Using the Decision-Makers' Programme Planning Tool for Male Circumcision Service Scale-up

Dakar, Sénégal
2-3 December 2008

MEETING REPORT

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

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Introduction

There is compelling evidence that male circumcision reduces the risk of female-to-male transmission of HIV. UNAIDS and WHO recommend that countries with high HIV prevalence and low levels of male circumcision introduce or scale up safe male circumcision services as part of a comprehensive HIV prevention strategy. Through a joint work plan on male circumcision, the United Nations (WHO, UNAIDS, UNFPA, and UNICEF) have developed operational guidance to assist and guide countries in developing policies and strategies for scaling up male circumcision services. The guidance on comprehensive approaches to male circumcision for HIV prevention includes a surgical manual and training modules, quality assurance guidance, a situational analysis toolkit, a self-assessment tool on legal and regulatory issues, a communications framework, and a monitoring and evaluation framework.

The Decision-Makers' Programme Planning Tool, which is part of the operational guidance, was developed by UNAIDS and Futures Institute under the USAID Health Policy Initiative. It supports policy development and planning for scaling up male circumcision services and allows analysts and decision makers to understand the costs and impacts of policy options. The tool has been applied in some countries and this meeting provided an opportunity for countries to share their experiences with its use.

Objectives of the meeting

Overall objective of the meeting:

- To provide a forum for countries to share results from use of the Decision-Makers' Programme Planning Tool and its components and to learn from the experiences of others.

Specific objectives of the meeting:

- To create a mutual peer-learning environment in which countries can inform and inspire each other about how and when the Decision-Makers' Programme Planning Tool can be used to inform decisions about whether and how to scale up male circumcision services for HIV prevention.
- To facilitate presentations by country technical persons of their experiences conducting facility surveys for costing analyses and using the tool for impact estimation. The meeting offers country decision-makers an opportunity to present their experiences using the output from the tool to guide their country's policy making and strategic planning.
- To build capacity among national AIDS programmes so they know what steps are needed if they wish to move forward with using the tool, and how they may request and obtain technical assistance.

Meeting participants

Eleven countries from the Eastern and Southern Africa region[1] were represented at the meeting. Each country was represented by 1-3 persons: A decision maker/programme manager who would be most likely to be able to use the tool outputs in assessing various programming options and/or a technical person with Microsoft Excel, costing or quantitative expertise best placed to populate and run the tool. The latter would usually be in the Ministry of Health while the decision maker/programme manager could be from

[1] Botswana, Kenya, Lesotho, Malawi, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. Mozambique and Rwanda were unable to attend.

the either the Ministry of Health or the National AIDS Commission. In addition there were representatives from UNAIDS, WHO, the Futures Institute, USAID Health Policy Initiative (HPI); and the Technical Support Facility (TSF) for Southern Africa. The full list of participants is shown in Annex 1.

Brief description of the Decision-Makers' Programme Planning Tool

The Decision-Makers' Programme Planning Tool is populated with country-specific data on demography (from the UN Population Division or Census data), sexual behaviour (from Demographic Health Surveys), HIV prevalence (from Antenatal Clinics or Demographic Health Surveys), and cost (data from the Ministry of Health or clinic costing studies, or using default values derived from costing information collected in similar countries).

The tool allows analysts and decision-makers to understand the costs and epidemic impact of various programming choices, for example, intended target population by age (newborn, adolescent, adult) and risk (e.g. sexually transmitted disease clinic attendees, seronegative men in discordant partnerships); service delivery mode (hospital, clinic, campaign); service provider type (surgeon, family physician, clinical officer); pace of scaling up (for example linear. slow, fast, S-shaped); and coverage target (for example 70% in 3 years, 80% in 8 years, 90% in 5 years). The tool takes into account adverse events; ancillary services (HIV testing and counselling; gender sensitivity programmes, public communication campaigns); and potential risk compensation (increased number of sexual partners, decreased condom use).

