funded partners have been asked to increase collaboration as possible.

In the context of USAID partnerships in Iringa, the Jhpiego male circumcision (MC) program was identified as the appropriate organization to spearhead partnerships. Specifically, as the MC program includes HIV testing and counseling, demand creation as well as service delivery, it has the potential to involve other USAID-funded organizations in Iringa.

Additionally, Jhpiego has been asked to reach more older men in its scaling up of VMMC services. As identified in the problem tree and in prior research in Iringa, barriers for older men in seeking VMMC service include: shame, fear and the notion that it is not for married men. While Jhpiego has adjusted service delivery on the supply side, with evening hours, special days and men-only providers to reduce barriers, older men clients remain few. Jhpiego has not really focused on the behavior change or the demand side of this issue, but it needs to be addressed. The use of partners on the ground in Iringa is the new strategy of Jhpiego to reach the older men.

Partnership Strategy Matrix

After attending a USAID-funded partners meeting on February 14, 2012 in Iringa, I became more involved with the work of Jhpiego as a partner to the other USAID funded organizations. Along with creating a network analysis map of the partners and their sub-grantees, I have read their work plans, reports and evaluations to identify potential partners to assist with our current challenge of reaching older male clients. Having a target population of older men, EngenderHealth Champion was the logical strategic partner for Jhpiego.

The EngenderHealth Champion project aims to increase men's involvement in preventing the spread of HIV in Tanzania. It has multiple partnerships in Iringa with grassroots organizations, government authorities and academic institutions. In Iringa, they have trained Community Action Teams (CAT) in community mobilization. Additionally, they have trained peer educators, as part of a work place initiative for HIV prevention, to work with communities on tea plantations. While evaluations of their work are limited, they report active engagement with different populations in the community.

A stakeholder meeting with Jhpiego and EngenderHealth Champion was held on March 1, 2012 to discuss areas for collaboration. A key area of collaboration was the use of EngenderHealth-trained, which work in urban areas in Tanzania including Iringa Town. The CATS would assist in demand creation for older male clients for VMMC service delivery. Jhpiego static sites in Iringa Town are Iringa Regional Hospital (IRH) and Ngome Health Centre, which have both faced low client flow in the past month and would like increase their client flow specifically with older men. CAT in Iringa consists of 20 trained volunteers who are trained in community mobilization and have experience with health messages for adults.

The lead person of the Jhpiego demand creation team organized a half-day training for the CAT volunteers to introduce them to the VMMC work and provide them with referral cards to distribute to potential clients. In the future, these referral cards, which are given to the doctor upon service delivery, would be a method of tracking the success of the volunteers in recruiting clients.

The partnership was piloted as part of demand creation activities for the visit of USAID-mission staff to IRH to observe VMMC static services on March 15, 2012. IRH received 50 clients on March 15, 2012, of whom 30 were over the age of 18. Unfortunately, no referral cards were presented on the day of the service. While it is possible that clients forgot to bring the referral cards—most clients are self-referred, the Jhpiego demand creation team believes that clients heard about services through another mean. Other demand creation activities for this day included radio ads, an announcement on a radio show and advertising by loudspeaker in the regional Tanzania Commission of AIDS vehicle. As IRH has been providing VMMC services since 2009, like many other static sites, it has already reached young clients or low-hanging fruit. Therefore, older clients are more likely to come if properly targeted in demand creation activities.

While the activity in March was successful, in the sense that it brought older clients, it did not provide valuable information on the newly formed partnership. Given the presence of CAT volunteers across Iringa region, Jhpiego still intends to scale-up this partnership during campaign and for its other static sites. Furthermore, in the 2012 Iringa winter campaign, the MC program intends to provide VMMC services at the Tanzania Wattle Company (TANWAT). EngenderHealth Champion, in their workplace initiative trained peer educators in community mobilization at TANWAT. The demand creation team hopes to use these same peer educators in spreading the message about VMMC to older clients.

