Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa

2012–2016

EMBARGOED FOR TRANSMISSION AND PUBLICATION UNTIL 12:00 NOON CET, MONDAY 5 DECEMBER 2011 (11 AM GMT, MONDAY)

World Health Organization

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

UNAIDS / JC2251E

Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa

2012–2016

EMBARGOED FOR TRANSMISSION AND PUBLICATION UNTIL 12:00 NOON CET, MONDAY 5 DECEMBER 2011 (11 AM GMT, MONDAY)

November 2011

Abbreviations

AU	African Union
BMGF	Bill & Melinda Gates Foundation
CDC	U.S. Centers for Disease Control and Prevention
EAC	East African Community
ICASA	International Conference on AIDS and STIs in Africa
M&E	monitoring and evaluation
MC	male circumcision
MDG	Millennium Development Goal
MNCH	maternal, newborn and child health
MoH	Ministry of Health
MOVE	Models for Optimizing the Volume and Efficiency of Male Circumcision Services
MSM	men who have sex with men
OGAC	Office of the U.S. Global AIDS Coordinator
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
RRI	Rapid Results Initiative
SADC	Southern African Development Community
SMS	short message service
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAIDS/HQ	UNAIDS Headquarters (Geneva)
UNAIDS/RST	UNAIDS Regional Support Team for Eastern and Southern Africa
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VMMC	voluntary medical male circumcision
WHO	World Health Organization
WHO/HQ	WHO Headquarters (Geneva)
WHO/AFRO	WHO Regional Office for Africa

Contents

Introduction

This document articulates a joint five-year framework for use among Ministries of Health (MoHs) and diverse country, regional and global stakeholders to accelerate the scale-up of voluntary medical male circumcision (VMMC) for HIV prevention in selected priority countries of eastern and southern Africa. It is intended to guide key stakeholders to collaborate and coordinate efforts for promoting country ownership, expanding coverage of this effective HIV prevention intervention, and contributing to "getting to zero" new infections. This joint strategic action framework 2012–2016 is consistent with, and aims to advance, the Joint United Nations Programme on HIV/AIDS (UNAIDS) 2011–2015 Strategy, the World Health Organization (WHO) Global Health Sector Strategy on HIV/AIDS, 2011–2015 and the five-year strategy of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). This framework has been developed through contributions from national programmes, Bill & Melinda Gates Foundation, PEPFAR, UNAIDS, World Bank and the WHO.

The joint framework outlines key strategic pillars and activities for both (1) accelerating the "catch-up" phase (i.e. efforts to provide safe medical male circumcision (MC) services, performed by trained health care personnel under hygienic conditions, to uncircumcised adult men [1]) and (2) initiating the "sustainability" phase (i.e. efforts to implement the routine offer of MC for infants and/or adolescents). The term "scale-up" is intended to encompass both the catch-up and sustainability phases.

The aim of the immediate catch-up phase is to rapidly achieve optimal coverage among adult men in age groups that are most likely to be sexually active. The sustainability phase will focus on efforts to reach adolescents who attain the age that has been prioritized for access to services. While the immediate priority is reaching adult men who are currently most at risk of HIV exposure during heterosexual intercourse, and initiating services for adolescents, steps will begin towards integrating the routine offer of medical MC into infant health programmes.

Rationale

Scale-up of early infant, adolescent and adult voluntary medical male circumcision is critically important to reduce the future burden of HIV in eastern and southern Africa. The urgency of bringing VMMC to scale stems both from the continuing large numbers of new HIV infections in sub-Saharan Africa and from the powerful effectiveness of male circumcision in reducing the risk of female–to–male sexual transmission. In 2005 and 2006 randomized clinical trials in three African countries demonstrated that VMMC reduces the risk of female–to–male sexual transmission by roughly 60% [2,3,4]. More recently, population-based data from ongoing research in Orange Farm, South Africa, have shown lower HIV prevalence and incidence (55% and 65% lower, respectively) among circumcised men than among uncircumcised men [5]. Thus, VMMC is an exceptional HIV prevention method, in that it offers life-long, substantial (albeit partial) protection against female–to–male sexual transmission of HIV as well as other STIs.

In 2007 WHO and UNAIDS issued recommendations to implement VMMC in settings with high HIV prevalence and low prevalence of MC. WHO and UNAIDS identified 13 priority countries for scale-up of VMMC: Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe. PEPFAR is supporting activities to implement VMMC in these 13 countries and also in Ethiopia, making a total of 14 priority countries.

Mathematical models demonstrated in 2009 that medical male circumcision is cost-effective, with 5–15 circumcisions averting one HIV infection in high HIV prevalence settings [6]. Epidemiological and economic modelling commissioned by PEPFAR and UNAIDS in 2011 determined that scale-up of VMMC in appropriate settings constitutes a high-impact intervention with excellent value for money [7]. Impact and costing estimates suggest that scaling up VMMC to reach 80% coverage among males 15–49 years old in the 14 priority countries by 2015 would entail performing 20.3 million circumcisions by 2015 and would avert 3.4 million, or 22%, of new HIV infections through 2025. An additional 8.4 million circumcisions would be needed between 2016 and 2025 to maintain the 80% coverage level. In addition, while the model shows that this scale-up would cost a total of US$1.5 billion by 2015, it would result in net savings (due to averted treatment and care costs) amounting to US$16.5 billion. Other models have suggested that VMMC scale-up would reduce HIV incidence in eastern and southern Africa by roughly 30–50% over 10 years [6]. Achieving the 80% prevalence target is consistent with universal access targets and national targets adopted in most of the priority countries.

By reducing the number of men who are living with HIV, scaled-up VMMC should also confer other substantial health benefits. MC has been shown to reduce urinary tract infections in infants and children [8], ulcerative sexually transmitted infections (STIs) [9], human papilloma virus, which causes cervical cancer in women [10,11], and bacterial vaginosis and trichomonas in the female partners of circumcised men [12]. Currently there is not enough evidence to support a recommendation to promote VMMC as a HIV prevention intervention for men who have sex with men (MSM) and transgender people [13].

Current situation

Scale-up of VMMC has been modest in most countries, with reportedly over 550 000 males circumcised for HIV prevention by the end of 2010 in the priority countries [14]. This represents 2.7% of the estimated approximately 20 million male circumcisions needed. The greatest success in scaling up adult VMMC has occurred in Nyanza Province, Kenya, where more than 230 000 men have been circumcised in recent years, representing 27% of the number of MCs needed nationally and 62% of the number needed in the province. Zambia and South Africa had circumcised over 80 000 and 130 000 men, respectively, by the end of 2010. Progress in implementing VMMC has been more limited in the other priority countries in the sub-region, with less than 25 000 male circumcisions performed in any one country. Nearly all the countries have seen the pace of scale-up quicken in 2010, however.

Among the priority countries (that is, except Ethiopia, which has a limited regional focus), most have made significant progress programmatically, with at least one component of a situation analysis conducted, and most have developed national policies and strategies. Many countries have a strategy for the coming five years, as well as a longer-term strategy that focuses on the provision of early infant and adolescent services. Leadership and advocacy vary greatly among countries and over time. All countries have coordination structures, but the effectiveness of their functioning varies. The Decision makers' programme planning tool [15] has been used to estimate cost, impact and pace of scale-up. Regulations have been assessed in some countries and revised as needed to address key issues such as task-shifting within service delivery settings. Several countries have developed quality assurance plans and monitoring and evaluation (M&E) frameworks. Many of the countries have communication strategies. Progress varies in strengthening systems for procurement of commodities and supplies and waste management.