The tool calculates the cost of male circumcision services by delivery mode based on clinical guidelines and locally-derived inputs on staff time and salaries, supplies, equipment, and shared facility and staff costs. It estimates the epidemic impact using a transmission model, fitted to surveillance data describing past prevalence trends, that calculates new infections by age and sex as a function of the current force of infection, coverage levels, and speed of scale-up. The tool incorporates sensitivity analysis for key inputs, including the impact of male circumcision on women. The tool estimates AIDS deaths, the number of infections averted, the cost per infection averted, and overall costs of different male circumcision programming options.

The flexibility of the tool allows for the incorporation of cost values in both local currency and US dollars, to accommodate the fact that several countries within region have fluctuating exchange rates.

Using the tool involves a number of steps. First, a technical team is selected. Then, historical and current epidemiological and behavioural data are collected and used to set up an impact model. Cost information is collected at central and facility level, and the cost per male circumcision performed is then determined. The cost and impact of alternate strategies are analyzed and the results are then used to conduct dialogue with stakeholders and decision-makers.

Country experiences

A number of countries have already used parts of or the entire tool. Some countries have completed detailed cost analyses; others have run the impact component of the tool; and others still have used the results to inform and guide decision-makers and programme planners.

Costing

Zambia

A costing study was carried out in 2007 by Constella-Futures in collaboration with Jhpiego. Direct and indirect cost data were collected retrospectively through interviews with clinical and administrative staff in the Ministry of Health, at health facilities (University Teaching Hospital, Livingstone Hospital, and private clinics offering male circumcision);and with implementing partners, such as Society for Family Health and Health Communication Partnership on male circumcision messaging and Jhpiego on male circumcision delivery and training. Representatives of WHO, UNFPA, UNAIDS, the Prevention and Sexual Transmission Working Group at the National AIDS Council, and the Male Circumcision Task Force were also interviewed.

When estimating the cost of male circumcision the following components were included:

- an initial visit for pre-surgical education, counselling and examination (manpower; counselling aids; test kits; information, education, and communication (IEC) materials; and stationery);
- a second visit for the surgical procedure under local anaesthesia (pre- and post-operative analgesics, local anaesthetics, surgical supplies and equipment, manpower, stationery, and antibiotics);
- two follow-up visits at 2 and 7 days post-surgery (manpower, surgical supplies and equipment, stationery, and IEC materials); and
- a fifth visit at one month (manpower and stationery).

The cost per male circumcision was estimated at US$ 47 with surgical costs taking up 77%, communications 16%, testing 4%, and pre- and post-operative counselling 3.5%.

Lesotho

The Lesotho costing study was also carried out by Constella-Futures and included 10 key informant interviews with health providers, government officials, donors, faith-based organizations (FBO), civil society organizations (CSO), other non-governmental organizations (NGO), and traditional healers. The study focused on adult male circumcision only. It considered different types of service provider (public, NGO or FBO), health facilities (district hospitals, referral hospitals, health centres), and geographical locations (rural, urban); as well as direct and indirect costs related to complications.

The cost per male circumcision was estimated at US$ 56. The proportions of the cost relating to the surgery, communications, testing, and pre- and post-operative counselling were comparable to the figures for Zambia.

Swaziland

A costing study done by Constella-Futures estimated the cost per male circumcision at US$ 51.

In addition, Swaziland conducted a costing study based on one “circumcision Saturday”. Six doctors (4 surgeons and 2 physicians in pre- and post-operative care and recovery), assisted by 5 nurses, circumcised a total of 40 males on 4 surgical tables in an 8 hour period. Pre-surgery counselling, surgical procedure, and post-surgery counselling were included into the costing analysis.

The cost per male circumcision on a “circumcision Saturday” was estimated at US$ 82. The actual cost was higher because many of the typical costs and supplies were waived, donated or deeply discounted. Counselling was provided at no cost by Population Services International (PSI); compensation to physician and nurse staff was at less than the usual rate; 3 project managers organized the event at no cost; translation, fuel, and phone costs were not included; administration costs were borne by the National Emergency Response Council on HIV and AIDS (NERCHA). Minimal marketing was undertaken to avoid a high turn out by clients.

Over 2,000 men have now been circumcised on “circumcision Saturdays” with minimal complications making them stakeholders in the HIV prevention response.