Use of tool in project management cycle

The partnership strategic matrix tool provided a way to identify the value-added of a partnership between Jhpiego and EngenderHealth Champion. There were several USAID partners who would be able to contribute to the work of Jhpiego; however, EngenderHealth Champion was able to address a current priority, reaching older men.

While the partnership strategy matrix assisted in planning, it was not able to define the quality of the partnership. Specifically, the Jhpiego MC team could not monitor the work of the CATs on the ground in their demand creation efforts. While referral cards were intended to measure the effect of their demand creation work, they were not an appropriate measure. If the Jhpiego demand creation team had not conducted any of its regular activities such as radio advertising, it would also have been possible to determine the effect of the CATs.

From this experience, I believe this framework is better suited for more complex partnerships. Furthermore, an ability to evaluate the partnership needs to be included in the planning. An additional line should be included in this matrix to address evaluation of the partnership.

Figure 6: Partnership Strategy Matrix

Activity Domains (List all)	Training of CAT volunteers	Recruitment of Older Clients	VMMC Service delivery at IRH	
	<ul style="list-style-type: none"> CAT volunteers selected DC team trains volunteers DC team provides volunteers with referral cards 	<ul style="list-style-type: none"> CAT spread message about VMMC in the community CAT emphasize the benefits of VMMC for older men CAT distribute referral cards to interested individuals 	<ul style="list-style-type: none"> VMMC clients receive services at IRH Service providers collect referral cards 	
Actors	<p><i>Strategic Partners:</i> Jhpiego MCHIP Demand Creation Team (DC), Engender Health Champion CAT</p> <p><i>Boundary Partners:</i> Iringa Regional Hospital Service Providers</p>			
Process Factors (Typically 3-5 factors)	Targeted messaging	Community partnership building		Active mission focused work
	<ul style="list-style-type: none"> Through this partnership, health messaging is more targeted as Engerhealth deliver timely/appropriate info on VMMC and DC reach their target audience 	<ul style="list-style-type: none"> The collaboration between these two organizations has external effects such as encouraging other organizations to partner 		<ul style="list-style-type: none"> Both organizations become more active in reaching their project mission through the partnership
Value-Adding Mechanisms (List and describe top 3-5)	Improves reach in the community	Include community members	Targets messaging for older clients	Partnership between USAID-funded NGOs as requested by USAID
	Jhpiego DC activities benefit from EngenderHealth’s experience in targeting an older population in the community	EngenderHealth Champion volunteers become more active in the community and Jhpiego reaches a new population	Jhpiego tries a new strategy for overcoming demand side barriers of reaching older men	Jhpiego and EngenderHealth spearhead the initiative to strengthen partnerships between USAID-funded NGOs
Impact on Service Coverage and Quality(Describe)	This partnership improves the reach of the VMMC program to its target population of older men and contributes to the work of EngenderHealth Champion to increase men’s involvement in preventing the spread of HIV			

Deliverable 6: Introduction of Inflow for Supply Chain Management

Module 1: Collaborative Technology for Project Management

[Inflow, a collaborative technology, was introduced to Jhpiego to improve supply chain management]

Background

Supply chain management specifically in HIV/AIDS programming can determine the success or failure of a program. Components of supply chain management include forecasting, identifying vendors, procuring commodities, managing the store of commodities, issuing commodities and auditing the use of commodities.

Challenges in supply management include stock outs, wasting of commodities due to expiry and incomplete distribution.

Male circumcision programming requires a long list of items and commodities for the successful completion of its activities. As Volunteer Medical Male Circumcision (VMMC) programming in Eastern and Southern African is scaled up, it becomes even more important to have smooth supply chain management given a higher demand for the same resources.

