Strengthening the Adolescent Component of National HIV Programmes through Country Assessments

REPORT ON PHASE 2 OF THE NAMIBIA “ALL IN” COUNTRY ASSESSMENT 2016
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Ministry of Health and Social Services
Joint United Nations Programme on HIV/AIDS
United Nations Children’s Fund

REPUBLIC OF NAMIBIA
April 2017
Phase 2 of the Namibia ALL IN Country Assessment was funded by the United States President’s Emergency Plan for AIDS Relief (PEPFAR) through the Centers for Disease Control and Prevention (CDC).

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ALL IN

#EndAdolescentAIDS
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<tr>
<td>AADM</td>
<td>Adolescent Assessment and Decision-Maker’s (tool)</td>
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<tr>
<td>AFHS</td>
<td>Adolescent Friendly Health Services</td>
</tr>
<tr>
<td>AfriYAN</td>
<td>African Youth and Adolescents Network</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ALHIV</td>
<td>Adolescent(s) Living with HIV</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Treatment/Therapy</td>
</tr>
<tr>
<td>BNA</td>
<td>Bottleneck Analysis</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CDC-COAG</td>
<td>CDC-UNICEF Co-operation Agreement</td>
</tr>
<tr>
<td>CSE</td>
<td>Comprehensive Sexuality Education</td>
</tr>
<tr>
<td>DHMIS</td>
<td>District Health Management Information System</td>
</tr>
<tr>
<td>DSP</td>
<td>Directorate of Special Programmes (in the MoHSS)</td>
</tr>
<tr>
<td>EDT</td>
<td>Electronic Dispensing Tool</td>
</tr>
<tr>
<td>EPMS</td>
<td>Electronic Patient Monitoring System</td>
</tr>
<tr>
<td>ESA</td>
<td>Eastern and Southern Africa Ministerial Commitment for CSE</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-Based Violence</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>HAMU</td>
<td>HIV and AIDS Management Unit (in the MoEAC)</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Testing and Counselling</td>
</tr>
<tr>
<td>LSBE</td>
<td>Life Skills Based HIV Education</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MGECW</td>
<td>Ministry of Gender Equality and Child Welfare</td>
</tr>
<tr>
<td>MoEAC</td>
<td>Ministry of Education, Arts and Culture</td>
</tr>
<tr>
<td>MoHSS</td>
<td>Ministry of Health and Social Services</td>
</tr>
<tr>
<td>MSYNS</td>
<td>Ministry of Sports, Youth and National Service</td>
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<tr>
<td>NAPPA</td>
<td>Namibia Planned Parenthood Association</td>
</tr>
<tr>
<td>NDHS</td>
<td>Namibia Demographic Health Survey (2013)</td>
</tr>
<tr>
<td>NDP</td>
<td>National Development Plan</td>
</tr>
<tr>
<td>NHSS</td>
<td>National HIV Sentinel Survey</td>
</tr>
<tr>
<td>NIMART</td>
<td>Nurse Initiated Management of Antiretroviral Therapy</td>
</tr>
<tr>
<td>NSF</td>
<td>National Strategic Framework (for HIV and AIDS Response in Namibia)</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>United States President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PITC</td>
<td>Provider-Initiated Testing and Counselling</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living With HIV</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission of HIV</td>
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<tr>
<td>RM&amp;E</td>
<td>Response Monitoring and Evaluation (subdivision of the DSP in the MoHSS)</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>VMMC</td>
<td>Voluntary Medical Male Circumcision</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Namibia is proud to be one of the countries which have implemented the ALL IN Phase Two Country Assessment. Following the ALL IN Phase One Country Assessment, which highlighted some limitations affecting coverage of high-impact programme interventions among adolescents, the Ministry of Health and Social Services rose to the challenge and conducted an in-depth analysis of the bottlenecks and gaps preventing the country from effectively reaching adolescents with high-impact interventions.

The training workshop on bottleneck analysis offered a unique capacity-building opportunity for programme and data practitioners, in turn giving Namibia a pool of expertise in data analysis and planning, which is essential for effective programme design for adolescents and HIV.

The participation of adolescents and young people in the bottleneck analysis and development of the regional plans offered first-hand information on the most pressing issues affecting adolescents. It was very rewarding to hear the voices of adolescents and young people on their experiences and perspectives with regard to the national HIV response. The Government will continue to provide platforms and engage adolescents in its efforts to ensure that programmes for adolescents are designed with and by adolescents themselves.

The ultimate result of Phase Two is the availability of costed regional plans on adolescents and HIV, including a monitoring and evaluation framework. This was the first time that multi-sectoral regional teams developed data-driven action plans through a bottleneck analysis methodology. These plans are informing the development of the new National Strategic Framework on HIV (2017/18-2021/22), which has a strong focus on adolescents. The regional plans have also informed the development of the “Global Fund Concept Note”, thereby contributing to the leveraging of HIV-related resources for adolescents, especially adolescent girls and young women.

The Ministry is committed to intensifying the national efforts to sharpen the focus on adolescents in the national HIV/AIDS response by ensuring that these regional micro-plans are well resourced and timeously implemented. Accelerated efforts will be made towards the realisation of positive results for adolescents, particularly in the provision of HIV testing and counselling, treatment and adherence support for adolescents living with HIV, voluntary male medical circumcision, and appropriate messaging on issues affecting adolescents so as to address stigma and discrimination.

Financial support from PEPFAR through the CDC, and partnership with UNICEF and UNAIDS, have made it possible for the Ministry to boast of the development of regional plans on adolescents and HIV/AIDS which are specific and relevant to each region.

The Ministry gratefully acknowledges the continuous support provided by UNICEF and UNAIDS in ensuring that adolescents and young people are a priority population group if the country is to end AIDS by 2030.

Dr. Andreas Mwoombola
Permanent Secretary
Ministry of Health and Social Services
Phase Two of the ALL IN Country Assessment process in Namibia presented an opportunity to mobilise efforts for adolescents through interrogating adolescents’ own data on low-performing HIV interventions in the seven high-burden regions identified during the first phase of the process. Following the implementation of Phase One, the Ministry of Health and Social Services carried out an in-depth analysis of the gaps and bottlenecks that hamper effective coverage of HIV interventions for adolescents. The bottleneck analysis was supported by PEPFAR through the CDC with technical assistance from UNICEF and UNAIDS.

A global team of programme and data experts in bottleneck analysis methodology from the UNICEF New York Office trained a multi-sectoral national task team on bottleneck analysis and planning to facilitate Phase 2. Using the Adolescent Assessment and Decision-Maker’s (AADM) tool, the task team acquired new knowledge and skills in data-driven planning and analysis, which prepared them to lead the process of developing regional micro-plans on adolescents and HIV. The AADM generated visual reports which enabled identification of bottlenecks and corrective actions.

The training workshop was followed by regional-level data gathering and analysis through consultative and participatory workshops which included participation of adolescents and young people. The workshops offered a platform for identification of solutions and prioritisation of interventions and strategies to address the bottlenecks.

To address the bottlenecks, the regions have developed corrective action plans aimed at:

- strengthening the stock-management system;
- increasing retention on ART amongst adolescents;
- increasing the number of health workers trained in AFHS;
- increasing the number of ART sites providing AFHS;
- achieving 100% viral load suppression; and
- curbing the rate of teenage pregnancies.

These regional plans include strengthened adolescent-focused messages while engaging parents and communities to support adolescent health-seeking behaviour for both HTC and ART aimed at improved adherence and virological suppression.