National, regional and global organizations have contributed to VMMC implementation in numerous ways. Since WHO and UNAIDS issued the 2007 recommendations, normative guidance and policy advice has been developed by the United Nations (UN) family to support countries in scale-up of adolescent and adult MC. PEPFAR and the Bill & Melinda Gates Foundation (BMGF) have provided significant technical and financial support. Numerous other non-governmental organizations, universities and consortia have provided diverse inputs into implementation efforts. The UN family has had a joint workplan since 2005, with further joint planning taking place with PEPFAR. A coordinated, focused action framework to accelerate scale-up is now needed to guide the coming five years.

Stakeholders involved in the joint effort to accelerate scale-up of MC

The national Ministries of Health of the 14 priority countries are the leaders of the VMMC scale-up at the country level. Core partners, listed here, are collaborating with them in the development, implementation and monitoring of this joint framework:

- Bill & Melinda Gates Foundation (BMGF)
- Centers for Disease Control and Prevention (US CDC)
- Department of Defense, U.S. Government (US DOD)
- Office of the U.S. Global AIDS Coordinator (OGAC)
- UNAIDS Secretariat Headquarters (UNAIDS/HQ)
- UNAIDS Regional Support Team for Eastern and Southern Africa (UNAIDS/RST)
- U.S. Agency for International Development (USAID)
- WHO Headquarters (WHO/HQ)
- WHO Regional Office for Africa (WHO/AFRO)
- The World Bank Global HIV/AIDS Program
- The World Bank country-level Health Team and Task Team Leaders of World Bank Health Operations.

A steering committee to guide progress on this action framework will be constituted from representatives of the Ministries of Health and some or all of these stakeholders. The committee will coordinate, oversee, monitor and adapt strategic activities over time. Membership of the steering committee may evolve over time and may be rotated, depending on agreement of the partners.

It is anticipated that other stakeholders may be engaged as partners in the implementation and monitoring of the strategic actions described in this document. These include the Global Fund to Fight AIDS, Tuberculosis and Malaria; the United Nations Children's Fund (UNICEF); the United Nations Population Fund (UNFPA); key non-governmental organizations such as AVAC (formerly AIDS Vaccine Advocacy Coalition), Clinton Health Access Initiative, EngenderHealth, Family Health International 360, Institute of Population and Public Health, International Center for AIDS Care and Treatment Programs, International Training and Education Center for Health, Jhpiego, Marie Stopes International, Population Services International; key professional associations (e.g. the American Urological Association, IVUMed (formerly International Volunteer in Urology, Inc) and surgical and nursing associations); civil society representatives; AIDS advocates; and advocates for men's and women's health and rights.

Linkages with other strategic frameworks

The framework outlined here is aligned with, and supportive of, existing global declarations and strategic frameworks on HIV. The Political Declaration on HIV/AIDS, adopted at the June 2011 High Level Meeting on HIV/AIDS at the United Nations General Assembly, reiterates the insistence of Member States that "prevention must constitute the cornerstone of the global HIV and AIDS response" and specifically pledges to "promot[e] medical MC where HIV prevalence is high and MC rates are low". MC scale-up will contribute to achievement of the Political Declaration's global goal of reducing the number of new sexually transmitted HIV infections by 50% by 2015.

The 2011–2015 UNAIDS Strategy calls for intensified partnerships to improve efficiency and focus in order to revolutionize HIV prevention [16]. Similarly, WHO's Global Health Strategy on HIV/AIDS, 2011–2015 recognizes safe medical MC as a preventive intervention in high-prevalence settings and calls for expanding the coverage of comprehensive, combined HIV prevention programmes in settings with generalized epidemics and leveraging the capacity of technical networks and partnerships [17]. The Southern African Development Community (SADC) HIV and AIDS Strategic Framework has as one of its main objectives a reduction in HIV incidence by 2015 in all SADC member states to 50% of the 2009 HIV incidence. The MC scale-up strategy is a key component of the strategy to achieve this regional goal [18]. The World Bank's Africa Region HIV/AIDS Agenda for Action 2007–2011 calls for evidence-based and prioritized HIV/AIDS strategies and mentions focusing on proven interventions (such as VMMC) and technical support for their implementation as a key World Bank strategy in Africa [19]. PEPFAR's five-year strategy recommends expanded investments in VMMC services, and BMGF's HIV strategy provides for efforts to improve HIV prevention in sub-Saharan Africa, including support for the scale-up of VMMC [20].

Vision and goals

This framework is guided by the vision that: *VMMC is established as an HIV-prevention social norm for neonates, adolescents and adults and acts in synergy with other HIV prevention, and reproductive health, strategies to move towards zero new infections in countries with generalized epidemics where the prevalence of MC is low.*

The framework seeks to contribute to the achievement of Millennium Development Goal (MDG) 6, which aims to ensure that the world has halted and begun to reverse the spread of HIV by 2015. The framework further aims to accelerate progress towards achieving the Global Health Sector Strategy on HIV/AIDS target for 2015 of reducing new HIV infections by 50% among young people ages 15–24 years.

Specifically, the framework seeks to achieve the following goal: *By 2016 countries with generalized HIV epidemics and low prevalence of MC have:*

a) VMMC prevalence of at least 80% among 15–49 year old males, and

b) Established a sustainable national programme that provides VMMC services to all infants up to 2 months old and at least 80% of male adolescents.

Research evidence, strategies, stakeholders, momentum, and technical and financial resources are available now to support the scale-up of this effective HIV prevention tool. It is crucial to intensify concerted efforts to scale up the catch-up phase and initiate the sustainability phase. The MoHs and partners that have joined together to develop this joint strategy and encourage other stakeholders to join with them to commit to achieving the goals and activities of this joint framework and realizing the promise of VMMC to reduce new HIV infections.

Underlying principles

The strategic directions outlined here are intended to reflect and adhere to certain fundamental principles:

- ***Country leadership and ownership.*** Countries themselves will own and lead efforts to bring VMMC to scale. To support countries in their efforts, the partners will align their efforts with national plans. Country ownership means that countries themselves—including national and sub-national governments, diverse sectors, civil society and affected communities—will actively embrace the above-described goal, determine national strategies and programmatic responses to achieve the goal, and drive progress, drawing on support currently available from various partners and agencies. Country ownership, with government committing national resources while mobilizing external resources for the programme, is essential to the acceptability, success and sustainability of VMMC programmes.
- ***Human rights.*** Medical MC will in all cases be voluntary, based on informed consent, non-coercive and carried out under safe conditions. This principle must be respected, including as it relates to access to information and the quality of counselling and care. MC must be provided in a non-discriminatory manner. Policies and programmes for HIV reduction through VMMC will be designed with the best interests of male children in mind as well as respect for children's rights to participate in decision-making. Given the importance of male circumcision in terms of HIV risk reduction, consideration will be given to allowing adolescents who have the capacity to appreciate risks and benefits access to male circumcision independent of parental consent [21].
- ***Gender dimensions.*** The effects of VMMC scale-up on women (including but not limited to their need to be educated regarding the benefits and limitations of VMMC) will be taken into account in national planning and programme implementation and will be monitored as services are expanded. The expansion of VMMC services provides opportunities for

education, behaviour change communication, greater gender equality through changing gender norms, improved reproductive health and promotion of respect for sexual partners and of communication between partners. Information on the benefits of medical MC, as well as on post-procedure care and HIV prevention measures, will be available for both women and men. The role of women, as sexual partners, sisters, and mothers, in decision-making about VMMC for men and for neonates will be recognized as of prime importance, better understood and addressed [22].