As a USAID-funded VMMC partner in Tanzania, Jhpiego orders certain commodities through the PEPFAR supply chain management system (SCMS). Given that the VMMC program is directly implemented through the government, Jhpiego must also work with the Government of Tanzania (GoT) to ensure that procurement of commodities follow the GoT guidelines. Therefore, there are many times during supply chain when there can be a complication that leads to a delay, for example: availability of commodities from PEPFAR, unforeseen changes in guidelines by the GoT, poor forecasting and/or monitoring of the store of commodities. The latter complication is avoided through the use of efficient and transparent inventory tracking programs.

Current Situation

Jhpiego uses a store ledger along with good requisition, store issue and delivery notes to track the inventory in its store. An Excel document captures the total of each item in each store. For forecasting, a separate Excel document is used, which has the formulas for the number of each item needed based on the VMMC activities and annual targets. Procurement is controlled from the Dar Es Salaam office.

Due to the expansion of the Jhpiego VMMC programming in Tanzania, there are now four operating stores for Jhpiego VMMC activities. These stores are in Dar Es Salaam, Iringa, Njombe and Tabora. The constant movement of items makes it difficult for the individual in charge of procurement, who is based in Dar Es Salaam, to keep track of the inventory in all stores. Additionally, there are no appointed store persons in the stores of Iringa, Njombe and Tabora; instead, it is an office manager who must keep track of the movement of items for the store in their office. During VMMC activities, which result in

high movement of items in and out of the store, an additional person is based in the store to control the movement.

A challenge in past VMMC activities has been the timely distribution of items to the health facilities, which delays the start of the VMMC activity. Specifically, in the November-December 2011 Mini-Campaign, many sites were delayed by a week due to the late arrival of items arriving from Dar Es Salaam. Furthermore, during the Mini-Campaign, the appointed store person did not receive training on the management of the store, which led to challenges in the monitoring and tracking of inventory.

Rationale

Based on past challenges and its continued growth, the VMMC Jhpiego team is focusing resources to improve supply chain management. One of our high priorities for improving the supply chain management is accurate tracking of inventory movement, which would improve our ability to forecast commodities to be ordered.

While waiting for technical assistance from the USAID PEPFAR SCMS team, I piloted Inflow, an inventory tracking program, during the February and March 2012 VMMC outreach activities. We were looking for a program that could work within our current system of good requisition, store issue and delivery notes, while allowing us to track movement of items remotely, to be used by multiple users at the same time, to notify us when items need to be re-ordered and to provide easy to read reports about inventory.

Pilot of Inflow

In preparation for the February 2012 VMMC outreach activity in Kilolo, I was assigned along with a doctor on the VMMC team to conduct a physical count of the items in the store in Iringa and Njombe. Following this lengthy activity, we submitted to Dar Es Salaam the updated inventory list, which was compiled to create a combined list that included the inventory in Dar Es Salaam, Iringa and Njombe. At that time, no items had been sent to Tabora. My experience counting inventory with the doctor was invaluable as it gave me additional insight to the daily use of each item. Therefore, during outreach activities, as the appointed store person, I was able to distribute and appropriately monitor the flow of items.

For the pilot of Inflow, I transferred all the data in the Excel document to Inflow. The basic package from Inflow can be downloaded for free from the internet; however, its use is limited. Therefore, I upgraded to the premium edition for a limited trial, which gave me more options, specifically the inclusion of an unlimited number of items in my inventory database. Inflow can be personalized, which allowed me to revamp a typical inventory tracking program for a business to our use as a store of commodities. For example, I changed the business language of sales quotes to good requisition, sales order to store issue and client to health site.

