



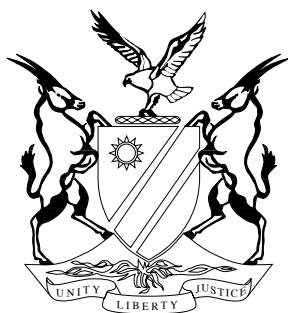
Republic of Namibia

Ministry of Health and Social Services

POLICY ON MALE CIRCUMCISION FOR HIV PREVENTION



September 2010



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FOREWORD

The Prevention of Human Immunodeficiency Virus (HIV) has never been a one-step process. Since the onset of the HIV/AIDS epidemic in the early 1980s, it has been clear that successful prevention programs should be comprehensive and continuously available to those at greatest risk of infection. The A-B-C strategy, which promotes abstinence, being faithful to one partner, and consistent and correct condom use, is the current gold standard for such comprehensive approaches that also include biomedical interventions and, increasingly coined into a new initiative called “combination prevention” strategies which link prevention with antiretroviral treatment.

With the publication of several promising studies on the protective effect of Male Circumcision (MC), an additional tool was added to the HIV prevention toolkit. In three ground-breaking studies, in South Africa, Kenya, and Uganda, MC, was shown to reduce the risk of HIV infection in men by up to 60%. Although this protection is not total – and offers no protection against HIV to women – the World Health Organization (WHO) and the Joint United Nations Programme on HIV and AIDS (UNAIDS) have both recommended MC for countries, like Namibia, where the population prevalence of HIV is high and few men are circumcised.

Following this recommendation, the potential impact of a national MC campaign on future HIV incidence rates in Namibia was modeled. According to these estimates, scaling up MC to reach 80 percent of adult and newborn males in Namibia by 2015 would avert almost 35,000 adult HIV infections between 2009 and 2025. With only 21% of Namibian men currently circumcised, reaching 80% coverage nationally will be a challenge – but not an insurmountable one.

In 2008, the Ministry of Health and Social Services (MOHSS) commissioned a series of surveys to determine the scope of potential demand for MC among Namibian men, as well as the healthcare system’s readiness to delivery these services on a mass scale. The findings of these surveys were encouraging.

There appears to be strong support for MC among men across the social and age spectrum in Namibia. The surveys found Namibian men generally accepted the known health benefits of MC, including reduced risk of HIV and other sexually transmitted infections (STIs). Based on the research, the MOHSS has developed targeted behavioural messages to educate individuals about MC services.

The facility readiness survey identified a number of critical needs within the healthcare system. These gaps, namely lack of available and trained medical staff dedicated to MC, are being addressed through training programs for physicians, recruitment of additional staff, potential task-shifting strategies for nurses, education on safe MC practices for traditional circumcisers and efforts to promote insurance coverage for MC services delivered in the private healthcare sector.

The surveys also highlighted a common thread: Despite its promise, MC must be treated as a supplemental, not a primary prevention method. In short, this policy reflects the government’s deep understanding that the effectiveness of MC will be determined not only by our success at increasing uptake among men, but by our success in linking circumcised men and their female partners to the other components (A-B-C) of the national HIV prevention strategy.

This policy is, therefore, built upon a strong evidence base – one constructed from international data from the scientific literature, and local, national data collected and analyzed in Namibia. In conjunction with other behavioral and biomedical prevention strategies described above, the expansion of MC services in Namibia will, in time, prove a cost-effective investment in the health of the nation.

On behalf of the entire MOHSS, I am pleased to present this first national policy on MC, and to preside over the launch of this important new biomedical intervention within our nation's comprehensive HIV prevention strategy.

Dr. Richard Nchabi Kamwi, MP
Minister of Health and Social Services

PREFACE

In March 2007, WHO and UNAIDS recommended the addition of Male Circumcision (MC) to comprehensive national HIV prevention policies in countries with high rates of HIV infection. This recommendation was based on the findings of several scientific studies in African countries which found that circumcised men were up to 60% less likely to be infected with HIV compared to men who were not circumcised. Following this announcement, the Minister of Health and Social Services, briefed the Cabinet on the WHO and UNAIDS recommendation, and detailed the rationale behind them and the country preparedness for scaling up a national programme to promote MC among Namibian men. With the Cabinet's approval, the MOHSS launched a process in mid-2007 to develop and ultimately implement a national MC strategy and programme.