UNICEF and UNAIDS will continue to support the Government to use innovative strategies to scale up and accelerate programme interventions for adolescents. Technical support will be provided towards implementation of the regional plans and national leveraging of resources towards a stronger-focused adolescent programme. In addition, further technical support will be provided to the Government for intensifying advocacy on adolescents and HIV/SRH programming, and for redirecting financial resources and efforts to subnational level and supporting implementation of high-impact interventions for adolescents.

Ms Micaela Marques De Sousa
Representative
UNICEF

Dr Tharcisse Barlhuta
Country Director
UNAIDS
7 REGIONS STUDIED

OMUSATI
OHANGWENA
OSHIKOTO
OSHANA
OTJOZONDJUPA
ERONGO
KHOMAS
KAVANGO
WEST
EAST
ZAMBEZI
KUNENE
OMAHEKE
HARDAP
//KHARAS

Angola
Zambia
Botswana
South Africa

Atlantic Ocean

South Africa

Report on Phase 2 of the Namibia “ALL IN” Country Assessment 2016
Background

Globally, adolescents are the only age group in which AIDS-related deaths are not decreasing, while in Africa, AIDS is the leading cause of death among adolescents. ALL IN is a global platform for action to accelerate the campaign to end adolescent AIDS by 2030. Namibia is one of the 22 countries which are globally implementing the ALL IN initiative. This initiative supports countries in strengthening the adolescent component of their national HIV programmes, through a three-phase country assessment process. Phase 1 is a rapid national assessment aimed at defining the priority adolescent populations (i.e. those who are most vulnerable or most at risk), their locations in the country, and the interventions that are most critical and are also low-performance interventions (i.e. the rates of service provision are low). Phase 2 is an in-depth analysis of gaps and bottlenecks that hamper coverage in the high-burden locations identified in Phase 1. The third phase involves planning and developing corrective actions to address bottlenecks and gaps. Namibia conducted Phase 1 in October 2015 under the leadership of the Ministry of Health and Social Services (MoHSS), and identified seven high-burden regions, six priority adolescent populations and seven priority interventions for the in-depth analysis of bottlenecks at sub-national level.

Objectives

The objectives of the in-depth analysis were to:
1) conduct determinant analysis of key indicators of supply, demand and quality of interventions to identify bottlenecks in high-burden geographical areas;
2) undertake causality analysis of the observed bottlenecks in relation to supply, demand and quality factors;
3) identify corrective actions to address the observed bottlenecks in the high-burden geographical locations; and
4) formulate regional micro-plans from the corrective actions for evidence-informed planning and monitoring.

Methodology

Bottleneck analysis was conducted using both quantitative and qualitative data-collection methods. Findings from Phase 1 were used to identify low-performance interventions and high-burden regions. Seven regions were identified: Erongo, Kavango East and West, Khomas, Omusati, Otjozondjupa and Zambezi. Regional profiles were used to select specific geographical locations in these regions and also priority interventions for each region. Five interventions were selected: HIV Testing and Counselling (HTC); Antiretroviral Treatment (ART); Voluntary Medical Male Circumcision (VMMC); Prevention of Teenage Pregnancy; and In-School Life Skills Based HIV Education (LSBE). Quantitative data using indicators of supply, demand and quality for selected interventions was collected and
analysed using the Adolescent Assessment and Decision-Maker’s (AADM) tool. This tool generated visual reports of the determinant analysis to identify the bottlenecks. Causes and corresponding corrective actions were identified through three qualitative methods: facilitated workshops; focus group discussions; and in-depth interviews with key stakeholders, including representatives of government, civil society organisations and adolescents.

**Results**

Major findings of the in-depth analysis were: (1) stock-outs of commodities for HTC, ART and VMMC due to supply-chain challenges; (2) unavailability of health workers trained on Adolescent Friendly Health Services (AFHS) in most of the selected regions; and (3) lack of AFHS provision in all seven regions – which affected accessibility of HIV services. Low initial utilisation was noted in HTC and VMMC, and low continued utilisation was noted in ART, HTC and VMMC. For these and other reasons, all regions except Zambezi selected HTC as an intervention. Low-quality data or data gaps of quality indicators were observed in all five interventions. Identified causes of the identified bottlenecks included lack of AFHS, poor stock control, lack of integrated HIV services, perceived lack of parental support and lack of adherence to guidelines. Proposed solutions included capacity building of health workers, approaches which are more adolescent-focused (e.g. teen clubs and messaging through different media), AFHS provision and data-improvement plans to address the observed data gaps.

**Lessons learnt**

The involvement of regional people in the ALL IN process improved ownership and stimulated data demand and utilisation. In addition, the process provided a platform to raise awareness on data use for planning, existing data gaps and policy updates. It also provided capacity building for regions on planning and on linking data with programming. The further step of developing regional plans with corresponding monitoring and evaluation plans offered a seamless process into the third phase, involving evidence-based planning. Other lessons learnt were that there are numerous national policies and guidelines which are not implemented at regional level, and there is a need to find strategic ways of capturing and disaggregating data, especially for age 10-14, in order to ensure data availability for the whole adolescent population. The main limitation was unavailability of data for certain variables, including unavailability of data for age 10-14 years across most of the interventions, and data gaps for some indicators in all interventions.

**Recommendations and next steps**

The country assessments are aimed at strengthening the adolescent component of the national HIV response. Key recommendations for facilitating this aim include: strengthening AFHS provision to align with initiatives such as disclosure; Nurse Initiated Management of Antiretroviral Therapy (NIMART); and Provider-Initiated Testing and Counselling (PITC). In addition, taking to scale identified best practices such as the teen club approach and integrating Sexual and Reproductive Health with HIV (SRH/HIV) would greatly improve adolescent programming. Other recommendations include: strengthening the multi-sectoral collaboration; meaningful involvement of adolescents; and use of adolescent-focused HIV and SRH messages. Adopting the Bottleneck Analysis (BNA) methodology at regional level provides a bottom-up approach for evidence-based planning of programmes. By formulating corrective actions and data-improvement plans, the ALL IN process provides a bottom-up approach to addressing equity and performance gaps in order to improve adolescent HIV programming. However, the successful implementation of these regional plans depends on their alignment with national processes. Consequently, the next steps are: resource mobilisation; and advocacy and monitoring of the regional plans through existing forums.
2.1 Country context

Namibia has a surface area of approximately 824,116 km² and is divided into 14 administrative regions. The 2011 Population and Housing Census found that Namibia had about 2,113,077 people, with about 2.6 inhabitants per square kilometre and thus the second-lowest population density in the world.¹

Namibia has a generalised and mature HIV epidemic, in which HIV is transmitted primarily through heterosexual and mother-to-child transmission. HIV prevalence among people of ages 15-49 is estimated to be 14%, with an estimated total of 260,000 people aged 15 and older living with HIV.

¹ Namibia Statistics Agency (NSA), Namibia 2011 Housing and Population Census Main Report.
The revised 2015 estimate projects an increase of the number of people living with HIV (PLHIV) to over 273,000 in 2017 and over 296,000 by 2020.2

According to the Namibia Demographic and Health Survey of 2013, HIV prevalence in the country has geographical heterogeneity between sites, with the highest prevalence rate at 23.7% and the lowest at 7.3%.3 Similarly, there is a gender disparity in HIV prevalence, with a prevalence of 16.9% among women aged 15-49 and 10.9% among men in this age group. The same gender disparity is observed among young people aged 15-24, with a prevalence of 4.4% among women and 2.7% among men. The National HIV Sentinel Survey (NHSS) of 2016 found an overall prevalence of 17.2% among pregnant women attending antenatal clinics, this being a slight increase from 16.9% in 2014. The upper bound prevalence was in Zambezi Region at Katima Mulilo site, at 32.9%. These results suggest that Namibia’s epidemic continues to be in the stabilisation mode, with slow yet sustained decreases in HIV prevalence among pregnant women since 2002.