Discussion

In this costing exercise it was felt that clearly stated assumptions are necessary. There is a range of costs in various settings (urban versus rural) and according to different models of scale-up (integrated versus vertical). It was noted that data quality checks when collecting data for this costing exercise are important.

The costing of male circumcision appears to be mainly for the procedure conducted by a surgeon. Service providers need to be expanded to include other cadres such as nurses because the availability of surgeons in most settings is limited. The cost of communication needs to include the community mobilization which was viewed as an essential component. Infrastructure costs are included as indirect costs because most of the facilities being used for the service are already established. Other factors that inflate unit costs need to be taken into consideration. One related suggestion was that training for male circumcision services could be integrated with other HIV prevention-related trainings, such as PMTCT.

It was noted that the timed duration of the procedure was different in diverse settings, with the longest duration reported as up to 1 hour in Zambia. In addition, though the schedule of follow-up visits differed in each of the three countries in which the costing was done, there was a consistently high percentage of defaulters on the last scheduled visit. The age of the clients in these countries was from 15-49yrs. The circumcision of younger clients was not considered, even though most countries are including this age group as part of a longer term strategy.

The methodology used for the costing of the one day circumcision service in Swaziland was different and, therefore, not directly comparable to that of Zambia and Lesotho. As a result, it was felt that the costing of the provision of male circumcision services using this vertical delivery method may not apply in other settings. As with Lesotho and Zambia, the costing did not include male circumcision services provided in the traditional sector. Although Swaziland is primarily a non-circumcising culture, Zambia and Lesotho do need to consider the issue of safety within the traditional sector.

Use of the tool

Namibia

The 5-step plan for male circumcision policy and programming in Namibia included 1) a desk review of available male circumcision data and mapping of service delivery facilities, 2) qualitative research on male circumcision acceptability including key informant interviews and focus group discussions, 3) a facility readiness survey, 4) an analysis of the costing and impact of rolling out male circumcision, 5) and a stakeholders' meeting to share results and develop a draft policy and a draft action plan.

The unit cost per male circumcision was calculated using information on services and share of facility time devoted to circumcision, cost of personnel, cost of drugs and supplies, and cost of equipment, as well as costs of overhead, support personnel, management, and supervision. The cost per male circumcision was estimated at US$ 80 for adults and US$ 68 for children.

The impact component of the tool projected that rolling out a male circumcision programme targeting all adult males and adolescents prior to sexual debut, reaching 80% coverage by 2015, would require a large number of circumcisions to be performed during the scale-up period (rising from 15 to 500 per day), followed by a constant but much lower number of circumcisions (60 per day) to maintain a steady state. It was projected that up until 2025, 661,000 male circumcisions would need to be performed at a total cost of US$ 52 million and would result in 77,000 HIV infections averted.

When factoring in the savings from expenditure for antiretroviral therapy, the net savings per infection averted would be US$ 6,500-7,000 resulting in total savings of approximately US$ 540 million during the period 2009-2025. HIV incidence would decrease by 47%, from 1.7 to 0.47 per 100 per year.

During the stakeholders' meeting held in Namibia in August 2008 the figures enabled stakeholders to see the potential cost savings and impact of rolling out a male circumcision programme. The ability to relate different priority groups and scenarios for scale-up to the needs for training and financial and human resources assisted the country in identifying the optimal combination of target population, roll-out speed, and coverage level. Based on these findings the Male Circumcision Task Force plans to submit a Male Circumcision Policy and Action Plan to the Ministry of Health and Social Services in December 2008, which will then be presented to the Parliament in early 2009.

From this experience of using the tool country representatives felt that understanding the details of the model can be challenging, and that substantial technical expertise is required. There is a need to produce a simple and clear presentation to government officials, experts in the country are needed to determine if the assumptions are appropriate for the country, and it is important to have someone in the country that understands and is able to explain the models. Despite the challenges with use of the tool the country thought it provides very useful information for decision-making.

Botswana

The plan for male circumcision programming in Botswana consists of a 6-month preparatory phase, a 12-month transition phase, and a 5-year implementation phase. The preparatory phase included a situation analysis using components of the WHO Situation Analysis Toolkit, and a costing and impact analysis using the Decision-Makers' Programme Planning Tool conducted under technical guidance from external consultants.