As a first step, the National AIDS Executive Committee (NAEC) formed a national MC Task Force to study the issue and conduct a comprehensive situation assessment for Namibia using a WHO assessment toolkit. The Task Force fulfilled its mandate through a Knowledge, Attitudes, Behaviours and Practices (KABP) survey, which asked Namibian men about MC and their willingness to accept circumcision if offered through the public healthcare system. The survey also gathered data on male sexuality and cultural traditions that have traditionally kept MC rates low in Namibia. The findings of this survey confirmed the need for MC services (only approximately 21% of Namibian men are currently circumcised), and identified a set of key behaviour change messages to mobilize demand (e.g. health and hygiene, STI prevention and the impact of MC on sexual pleasure).

In addition, the MC Task Force conducted a facility readiness study, which identified strengths and gaps in the healthcare system's capacity to perform MC on a mass scale, as well as task shifting opportunities for nurses. The readiness study also initiated a deeper review of safe MC practices by traditional circumcisers. The Task Force also reviewed the current scientific literature, and developed tools to initiate a national dialogue on MC. This dialogue, Stakeholder Consultation Meeting was held in August 2008 and sought to engage political, religious and traditional leaders as well as health professional, traditional circumcisers, the media, men's groups and the general public. Stakeholders' inputs have been critical for planning and the development and ultimate launch of MC services in Namibia. To this end, MC was added to the agenda of the first National Male Leadership Conference on HIV/AIDS in February 2008. The final report from that conference called for the promotion and expansion of MC services in Namibia. In August 2008, senior government officials attended a MC Breakfast Meeting at which the results of the situation assessment were presented. This policy, which describes the rationale and implementation strategies for MC in Namibia, is built on results of a broad consultative process involving stakeholders and technical experts.

The Ministry is grateful to the MC Task Force and other stakeholders who participated in the development process and who continue to support the implementation of this important HIV prevention tool. This policy is a reflection of your skills, dedication and commitment to halting the spread of HIV in Namibia.

Mr. Kahijoro Kahuure
Permanent Secretary

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ABC	Abstinence, Be Faithful, Condomise
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
DSP	Directorate of Special Programs
FBO	Faith-Based Organization
GIS	Geographic Information System
GRN	Government of the Republic of Namibia
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HPCNA	Health Professional Councils of Namibia
HTC	HIV Testing and Counseling
IEC	Information, Education and Communication
I-TECH	International Training and Education Center on Health
IR	Intermediate Results
Jhpiego	An international health organization affiliated with John Hopkins University
KAPB	Knowledge, Attitudes, Practices and Behaviours
MC	Male Circumcision
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MoHSS	Ministry of Health and Social Services
NAC	National AIDS Council
NaCCATuM	Namibia Co-ordinating Committee for HIV/AIDS, Tuberculosis and Malaria
NACOP	National AIDS Co-ordination Programme
NAEC	National AIDS Executive Committee
NBC	Namibia Broadcasting Corporation
NDF	Namibia Defense Force
NGO	Non-governmental Organization
NDS	National Development Strategy
NSF	National Strategic Framework
NSP	National Strategic Plan

OC	Outcome
OP	Output
OVC	Orphans and Vulnerable Children
PITC	Provider-Initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RCT	Randomised Controlled Trials
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TAC	Technical Advisory Committee
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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1. INTRODUCTION

1.1. Background

Recent research has found that Male Circumcision (MC) could reduce the risk of HIV transmission from women to men considerably. Three randomised controlled trials in South Africa, Uganda, and Kenya were conducted to establish the efficacy of MC on HIV acquisition. These studies found that circumcised men were less likely to become infected with HIV in comparison to uncircumcised men, with the reduction in risk estimated between 51% and 60% .

As a result of these findings, in March 2007, the World Health Organisation (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommended that MC be included in countries strategy for preventing the transmission of HIV from women to men.

These recommendations articulate clearly that MC should not replace traditional prevention approaches but should be part of a comprehensive prevention package that include in addition to the surgical act of circumcision: active sexually transmitted infection (STI) screening and management, behavioural counselling with component on partner reduction, provider initiated HIV counselling and testing and condom promotion.