As a result of the Government of Namibia’s commitment to combating HIV, this country’s scale-up of Antiretroviral Treatment (ART) has been one of the most robust in the world. In 2016, the coverage of ART among all PLHIV is at 69%, with 67% of adults and over 95% of children aged 0-14 receiving ART. Similarly, PMTCT coverage is above 95% among HIV-positive pregnant women.4 Moreover, these coverage rates have been achieved with a mainly national budget. In the 2013/14 fiscal year the Government provided 64% of the overall expenditure on antiretroviral (ARV) medicines.5

The Revised Namibia National Strategic Framework (NSF) for HIV and AIDS Response in Namibia 2010/11-2016/17 adopted the investment approach for prioritising and investing in national responses to HIV/AIDS. In addition, Namibia has adopted the 2016 WHO ART guidelines, and currently the Test All model is being piloted in three regions.

2.2 Overview of Phase 1 of the Rapid National Assessment

Globally, adolescents (ages 10-19 years) are the only demographic group in which AIDS-related deaths are not decreasing.6 In addition, AIDS is the leading cause of death among adolescents in Africa.7 ALL IN is a platform for action and collaboration to drive better results with and for adolescents through critical changes in programmes and policy. ALL IN aims to unite actors across sectors to accelerate reductions in AIDS-related deaths by 65% and new HIV infections among adolescents by 75% by 2020, and thereby set the global AIDS movement on track to end the epidemic among adolescents by 2030.

Namibia is one of 22 countries which are globally implementing the ALL IN initiative. ALL IN supports countries to identify gaps and define priority actions to accelerate the HIV response for adolescents and to reach targets by 2020. This is achieved through a three-phase country assessment. Phase 1 consists of a rapid national assessment aimed at defining the priority adolescent populations (i.e. those who are most vulnerable or most at risk), their locations in the country, and the interventions that are most critical and are also low-performance interventions (i.e. the rates of service provision are low). Phase 2 consists of an in-depth analysis of gaps and bottlenecks that are hampering coverage in the high-burden locations identified in Phase 1. The third phase harmonises decisions

3 MoHSS and Namibia Statistics Agency (NSA), Namibia Demographic and Health Survey 2013.
4 MoHSS, Spectrum Estimates 2016.
and outputs from Phases 1 and 2 into a multi-sectoral action plan aimed at improving the adolescent component of HIV programmes at sub-national level.

In Namibia, the Phase 1 assessment was conducted in October 2015 under the leadership of the MoHSS, through a consultative process involving international development and implementing partners, civil society organisations, and representatives of adolescent and youth groups including adolescents living with HIV (ALHIV).

The assessment consolidated available data from various sources in Namibia using the Adolescent Assessment and Decision-Maker’s (AADM) tool, which revealed and facilitated analysis against the demographic, HIV epidemiological, HIV programmatic and broader programme indicators.

Key data sources were:
- the report on the Namibia Demographic and Health Survey (NDHS) 2013;
- the report on the National HIV Sentinel Survey 2014;
- UNAIDS 2014 HIV and AIDS estimates (generated by the software called “Spectrum”);
- a review of documents – reports, policy documents and programmatic data;
- qualitative assessments – focus group discussions and expert opinions on programmes;
- the MoHSS’s District Health Information System (DHIS);
- “Synthesis of the Namibia AIDS Epidemic based on Most Recent Epidemiological Data, March 2015” (MoHSS/UNAIDS); and
- the National Guidelines for Antiretroviral Therapy disseminated in January 2014.

The rapid national assessment generated findings on: the HIV epidemic and programme response as regards adolescents in Namibia; specific data relating to this response; and the adolescent-related policy and programme environment.

**Adolescent HIV epidemic and programme response in Namibia**

Adolescents represent about a quarter (23%) of the total Namibian population, although this varies across regions. The HIV prevalence rate among adolescents is equal among females and males in the 10-14 age group, but gender disparity increases with age, such that the rate among females aged 20-24 is almost twice as high as the rate among males in the same age group. Similarly, there are more adolescent girls living with HIV than boys. In 2014, the estimated total number of ALHIV in Namibia was 11 035 – 6 087 girls and 4 948 boys. In addition, there are geographical variations among female and male ALHIV in Namibia: about two out of every three adolescent boys living with HIV are in two regions, namely Zambezi (34%) and Omusati (32%), whereas the adolescent girls living with HIV are more widely distributed, with about 18% in Omusati, 17% in Zambezi and 13% in Otjozondjupa.

In the years 2010-2015, Namibia saw an overall decrease in new HIV infections among adolescents from 1 200 to 1 000. However, if this rate remains steady, the projected reduction by 2020 will be 25%, which falls short of the 2020 target of 75%.

Programmatic responses explore: HIV interventions; key combination prevention interventions; social and programmatic enablers; and cross-sectoral interventions.

**HIV interventions**

The uptake of HIV testing is low among adolescents in Namibia, with only 28.5% of females and 13.9% of males aged 15-19 tested in the last 12 months. Moreover, none of the regions are on track
with the coverage of HIV testing of adolescent boys, and only two regions are on track with testing of girls. In contrast, for the 20-24 age group, all regions are on track for females and 50% are on track for males.

For ART, coverage among adolescents is 74% among girls and 86% among boys, both rates being below the national target. The coverage is highest in the 10-14 age group, at 92% among girls and 94% among boys. There is a sharp decline in the 15-19 age group, especially among girls, at 61% among and 76% among boys. The coverage further declines in the 20-24 age group, at 39% among women and 14% among men. The declining ART coverage with age and corresponding low HIV testing rates indicates challenges in initiation among newly infected adolescents and young adults and retention of patients on ART as they transition into adulthood. Viral suppression is 74% and 70% for adolescent girls and boys on ARVs respectively, which is below the national target of 80%. The viral load suppression is higher in the 10-14 age group, at 73% compared to 63% among those aged 15-19. Similarly, viral load suppression is higher among girls than boys in both age groups. The regional data shows that coverage is on track in six regions. However, it is important to note that this viral suppression data is limited, and it is advisable to monitor the trend over time with the ongoing implementation of routine viral load testing.

**Key combination prevention Interventions**

Condom use among adolescent is 61% and 75% among girls and boys respectively, which is lower than the national coverage target of 85% for girls and 90% for boys. Similarly, coverage for adolescent male circumcision is at 21%, which is far below the national target of 45%.

**Social and programmatic enablers**

For comprehensive knowledge on HIV, the estimated coverage in the 15-19 age group is 56% among girls and 51% among boys, which are very low rates compared to the national target of 90%. The older males (20-24) are no more knowledgeable, as is indicated by the same rate of 51% compared to 68% among their female counterparts. Data also shows that coverage for adolescents is not on track in any region.

**Cross-sectoral interventions**

The prevalence of sexually transmitted infections (STIs) is at 10% among girls and 5% among boys, both rates being five times higher than the national targets.

The rate of teenage pregnancy is 19% nationally. However, data reveals large disparities in teenage pregnancy rates, ranging from 38% to 9% across the regions. In addition, the 2013 NDHS report observes that the teenage pregnancy rate in Namibia had increased by 5% since the 2006-07 NDHS.

