Ministry of Health and Social Services
National AIDS and STI Control program
MALE CIRCUMCISION IN NAMIBIA

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OUTLINE
• Background
• Progress to date
• Challenges
• Lessons learnt
• Strategies to address challenges
• Key next steps
Background

- HIV prevalence in pregnant women as per 2010 sentinel survey stood at 18.8%
- Estimated adult prevalence is 13.3%
- MC prevalence is low in Namibia at 21% of males aged 15-49 years
- Government endorsed MC as an HIV prevention strategy in 2008; pilot started in 3 facilities in 2009
- MC policy document developed and launched March 2011
- Key players: implementation largely by MoHSS supported by development partners
Progress to date ..

- MC rolled out to 33 districts
- MC Training curriculum developed
- 135 clinicians (50 doctors and 84 nurses) and 80 Community Counselors trained
- National, regional and districts managers trained
- Dedicated MC staff recruited (4 doctors and 10 nurses)
- 11’779 MC procedures performed to date against a projected target of > 100 000; 95% had HIV test
- Draft MC strategy developed
- Progress on task shifting
Challenges

• Delays in finalizing MC strategy and implementation plan to guide program scale-up
• Trained non dedicated staff have overwhelming competing priorities due to critical staff shortage
• Dedicated staff thinly distributed in 10 regions
• Services are only provided through fixed health facilities
• No outreach/mobile or campaigns conducted due shortage of staff
Challenges cont’

• High staff turnover leading to loss of MC dedicated staff.
• Infrastructure in some facilities is a challenge
• Massive MC community mobilization conducted
• M & E system not integrated in MOHSS HIS
Lesson learned

• Service delivery platforms that include fixed, mobile, and outreach sites and campaigns could deliver results
• Involvement of other players in service delivery is crucial
• Align all partners/players to new strategy and define roles
• Involvement of regional and district management teams in recruitment and deployment of dedicated teams is vital
Lesson learned

- NSF targets should be revised and set new regional targets
- Confining resources in high prevalent areas with low circumcision rates; epidemiologically driven
- Dedicated teams doing more and task shifting possible;
- Trained non-dedicated staff have overwhelming competing priorities
Strategies for addressing challenges

- Finalize draft MC strategy and implementation plan that will entail:
  - Selection of prioritized regions with high HIV prevalence and low MC prevalence to scale up
  - Implementation of mixed model service delivery approach in all prioritized regions through public and private sectors/CSO
  - Recruiting regional based MC dedicated teams for each region for the duration of the project
Strategies for addressing challenges cont’

• Involve all stakeholders in the development of MC strategy and implementation plan
• Establish regional and district committees to help plan and advise on scale up
• Recruit regional MC coordinators
• Strengthen communication for demand creation
• Align all partners/players to new strategy and define roles
Key next steps

- Finalize draft MC and implementation plan to guide program scale up
- Consultation meetings with all stakeholders
- Recruit enough dedicated doctors and nurses to scale up MC
Key next steps

• Implement regional approach by selecting limited prioritized regions with high HIV prevalence and low MC prevalence
• Implement mixed model
• Improve MC communication models to educate communities and create demand