These developments have been of great interest to Namibia, where the HIV prevalence among pregnant women is estimated at 17.8%¹ and among the highest in the world. From the first sentinel surveillance in 1992 where the HIV prevalence was 4.2%, prevalence peaked to 22% in 2002 and stabilized to around 20% until 2008, when it declined to 17.8%. In its Medium Term Plan III for HIV/AIDS, the Government of Namibia acknowledges HIV prevention as critical to the national response to HIV and AIDS. Although the recent decline in HIV among young pregnant women suggests that incidence is declining and that some prevention efforts are working, a stronger response is needed. The Ministry of Health and Social Services (MoHSS) is committed to including MC as an additional HIV prevention intervention to ensure additional impact on the epidemic. Other HIV prevention strategies are HIV counseling and testing, abstinence, be faithful to one tested partner, consistent and correct condom use, screening and treatment of STIs, prevention of mother to child transmission (PMTCT), reduction in multiple concurrent partners, blood safety and universal precautions.

MC for adolescents and adult males will be integrated into existing sexual and reproductive health services and will serve as an entry point to reach males with wider sexual, and reproductive health services and gender messages including messages about healthy male sexual norms and prevention of gender-based violence. The integration of HIV prevention strategies will ensure the efficient use of resources and also ensure that MC does not divert resources from other essential interventions. MC is an important component of Namibia's national HIV prevention strategy and the National Strategic Framework (NSF) for HIV and AIDS 2010-2016.

The expected reduction in new HIV infections from providing safe, accessible, voluntary MC services will move Namibia toward achieving its development goals identified in Vision 2030 and its MDGs on HIV/AIDS.

¹ Ministry of Health and Social Services (2008). National HIV Sentinel Survey. MOHSS, Windhoek.

1.2. Country situation assessment on male circumcision for HIV prevention

As part of the preparation process for the roll out of MC as an HIV prevention strategy in Namibia, the MC Task Force carried out a situation assessment in 2008. The situation assessment was an adaptation of WHO's MC Situation Analysis Toolkit and consisted of four components of research to inform development of a national policy and action plan. These are:

- A desk review of existing literature/research on male circumcision in Namibia as well as a mapping of currently available medical providers of male circumcision;
- Key informant interviews and focus group discussions on attitudes and perceptions toward male circumcision;
- An assessment of the public facilities and their readiness to roll out male circumcision services;
- An analysis describing the cost and impact of an uptake in male circumcision services.

The following are the highlights of the situation assessment:

- About one fifth of adult men (15-49 years) in Namibia are circumcised. The prevalence is highest in Kunene and Omaheke regions (50% and 57%), and mostly done by traditional circumcisers. Regions in the north (Omusati, Ohangwena, Oshana and Caprivi) have low prevalence of male circumcision. With a wide distribution of health facilities in these regions, there is an opportunity for scale-up of medical circumcision.
- There is general support for scale up of male circumcision at all levels. The perceived benefits of male circumcision were: health and hygiene; STI prevention; sexual pleasure; tradition and normative pressure. There was need for comprehensive education and behaviour change communication on male circumcision matched with services in order to manage demand.
- Currently medical circumcisions can only be performed by doctors and in hospitals. However, there is a shortage of resources for MC scale-up. There is need to shift tasks from doctors to nurses, strengthen health systems and linkages with private sector (providers, medical aid and employers) and traditional circumcisers as Namibia scales up safe MC services.
- Studies on the cost and impact of MC show that it is a cost-effective intervention compared to other HIV programmes. Scaling-up MC to reach 80 percent of adult, adolescent and newborn males in Namibia by 2016 would avert almost 35,000 adult HIV infections between 2009 and 2025².

A stakeholders meeting, chaired by the Minister of Health and Social Services, Honourable Dr. R.N. Kamwi, was held in August 2008. The objectives were to explain the international evidence of male circumcision on HIV incidence; share the results of the situation assessment; and develop a policy and action plan for rolling out male circumcision services in Namibia. The meeting was attended by about 150 participants from government, civil society, development partners, private sector, religious organizations and traditional circumcisers.

In addition to sharing the results of the studies described above, key results from the stakeholders meeting included:

- A better understanding of the practices of traditional circumcisers and a declaration to work together on the roll-out of MC services.
- A call for additional research to understand motivating factors for MC as a public health intervention that cuts across cultures.
- Information through a communication campaign on the benefits and risks of MC
- An official government support and commitment to the roll-out of MC

² Health Policy Initiative, "The Potential Cost and Impact of Expanding Male Circumcision in Namibia", 2009

- A need to meet demand guided by policy and action plans under government leadership. Namibia can learn from others as it develops its scale-up plan for MC as an intervention for HIV prevention.
- Participants input into policy and action plans development for MC.

