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

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Epafras Anyolo
MC Coordinator

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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