- ***A comprehensive package of services for HIV prevention.*** VMMC provides men only partial protection from HIV acquisition and should always be understood as but one element of a comprehensive HIV prevention package. VMMC will be situated within a minimum package of services (including HIV testing and counselling, safer sex education, STI management and condom promotion) and a comprehensive continuum of HIV prevention strategies. Also, it will be appropriately linked to other programmes and services such as male reproductive health services and care and treatment for HIV-positive men. Efforts to strengthen health systems will play a major role in ensuring the success of VMMC programmes.
- ***Combination of dedicated and integrated approaches to maximize public health benefits.*** Services (staff, space, logistics) and strategies specifically dedicated to scale-up of VMMC may be essential during the initial, catch-up phase. Over the long term, however, VMMC services must be carefully integrated into planning for comprehensive HIV prevention and sexual and reproductive health programming and for the health sector's response to HIV.
- ***Strategic, coordinated action:*** In view of the potential of VMMC to influence the epidemic in eastern and southern Africa, in the context of existing human and financial resource realities, strategic and coordinated action at all levels (local, national, regional, global) is essential to achieving success in an efficient manner. Partners will provide or facilitate high-quality and timely technical assistance to support programme implementation and scale-up, including assisting countries in identifying and addressing implementation bottlenecks or challenges as they emerge.

Strategic pillars

The remainder of this framework proposes strategic activities under seven pillars:

- leadership and advocacy
- country implementation
- innovations for scale-up
- communication
- resource mobilization
- monitoring and evaluation
- coordination and accountability.

There is inevitably a degree of overlap among the strategic pillars. For example, while communication has a central role and therefore deserves its own discussion, communication also will play a role in supporting success in most other strategic areas. Similarly, monitoring and evaluation cover country activities as well as regional and global activities.

Pillar 1: Leadership and advocacy

The 2011 Political Declaration on HIV/AIDS emphasizes the importance of "decisive, inclusive and accountable leadership to revitalize and intensify the comprehensive global HIV and AIDS response". Experience to date in implementing VMMC services has underscored the importance of sustained national political leadership, advocacy and the engagement of key stakeholders [23]. Although there was substantial media attention and discussion following the HIV research breakthroughs regarding VMMC in 2005–2006, the level of energy and attention to this issue has substantially diminished since that time. Numerous stakeholders are engaged in important work supporting VMMC implementation, but significantly greater support must be built and sustained at country, regional and global levels. The activities under this pillar are intended to accelerate the development of strong, visible, sustained national leadership for MC scale-up in each of the 14 focus countries as well as at the global and regional levels.

Strategic activities

- ***Identify, cultivate and mobilize VMMC champions at local, country, regional and global levels to build a network of supporters.*** It is recommended that the MoH in each priority country identify, cultivate and support potential VMMC champions (such as sports and entertainment celebrities, leading media figures, and international leaders). They should be

provided with information and support to effectively advocate VMMC as an HIV prevention strategy. Meetings will be held with Champions for an HIV-Free Generation to mobilize action to increase the visibility of, and support for, VMMC scale-up. Regional directors of key agencies will be sensitized and encouraged to speak out and support VMMC. Meetings will be held between key African leads and heads of UN agencies to encourage strong, visible support for VMMC scale-up.

- ***Leadership by Ministries of Health.*** It is recommended that MoHs demonstrate visible leadership and support for VMMC on an ongoing basis. MoHs will work with other appropriate ministries, such as youth ministries, and with local government to mobilize greater support. Partners will support and strengthen the leadership capacity of MoHs in this effort.
- ***Engage Ministers of Finance.*** It is recommended that Ministries of Health, in collaboration with key partners, engage Ministers of Finance, emphasizing the substantial long-term savings on health and social expenditures for governments to be gained by investing early and vigorously in VMMC service scale-up, thus making available government resources for other deserving purposes in the future ("fiscal space creation").
- ***Encourage strong, visible support among regional bodies.*** It is recommended that MoHs engage with key regional groups (e.g. African Union, SADC, East African Community and UN family regional leaders), encouraging them to provide regional leadership for and support to countries in scaling up their VMMC services.
- ***Peer-to-peer leadership.*** Financial, technical and logistical support will be provided for peer-to-peer meetings among MoHs and stakeholders to share best practices and experiences in VMMC scale-up both within and between the priority countries.
- ***Optimize use of existing materials.*** Partners will collaborate to identify optimal strategies for using or adapting existing materials (e.g. reports, fact sheets, newsletters, communication materials). Effective materials will be created or usage expanded to address any specific gaps in advocacy efforts.
- ***Develop, and revise over time, an advocacy strategy at national, regional and global levels.*** Partners will unite around global, regional and national advocacy strategies that include a series of compelling key messages for VMMC. Key messages will address not only the public health benefits of MC scale-up but also its favourable economic implications, its potential benefits for women and its added value for other services (such as HIV testing and counselling). These will be communicated in brief, attractive advocacy materials and disseminated through appropriate channels.
- ***Support technical officers.*** Programme/technical officers in countries should keep national leaders informed of important developments and new messaging for VMMC. Partners will be available to assist technical officers and strengthen their capacity in leadership, management and advocacy. VMMC will be included as part of the agendas of appropriate existing country partnerships and Technical Working Groups (TWGs).

- ***Support grass-roots advocacy.*** The role of civil society in advocacy at all levels needs to be enhanced. Grass-roots organizations, strategically selected for their proven ability to influence political and community leaders, will be encouraged and provided with appropriate financial and technical support, as needed, to advocate VMMC scale-up. Specific efforts will be made to engage women's groups, youth groups and other key community partners.
- ***Cultivate strong country- and regional-level support among international partners.*** Global partners will take steps to build strong engagement from regional and country offices within their organizations in support of the scale-up of VMMC.
- ***Strategically use key events to build support for VMMC scale-up regionally and in countries.*** Partners will collaboratively support countries to develop and implement plans to promote VMMC scale-up at key upcoming events, including the 2011 International Conference on AIDS and STIs in Africa (ICASA), the 2012 International AIDS Conference, key regional meetings (e.g. African Union (AU), SADC) and meetings of key professional societies.

Pillar 2: Country implementation

Countries will lead implementation of VMMC, and international partners will collaborate with them. Partners will coordinate and harmonize their efforts to assist countries in programme implementation. Efforts to accelerate the scale-up of VMMC will be informed by a thorough analysis of the national environment and the respective roles, responsibilities and comparative advantages of diverse stakeholders. Target-driven, costed national operational plans will drive implementation and ensure the efficiency, effectiveness and sustainability of VMMC services. Diverse in-country resources and multisectoral fora will be strengthened to support implementation.