Based on the situation assessment the participants at the Stakeholders Meeting agreed that safe, voluntary, MC was a viable and appropriate additional HIV prevention strategy for Namibia.

2. POLICY GOAL, OBJECTIVES AND CONTEXT

2.1. Policy Goal

programs for HIV prevention in combination with other effective HIV prevention strategies. This will contribute significantly to achieving the Millennium Development Goals (MDG 6) of halting and beginning to reverse the spread of HIV/AIDS by 2015. In order to achieve the expected public health impact on the HIV epidemic, a target based on mathematical modeling has been set to circumcise 80% of neonatal, adolescent, and adult males by 2015/16 .

This policy has been developed to provide a framework for policy-makers, programme managers and service providers to support the scale-up of safe MC. It complements the National Policy on HIV/AIDS and other existing related policies.

Policy Objectives

More specifically the policy seeks to:

- Provide guidance and clearly defined roles on how male circumcision services will be scaled-up in Namibia.
- Describe actions necessary to ensure that services provided are voluntary, safe and reflect Namibia's commitment to human rights.
- Present the plans for targeting different sections of the population with information on male circumcision in order to most effectively prevent new HIV infections in the country.
- Increase to 80% the number of neonatal, adolescent and adult males receiving safe MC services from the current baseline of 21% by 2015/16³.

2.2. Guiding Principles for an Enabling Environment

The male circumcision policy shall be guided by the principles stated in the National HIV/AIDS Policy, including:

- Broad political leadership and commitment towards providing MC services
- Promotion and protection of human rights
- Reduced stigma and discrimination related to HIV and circumcision status
- Information and referrals for male circumcision should be integrated into other HIV prevention, care and treatment, support, and reproductive health services
- Transparent and accountable governance with sufficient resources for sustainability and
- Programming and services provision based upon scientific evidence to ensure safety

³ Refers to NSF 2010/16

Additional guidance for achieving an increased uptake of MC services is as follow

- Involve women in MC service programming as partners and mothers
- Involve young people in MC programmes, both in-school and out-of-school
- Target most-at-risk populations for MC intervention
- Include marginalized groups and different ethnic groups in MC planning
- Involve faith based organizations (FBOs), traditional leadership, traditional circumcisers and health practitioners in planning and programming of MC services and
- Involve persons living with HIV and AIDS.

The policy shall apply to government and non governmental stakeholders involved in programming for safe MC for HIV prevention in Namibia. Relevant government ministries and bodies such as MOHSS; Ministry of Education; Ministry of Youth, National Service, Sports and Culture; Ministry of Gender and Child Welfare; Ministry of Regional, Local Government and Housing and Rural Development, as well as national and international Non-Governmental Organizations (NGOs and FBOs); private health practitioners and other partners are required to adhere to this MC policy.

The Task Force will collaborate with Health Professional Councils of Namibia (HPCNA) and all relevant regulatory bodies to ensure compliance with all scope of practice and high standard in the provision of safe medical MC.

3. MALE CIRCUMCISION POLICY STATEMENTS

The Government of the Republic of Namibia (GRN) recognizes MC as an effective and additional prevention intervention in the fight against HIV and AIDS in formulating this policy. MC is part of a national comprehensive HIV prevention package and shall be available to all males who voluntarily request it, including to male neonates whose parents or guardian voluntarily request the service for them.

MC should be integrated into other existing prevention strategies and be used as an entry point to reach males with wider sexual and reproductive health services and gender messages including messages about healthy male sexual norms and prevention of gender-based violence.

In line with WHO/UNAIDS recommendations, voluntary medical MC should be part of a prevention package offering at minimum the following services:

- Provider-initiated HIV counseling and testing
- Active syndromic STI screening and management
- Behavioral counseling including being faithful and partner reduction messages
- Condom promotion and distribution

This policy complements the National Policy on HIV/AIDS and shall be revised as new information on MC and HIV prevention becomes available in Namibia and internationally. Areas of MC programming covered in this policy document are:

- Groups targeted for intensive education on MC who are likely to have the greatest public health impact;
- Human resources and training for service providers required for MC roll out;
- Integration of male circumcision into existing health services;
- Safety and quality assurance;
- Communication and advocacy;
- The role of culture and traditional circumcisers;
- Human rights, ethics and legal issues.

Underlying these policy areas is the institutional framework to provide oversight of MC policy and programming in the country as described in Section 4.