Alcohol consumption is reported by nearly half of the adolescent boys (46%) and one in every four adolescent girls (25%). In addition, more than a third of adolescent girls (34%) report having experienced physical or sexual violence.

**Data-related issues**

There is much programmatic data at both regional and national level. However, it is neither easily accessible nor well analysed. In addition, different programmes apply different age classifications, with the result that data on adolescents, especially for ages 10-14, is not easily accessible.
Adolescent policy and programme environment

The adolescent policy and programme environment is assessed by assessing performance in eight dimensions of policy-making and programming, with a summary score on a scale of 0-10 used to illustrate the relative strengths of Namibia’s performance in each area, based on the perspectives of the four stakeholder groups consulted (Table 1).

As the last column in Table 1 shows, coverage was not on track in any of the eight dimensions. The largest coverage gaps were in Monitoring and Evaluation (M&E) and National Situation Analysis (of adolescent programmes). There has been some progress in the areas of Legislation, Adolescent and Youth Participation and Resource Mobilisation. Although there has been substantial progress as regards National Policies, Strategies or Plans of Action, Co-ordination Mechanism and Consultative Processes, there is a large disconnect between adolescents and other stakeholders in terms of perspectives of these matters.

Table 1: Stakeholder Assessment of Enabling Environment for Adolescent Programming in Namibia

<table>
<thead>
<tr>
<th>Programming Dimension</th>
<th>Government</th>
<th>International Development Partners</th>
<th>Civil Society Organisations / NGOs</th>
<th>Adolescents / Youth</th>
<th>Overall Country Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Situation Analysis</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>National Policies, Strategies or Plans of Action</td>
<td>9</td>
<td>9</td>
<td>8</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td>Co-ordination Mechanism</td>
<td>8</td>
<td>10</td>
<td>10</td>
<td>4</td>
<td>8.0</td>
</tr>
<tr>
<td>Consultative Processes</td>
<td>8</td>
<td>7</td>
<td>8</td>
<td>4</td>
<td>6.8</td>
</tr>
<tr>
<td>Legislation</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>6</td>
<td>5.8</td>
</tr>
<tr>
<td>Adolescent and Youth Participation</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>4.3</td>
</tr>
<tr>
<td>Resource Allocation and Mobilisation</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3.8</td>
</tr>
<tr>
<td>Monitoring and Evaluation</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0.5</td>
</tr>
</tbody>
</table>

**COLOUR KEY**

- On track (9-10)
- Substantial progress (6-8.9)
- Some progress (3-5.9)
- No progress / very little progress (0-2.9)
Phase 1 of the country assessments was aimed at informing the in-depth analysis to be undertaken as Phase 2. This required defining:

- priority adolescent populations on whom to focus the programme response;
- high-impact HIV programmes and cross-sectoral opportunities for accelerating results among adolescents; and
- high-burden geographical locations in which to focus programme interventions for maximum impact.

Based on the results of Phase 1, the **priority adolescent populations** defined for the programme response and the analysis in Phase 2 were:

1) adolescent girls and young women;
2) adolescents living with HIV;
3) adolescent mothers and pregnant adolescents;
4) adolescents out of school;
5) adolescents engaged in transactional sex or selling sex; and
6) adolescent girls and boys aged 10-14 years.

The **priority interventions** examined in Phase 2 are:

1) HIV Testing and Counselling (HTC);
2) Antiretroviral Treatment (ART);
3) Voluntary Medical Male Circumcision;
4) Prevention of Teenage Pregnancy;
5) Condom Use;
6) Comprehensive HIV Knowledge; and
7) Alcohol and Substance Abuse.

Seven regions were identified as **high-burden locations** for adolescent HIV: Erongo, Kavango East and West, Khomas, Omusati, Otjozondjupa and Zambezi.
3.1 Introduction to the in-depth analysis

The coverage of the selected interventions in the adolescent HIV high-burden areas was explored in this phase, as per the regional prioritisation matrix shown in Table 2 (next page).

Regional data was not available for the interventions on Condom Use and VMMC, and the cross-cutting interventions on Gender-Based Violence (GBV).
### Table 2: Regional Prioritisation Matrix

<table>
<thead>
<tr>
<th>Region</th>
<th>Geographical distribution of HIV among adolescents</th>
<th>HTC coverage gap</th>
<th>Comprehensive knowledge about HIV coverage gap</th>
<th>Adolescent pregnancy gap</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Erongo</td>
<td>12%</td>
<td>0%</td>
<td>23%</td>
<td>30%</td>
</tr>
<tr>
<td>Kavango</td>
<td>11%</td>
<td>0%</td>
<td>3%</td>
<td>36%</td>
</tr>
<tr>
<td>Khomas</td>
<td>0%</td>
<td>11%</td>
<td>14%</td>
<td>30%</td>
</tr>
<tr>
<td>Omusati</td>
<td>18%</td>
<td>32%</td>
<td>24%</td>
<td>40%</td>
</tr>
<tr>
<td>Otjozondjupa</td>
<td>13%</td>
<td>12%</td>
<td>21%</td>
<td>36%</td>
</tr>
<tr>
<td>Zambezi</td>
<td>17%</td>
<td>34%</td>
<td>11%</td>
<td>33%</td>
</tr>
</tbody>
</table>

Source: NDHS 2013.

This second phase of the rapid assessment provided an opportunity to examine in more depth the delivery of the selected priority interventions to the selected priority (i.e. most vulnerable or most at risk) groups of adolescents in the selected high-burden locations in order to identify bottlenecks currently limiting the impact of these interventions among adolescents. This would in turn facilitate acceleration towards the 2020 results in the ALL IN framework: a 75% reduction in new HIV infections; a 65% reduction in AIDS-related deaths; and elimination of stigma and discrimination.

#### 3.2 Objectives

The overall objective of Phase 2 was an in-depth analysis of bottlenecks and gaps limiting effective coverage of priority HIV and Sexual and Reproductive Health (SRH) programme interventions among adolescents in order to identify corrective actions to address these bottlenecks and gaps. A further main objective was to develop the corrective actions into regional micro-plans for evidence-informed planning and monitoring. Specific objectives were to:

1. conduct **determinant analysis** of key indicators of supply, demand and quality of interventions to identify bottlenecks in high-burden geographical areas;
2. conduct **causality analysis** of the observed bottlenecks in relation to supply, demand and quality factors;
3. identify **corrective actions** to address the observed bottlenecks in the high-burden geographical locations; and
4. formulate **regional micro-plans** from the corrective actions for evidence-informed planning and monitoring in order to improve adolescent programme implementation.

#### 3.3 Methodology

##### 3.3.1 Process

The in-depth analysis (Phase 2) was conducted by a multi-sectoral Task Team guided by the MoHSS. The Task Team consisted of representatives of government ministries, civil society organisations (CSOs), development partners, adolescents and youth networks. A detailed list of the Task Team members is included in this report as Appendix 1.

The steps taken for this in-depth analysis were as follows:
1. Meeting led by the MoHSS to introduce and launch Phase 2. In this meeting, the MoHSS engaged the Task Team which steered Phase 1 to continue with Phase 2. The MoEAC and MoSYNS played a central role in this team, which was established out of the existing Response Monitoring and Evaluation Technical Working Group (RM&E TWG) and the Combination Prevention Technical Advisory Committee (TAC) for ownership and sustainability. A National Consultant was recruited to support the team’s work. The Task Team:

- conducted a review of documentation to determine the availability, access and utilisation of the selected interventions, including mapping of service delivery platforms of the selected interventions;
- reviewed and validated the indicators for the in-depth analysis to ensure alignment with the country context and service delivery platforms; and
- formulated an inception report detailing the process, methodology, activities and timelines for Phase 2.