Strategic activities – Expanding access to VMMC services

- ***Discuss and plan the catch-up and sustainability phases for scale-up and the steps required to move forward effectively.*** Expansion plans will reflect the fact that achieving maximum prevention impact from adult VMMC requires prioritizing and focusing resources. Since resources are limited, they should be devoted initially to the catch-up phase, with the goal of reaching 80% prevalence levels among men in geographic areas with the highest HIV prevalence and lowest MC prevalence. Allocating resources evenly across all age groups initially would result in less preventive impact. It is recommended that countries develop their implementation strategies considering the pace and timing of scale-up of the different phases and taking into account relevant programmatic implications, with the support of partners. Countries should involve key stakeholders in each phase and assign focal persons to appropriate programmes. For example, while the catch-up phase may fall within the purview of the national HIV prevention programme, the adolescent phase may also be the

responsibility of adolescent programmes, and early infant MC may be situated in maternal and child health programmes. Therefore, countries may need to consider designating a focal person and sub-task forces within these other programmes. Integration within programmes and decentralization of services should be considered. More guidance may be required on implementation strategies.

- ***Select optimal expansion and service delivery approaches for the catch-up phase to reach adult males.*** On the basis of country-specific assessments and best and evolving practices from other countries, each country should select optimal expansion approaches (e.g. geographical expansion) and service delivery approaches to reach adult males, including use of national or sub-national campaigns. Integration or links with other national health campaigns should be considered. It is recommended that countries involve a range of service providers beyond the public sector, as government facilities alone are unlikely to achieve the targets necessary for population-level impact. User-friendly male services that reach men at convenient times and places through outreach should be drawn upon or developed.
- ***Identify approaches to integrate and expand VMMC services for adolescent males.*** While focusing resources on the catch-up phase, it is important at the same time to identify approaches to reach new cohorts of adolescents and to refine the service delivery package. VMMC should be integrated into youth-friendly sexual and reproductive health services; liaison with school curricula, sports and other programmes should be established. There may be a need to review, revise or develop an appropriate policy or guidance with respect to informed consent for minors.
- ***Integrate into early infant care.*** At the same time that countries take immediate steps to implement catch-up initiatives for men ages 15–49 years and programmes to reach young males who transition into mid-adolescence and adulthood, efforts should be made to begin integrating the routine offer of VMMC into early infant care services. Countries may need to review, develop, revise and implement policies and strategies in this area and to integrate VMMC with key programmes such as sexual and reproductive health and maternal, newborn and child health (MNCH) services. Countries should share lessons on creating social norms around neonatal circumcision as part of essential health services.
- ***Identify optimal commodity procurement and supply management.*** Based on assessments of national systems for procurement and supply management of commodities required for VMMC, countries should identify steps and resources required to strengthen such systems. Relevant partners will provide appropriate assistance where needed. Quantification, gap analysis, and measures to address gaps and mobilize resources should be undertaken to develop an efficient national procurement system.
- ***Implement ongoing quality assurance programmes.*** As expansion takes place, quality may be compromised. It is recommended that countries develop and implement quality assurance processes and mechanisms to maintain or strengthen the quality of VMMC services. In undertaking such efforts, countries should avail themselves of existing technical resources. Countries should consider other quality improvement efforts underway in the country and coordinate/harmonize with these mechanisms or systems. Where traditional circumcision

is undertaken, countries should increase dialogue with traditional providers and encourage improved practices for safe and effective male circumcision through training, collaboration and linkages into the health care system as well as through regulation.

- ***Institute tailored training.*** It is recommended that each country implement and/or strengthen tailored, evidence-based training programmes for physicians, nurses, facility and hospital managers, programme managers, counsellors, volunteers and community workers, in collaboration with partners where requested. Focused training initiatives should be developed for key components of VMMC service provision, including community mobilization, post-operative care and demand creation. Training should be integrated into pre-service education in health training institutions and into refresher courses for those in practice. Training should include community and traditional leaders as appropriate.

Strategic activities – National assessments

- ***Assess progress and implementation capacity.*** It is recommended that national VMMC task forces annually collect and analyse locally appropriate strategic information on the status of VMMC scale-up. This analysis should inform planning and programming of national approaches to service scale-up and enable international partners to develop tailored, country-specific plans harmonized with national efforts. Assessments should be repeated at least every 12 months to maintain ongoing monitoring of national progress, to identify barriers that need to be addressed, and to more closely harmonize the efforts of PEPFAR, WHO, UNAIDS and other partners that already conduct periodic assessments. More in-depth assessments may be performed every two to three years.
- ***Quantify capacity-building needs.*** It is recommended that each country quantify and characterize training and capacity-building needs, consider solutions to constraints and draw on current, or seek new, resources.
- ***Assess partners' capacities in each priority country.*** Countries and partners should periodically analyse the capacities, strengths and comparative advantages of each potential implementing partner (national and international) to contribute to VMMC scale-up. Steps required to strengthen capacities should be identified and implemented.
- ***Regional meetings.*** It is recommended that country representatives convene with national, regional and global partners at least annually to assess progress; to identify key issues, obstacles and challenges; to share best practices and to collaboratively strategize on how to accelerate scale-up.

Strategic activities – Country-specific operational plans

- ***Develop/revise strategies and operational plans as needed.*** It is recommended that countries develop national HIV prevention strategies supported by clear criteria that prioritize proven interventions and costed operational plans. National task forces for VMMC, working

collaboratively with national HIV prevention working groups, should identify areas where technical support is needed in the development or revision of strategies and operational plans for VMMC scale-up. Then, based on country requests, core partners will provide or facilitate technical support to assist countries in using strategic information as described above. Operational plans should address both the catch-up and sustainability phases, be incorporated into national HIV prevention and maternal and child health strategies and plans and included in funding proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria. They should include time-bound national targets and clear strategies for scale-up, and reflect national decisions on key aspects of the delivery of VMMC services (e.g. recommended MC techniques, approved cadres of health workers, range of agreed delivery modalities).

- ***Estimate resource needs.*** Where plans for scale-up have not been costed, countries, in collaboration with partners as necessary, should cost operational plans and clarify the total quantity of resources needed to support VMMC scale-up.
- ***Promote synergies between VMMC services and other health initiatives.*** It is recommended that countries identify and take steps to capture potential synergies between VMMC services and other health services (such as HIV testing and counselling, referrals to care and treatment, adolescent sexual and reproductive health services, injection and surgical safety). Countries should consider strengthening provider-initiated information on MC.

Strategic activities – Community engagement/mobilization/ preparation and demand creation

- ***Identify and engage key community gatekeepers.*** It is recommended that countries identify and engage key community gatekeepers in discussions on MC to identify potential community support for scale-up and to address resistance. Discussion fora should focus on concerns of the community, should identify optimal messages to promote VMMC (e.g. the scientifically proven benefits of VMMC, community demand, existing or prior circumcision practices in the local population, hygiene benefits), and should encourage gatekeepers to contribute to the acceptance and scale-up of VMMC.
- ***Support South–South "best practice" sessions on community engagement.*** Country stakeholders with successful track records of community engagement for VMMC should share experiences, perspectives and strategies with stakeholders in other countries. Regional and international partners will provide financial, technical and logistical support for such horizontal collaboration.
- ***Mobilize financial and technical support for community education and mobilization.*** It is recommended that countries mobilize resources from national and local budgets to support robust community education initiatives. Countries may request technical support to assist them in identifying resources for community mobilization as well as direct support to communities to identify their own resources.