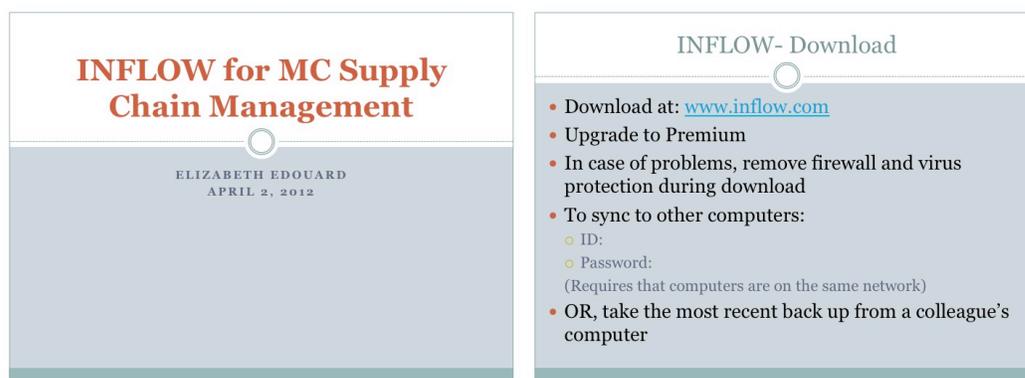
The pilot of the program was successful in that it gave me up-to-date information based on orders and distribution of items. Additionally, if a store issue note was written outside of the program, I was able to upload the information and scan the hard copy of the store issue note. Unfortunately, the multi-user mode did not function as expected as I was in the field office and on a different network from the procurement person in the Dar Es Salaam office. However, Inflow provided easy to read reports that I could email to the Dar Es Salaam office.

There were still challenges in the supply chain management given that many items were taken from outside the store and were delivered to sites, without ever entering the inventory database of the store. Additionally, miscounting of items or the delivery of items without a store issue note created a challenge in knowing the exact number of items in store. And, ultimately, the changing of the HIV testing algorithm led to a shortage of HIV test kits across the country, and therefore, a lack of HIV test kits at our outreach health sites.

Explanation of Inflow

After piloting Inflow and determining its positive impact on our supply chain management, I developed a PowerPoint presentation that provides step by step instructions on its use. I walked through this PowerPoint presentation with the relevant individuals who would be using the program and I distributed a copy of the presentation to all members of our VMMC team. Several challenges remain to be resolved in the supply chain management of Jhpiego's VMMC program; however, the introduction of Inflow has improved transparency and accuracy of tracking movement of items from the stores.

Figure 7: Presentation of Inflow



Main Features (Home Page)

- Inventory
- Good and Requisition
- Store Issue
- Health Site
- Vendor
- Procurement

Inventory

- **Inventory list**
 - Search by location or item
- **Add item**
 - Specify item details including unit, number in each location, when to alert for re-stock...
 - Save item
- **Transfer item**
 - Between Dar Es Salaam, Tabora, Iringa and Njombe
- **Adjust stock**

Good Requisition Form

- **Specify Health Facility**
 - Fill in details about site manager
- **List all items**
 - Red Exclamation will appear if item is out of stock
- **Optional: Add note**
- **Export or Print**
- **Finalize order then transfer to store issue note**

Store Issue Note (1)

- **Revise store issue note**
 - Note: Ensure order is accurate and does not solely reflect the good requisition form
- **Number store issue note**
- **Enter items in Pick List**
 - Specify store
- **Export or Print Pick List (It does not have prices)**
 - Add line for Issued by/Received by and signature
- **Send to site**
- **When the signed copy of the store issue note returns to the store, select complete order**
 - Items will be deducted/transferred from inventory

Store Issue Note (2)

- **At the end of an MC activity, when items (especially equipment) return to the store:**
 - Go to the store issue note and use the **RETURN** and **RESTOCK** functions
- **All hard copies of signed store issue notes/delivery notes should be scanned and attached to the soft copy on the inflow server**

Vendor/Procurement

- **Add vendors**
- **This function has not yet been tested**
- **(To be discussed)**

Reports

- **Report of inventory by store or by item**
 - No need for excel document
- **Report of inventory movement**
- **Count sheet**
 - Useful for comparison when conducting a physical count
- **Other reports available**