2. Orientation workshop on Bottleneck Analysis (BNA) methodology, facilitated by a UNICEF team of programme and data experts from UNICEF Headquarters in New York. Participants were drawn from the MoHSS, MoEAC and MoSYNS (service providers and programme managers at national and regional level), CSOs, UN partners and adolescent and youth networks, including representatives from Uganda and Rwanda, whose presence facilitated South-South learning. The workshop introduced the BNA methodology to the participants, and enabled them to:

- review data and gain clarity on the findings of Phase 1 of the rapid assessment;
- incorporate data that became available after Phase 1 was conducted;
- identify remaining data gaps; and
- select interventions to be examined further in the regions.

3. Data gathering, analysis and planning. This was conducted mainly at sub-national (regional) level after the BNA orientation workshop. This process involved the following:

- Establishment of regional core teams, each comprised of MoHSS regional management team members and representatives of different sectors, and an implementer for data gathering. Each core team led the data-gathering process at regional level, including defining and contextualising indicators with the support of the national consultant. This generated data-gathering capacity and ownership of the regional data-gathering process.
- Formation of cluster teams composed of representatives of government ministries, CSOs and UN partners as well as a regional representative, to support the BNA process at regional level.
- Regional workshops in all seven selected regions – with the two Kavango regions conducting a joint workshop. In-depth analysis was conducted in these workshops with the support of the cluster teams. Participants in these workshops were adolescents and young people, regional representatives of government ministries and other regional stakeholders. These workshops used the BNA methodology as well as the AADM tool for analysis and planning.

4. National workshop to validate the in-depth analysis conducted in the regional workshops. The participants included the regional teams and other representatives of government ministries, CSOs and development partners. The regional teams presented their work plans, which provided a forum for peer review and an opportunity for the different stakeholders to review, endorse and advance the work plans in relation to ongoing policy issues and existing programmes.

3.3.2 Research design

Both quantitative and qualitative data-collection methods were used for this analysis, including facilitated workshops, focus group discussions and in-depth interviews with key stakeholders (i.e. government, CSO and adolescent representatives), in alignment with the national multi-sectoral HIV response. A desk review of policies, strategic plans, health survey reports, HIV-related guidelines and programme reports and reports on adolescent-focused SRH interventions was also conducted.
3.3.3 Selection of sites and interventions

The selection of sites for the in-depth analysis was based on the results of Phase 1, which showed a high burden of adolescent HIV in seven regions: Erongo, Kavango East and West, Khomas, Omusati, Otjozondjupa and Zambezi. The high-burden geographical locations within these regions were selected during the orientation workshop, with the help of regional stakeholders such as the MoHSS and CSOs. By reviewing regional profiles based on data from Phase 1, low-performance interventions, high-burden districts and most-at-risk adolescent populations were identified for each region. This facilitated the selection of the geographical locations and the priority intervention(s) for each region. The selected sites and interventions for each region are shown in Table 3.

Table 3: Priority Interventions and High-Burden Geographical Locations

<table>
<thead>
<tr>
<th>Region</th>
<th>Intervention(s)</th>
<th>Geographical site(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erongo</td>
<td>HTC</td>
<td>Swakopmund and Walvis Bay Health Districts</td>
</tr>
<tr>
<td>Kavango East</td>
<td>ART; HTC</td>
<td>Rundu Health District</td>
</tr>
<tr>
<td>Kavango West</td>
<td>ART; HTC</td>
<td>Nankudu Health District</td>
</tr>
<tr>
<td>Khomas</td>
<td>HTC; LSBE</td>
<td>Windhoek Health District</td>
</tr>
<tr>
<td>Omusati</td>
<td>VMMC; HTC</td>
<td>Oshikuku, Tsandi, Okahao and Outapi Health Districts</td>
</tr>
<tr>
<td>Otjozondjupa</td>
<td>HTC</td>
<td>Grootfontein Health District</td>
</tr>
<tr>
<td>Zambezi</td>
<td>ART; Teenage Pregnancy</td>
<td>Katima Mulilo Health District</td>
</tr>
</tbody>
</table>

ART = Antiretroviral Therapy ● HTC = HIV Testing and Counselling ● LSBE = Life Skills Based HIV Education ● VMMC = Voluntary Medical Male Circumcision

3.3.4 Data collection

In the four-day orientation workshop held prior to the data-collection process, a team of global facilitators trained national and regional stakeholders to:
- conduct determinant analysis in order to identify bottlenecks limiting programme performance;
- undertake causality analysis of bottlenecks;
- develop appropriate actions to address the identified gaps; and
- consolidate the corrective actions into region work plans to improve adolescent programmes.

In addition, cluster teams composed of representatives of regional and national stakeholders and adolescents were formed to support the data-collection process at regional level.

Quantitative data was collected for the determinant analysis, and qualitative data was gathered for the causality analysis.

Determinant analysis

The first step was to select and define the indicators to be used for the in-depth examination of determinants affecting supply, demand and quality of the selected interventions.

The determinant indicators were:
- Supply – commodities, human resources and accessibility;
- Demand – utilisation and continuity; and
- Quality – standards of the interventions.
Generic indicators for most of the interventions were provided in the guidance document. However, selection of the indicators was crucial, and was based on data availability, country context and service-delivery platforms of the interventions. Figure 1 below illustrates the process used to define indicators for the determinant analysis of selected interventions.

Figure 1: Flow Chart for Defining Service Delivery Coverage Indicators

The next step after defining indicators was the collection of data for the analysis. This required:
1) identification of programme service sites across the different delivery platforms for data collection;
2) collecting or abstracting programme data from the monitoring systems; and
3) adopting the programme target population / catchment area population in the selected sites as denominators to measure coverage for demand and quality indicators.

Most services had defined targets, which were used as denominators for demand and quality indicators. However, there were some exceptions. An interesting case was VMMC, the provision of which is guided by the Namibia National Male Circumcision Strategy and Implementation Plan 2010/2011-2015/2016. This strategy provides regional annual targets, but these are for the 15-49 age group, thus the target for the 15-19 group had to be obtained from the proportion of male adolescents aged 15-19 among the 15-49 age group from 2015 population projections. Another case was ART demand and quality indicators, for which the denominator had to be changed from “estimated number of adolescents living with HIV” to “number of adolescents who tested positive for HIV in the last 12 months” in order to reflect the indicator timelines. Similarly, denominator indicators for continuity and quality had to be changed to “number of adolescents who tested positive for HIV and were initiated on treatment last 12 months”. A detailed list of the indicators and definitions is included in this report as Appendix 2.

Key data sources were the 2013 NDHS, health facility records, programme records, District Health Information Systems and electronic national data systems.

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The data collected was then entered into the AADM Phase 2 tool. This tool then generated bar graphs depicting availability of commodities, human resources and access, and coverage in relation to initial utilisation, continuity and quality for each intervention. These graphs, which were clearly outlined as either demand-side or supply-side, facilitated identification of the bottlenecks of each intervention.