- ***Support grass-roots community mobilization initiatives.*** It is recommended that countries cultivate and support grass-roots champions for community mobilization regarding MC. Financial support should be obtained to help strategic grass-roots organizations and networks plan and implement community mobilization efforts on VMMC scale-up, with partners' support as needed. Consideration should be given to mobilizing relevant available community networks that have a broader focus, including community health workers and extension workers.
- ***Support the engagement of women, girls and young people.*** Countries should make specific, locally appropriate efforts to engage women and girls (e.g. mothers, wives, pregnant women, girlfriends, sisters, girls in school) in supporting VMMC scale-up, to educate them about the benefits and limitations of adult VMMC as well as early infant male circumcision, and to encourage women to urge men to consider becoming circumcised. Where requested, partners will provide financial and technical support. Women can be engaged through multiple fora, such as antenatal services, women's groups, patient/client education and schools.

Pillar 3: Innovations for scale-up

Successful scale-up of antiretroviral treatment and services to prevent mother-to-child transmission of HIV have benefited from innovation and "learning by doing". In the brief period in which priority countries have worked to implement MC services, innovative practices have already emerged. In an effort to capture the enormous prevention and cost savings potential of MC, concerted efforts will be needed to create incentives for innovation and to rapidly disseminate emerging improvements in MC methods and approaches to service delivery. This section focuses on innovations related to technology, commodities, human resources and the overarching need for operations research.

Strategic activities – Technologies, including new devices

- ***Conduct research, including evaluation trials.*** Research required to inform public health decisions on the use of new technologies for MC, including devices, will be specified. The conduct of such research will be catalysed, including by means of financial and technical support for studies, and the progress of ongoing and planned studies will be monitored. The aim of this research is to promote the development of and to validate technologies that may improve service efficiency, maximize safety and effectiveness, decrease cost, and encourage greater demand for VMMC services. Partners will play a key role in this strategic activity. Processes established at the global level for the technical review of new technologies will be disseminated to countries and key stakeholders.

- ***Prepare normative guidance.*** Normative evidence-based guidance on emerging technologies such as devices will be prepared in a timely manner at the global level, with particular attention to ensuring that new technologies are safe and at the same time facilitating the rapid introduction and uptake of new devices in appropriate settings.
- ***Estimate demand.*** As new technologies become viable options, countries should estimate demand and the personnel and supplies needed for scale-up.
- ***Negotiate favourable pricing.*** Negotiations at global and regional levels with the makers or owners of new technologies will be undertaken to obtain the most favourable pricing for priority countries.
- ***Introduce and roll out new technologies.*** Countries should consider the use of specific technologies, such as devices, in MC scale-up and develop and implement strategic plans for introduction and roll-out, including procurement and appropriate disposal. Donor requirements should be ascertained. Training programmes should be developed to support use of new technologies by appropriate personnel. Other programmatic elements, such as procurement and disposal, should also be considered, and guidance developed, at the global level as needed.
- ***Advocate adoption of new devices.*** It is recommended that countries, in collaboration with partners, plan, implement and adapt advocacy strategies to support the introduction and adoption of new devices to accelerate circumcision scale-up.
- ***Address the public.*** Using all appropriate means (including those described in the section below, Pillar 4: Communication), countries should implement comprehensive country-focused communication strategies to educate the public about new devices and to generate demand for their utilization.
- ***Review costs and benefits.*** As new technologies are validated and introduced, countries may need to perform cost-effectiveness analyses on the use of the technology and to revise cost estimates for VMMC scale-up accordingly.
- ***Monitor adverse events.*** Countries should monitor adverse events related to use of all MC devices (see Pillar 6: Monitoring and Evaluation, below).

Strategic activities – Human resources and other innovations

- ***Develop staffing models.*** It is recommended that countries, in collaboration with partners, develop and test potential staffing models (e.g. efficient staffing, volunteer health care workers) for MC scale-up.
- ***Identify best practices.*** It is recommended that countries document and disseminate best practices to address human resource shortages for VMMC initiatives and the cost of adopting such practices.

- ***Explore task-shifting and task-sharing.*** Task-shifting and task-sharing should be considered as a means to accelerate the scale-up of VMMC services. Based on best practices and specific national circumstances, it is recommended that countries develop, implement and monitor national policies for task-shifting and task-sharing. Partners will provide technical assistance and support for advocacy and research as needed.
- ***Assess human resources in-country.*** It is recommended that countries assess existing national resources at the MoH and also other resources that might be mobilized to support VMMC scale-up, including retired nurses, volunteers and medical students. The benefits and cost of these diverse options should be identified. Countries also should consider seasonal fluctuations in demand for VMMC in order to inform the shifting of staff as needed.
- ***Encourage other innovations.*** Novel approaches to surgery and services, such as the Models for Optimizing the Volume and Efficiency of MC Services (MOVE) and the Rapid Results Initiative (RRI) used in Kenya, will be required to meet the ambitious goals set. Country programmes will be encouraged to develop their own efficiency approaches to provide high-volume, high-quality services, and these new approaches should be shared throughout the region.

Strategic activities – Promoting further innovation for improved access

- ***Encourage flexible service delivery.*** It is recommended that countries encourage VMMC delivery sites to implement flexible approaches that increase access (e.g. evening and weekend hours for clinics, mobile clinics with follow-up support, temporary clinics, timing mass campaigns with holidays). Countries should collaborate with partners to document and disseminate best practices and lessons learnt to date.
- ***Conduct operational and implementation research.*** Operational and implementation research will be carried out to identify promising new delivery approaches for both the catch-up and sustainability phases. Research also will explore campaigns that link promotion of VMMC with other services, such as HIV testing and counselling, couples counselling, services to prevent mother-to-child transmission, STI treatment, referrals to treatment, family planning and antenatal care, as opportunities to reach both adult and newborn males. Countries should explore possible mechanisms to support community-based research including through university partnerships.

Pillar 4: Communication

Effective, population-focused communication is central to the success of VMMC campaigns, affecting the impact of advocacy efforts, public education, community mobilization, demand creation, and avoidance of potential risk compensation. Communication strategies will be developed, implemented, overseen and adapted at national and community levels to address specific community needs. Communication is a cross-cutting activity, intersecting with previously described activities in advocacy, community mobilization and roll-out as well as other components of VMMC scale-up.

Strategic activities

- ***Conduct country-specific communication assessments and develop communication strategy.*** Countries should conduct strategic assessments of the communication environment for VMMC scale-up. Based on these assessments, countries should develop costed communication strategies, if such strategies do not currently exist. Assessments and resulting strategies should consider the full range of communication approaches. Assuring that communication is locally appropriate is key and will be the focus of national communication strategies.
- ***Identify key messages to promote scale-up.*** It is recommended that countries engage communication specialists to help them identify and operationalize key messages to promote scale-up of VMMC, particularly among populations with low demand. Key messages will include other benefits of MC, in addition to HIV prevention, to men and women such as improved hygiene and protection from additional STIs including HPV, the cause of cervical and penile cancer. In addition to health benefits, other benefits of VMMC will be explored as possible message content.
- ***Effectively use media and social networking to promote scale-up.*** It is recommended that country-focused and country-generated mass media campaigns on VMMC be implemented, using diverse media. Use of social networking will be explored.
- ***Identify and implement innovative communication tools and strategies to promote scale-up and high-quality service delivery.*** It is recommended that countries (including individual service sites) employ SMS messaging and other innovative communications tools to help ensure that clients return for appointments and to address other communication needs associated with follow-up.
- ***Document and disseminate best practices in MC-related communication.*** It is recommended that countries, in collaboration with international partners, monitor, document and disseminate effective communication models, strategies and approaches on VMMC. Evaluation of communication strategies, resources and interventions, at national, regional and global levels, should be conducted to inform improvements.