The results informed the development of a national male circumcision strategy. This is an add-on strategy which is a component of the comprehensive HIV prevention policy. No specific male circumcision policy was developed. The country has made a decision to roll out male circumcision to 0-49 year old HIV-negative males, reaching 80% coverage in 5 years.

Uganda

The effect of male circumcision on HIV prevention is now widely known in Uganda, and there is public demand for government action. However, a cautious approach is being taken to avoid a situation where a policy is announced before the health system is ready to absorb the turn-out of clients. A number of milestones need to be met:

- A transparent consensus building process must be ongoing using multiple strategies
- A situational analysis needs to be conducted to gauge acceptability of and health systems capacity for male circumcision
- A communication strategy for male circumcision must be drafted to facilitate effective and accurate communication, and
- A National Task Force for male circumcision must be formed to spearhead male circumcision policy development.

To bring all stakeholders on board, the results of all male circumcision research have been disseminated, national and regional consensus building workshops have been held, stakeholders have been briefed (religious leaders, media houses, traditional circumcisers, etc), and there is a national debate on male circumcision including talk shows on radio and TV stations. All is now set for modelling of the cost and impact of male circumcision in Uganda, which will be a joint work of the Ministry of Health, Makerere University School of Public Health, and the Futures Institute.

The process will start with data collection and search for key references, including referring to the work that has been done in Lesotho, Swaziland, Zambia, Namibia, and Botswana. The model will then be populated and run, and the results will be presented at an academic forum before presentation to key stakeholders. The National Task Force for Medical Male Circumcision will be re-launched and will start an active policy development process, accompanied by active programme planning, resource mobilization, and capacity building. Male circumcision for HIV prevention will be introduced as part of the ABC+ strategy – not as a stand-alone strategy – and the programme is likely to be launched in 2009 when the policy is finalized.

The identified challenges include the vast variation by district of male circumcision prevalence across the country. The north and central provinces, generally, have a higher prevalence of male circumcision. Other concerns are that the current health infrastructure, including the human resources for health, may not be able to support the scale-up of male circumcision. Further challenges are that communications on the risks and benefits of male circumcision are not always accurate and circumcisions that take place in the traditional sector are not always safely conducted.

Efforts to scale up male circumcision in Uganda are slow and are a challenge, as compared to the experience in rolling out HIV prevention programmes in the 80s which was much more successful. The political will and support for the former has been varied.

Discussion

The outputs of the tool were regarded as useful for advocacy directed to politicians. Particularly important components of this advocacy are the savings per HIV infection averted and the total cost savings of male circumcision compared to antiretroviral therapy. The amount of the savings makes them politically attractive, regardless of the period of time over which these savings will take place. It is important to continue to collect and publish data on the impact of the scale-up of male circumcision. Governments need to have a strategic plan for financing male circumcision service scale-up, given concerns about available domestic and external funding for health and health-related programmes.

The data collection process for input into the tool may need to be simplified. Some of the data would already be available from the institutional mechanisms in place. However, a simplified tool for data collection may be necessary so that it can be used at the lowest level of health care provision.

Surgeons conduct the services among both HIV-negative and HIV-positive individuals, but the costing and modelling is based on circumcising HIV-negative individuals only. Those that still want the services are not denied the service. The time frame for the application of the tool is approximately 1-4 months.

Technical support

Technical assistance for different steps in the male circumcision for HIV prevention programming cycle is available from various sources including the Technical Support Facility (TSF) for Southern Africa, the TSF for Eastern Africa, Futures Institute, Health Policy Initiative, Jhpiego, UNAIDS, and WHO.

The TSF works within the thematic areas of prevention; gender; harm reduction; men who have sex with men; sex workers; and crisis, conflict, and humanitarian issues. The Facility can provide technical assistance for planning (including costing and budgeting), implementation, management, monitoring and evaluation of programmes; organizational development; and proposal writing for the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM). Another separate area is GFATM implementation support.