**Causality analysis**

This involved exploring the underlying causes of the bottlenecks identified in the determinant analysis. This was qualitative data, collected in the regional workshops using a highly participatory approach – encompassing adolescent consultation, group contribution and consensus building – to explore immediate causes, underlying causes and structural causes of the observed bottlenecks. This was crucial in identifying the main factors contributing to low coverage of interventions. The format used to explore the multiple causes of the identified bottlenecks is shown in Figure 2.

### Figure 2: Work Sheet for AADM BNA Causality Analysis

<table>
<thead>
<tr>
<th>Identified BOTTLENECKS</th>
<th>WHY 1: Immediate Causes</th>
<th>WHY 2: Underlying Causes</th>
<th>WHY 3: Structural Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Identification of corrective actions**

The third step built on the previous steps and used the same participatory approaches at the same regional workshops to formulate solutions for the identified multiple causes of the bottlenecks. Figure 3 shows the format used to generate solutions. This involved prioritisation of the solutions and strategies, focusing on what can be done with the available resources and what is applicable to the regional context. The guiding questions in formulating solutions were as follows:

1. Is the proposed solution likely to have an impact?
2. Is the proposed solution feasible (taking into account policy and existing capacity)?
3. Is the proposed solution cost-effective (taking into account affordability, funding availability and cost benefit)?
4. Is the proposed solution acceptable to key stakeholders and beneficiaries?
5. Is the proposed solution going to help to reach those populations with the highest unmet need?

### Figure 3: Work Sheet 2 for BNA Causality Analysis, Solutions and Strategies

<table>
<thead>
<tr>
<th>IDENTIFIED BOTTLENECK</th>
<th>CAUSES OF BOTTLENECK</th>
<th>PROPOSED SOLUTIONS</th>
<th>PROPOSED STRATEGIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTERVENTION:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Why 1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Why 2:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Why 3:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Why 1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Why 2:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Why 3:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Consolidating corrective actions into regional micro-plans

This involved reviewing action plans for the different selected interventions into a regional work plan for each region. This was done by defining objectives, outputs and activities for the different selected interventions. The objectives were expressed as a change in the coverage of the selected intervention, while outputs were related to reduction of the identified bottlenecks. Activities were expressed as the actions to be undertaken to achieve the outputs. In addition, the action plan had timelines and persons responsible for overseeing the activities and indicators of the activities. In addition to the corrective actions, data-improvement plans were developed for the observed data gaps in both Phase 1 and Phase 2 of the country assessment.

3.3.5 Data quality

In the regional workshops, stakeholders validated data for determinant analysis, which involved validating the indicators, data sources and timelines that had been entered into the AADM tool. All of the data from determinant analysis, causality analysis and the micro-plans was then presented in the national validation workshop. The participants in this two-day workshop were multi-sectoral, and included MoHSS programme managers at regional and national level, representatives of the Ministry of Sport, Youth and National Service and Ministry of Education, Arts and Culture, and representatives of CSOs, adolescents and youth networks, donor agencies and UN agencies. The input from this validation process was used to finalise the regional micro-plans.

3.4 Results

This section describes results from the determinant and causality analyses, the corrective actions including data-improvement actions, and the corresponding action plans.

The results are presented by region (in alphabetical order), and describe:
- the selected interventions and geographical sites for the in-depth analysis;
- findings from the determinant analysis and the bottlenecks identified;
- the immediate, underlying and structural causes of the bottlenecks;
- the corrective actions identified; and
- the objectives of the regional micro-plans.

The regional micro-plans are included in this report as Appendix 3.

3.4.1 Erongo Region

Selected interventions and geographical locations

Erongo Region selected HTC as the priority intervention. Initially Erongo also selected Prevention of Teenage Pregnancy, but dropped it due to lack of determinant indicators. The selected geographical sites were Swakopmund and Walvis Bay Health Districts.

Determinant analysis

Across Erongo’s 13 HTC sites, availability of commodities was 92%. Availability of human resources was only 23%, and accessibility was 0% as none of the sites provided AFHS. Graph 1 (next page) shows the supply-side determinants of HTC for adolescents, and Graph 2 shows the demand-side determinants. As in other regions, national data was used for utilisation and continuity indicators,
and show utilisation at 25% and 42% and continuity at 14% and 29% for male and female adolescents (age 15-19 years) respectively. For quality, 100% of the HIV-positive male adolescents and 94% of the HIV-positive female adolescents had been linked to treatment and care services.

Graph 1: Supply-side determinants of HTC for adolescents (age 15-19 years) in Erongo Region

Graph 2: Demand-side determinants of HTC for adolescents (age 15-19 years) in Erongo Region

The prioritised bottlenecks were as follows:

- **Commodities**: Only 23% of facilities currently providing HTC services have at least one health worker trained on adolescent-friendly health services.
- **Accessibility**: Only 8% of health facilities currently providing HIV testing have Adolescent/Youth Friendly Health Services (per national guidelines).
- **Continuity**: Only 14% of males and 29% of girls aged 15-19 were tested for HIV and received their test results in the last 12 months.

**Causality analysis**

The low availability of health workers trained in AFHS was associated with an inadequate number of staff trained in AFHS – an inadequacy linked to high turnover of health workers and infrequent AFHS trainings. The causes of low accessibility associated with provision of AFHS were identified as health workers not being familiar with the AFHS guidelines, and health workers' lack of awareness of adolescent needs. Underlying causes identified were poor mechanisms for those trained on AFHS to transfer knowledge and implement the programme. Low continued utilisation of HTC services was associated with low perception of risk and poor health-seeking behaviour: “Adolescents do not have time or are too young to think about HIV/AIDS.” Underlying causes identified were not being sure of parental/family support, and health workers' discriminatory or moralistic attitudes towards adolescents seeking HTC: “Where is your partner?”; “You are too young to have sex.” Such attitudes are linked to stigma and discrimination and lack of knowledge on the part of parents and elders as regards adolescent health needs.
Corrective actions

The proposed strategy for addressing availability of trained health workers in AFHS was training on both the pre-service and in-service levels. To address provision of AFHS, it was proposed that trained staff should orientate the other staff to ensure the implementation of AFHS at health facilities. Other proposed strategies were: AFHS guidelines to be implemented at all health facilities; and individual staff members to be oriented on their roles and responsibilities in the implementation of the AFHS guidelines. All of these strategies for AFHS would be supported by implementation of the AFHS guidelines through supervision, and by monitoring AFHS during the regular supervisory support visits. Proposed strategies for continuity in utilisation of HTC included: raising adolescents’ awareness of HTC; adolescent-focused messaging on HTC; and provision of integrated SRH/HIV services for adolescents.

Regional micro-plans

Objective of the micro-plan: Coverage of HTC among adolescents aged 15-19 increased from 14% for males and 29% for females to 75% for both sexes by December 2017.

Corresponding outputs:
- Proportion of facilities currently providing HTC which do not have Adolescent/Youth Friendly Health Services (as per national guidelines) reduced from 40% to 2%.
- Proportion of adolescents aged 15-19 who did not test for HIV or did not receive their test results in the last 12 months reduced from 86% among males and 71% among females to 40% among both sexes.

3.4.2 Kavango East and West Regions

Selected interventions and geographical locations

In 2013, Kavango Region was split into Kavango East and Kavango West Regions. Although these are two separate administrative regions, regional health services are still provided by one regional management team. For Phase 2, the two Kavango regions combined their data, and selected ART for Adolescents Living with HIV (ALHIV) and HTC for Adolescents as their priority interventions in both regions. The selected geographical locations were Rundu Health District in Kavango East and Nankudu Health District in Kavango West. Key supply, demand and quality indicators were used for both interventions.