- ***Mobilize grass-roots capacity to implement community-focused communication strategies.*** It is recommended that countries pursue focused efforts to mobilize key groups, including but not limited to women, young people and community and traditional leaders, to encourage men in their communities to become circumcised.

Pillar 5: Resource mobilization

Sufficient and predictable financing will be required to achieve goals for the catch-up and sustainability phases of medical MC scale-up. VMMC will be incorporated into comprehensive national HIV prevention strategies and integrated into other national frameworks and strategies, including health sector strategies, poverty reduction strategies, maternal, child and reproductive health strategies and multisectoral HIV strategies and plans. Country-specific resource mobilization plans should be developed and/or reviewed at appropriate intervals, informed by a clear awareness of existing resources and the amount of additional resources and the advocacy needed to obtain resources. Earlier sections of this framework have addressed the importance of the cost-savings and economic benefits to be gained. Resource mobilization strategies should take into account this long-term perspective and the need over time to shift from external financing to domestic sources.

Strategic activities

- ***Estimate country-specific resource needs and resource availability.*** Countries should quantify resources currently available for MC scale-up and amounts needed to achieve national targets for catch-up and sustainability and should develop strategic plans for closing resource gaps (see Pillar 2: Country implementation, above). These estimates should be revisited periodically, since unit costs for delivery of VMMC are likely to decline as services are brought to scale and as new devices emerge.
- ***Conduct country-specific assessments of economic impact.*** Countries should project the long-term fiscal benefits of rapid scale-up of MC and use this information for advocacy and planning.
- ***Use available financing channels to support scale-up.*** Countries should examine and seek appropriate sources of financing to support the scale-up of MC, including both domestic and international sources (e.g. Global Fund, BMGF, PEPFAR, World Bank, UNITAID). Over time greater reliance on national and local resources will be needed, and planning for this should be initiated or strengthened.
- ***Consider the private sector.*** It is recommended that countries explore new sources of financing from the private sector (such as business) to support MC scale-up.
- ***Cover MC in health insurance.*** It is recommended that countries explore strategies to integrate coverage of MC services into private and public health insurance schemes.

- ***Undertake regional assessments and resource mobilization.*** It is recommended that regional bodies (e.g. SADC, East African Community (EAC)) cost regional activities and mechanisms to support scale-up of VMMC (e.g. special regional initiatives to facilitate collaboration on scale-up). Partners will provide or facilitate technical assistance to support the mobilization of resources needed for such regional activities.

Pillar 6: Monitoring and evaluation

Countries should collect, disseminate and make optimal use of strategic information on effectiveness, epidemiological impact, economic impact, and programme performance and management. Collection and analysis of strategic information on VMMC should be incorporated into existing mechanisms for monitoring and evaluation.

Strategic activities

- ***Make country-specific M&E assessments.*** Countries should undertake country-specific assessments of monitoring and evaluation needs relating to VMMC scale-up.
- ***Build capacity for M&E.*** Robust national capacity for target setting and M&E relating to VMMC scale-up should be built and incorporated into national health management information systems. Activities will be supported to harmonize M&E systems between partners and countries.
- ***Establish routine reporting.*** Reporting on progress in scaling up VMMC should be incorporated into national information systems, and local data use should be emphasized. Data will be age-disaggregated to permit an assessment of progress towards each of the phases of scale-up and their targets. National and global progress reporting frameworks, processes and reports will be standardized so that reporting to regional and global levels will be better harmonized (e.g. Demographic and Health Surveys, annual health sector reporting to WHO). Partners will use this information to create a running "scorecard" on progress in scaling up VMMC, thus informing their efforts to better target financial and technical support to address implementation bottlenecks.
- ***Use data to improve programmes.*** Countries should assess the quality of data and increase the strategic use of data to improve programmes. The strengths and weaknesses of available data and the steps needed to improve the quality, completeness and timeliness of reported information should be identified. Countries should implement systems that provide incentives to programmes, clinics and other service sites to use monitoring data to improve service quality.
- ***Incorporate MC-relevant data collection into related services.*** Information regarding referrals of men for circumcision should be incorporated into standard service forms and data reporting for HIV testing and counselling, antenatal HIV services, neonatal and infant services and other relevant services.

- ***Publish annual reports.*** Countries should produce annual reports (as part of larger reports or independent reports) that document progress in VMMC. WHO and UNAIDS will produce an annual report on MC scale-up in the region and will work closely with MoHs and other key agencies such as PEPFAR to harmonize reporting. Using both quantitative and qualitative information, the report will identify and discuss elements that facilitate or hinder progress in bringing VMMC services to scale. In particular, it will identify best practices and innovative delivery methods. These annual reports will permit ongoing assessment of progress towards agreed goals and targets.
- ***Evaluate impact.*** Evaluations should be conducted of the epidemiological and economic impact of MC scale-up.
- ***Review and periodically assess information needs.*** Countries, in collaboration with partners, should regularly review operational research priorities for MC scale-up, assess available evidence from the research and make adjustments to ensure research is conducted that provides useful information to inform scale-up and to identify the need for revisions to strategic approaches.
- ***Monitor adverse events.*** Countries should establish adverse event surveillance systems and use surveillance data to improve service quality and address problems in a timely manner. International technical agencies will provide guidance on the field-testing of standardized definitions and reporting of adverse events.
- ***Identify best practices.*** Countries, in collaboration with partners, should jointly identify best and promising practices in MC scale-up and agree on strategies for documenting and disseminating best practices (see Pillar 7: Coordination and accountability, below).

Pillar 7: Coordination and accountability

Mechanisms will be established for regular follow-up, monitoring of progress and assessment and revision (where indicated) of strategic directions. National programmes will lead in coordinating efforts within their countries and should set milestones to mark progress towards national goals (see other pillars). Harmonized efforts of core partners to support national strategies and plans should lead to accelerated action and effective leveraging of resources. Regional coordination and accountability also are needed.

Strategic activities

- ***Agree on key milestones, expected results and plans.*** Based on country-defined goals and targets, partners will jointly agree on key VMMC milestones and will hold themselves collectively and individually accountable for results. The partners will collaborate to develop an annual joint workplan. Its initial iteration will focus on 2012.

- ***Obtain agency and partner commitments.*** Countries will receive commitments of support for VMMC scale-up. Each agency will promote broader engagement within its respective agency to meet these commitments.
- ***Account for progress on agreed responsibilities.*** Countries, in collaboration with partners, should establish agreed indicators and metrics to measure progress in implementing the strategic activities. Collective progress will be reviewed annually, and joint plans and strategic activities will be revised where appropriate.
- ***Coordinate regularly among partners.*** Partners will meet periodically by conference call to assess progress and at least once annually face-to-face to review results and examine the need to refine roles, responsibilities, timelines, strategies and/or activities. Additional workshops will be held as appropriate to address emerging issues.
- ***Strengthen country MC task forces.*** Countries need to lead task forces, with partners buying in and providing support, to enhance the complementarity and avoid the duplication of MC activities. Models of effective task forces will be shared, and countries should identify strategies to strengthen task forces to ensure that they are robust, inclusive and committed to the rapid scale-up of MC. Best practices for engagement with international and regional partners will be identified. Integration of MC task forces into existing HIV prevention coordination mechanisms will be encouraged.
- ***Conduct joint missions where indicated.*** It is recommended that countries work with external partners to organize joint missions that help to harmonize partners' efforts in support of national VMMC scale-up.