Challenge: Multi-User mode

- **All computers must be on the same network for multi-user mode**
 - Store personnel are in DSM, Iringa, Njombe and Tabora
- **It is possible to link computers on the internet**
 - Internet connectivity is poor and unreliable
 - Complicated feature
- **Possible solution:**
 - Save back ups and email the information (It would also serve to check and balance the movement of items)
 - OR, email reports of inventory

Deliverable 7: Mapping Exercise for Strategic Planning

Module 3: GIS

[Mapping of health facilities and programmatic data in the context of population at the ward level informed programmatic planning]

Background

Geographical Information Systems, or GIS, a computer-based software offers the ability, through the input, output and manipulation of data, to spatially visualize information mainly in the form of maps that reveals different patterns and relationships. The power of a tool, such as GIS in work by organizations, spans the scope of most work, given that the visualization of information can increase knowledge and capacity for any task. For an organization, having better information can improve its capability to deliver services in both normal situations and emergencies. One of the main limitations to GIS work is access to data.

Prior to joining Jhpiego, I assisted in the management of a USAID MEASURE project, which was collecting spatial data on health facilities and HIV hot spots in the Iringa region in Tanzania to use in assessing the coverage HIV prevention activities implemented by USAID-funded partners. Jhpiego, as one of the USAID-funded partners, was granted access to the data that were collected. Unfortunately, as the data was collected in 2010, when Jhpiego had only completed about 10,000 circumcisions—compared to the current number of 70,000 – it did not offer valuable information for programmatic planning.

Having limited experience in GIS, I volunteered to add Jhpiego's data to the current spatial data to create maps that would be useful in monitoring and evaluating our work, selecting sites and gaining a better sense of the population distribution in Iringa region. After collecting coordinates for missing health facilities from the original data and projecting the 2002 population for 2012, I developed a series of maps with health facilities and the number of MCs done disaggregated by age overlaid on ward level population data disaggregated by age.

Originally, I intended to use the data that had been collected by the MEASURE team. However, in my last month of work, I identified two alternative sources, Jhpiego MAISHA program and Government of Tanzania, which provided more reliable and extensive data. Furthermore, they provided me with data on health facilities in Tabora, which enabled me to produce maps with our programmatic data overlaid with ward level population data and roads to assist in our initial scale-up planning of VMMC in Tabora.

Findings

The preliminary findings from the mapping exercise were tailored to inform site selection for the VMMC 2012 winter campaign held in June and July 2012. The sites selected

based on the mapping exercise focus on areas in the region with a large population that had not yet been reached with VMMC services, as shown in Figure 8.

The mapping exercise also highlighted the areas, in which the USAID combination prevention study would be taking place from June 2012 to June 2015. Internal decisions with regard to programmatic planning remain to be made with respect to the timing of the scale-up of VMMC activities and the launch of study.

In the context of monitoring and evaluation, findings showed that VMMC service delivery sites had strategically been selected in areas with a large and dense population. Age disaggregated maps illustrated that many older men, especially in the 20-24 age bracket, remain to be circumcised across the region. Other findings and recommendations will remain internal to the Jhpiego MC team.