Determinant analysis

For ART, all 26 sites reported availability of ART commodities. Other supply-side determinants were 15% for human resources and 0% for accessibility. Graph 3 shows the supply-side determinants of ART for adolescents in Kavango East and West.

On the demand side, initial utilisation was above 100% for both male and female adolescents in both the 10-14 and 15-19 age groups. This was attributed to clients being tested elsewhere and then being initiated on ART in Kavango East/West – as was also reported in Zambezi Region. Continuity of ART was 100% among adolescent females aged 10-14 and 67% among males in the same age group. In the 15-19 age group, continuity was 81% among females and 60% among males. Quality was 67% among males and 51% among females in the 10-14 age group, and the trend was similar in the 15-19 age group, at 63% among males and 47% among females. Graph 4 shows the demand-side determinants of ART for adolescents in Kavango East and West.
For the HTC intervention, availability of commodities was 100% at all 51 sites. Other supply-side determinants were 10% for human resources and 2% for accessibility (Graph 5).

Demand-side determinants for HTC were conducted on adolescents aged 10-19 as per the indicator definition. National data was used for initial utilisation and continuity indicators, because regional data sets were very small. However, regional data was used for the quality indicator. Initial utilisation was 25% and 42% among males and females respectively. This measured the adolescent who had ever tested. Continuity was 14% among males and 29% among females, and measured adolescents who had tested and received results in the last 12 months. Quality was 0% among males and 50% among females, and measured the linkage between HTC and ART services. Graph 6 shows the demand-side determinants of HTC for adolescents.
In prioritising of the bottlenecks, the Kavango regions considered HTC as the entry point for ART, and reasoned that addressing the supply-side bottlenecks identified for HTC would address these determinants for ART. The rationale was that all of the HTC sites were currently ART sites, whereas not all ART sites were HTC sites. However, with the rollout of NIMART, all HTC sites are potential ART sites. Similarly, these regions prioritised continuity over initial utilisation of HTC, since this would ensure that adolescents are aware of their HIV status.

The prioritised bottlenecks on which the causality analysis was conducted were as follows:

**HTC intervention:**
- **Accessibility:** 98% of health facilities currently providing HTC services do not have Adolescent/Youth Friendly Health Services (as per national guidelines).
- **Continuity:** Only 14% of male adolescents and 29% of female adolescents were tested for HIV and received their HIV test results in the last 12 months.
- **Quality:** 56% of adolescents who tested positive for HIV were not enrolled in HIV care services (Pre-ART or ART) in the last 12 months.

**ART intervention:**
- **Continuity:** Only 67% of male adolescents aged 10-14 and 60% of male adolescents aged 15-19 who tested positive for HIV were initiated on treatment, and are alive and on treatment 12 months after initiation.
- **Quality:** Only 52% of adolescents aged 10-14 and 57% of adolescents aged 15-19 who were initiated on treatment are virologically suppressed (viral load below 1000 copies) at 12 months after initiating treatment.

**Causality analysis**

The unavailability of health workers trained in AFHS was linked to high staff turnover with no recent trainings, which was attributed to the AFHS guidelines not being implemented. This in turn affected accessibility, in that health facilities lacked AFHS. On continuity of HTC, the low testing rates among adolescents in the last 12 months were attributed to fear of positive results linked to the need for parental consent for young adolescents and a perceived lack of parental support for older ones. The low quality of HTC was attributed to lack of monitoring of the linkage between HTC and ART in tracking clients who tested positive and were linked to care and treatment services. Retention in ART showed poor continuity of ART, which was linked to defaulting due to lack of parental and community support because of stigma and discrimination. On quality of ART, the poor virological suppression was attributed to poor adherence due to poor treatment literacy among adolescents.

**Corrective actions**

Proposed strategies to address availability of AFHS services were frequent trainings on AFHS and implementation of the AFHS guidelines. This would address both human resources and accessibility in
both the HTC and ART interventions. For continuity, adolescent-focused messages were suggested, along with engaging parents and communities to support adolescent health-seeking behaviour for both HTC and ART, including quality of ART, which is virological suppression that is dependant on adherence. Linking HTC and ART services, including tracking linkage of clients who tested positive to treatment and care services, was identified as a strategy to address quality in HTC. The Kavango regions proposed including all regional stakeholders in the existing quarterly data review meetings in order to ensure sharing of data for evidence-based planning.

Regional micro-plans

The corrective actions from the causality analysis were used to formulate the action plan. The action plan had two objectives that addressed the two interventions.

First objective: Coverage of HTC among adolescents aged 15-19 increased from 29% to 80% among females and 14% to 70% among males by December 2017.

Corresponding outputs:
- Proportion of health facilities currently providing HTC services that do not have Adolescent/Youth Friendly Health Services (as per national guidelines) reduced from 98% to 30%.
- Proportion of male and female adolescents aged 15-19 who did not test for HIV or did not receive their test results in the last 12 months reduced from 86% to 30% among males and 71% to 20% among females.
- Proportion of adolescents (aged 15-19 years) who tested positive and were not enrolled in HIV care services (pre-ART and ART) in the last 12 months reduced from 56% to 25%.

Second objective: Coverage of ART among ALHIV aged 10-19 increased from 80% to 95% among females and 41% to 80% among males by December 2017.

Corresponding outputs:
- Proportion of male adolescents who are not on treatment or alive 12 months after ART initiation reduced from 34% to 25% among those aged 10-14 and 40% to 30% among those aged 15-19.
- Proportion of ALHIV aged 15-19 who were initiated on ART and are not virologically suppressed (viral load below 1000 copies) at 12 months after initiation reduced from 48% to 35% among those aged 10-14 and 43% to 30% among those aged 15-19.

3.4.3 Khomas Region

Selected interventions and geographical locations

Khomas selected In-School Life Skills Based HIV Education (LSBE) for adolescents in the 10-14 and 15-19 age groups, and HTC for adolescents. In Khomas only one location was selected, this being Windhoek Health District. LSBE is provided by the MoEAC while the MoHSS provides the HTC services.

Determinant analysis

LSBE: Supply-side determinants were based on LSBE provision in the 54 primary schools. On commodities, entailing measuring availability of the LSBE syllabus, the assumption was that each school that provides LSBE has the syllabus, but there was no available data to support this assumption. Availability of human resources was linked to accessibility as only the 44 primary schools which had trained LSBE teachers provided LSBE, with a rate of 81% for both indicators (Graph 7).
Graph 7: Supply-side determinants of In-School LSBE for adolescents (age 10-19 years) in Khomas Region

For demand-side indicators, utilisation measured provision of LSBE in the fourth year of primary school, which was 81% as this was linked to accessibility and human resource indicators. Continuity, on the other hand, measured provision of LSBE in the first year of secondary school, and 28 (90%) out of the 31 schools provide LSBE. There was no data on quality, which measured proportion of in-school adolescents with specific comprehensive knowledge of HIV. Graph 8 shows the demand-side determinants of LSBE in Khomas.

Graph 8: Demand-side determinants of In-School LSBE for adolescents (age 10-19 years) in Khomas Region

HTC: All 13 sites had availability of HTC commodities, and all also had at least one health worker trained in AFHS. Notably, only 8% of these sites provided AFHS (Graph 13).

Graph 9: Supply-side determinants of HTC for adolescents (age 15-19 years) in Khomas Region

Graph 10: Demand-side determinants of HTC for adolescents (age 15-19 years) in Khomas Region
For the demand-side determinants, national indicators were used for utilisation and continuity, showing utilisation at 25% and 42% for male and female adolescents, and continuity at 14% and 29% for males and females (aged 15-19) respectively. For quality, none of the HIV-positive male adolescents and only 2% of the females had been linked to treatment and care services.