Roles and responsibilities of core partners

Roles and responsibilities of partners are described here. The lead and supporting agencies for activities under each of the above-mentioned strategic pillars are indicated in the Appendix that follows.

Bill & Melinda Gates Foundation

The Bill & Melinda Gates Foundation recognizes that VMMC is a powerful tool for prevention of HIV infection. Realizing that scale-up of VMMC needs to be driven and organized by the Ministries of Health in each of the target countries and also to have the support of civil society, the foundation will work to support advocacy for VMMC at multiple points. Technical assistance support will be provided when needed to help Ministries coordinate on-the-ground partners, determine capacity and financial needs, develop operational plans and initiate programmes. In the past the foundation has convened multiple important stakeholder consultations, and it anticipates continuing in this role as a convener. Also, the foundation may provide time-limited support to a few selected countries to assist with and catalyse scale-up. Because innovation may make VMMC easier, faster and more affordable and therefore aid in scale-up of services, the foundation will continue to support development, clinical and operational research and advocacy for novel innovations to aid VMMC, such as devices.

UNAIDS

The Joint United Nations Programme on HIV/AIDS brings together the efforts and resources of 10 UN system organizations to the global AIDS response. Cosponsors include UNHCR, UNICEF, World Food Programme, United Nations Development Programme, UNFPA, United Nations Office on Drugs and Crime, International Labour Organization, United Nations Educational, Scientific and Cultural Organization, WHO and the World Bank. While headquartered in Geneva, the UNAIDS Secretariat works on the ground through offices in more than 80 countries covering 98 countries worldwide. UNAIDS led the first UN work plan in 2005-6 and now its Regional Support Team for eastern and southern Africa coordinates UNAIDS support for VMMC scale-up. UNAIDS assists countries to undertake modelling and costing studies, provides guidance on ethical and human rights considerations related to VMMC service scale-up and supports countries to undertake legal and regulatory self-assessments, and advises on communications strategies. UNAIDS coordinates support to countries on prospective monitoring and evaluation to improve services and measure progress toward country objectives for VMMC service scale-up.

United States Government: PEPFAR

The President's Emergency Plan for AIDS Relief (PEPFAR) is the United States initiative to fight HIV/AIDS globally, including support to voluntary medical male circumcision for HIV prevention.

In August 2011 PEPFAR released new HIV prevention guidance emphasizing evidence-based, high-impact HIV prevention interventions. The guidance prioritizes VMMC as a core intervention in settings where MC prevalence is low and HIV prevalence is high. Accordingly, it is anticipated that the PEPFAR Country Operational Plans for the coming fiscal year will increase support for rapid scale-up of VMMC.

PEPFAR provides bilateral support for VMMC to 14 countries in southern and eastern Africa, with technical and financial assistance in collaboration with national governments. In these countries PEPFAR supports a wide range of activities, including implementation science, support for policy and strategy development and programme implementation.

The World Bank

The World Bank is committed to supporting the efficient scale-up of proven HIV prevention programmes, in line with its corporate focus on HIV prevention, its regional HIV strategy (Africa Agenda for HIV Action) and its core mandate within the UN system. In relation to MC, the World Bank is committed to support the financing of MC scale-up by providing funding upon government request, analytical support to improve allocative decision-making and delivery efficiency, and evaluations to strengthen the evidence for population-level effectiveness and highest efficiency roll-out.

World Health Organization

The World Health Organization embraces action at all three levels of the Organization and across WHO departments. The Regional Office for Africa is the primary regional office involved in scaling up this intervention, along with the national offices. WHO is the lead organization within the UN system for supporting the scaling up of MC service provision. The World Health Organization's contributions focus on providing normative guidance, policy and programme advice and implementation guidance; developing and disseminating a broad range of products and providing technical services to support country action; strengthening alignment and harmonization among stakeholders; convening different constituencies, sectors and organizations for a coordinated and coherent health sector response to HIV; and monitoring progress towards quality interventions and achievement of agreed HIV goals.

Appendix

Partner-specific roles and responsibilities by strategic activities

The following tables indicate the strategic activities to which currently involved agencies intend to contribute. As countries are essentially involved in all areas, and details vary by country, a specific column is not included for MoHs. It should be re-emphasized that countries must be in the lead, and the contributions by agencies indicated below to specific activities constitute a supportive role, in consultation with countries. Ultimately, the roles and responsibilities of the partners at the country level will be defined based on country requests and dialogue with in-country teams. A column for "others" is available to provide space for other interested agencies to be added.

This appendix identifies PEPFAR as the partner that will act on behalf of the U.S. Government, with the expectation that PEPFAR will determine roles and responsibilities of individual U.S. agencies (e.g. USAID, CDC, OGAC, US Department of Defence) for specific activities. Designated activities of WHO and UNAIDS encompass all levels of these organizations.

Bold-faced "**XX**" designations denote lead partners in specific areas of support to country programmes.

Pillar 1: Leadership and advocacy

Activity	BMGF	PEPFAR	UNAIDS	WHO	World Bank	Others
Cultivate champions	**XX**	X	X	X		
Leadership by MoH	X	X	X	**XX**		
Engage Finance Ministry					**XX**	
Encourage support of regional bodies			X	X		
Peer-peer leadership			X	**XX**		
Optimize use of existing materials		X				
Develop advocacy strategy			**XX**	X		
Support technical officers	X	X	X	**XX**		
Support grass-roots advocacy	**XX**		X			
Cultivate country and regional support within partner agencies	X	X	X	X	X	
Event mapping & planning	X	X	X	X	X	

Pillar 2: Country implementation

Expanding service access

Activity	BMGF	PEPFAR	UNAIDS	WHO	World Bank	Others
National decision-making on expansion and service delivery approaches for different phases	X	X	X	**XX**		
Commodity procurement and supply management		X			X	
Quality Assessment		**XX**		X		
Training		**XX**				

National assessments

Activity	BMGF	PEPFAR	UNAIDS	WHO	World Bank	Others
Country assessment		**XX**	X	X		
Quantify capacity needs	X	**XX**				
Partner capacity assessment		**XX**				
Regional meeting	X	X	X	**XX**	X	

Country-specific operational plans

Activity	BMGF	PEPFAR	UNAIDS	WHO	World Bank	Others
Develop/revise strategies operational plans	X	**XX**	X	X	X	
Estimate resources needed (in countries where such estimates have not been developed)		X	X		XX	
Promote synergies between MC and other services		**XX**	X	**XX**	X	

Community mobilization and demand creation

Activity	BMGF	PEPFAR	UNAIDS	WHO	World Bank	Others
Engage gatekeeper			X		X*	
Support South–South best practices		**XX**			X*	
Resources for community engagement	X	**XX**	X		X*	
Support Grass-roots champions	**XX**	X	X		X*	
Engage women and girls	X	X	X		X*	