3.1. Target groups

In order to reach the target of 80% of neonatal, adolescent, and adult males circumcised from the current baseline of 21% by 2015/16, MC services will be offered to all Namibian men. However, for programming purpose, the following groups will be prioritized to maximize public health benefit:

- Boys and men in the age group 10-49 years;
- Male neonates
- High-risk men (e.g. men with concurrent sexual partners, HIV-negative men with HIV-positive female sex partners)

The epidemic pattern of HIV should be considered for the phased rollout and targeting of MC services. This shall include the targeting of regions with high HIV prevalence and low circumcision rates, the availability of resources, and existing infrastructure.

3.2. Human Resources and Training

- MC services should be offered by doctors and appropriately trained registered nurses and midwives under the guidelines put forth by the MOHSS and the HPCNA to ensure safe, comprehensive MC services.
- Task shifting and task sharing⁴ strategies from medical officers to registered nurses and midwives to improve efficiency and increase the number of providers skilled in various clinical aspects of the MC procedure should be developed in collaboration with the HPCNA and incorporated into training and policy documents.
- Initial and refresher training should be provided to medical officers and other health care workers on the minimum package of safe MC services (see 3.4 below)
- Supervision plans should be put in place to assess/verify competency and adherence to standard operating procedures for health care workers performing clinical components of MC surgery.
- Health care workers performing MC should be trained as per the WHO Training Manual on MC under local anesthesia and/or other international standards and should be certified by the MOHSS and work in accordance with their registration with the HPCNA
- In the short-term, catch-up strategies shall be considered to meet the backlog of adolescents and adult males that need to be circumcised. The strategies could include, but are not limited to conducting dedicated MC days, using mobile circumcision teams, and temporarily recruiting volunteer physicians from outside Namibia to assist with circumcision campaigns.
- The MOHSS will collaborate with existing Traditional Circumcisers and will provide them with orientation support and training to ensure safety and hygiene of their practice.

3.3. Facilities

Facilities with the capacity to meet the following standards may be equipped to provide MC services:

- Minor surgery is currently (or could be) performed and MC may be performed according to accepted guidelines;

⁴ WHO (2007) Task shifting and sharing to tackle health worker shortages. Geneva. WHO.

Task shifting refers to a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. By reorganizing the workforce in this way, task shifting presents a viable solution for improving health care coverage by making more efficient use of the human resources already available and by quickly increasing capacity while training and retention programmes are expanded.

- There are appropriate medication, supplies and equipment (including emergency and resuscitation equipment) with observation facilities;
- There are appropriately trained and competent staff to provide MC surgery and pre- and post-operative assessments;
- There is an effective management and supervision system in place;
- There is compliance with sterilisation standards and infection control;
- MC and HIV information and education are available and provided;
- Provisions for patient referral are in place in the event of adverse effects and routine follow-up care may be provided;
- HIV testing and counseling, STI screening and treatment, and risk reduction counseling, and condoms are all available on site or by referral and
- Systems for monitoring and evaluation are in place and adhered to.

Hospitals and health centers with the capacity to address criteria for each standard can be assessed and equipped (and brought up to standard, if necessary) to meet the minimum quality assurance standards for safe MC delivery. MC may be done in settings other than health facilities provided the minimum standards outlined above are addressed.

3.4. Integration

Medical MC for adolescents and adult males will be integrated into existing Sexual and Reproductive Health (SRH) services and will serve as an entry point to provide males with services that include family planning (counseling, commodities and/or referral), sexual dysfunction, fertility screening and management and messages on the prevention of gender-based violence amongst others.

MC services shall be offered as part of a comprehensive HIV prevention package. The recommended minimum package includes:

- Access to provider-initiated HIV testing and counseling (PITC) ideally located on site;
- Syndromic screening for STIs and treatment when indicated;
- Behavioral counseling which includes counseling on the ABCs of HIV prevention and partner reduction;
- Promotion and provision of condoms and
- MC surgical procedure as described in the national Standard Operating Procedures (SOPs).

MC for neonates should be integrated within hospitals and clinic maternity wards routine services. The recommended minimum package for neonatal circumcision includes:

- Information and education on MC
- Parental/guardian consent
- Post procedure follow-up plans

3.5. Safety and Quality Assurance

- The MOHSS and the HPCNA shall develop SOPs to guide clinical practice. Such protocols and guidelines shall be based on WHO and internationally recommended techniques⁵.