UNAIDS/TSF has a database of 400-1,000 consultants per region and has provided over 10,000 days of consultant services per year. TSF consultants could potentially assist with all the tools available for male circumcision planning and programming, including the Decision-Makers' Programme Planning Tool. Technical assistance from TSF can be accessed through the UNAIDS country office and/or the UNAIDS Regional Support Team to allow pro-active planning of support. The UNAIDS Technical Assistance Fund (TAF) has some funds which can be accessed through this mechanism.

Apart from the TSF there are other sources of support. The Health Policy Initiative (HPI) is funded by USAID and supported the development of the DMPPT. Funds exist in HPI to expand the use of the DMPPT to other countries. There are also funds available through HPI for health systems strengthening and policy development. The requests for funding need to be country driven, with in-country capacity development.

Jhpiego is PEPFAR-funded and provides technical assistance but not funding. The main area of focus is reproductive health. Currently the organization is implementing regional training on male circumcision in Zambia, as part of the capacity building for the scale-up of male circumcision. The training is conducted over a two week period (didactic for a week and surgical training for 1 week). This work is primarily within the public sector.

Other training components are being considered such as on-the-job training for individuals with some form of surgical background. As Jhpiego does not provide funding, countries need to explore funding opportunities such as the Bill and Melinda Gates Foundation (BMGF) and the GFATM.

The UN Inter-Agency Task Team (IATT) on male circumcision is involved in the development of tools and guidelines. For technical support requests to develop policy, strategy, and implementation plans, governments can also contact the WHO country office, which can assist in identifying the technical support needs. It is also possible to contact individuals within the IATT who will channel requests accordingly.

Country status, plans and future needs

Other countries presented on their current status in male circumcision scale-up, plans, and anticipated future needs.

Kenya

The country has a total population of 37 million people, with an HIV prevalence that ranges from 1-15% across the regions. Approximately 85% of adult males are circumcised, in traditional settings and in the formal health sector. The development of national guidance for male circumcision commenced in 2007 and was recently launched nationally.

The main achievements thus far are the extensive involvement of stakeholders including community leaders and politicians from non-circumcising communities. Politicians have come out in support of the intervention and anecdotal evidence shows a 3- to 4-fold increase in the demand at health facilities.

The proposed next steps are the development of guidelines for the delivery of safe male circumcision services; the inclusion of male circumcision as a prevention intervention in the HIV strategic plan which will include costing of the intervention; health facility assessments; monitoring the knowledge attitude; and practice of the intervention.

Malawi

Male circumcision is practiced in certain parts of the country largely for religious and cultural reasons and to a lesser extent for medical and hygiene reasons. Most of the male circumcisions are conducted by traditional leaders as part of initiation ceremonies.

Three stakeholder consultations have been held and results have been disseminated. There is in principle consensus that Malawi should pursue male circumcision as an add-on option for HIV prevention. Further consultations would be required particularly with traditional and religious leaders, and policy makers. A rapid assessment of both traditional and medical circumcision is being carried out. In addition, a national task force on male circumcision and HIV prevention is being established.

The country is currently conducting a situational analysis which will review, among other things, the acceptability of male circumcision, applicability, feasibility, cost implications and related biomedical, social, cultural, and religious issues. With the completion of the situation analysis there will be the development of a national policy, strategy and operational plans, and resource mobilization.

South Africa

South Africa is currently considering male circumcision as an add-on strategy for HIV prevention. The goal of the national HIV strategy is to reduce new HIV infections by 50% by 2011. The major concern is the safe provision of male circumcision services. A discussion document developed by South African National AIDS Council (SANAC) is being used now in the consultations.

The traditional sector is involved, with consultations taking place in the provinces that perform male circumcision (mainly Limpopo and Eastern Cape). Safety of the procedure in the traditional sector is paramount. Basic recommendations or resolutions came out of a SANAC meeting held on 8th October 2008. Discussions are going on in SANAC about focusing initially on those individuals that are already motivated to undergo the procedure when the services are readily available. In-country flexibility is seen as important.

Tanzania

Not much progress has been made on the scale-up of male circumcision. There is currently an effort to map out male circumcision in the country, most of which is conducted by traditional providers.