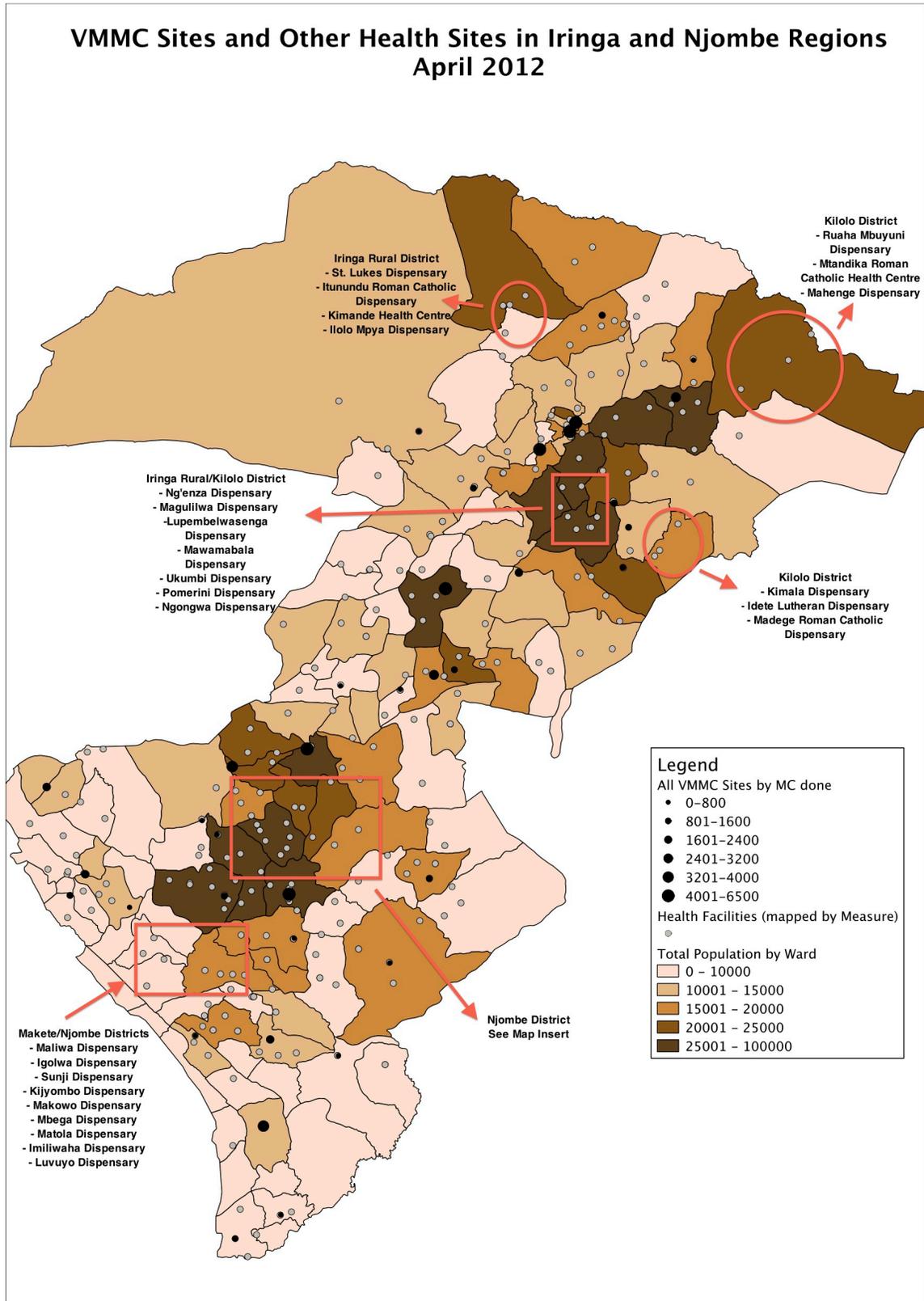
Use of Tool in Project Cycle

In prior years, site selection was determined based on recommendations by the Regional Medical Officer and District Medical Officer. After expressing appreciation and awe about the information contained in the maps, one of my co-workers told us all cautiously, “If this map is accurate, it will change the way we conduct site selection!” This statement proved to me the value of GIS and in this case, the work that I had completed. As I write this report, two other co-workers are in the field visiting the sites mentioned on the map to assess their capacity as VMMC service delivery sites.

Some of the maps have also been shown to visitors providing technical assistance to the MC program, government officials enquiring about the MC program and our colleagues at USAID who fund our program.

In my limited time in the Dar Es Salaam office, I am training colleagues, especially on the monitoring and evaluation team, how to use in QGIS, the free alternative to ArcGIS, to ensure continuity of the work.