⁵For more details see WHO, UNAIDS and JHPIEGO (2007) Manual on male circumcision under local anaesthesia (<http://www.who.int/hiv/topics/malecircumcision/en>)

- Minimum standards for safe MC services will be developed in line with WHO guidance for the delivery of safe quality services. These standards shall guide the setting up and provision of safe MC services and shall include: guidance on supervision and management of services; the minimum package of services; competency of providers; information provision; assessment, care and follow-up of clients; availability of drugs; supplies and equipment; continuity of care; referral systems and monitoring and evaluation.
- MC for HIV prevention shall be performed under local anesthesia in order to expand services to as many facilities and providers as possible and minimize health risks for the clients. General anesthesia should only be administered in special circumstances, when clinically indicated.
- Certification and regulation of all service providers shall be done within the medico-legal framework and the governing bodies within the MOHSS and HPCNA.
- Effective MC Supply Chain Management systems shall be developed and integrated within existing systems to ensure central, timely and cost-effective distribution of safe MC equipments, materials and commodities.

3.6. Socio-Cultural Issues and Traditional Circumcisers

- Scaling up of MC shall be sensitively handled, with respect shown for the diverse cultural practices. The Government of Namibia shall ensure that MC is promoted and delivered in a culturally appropriate manner that minimizes stigma associated with circumcision status.
- Women and girls should be involved in discussions and decisions about MC. Messages targeted directly to women and girls about MC's risks, benefits, and limitations to both males and females are essential.
- Government shall ensure engagement and participation of key community leaders in discussions and implications of safe MC programmes.
- Involvement of and training for traditional circumcisers in planning for MC programming will be encouraged.
- Traditional circumcisers shall be encouraged and assisted in developing and maintaining a coordinating body so that they can be supported to ensure compliance with the minimum safety and quality standards.
- MOHSS and its partners shall provide training and supplies accordingly in order to ensure compliance with the minimum safety and quality standard.

3.7. Information, Education and Communication Issues

- Information Education and Communication (IEC) is a cornerstone of a national MC program. The government will facilitate the development of a National Male Circumcision Communications Strategy that integrates evidence-based male circumcision communications into a wider HIV prevention communications approach and package.
- The National Male Circumcision Communications Strategy will lay the groundwork for the provision of behavior change communications that will facilitate primary and secondary audiences to make informed choices. Target audiences shall include:
 - o Primary: clients, males ages 10-49 years, most at risk males, parents and caregivers of males under the age of consent.
 - o Secondary: family members (people who influence male decision making); and women. Messages targeting directly women and girls about MC's risks and benefits to both males and females are essential.
 - o Secondary: opinion makers, religious, political, traditional, and business leaders; newly circumcised males and their partners.

- o Secondary: providers (public, private and traditional health sector; professional associations in medical and related fields; and medical insurance).
- o Secondary: Persons living with HIV and AIDS.
- The National Male Circumcision Communications Strategy shall provide direction on key communication messages for target groups and populations, including:
 - o MC is an additional HIV prevention measure promoted in the context of comprehensive HIV prevention strategies.
 - o MC does not provide 100% protection from HIV infection and circumcised men should use other effective HIV prevention measures including abstinence, partner reduction, consistent and correct condom use, and knowledge of HIV status of oneself and sexual partners.
 - o The HIV prevention benefits of MC are only for circumcised HIV negative males.
 - o Complete healing from MC surgery requires 6 weeks, and resumption of sexual activity before this 6-week period after operation may delay wound healing and increase a patient's risk of becoming HIV infected (if he is HIV negative) or infecting his sex partners with HIV (if he is HIV positive).
- The National Male Circumcision Communications Strategy shall promote a mix of advocacy, interpersonal communications, mass media, and substantial community dialogue. It shall also highlight the need for appropriate local messaging, and well coordinated reinforcement of messages and communications between all channels.
- MC advocacy approaches shall reach leadership at national and community levels and ideally these leaders should play a substantive role in MC communications.
- Partners shall implement activities under the National MC Communications Strategy in coordination with the overall development and roll out of MC services.