Pillar 3: Innovations for scale-up

Technologies, including new devices

Activity	BMGF	PEPFAR	UNAIDS	WHO	World Bank	Others
Conduct research and reviews on technologies	**XX**		X	**XX**		
Prepare normative guidance				**XX**		
Estimate demand	**XX**		X			
Negotiate pricing	**XX**					
Introduce and Roll-out		X	X	X		
Advocacy	**XX**	X	X	X		
Communication		**XX**	X			
Reviews of cost estimates	X		X		**XX**	
Monitor		X		X		

Human resources

Activity	BMGF	PEPFAR	UNAIDS	WHO	World Bank	Others
Model programmes		**XX**				
Best practices		**XX**	X	X		
Explore task-shifting and task-sharing		X		**XX**		
Assess HR		**XX**			X	
Encourage innovations		X		**XX**		

*Through funding at country level

Promoting further innovation including for improved access

Activity	BMGF	PEPFAR	UNAIDS	WHO	World Bank	Others
Flexible service delivery		**XX**			X*	
Conduct/catalyse operational research	X	X	X	X	X*	

Pillar 4: Communication

Activity	BMGF	PEPFAR	UNAIDS	WHO	World Bank	Others
Communication assessments		**XX**	X		X*	
Identify key messages		X	**XX**		X*	
Use effectively mass media		**XX**	X		X*	
Identify and use innovative communication tools		**XX**	X		X*	
Document best practices		**XX**	X		X*	
Mobilize grass-roots communication	X	**XX**	**X**		X*	

Pillar 5: Resource mobilization

Activity	BMGF	PEPFAR	UNAIDS	WHO	World Bank	Others
Estimate resource needs and availability		X	X		**XX**	
Estimate economic impact		X	X		**XX**	
Use available funding; consider other sources (private, insurance)	X	**XX**	X	X	X*	
Regional assessments	X		X		X*	

*Through funding at country level

Pillar 6: Monitoring & evaluation

Activity	BMGF	PEPFAR	UNAIDS	WHO	World Bank	Others
M&E assessments		**XX**	X	X	X*	
Build ME capacity-		**XX**	X	X	X	
Routine reporting re MC		**XX**	X	**XX**	X*	
Use data to improve service quality		**XX**	X	X	X*	
Incorporate MC into other service reporting structures		**XX**	X	X	X*	
Publish annual report		X	**XX**	**XX**		
Evaluate impact	**XX**	X	X		X	
Review periodic progress	**X**	X	**XX**	X	X*	
Monitor adverse event		X	X	X	X*	
Best practices	**X**	X	X	X	X*	

Pillar 7: Coordination & accountability

Activity	BMGF	PEPFAR	UNAIDS	WHO	World Bank	Others
Agree on milestones	X	X	X	X	X	
Obtain agency commitments	X	X	X	X	X	
Account for progress	X	X	X	X	X	
Regular meetings	X	X	X	**XX**	X	
Strengthen MC task forces				**XX**		
Conduct joint missions (where indicated)	X	X	X	X	X	

*Through funding at country level

References

1 Manual for male circumcision under local anaesthesia. WHO/UNAIDS/Jhpiego, December 2009.

2 Auvert B et al. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 trial. *PLoS Med,* 2005, 2:e298.

3 Bailey RC et al. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial. *Lancet,* 2007, 369:643–656.

4 Gray RH et al. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomized trial. *Lancet,* 2007, 369:657–666.

5 Lissouba P. Adult male circumcision as an intervention against HIV: An operational study of uptake in a South African community (ANRS 12126). *BMC Infectious Diseases,* 2011, 11:253, 2011.

6 UNAIDS/WHO/SACEMA Expert Group on Modelling the Impact and Cost of Male Circumcision for HIV Prevention. Male circumcision for HIV prevention in high HIV prevalence settings: What can mathematical modelling contribute to informed decision making? *PLoS Medicine*, 2009, 6: e1000109. doi:10.1371/journal.pmed.1000109.

7 Njeuhmeli E et al. Voluntary medical male circumcision: modeling the impact and cost of expanding male circumcision for HIV prevention in eastern and southern Africa. *PLoS Medicine*, 2011, 8: e1001132. doi:10.1371/journal.pmed.1001132.

8 Shaikh N et al. Prevalence of urinary tract infection in childhood: a meta-analysis. Pediatric Infectious Disease Journal, 2008, 27:302.

9 Gray RH et al. Effects of genital ulcer disease and Herpes simplex virus type 2 on the efficacy of male circumcision for HIV prevention: analyses from the Rakai trials. *PLoS Medicine*, 2009, 6(11):e1000187.

10 Wawer M et al. Effect of circumcision of HIV-negative men on transmission of human papillomavirus to HIV-negative women: a randomized trial in Rakai, Uganda. *Lancet Online,* January 7, 2011. DOI:10.1016/S0140–6736(10)61967–8.

11 Castellsague X et al. Male circumcision, penile human papillomavirus infection, and cervical cancer in female partners. *New England Journal of Medicine,* 2002, 346:1105.

12 Gray RH et al. The effects of male circumcision on female partners' genital tract symptoms and vaginal infections in a randomized trial in Rakai, Uganda. *American Journal of Obstetrics and Gynecology*, 2009, 200(1):42,e1–42,e7.

13 *Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach.* Geneva, World Health Organization, 2011.

14 Joint United Nations Programme on HIV/AIDS (UNAIDS). *AIDS at 30: nations at a crossroads.* Geneva, UNAIDS, 2011.

15 Bollinger L, DeCormier Plosky W, Stover J. *Male circumcision: Decision makers' program planning tool, calculating the costs and impacts of a male circumcision program.* Washington, D.C., Futures Group, Health Policy Initiative, Task Order 1, 2009.

16 Joint United Nations Programme on HIV/AIDS (UNAIDS). *Getting to zero: UNAIDS 2011–2015 strategy.* Geneva, UNAIDS, 2010. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2034_UNAIDS_Strategy_en.pdf

17 *Global health sector strategy on HIV/AIDS 2011–2015.* Geneva, World Health Organization, 2011.

18 Southern African Development Community (SADC) Secretariat. *SADC HIV and AIDS strategic framework (2010–2015).* [Gabarone], SADC, 2009.

19 International Bank for Reconstruction and Development (IBRD)/The World Bank. *The World Bank's commitment to HIV/AIDS in Africa: our agenda for action, 2007–2011.* Washington, D.C., IBRD/The World Bank, 2008.

20 President's Emergency Plan for AIDS Relief (PEPFAR). *PEPFAR's five-year strategy.* Washington, D.C., PEPFAR, 2009. *http://www.pepfar.gov/strategy/document/133251.htm*

21 Joint United Nations Programme on HIV/AIDS (UNAIDS). *Safe, voluntary, informed male circumcision and comprehensive HIV prevention: programming: guidance for decision-makers on human rights, ethical and legal considerations.* Geneva, UNAIDS, 2008. http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2008/jc1552_circumcision_en.pdf

22 Hankins C. Male circumcision: implications for women as sexual partners and parents. *Reproductive Health Matters*, 2007, 15(29):62–7.

23 See "The path Kenya walked" presentation from the September 2010 MC communications meeting held in Durban, South Africa: http://www.aidstar-one.com/focus_areas/prevention/resources/technical_consultation_materials/Male_Circumcision_Communication_Meeting_Durban

UNAIDS
20 AVENUE APPIA
CH-1211 GENEVA 27
SWITZERLAND

Tel.: (+41) 22 791 36 66
Fax: (+41) 22 791 48 35
e-mail: distribution@unaids.org
www.unaids.org