Figure 8: Map for site selection 2012



Case Study

[This case study explores issues in the current scale-up of the VMMC program]

Jhpiego, VMMC Program in Tanzania: A Case Study on Scale-Up

Elizabeth Edouard
Monterey Institute of International Studies
Spring 2012

Acronyms

- Voluntary Medical Male Circumcision (VMMC)
- United States Agency for International Development (USAID)
- President's Emergency Plan for HIV/AIDS (PEPFAR)
- Early Infant Circumcision (EIC)
- Male Circumcision (MC)
- Tanzania (TZ)
- Government of Tanzania (GoT)

Context

- VMMC scale-up in 13 priority countries in Eastern and Southern Africa (High HIV prevalence and low levels of MC)
- Provision of 80% VMMC coverage in these 13 countries could avert 4 million new HIV infections by 2015
 - Target: 20.3 million circumcisions among men 15-49 years of age by 2015
- PEPFAR-funding for *emergency* activity
 - Not expected to be sustainable at this caliber

Context in Tanzania

- Implementation of national strategy for scaling up male circumcision (2010-2015)
- First Phase: Implementation in 8 priority regions (Mbeya, Iringa, Shinyanga, Rukwa, Kagera, Tabora, Mwanza and Mara)
 - Second Phase: Implementation in other regions of low MC prevalence rates and/or high HIV prevalence
 - Third Phase: Routine implementation of neonatal circumcision
- Goal: 2.8 million circumcisions among men 10-34 years of age by 2015
 - Priority: 10-24 year olds
 - Second Priority: 25-34 year olds

Jhpiego VMMC Program

- Implementation of VMMC in Iringa and Tabora regions through the GoT
- Service delivery styles: campaign (annual in winter), outreach (remote sites), static (year-round sites)
- Total MCs done to date:
 - Iringa: ~71,000
 - Tabora: ~6,000
- Developed with GoT a national monitoring and evaluation system for VMMC

Scaling-up of VMMC

- Past scale up in Iringa Region:
 - Pilot in 2009:
 - Campaign in 2010: 10,352 MCs
 - Campaign in 2011: ~30,000 MCs (Iringa Region)
 - 2012: 1 mini-campaign, 2 outreach activities, 1 winter campaign (Iringa)
- Planned scale up (targets):
 - Continued scale up of VMMC in Iringa (60,000 MCs in 2012)
 - Increased MCs in Tabora (10,000 MCs in 2012)
 - Increased MCs of men 20+ years old
 - Pilot of Early Infant Circumcision (EIC)

Priorities/Interests

- USAID
 - Reaching older male clients in VMMC service delivery to reduce current HIV prevalence in Tanzania
 - Initiating EIC services in Tanzania to remain cutting edge in the VMMC field
 - Demonstrating success of VMMC, as a low-cost HIV prevention approach
- Government of Tanzania
 - Reducing HIV prevalence
 - Ensuring sustainability of VMMC
 - Provision of services that are suitable in the country context
- Jhpiego
 - Implementing VMMC services and reaching USAID targets
 - Training government providers to ensure sustainability of services
 - Developing appropriate monitoring and evaluation tools to track coverage

VMMC Scale Up: Challenges

- Adequate resources
 - Funding, office/store space, political support, staff
- Divergent priorities/Managing expectations
 - Older men
 - EIC
- Logistics (ex: commodities)
 - Internal communication
 - Supply chain management difficulties
 - Fast expanding program (growing pains)
 - Large geographical area

Issue Analysis: Scale Up with Limited Resources

Given limited funding and high expectations from USAID and GoT, how can Jhpiego best use its current resources to scale up VMMC in Tanzania in the context of reaching its targets?