3.8. Human Rights, Ethics and Legal Issues

A key consideration in the provision of MC services is the issue of non discrimination in the access to services:

- The Government of Namibia shall ensure that safe MC is provided with full adherence to medical ethics and human rights principles and in compliance with the national legal framework. MC is voluntary and informed consent, confidentiality and absence of coercion will be assured.
- For neonates, infants and minors, informed consent shall be obtained from parent(s) or guardian(s) including care-givers or social workers. They shall be provided with sufficient information regarding the benefits and risks of the procedure in order to determine what is in the best interests of the child. As minors become competent to make decisions, their views shall be increasingly taken into account and informed. Minors will provide non-coerced assent.
- HIV testing and counseling shall be routinely offered on a voluntary basis to all men prior to circumcision, but refusal to take an HIV test shall not constitute grounds for denying circumcision to that individual.
- Circumcision shall be provided to men living with HIV or unknown status if they request it unless medically contra-indicated. However, these men will be informed that there is no evidence to suggest that circumcision protects their sex partners from being infected by them. Those testing HIV positive as part of the provider initiated testing of the MC program should be appropriately referred for care and treatment
- Social and behavioural communication strategies shall avoid stigmatization and discrimination with respect to circumcision status.
- An enabling environment shall be put in place for safe MC through the involvement of all key stakeholders, including traditional circumcisers.

4. INSTITUTIONAL ARRANGEMENTS

The Government of Namibia will provide the leadership in the planning and implementation of safe male circumcision scale-up. However it is recognized that partnerships with other government bodies, civil society organizations (NGOS and FBOS) and international and development partners is essential for the success of MC roll out.

4.1. The Ministry of Health and Social Services

The Directorate of Special Programmes (DSP), in the MOHSS will coordinate the planning and implementation of the roll out of safe MC services, ensuring that MC services are integrated with other HIV/AIDS and reproductive health services.

MOHSS will coordinate with other government entities including, but not limited to primary and tertiary care and pharmaceutical services.

DSP will have overall responsibility for implementing this policy, developing a national strategic plan, a costed action plan, national guidelines and SOP. The DSP will also ensure training of providers, quality control and resources mobilization and allocations for MC scale up. Although DSP in the MOHSS will take the lead in rolling-out MC services in Namibia, there are many other governmental, NGOs and development partners involved in MC scale up.

The HPCNA will play important roles in setting standards for nurses and other health care providers. Nongovernmental organizations, FBOs and development partners will be integral in providing ongoing training for health care professionals, and will play important roles in helping to educate the community about MC and assist with demand creation and linkages to service. Finally, communities in Namibia are the most important partner in MC roll-out .They must understand the importance of MC and access these services.

4.2. Technical Committee for Prevention

The Technical Committee for Prevention shall assist the country with the oversight and the technical guidance for scaling up safe MC services. The Technical Committee will be convened by the National Prevention Coordinator and shall meet as needed and develop sub-committees accordingly to focus on specific areas. The Technical committee shall comprise of representatives of all stakeholders relevant to prevention services and shall report regularly to NAEC.

4.3. Funding

- In line with other public health and HIV interventions such as the provision of antiretroviral therapy, MC for HIV prevention shall be provided at a minimum cost applicable in public health facilities.
- Costing and impact study results will inform programming and service delivery. Elements of a comprehensive package of MC services to be costed include: human resources, communications, demand creation, HIV testing and counseling, pre-and post-circumcision information and education, training of providers (counseling and surgical skills course), promotion and provision of condoms and STI screening and treatment.
- Advocacy activities shall be held with Namibian Medical Aid Fund to encourage coverage of elective MC for preventative purposes at reasonable cost.
- Additional technical and financial resources will be mobilised from the government budget as part

of the commitment of the Government to the Abuja Declaration of 2001 and the MDGs, and from other bilateral and multilateral funding mechanisms.

- Measures shall be put in place to ensure efficient use of resources. Additionally, efforts will be made to ensure that MC does not divert resources from other essential interventions.

4.4. Monitoring and Evaluation

Standard monitoring and evaluation indicators related to the goal and objectives of safe MC programming have been developed and included in the results framework of NSF,

the National Prevention Strategy, and in the Health Information Systems (HIS) in line with the “Three ones” principle. These include numbers of males circumcised by 2015/16 as per Table 1 below. Additionally, information on occurrence of adverse events, number of STIs diagnosed and treated, number of people tested, number of trained providers and service delivery sites, supplies of commodities and equipment may be collected. Demand for and delays in receiving services, behaviour change, knowledge, attitudes, and beliefs about MC, and changes in HIV incidence following implementation may be evaluated through operations research and targeted evaluations.