A situation analysis underway in three regions, one of which is among traditional circumcisers, is expected to be completed in January 2009. The country is considering scale-up of male circumcision in both the formal health sector and the informal health sector. Clarification at a national level is needed to secure acceptance of male circumcision in the traditionally non-circumcising groups; to identify the role of traditional circumcisers; and to plan the deployment of personnel, supplies, and instruments.

The challenges so far are in the development of policy and guidance and in expanding services and training of service providers to cope with increased demand. In addition, there is a desire to reduce the cost to clients and to introduce neonatal services. There is a pressing need to develop a communication strategy and to develop national guidelines on male circumcision.

The Tanzania Commission for AIDS (TACAIDS) is set to coordinate the efforts. The Ministry of Health and Social Welfare will lead on policy and strategy development. Other sectors will provide support for communication. There is a need to establish a widely representative task force and incorporate messaging relating to women.

Zimbabwe

The situation analysis has been completed and the development of a policy for male circumcision is underway. The resources available for the scale-up of male circumcision are currently from Population Services International (PSI)/Bill and Melinda Gates Foundation (BMGF). WHO and UNFPA have committed funds for the development of the male circumcision policy. Further resource mobilization will be continued. The communication strategy is under development.

Service delivery training is required including on minimum standards, training guidelines, and advocacy and communications. Implementation of male circumcision services will initially be vertical and down to the lowest possible level of the health system. This implementation will progressively be moved to an integrated approach. Central hospitals will provide referral points for these services.

The country has expressed interest in applying the Decision-Makers' Programme Planning Tool.

Discussion

The discussions included broader issues relating to the scale-up of male circumcision.

It was recognized that communication strategies on male circumcision should be targeted at all age groups, and men of differing marital status, through segmenting the population. Serodiscordant couples are an important target group. Furthermore, the use of existing structures and taking advantage of all opportunities are essential to disseminating correct and tailored messages. The discussion of sex and sexuality is an important issue for a family, as is couples counselling to support the male circumcision procedure and to minimize misunderstandings about the need to abstain sexually until complete wound healing, the partial protection conferred by male circumcision, and other issues. Decision-making on accessing male circumcision services is important for both men and women, and messages on the indirect benefits for women need to be included in the counselling. Younger children need to be included in these target populations. Counselling was also seen as an important opportunity for messaging on broader HIV prevention and on male sexual and reproductive health issues. This includes the postponement of the procedure in order to treat active sexually transmitted infections.

The safety of male circumcision in the traditional sector and related HIV prevention messages are an important reason for good collaboration and cooperation between the formal public sector and the informal private sector. Furthermore, even though government needs to be in charge of the roll out of male circumcision, all sectors need to be consulted and agreements on collaboration reached. In some socio-cultural contexts, the appropriate “disposal” of the foreskin is relevant.

It was agreed that in places where the services were being provided at present the gender of the service providers did not constitute a barrier to service provision. Ethical issues relating to the provision of the service were considered to include the number and gender of persons present during the procedure. Furthermore, if the client is uncomfortable with the gender of the individual performing the procedure, it can be postponed.

A high acceptability of the scale-up of male circumcision in countries in the eastern and southern African region was evident but concerns were raised about the available human resources for health. In addition, health expenditure per capita in these countries is not high (estimated at between US$12 and US$42). As a result, sustainable additional resources through the Global Fund to fight AIDS , Tuberculosis and Malaria (GFATM) and the US President’s Emergency Plan for AIDS Relief (PEPFAR), among others, would need to be secured.

Next steps

Countries that expressed interest in the costing and the use of the Decision-Makers’ Programme Planning Tool (for example Zimbabwe and South Africa) are encouraged to request technical assistance to be able accomplish this. Follow-up will be through the UNAIDS/RST and WHO.

The UN/IATT on male circumcision has an upcoming strategic planning meeting in which the anticipated technical support requirements for countries will be consolidated. Prior to this meeting the TSF and UNAIDS will work together to outline a technical assistance plan to include utilising the TSF trained consultants.

Annex 1

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UNAIDS

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