Best Practices in Scale Up¹

- **Achieve clear understanding of model's core elements**
- **Avoid dilution of quality over time**
- **Achieve proper balance between preserving original model's essential properties and local adaptations**
- Important qualities of scale-up:
 - Stakeholder ownership
 - **Alignment of attitudes and culture**
 - Effective communication
 - **Clear, specific, agreed upon goals and outcomes**
 - **Strong plans (Well-implemented, closely monitored to distinguish between what's "on the ground" and to make needed mid-course corrections)**
 - Supportive policies and laws
 - Evidence of strong outcomes, quality, high potential
 - Adequate resources (\$ and others)
 - **Strong leadership (champions)**

1. Levinger, Beryl. "ip514f09_3" *Managing SCOs*. Fall 2010

Scale Up: Reaching Older men

A majority of MC clients have been 10-18 years old (low hanging fruit). Older men are a difficult population to reach (high hanging fruit). Therefore, it is more expensive programmatically to target older men. To reach 80% of the population, Jhpiego will have to circumcise older men during its program cycle.

Current position of stakeholders:

- USAID has prioritized older men, as the target audience for VMMC
- GoT has prioritized 10-24 year olds, as the target audience for VMMC
- Jhpiego has to meet its annual USAID targets of MCs (no age specification, yet)

Information hole: Are there quick wins in reaching older men? Would USAID accept a lower target if a certain percentage of MCs were older men?

Recommendation: a) Service providers should better inform Jhpiego VMMC program management of strategies that have worked to attract older men. For example, older men in a number of static VMMC service delivery sites requested services in the evening to ensure that no one in the community especially women would see them. b) Jhpiego should discuss with USAID the importance of reaching low hanging fruit in this fiscal year and scaling up to reach older men after more research has been conducted on quick wins

Scale Up: Pilot of EIC

Currently, Jhpiego is implementing VMMC for clients 10+ years of age. The inclusion of EIC in VMMC service delivery is normally scheduled when a program reaches maturity, which is measure by almost complete saturation of target population

- USAID believes VMMC in Iringa is reaching maturity and has indicated a pilot of EIC as a priority for scale up of VMMC in Iringa
- GoT has not yet been consulted in planning for EIC in Iringa region
- Jhpiego is stretched thin given scale up of VMMC in Tabora region

Information Hole: What are the policies and resources that need to be in place to implement EIC?

Recommendation: a) A priority of Jhpiego should be to discuss EIC with the GoT, especially in the context of developing stakeholder buy-in. b) Avenues for implementation of EIC should be further discussed, in the context of challenges in sustainability at health facility level.

Lessons Learned

- Manage expectations of donors in rapid scale up
- Use “on the ground” information to plan and scale up programs to ensure feasibility
- Prioritize buy-in from the government in programming
- Quality of the program should be monitored, especially in cases of rapid scale up
- The leader in the scale up of programming must take responsibility for maintaining quality and ensuring consensus from all stakeholders throughout the process

References

- Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R, et al. (2005) Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 Trial. PLoS Med 2: e298. Doi: 10.1371/journal.pmed.0020298.
- Bailey RC, Moses S, Parker CB, Agot K, Maclean I, et al. (2007) Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial. Lancet 369: 643–656.
- Fimbo B, Samky E, Machaku M. (2012) SYMMACS: Systematic Monitoring of the Male Circumcision Scale-Up in Eastern and Southern Africa- Tanzania Country Progress Report.
- Gray R, Kigozi G, Serwadda D, Makumbi F, Watya S, et al. (2007) Male circumcision for HIV prevention in men in Rakai, Uganda: a randomized trial. Lancet 369: 657–666.
- MCHIP. “MCHIP Vision and Strategy” <http://www.mchip.net/node/13>. Accessed April 3, 2012.
- Plotkin M, Kuver J, Curran K, Mziray H, Mahler H, Prince P et al. (2011) Embe Halijamenywa: The unpeeled mango- a qualitative assessment of views and preferences on VMMC in Iringa region-Tanzania.