Operational research and programme evaluation on safe MC and HIV prevention shall be encouraged and supported including amongst traditional circumcisers. These studies should complement and improve the information collected during the situation assessment.

The target numbers to be reached in each target group shall be assessed according to epidemiological and demographic data.

Finally, standardized data collection tools, and interpretation and dissemination systems shall be developed and will be maintained through a nationally coordinated M&E system.

Annex 1: M&E

Table 1: Monitoring and Evaluation plan for MC as per NSF

Prevention impact level results	Outcome level results	Programs and their output level results
<p>Fewer adults become infected with HIV</p> <p>IR-1: Annual number of new infections has reduced by 50% between FY2010/11 to FY2015/16 (NDP3 goal 14).</p> <p>Fewer young people are HIV positive:</p> <p>IR-2: % of pregnant women attending ANC aged 15-24 who are HIV infected reduced from 11% in 2008 to 5% by FY2015/16</p>	<p>Reduce risk of infection in the general population if possible exposure has occurred, by ensuring that:</p> <p>OC20: More men are circumcised by a health professional: % boys and men aged 10-49 who reported being circumcised by a health professional increased from 15%⁶ in 2007 to 40% in FY2015/16.</p>	<p>Comprehensive Male circumcision program for all newborns and males in Namibia</p> <p>OP28: Between FY2010/11 and FY2015/16, 450,000 men would have been circumcised as part of the minimum package of MC for HIV prevention services.</p> <p>OP29: % of health facilities that provide MC surgery as part of the minimum package of MC for HIV prevention services in the last 12 months has increased from 5% in 2008 to 60% in FY2012/13 and to 90% in FY2015/16.</p> <p>OP30: Between FY2010/11 and FY2015/16, 167, 900 male newborns have been circumcised in the first week of life (80% of newborns).</p> <p>OP31: % primary caregivers reached with male circumcision communication interventions has increased from less than 5% by 2009 to 70% by FY2012/13 and to 90% by FY2015/16</p>
	<p>OC21: Most newborns are circumcised at a health facility just after birth: % of newborn male infants circumcised in a health facility in the first week of life is increases to 80% in FY2015/16.</p>	
	<p>OC22: Circumcised men continue to use condoms when they have sex: Among circumcised men aged 15-49 who had higher-risk sex in the past 12 months, the % who used a condom with last non-cohabiting partner has increased from 81.3% in 2007 to 90% in FY2015/16.</p>	
	<p>OC23: Circumcised men have fewer sexual partners: Among the circumcised men aged 15-49 who had sexual intercourse, the percentage who had multiple partners in the last 12 months decreased from 18.1% in 2007 to 10% in FY2015/16</p>	

⁶ Although the DHS percentage states 11%, this 11% includes those persons not circumcised at health facilities. Closer inspection and further calculations reveal that it is 15% of men who have been circumcised at a health facility, which is the baseline that the indicator definition calls for. OC20: Slight change from NSF because this is a programmatic policy.

ANNEX 2: GLOSSARY

Male Circumcision refers to the surgical removal of the foreskin (prepuce) from the head of the penis.

Randomized Controlled Trials is a type of scientific experiment most commonly used in testing the efficacy or effectiveness of health care services.

Certification refers to the process of having a system's security posture formally assessed (certified) and approved by the appropriate authorities designated by the organization that own the system.

Integration of services refers the combining and provision of different health care services together as a means of achieving greater access to care, increased participation, more equity and enhanced effectiveness, particularly in situation where a critical shortage of resources forces planners to look for new cost – effective solutions.

HIV Prevention Package refers to all effective HIV preventives measures which includes: promoting delay in the onset of sexual intercourse, abstinence from penetrative sex and reduction in the number of sexual partners; providing and promoting correct and consistent use of male and female condoms; providing HIV testing and counseling services; providing services for the treatment of sexual transmitted infections and provision of male circumcision.

Quality Assurance refers to the process of verifying or determining whether the products or services meet or exceed customer expectations.

Syndromic Management refers to the treatment of STIs based on the symptoms and signs of the specific infections.

Traditional Circumcisers refers to the persons who are culturally accepted to perform male circumcision in their communities for cultural and religious reasons.

Task Shifting refers to a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. By reorganizing the workforce in this way, task shifting presents a viable solution for improving health care coverage by making more efficient use of the human resources already available and by quickly increasing capacity while training and retention programmes are expanded.

Task Sharing refers to one task that is being performed by two health workers who are complimenting each other.