Thus the priority bottlenecks identified were as follows:

**LSBE intervention:**
- **Commodities:** No available (verified) data on the number of primary schools with a curriculum for LSBE.
- **Accessibility:** 19% of primary schools do not provide LSBE or Comprehensive Sexuality Education (LSBE/CSE) in the current academic year.
- **Continuity:** 10% (approximately 4,000 learners) in Khomas secondary schools do not receive LSBE/CSE in their first year of secondary school.
- **Quality:** No available data on in-school adolescents who know the three ways that HIV/STIs are transmitted and two HIV/STI prevention methods.

**HTC intervention:**
- **Accessibility:** 92% of health facilities currently providing HIV testing are not adolescent/youth friendly (as per national guidelines).
- **Continuity:** Only 14% of male and 29% of female adolescents (aged 15-19) respectively have tested for HIV and received their result in the last 12 months.
- **Quality:** 0% of the male and 98% of the female adolescents (aged 15-19) who tested positive for HIV were not enrolled in HIV care services (pre-ART or ART) in the last 12 months.

**Causality analysis**

On LSBE, commodities entailed measuring syllabus, and although there was a general assumption that each teacher who taught LSBE had a curriculum, this data was not collected. Accessibility was linked to human resources as LSBE was provided only in the schools with trained teachers. This was attributed to lack of teachers trained in LSBE, which in turn is attributed to LSBE not being considered a promotion subject and having no career growth. This also applied to provision of LSBE in secondary schools, although the proportion of secondary schools with provision of LSBE is higher. Regarding quality, there was no data, because this indicator was not monitored.

With HTC, low accessibility was attributed to lack of implementation of the AFHS guidelines despite availability of trained health workers. Causes of low utilisation of HTC services were identified as fear of positive results, lack of parental support due to stigma and discrimination, and lack of disclosure of HIV status by parents. The poor linkage of HIV-positive adolescents to treatment and care was linked to the separation of HIV and ART services at health facilities.

**Corrective actions**

Proposed strategies to address data gaps in commodities was to revise the data-collection tool and reports to incorporate availability of LSBE syllabus. This was also proposed for the quality indicator. Proposed solutions for provision for LSBE was to have more training of teachers on LSBE.

The proposed strategy for addressing accessibility of HTC was to implement the AFHS guidelines. Proposals for addressing continuity in HTC included raising awareness of the importance of HTC among adolescents, and provision of mobile HTC in schools. On quality, the proposed strategy was the integration of HTC and ART services.
Regional micro-plans

The regional micro-plans had two objectives.

First objective: Coverage of adolescents (aged 10-19) with comprehensive knowledge of HIV increased from 65% among females and 78% among males to 90% among both sexes by December 2017.

Corresponding outputs:
• Proportion of primary schools that have at least one teacher providing school-based Life Skills / Comprehensive Sexuality Education (CSE) reduced from 19% to 10%.
• Proportion of secondary schools that do not provide LSBE/CSE in the first year of secondary school reduced from 10% to 0%.
• Improvement of collection and management of data to inform provision of LSBE to in-school adolescents.

Second objective: Coverage of HTC among adolescents aged 15-19 increased from 29% to 80% among females and 14% to 70% among males by December 2017.

Corresponding outputs:
• Proportion of health facilities providing HTC that do not have adolescent-friendly services reduced from 86% to 40%.
• Proportion of adolescents aged 15-19 who did not test for HIV or did not receive their test results in the last 12 months reduced from 86% to 30% among males and 71% to 20% among females.
• Proportion of adolescents aged 15-19 who tested positive for HIV and were not enrolled in HIV care services (Pre-ART or ART) in the last 12 months reduced from 100% to 40%.

3.4.4 Omusati Region

Selected interventions and geographical locations

Omusati Region selected Voluntary Medical Male Circumcision (VMMC) for adolescents and HTC for adolescents. Data was collected from all four districts, namely Oshikuku, Tsandi, Okahao and Ouitapi. Key supply, demand and quality indicators were used for both interventions.

Determinant analysis

VMMC: Twenty-nine sites in Omusati provided VMMC services. Availability of commodities for VMMC was 48%, and accessibility was 58%. Availability of human resources was 100% as all the health care providers of VMMC had been trained to counsel adolescents on VMMC (Graph 11). Demand-side determinants were in the same range, at 32% for utilisation, 31% for continuity and 30% for quality (Graph 12). However, there was a data gap on utilisation as not all referrals from VMMC were recorded.

Graph 11: Supply-side determinants of VMMC for male adolescents (age 15-19 years) in Omusati Region
HTC: Availability of commodities was only in 2% of the 46 sites that provided HTC. Only 40% of the facilities had health workers trained in AFHS, and only these sites provided AFHS, hence the same for accessibility. However, this data is from only one district, as there was a data gap for both human resources and accessibility in the other three districts. Graph 13 shows the supply-side determinants of HTC, and Graph 14 shows the demand-side determinants of HTC for adolescents.

For demand-side determinants, national indicators were used for utilisation and continuity, and the results are the same as in Kavango Region. For quality, only 46% of the adolescents who had tested HIV positive had been linked to care.

From the determinant analysis, the following priority bottlenecks were identified:

**VMMC intervention:**
- **Commodities:** 52% of the sites providing VMMC services reported stock-out of essential commodities.
- **Accessibility:** Only 58% of the sites that are providing VMMC services had ever provided services to adolescents.
- **Utilisation:** Only 32% of the adolescents estimated to be in need of VMMC had received VMMC in the last 12 months.
Utilisation was directly linked to continuity, which measured post-operative follow-up visits, hence utilisation was identified as the bottleneck for VMMC. This was based on the region’s rationale that addressing utilisation would provide more clarity on continuity.

**HTC intervention:**

- **Commodities:** 98% of the health facilities providing HTC in the region reported stock-out of HTC commodities in the last three months.
- **Accessibility:** 60% of the health facilities providing HIV testing are not adolescent/youth friendly.
- **Continuity:** Only 14% of male and 29% of female adolescents (aged 15-19) were tested for HIV and received their result in the last 12 months.
- **Quality:** 54% of the adolescents (aged 15-19) who tested positive for HIV were not enrolled in HIV care services (pre-ART or ART) in the last 12 months.

**Causality analysis**

The unavailability of commodities for VMMC was linked to poor stock management that is related to a lack of training on stock management as well as long procurement procedures. Low accessibility was attributed to a shortage at the facilities of staff trained on VMMC, as the current trained staff were based at regional level and provided VMMC services on an outreach basis. The low utilisation of VMMC services was linked to the need for parental consent for adolescents under 18 years of age, and also the misconception that it is mandatory for one to have an HIV test before VMMC. The data gap on quality was attributed to the current VMMC reporting tool. Similarly, the lack of available data for the 10-14 age group, despite the provision of VMMC to some in this group, was attributed to limitations in the data-collection tool.

For HTC commodities, lack of availability was linked to poor stock management due to low human capacity – as in VMMC. Lack of implementation of AFHS guidelines was identified as the cause of the low accessibility. Parental consent, perceived lack of parental support and poor health-seeking behaviour among adolescents were identified as the causes of low utilisation of HTC services. In addition, the different age of consent with regard to other reproductive services such as family planning and STI and HTC services was cited as a barrier for adolescents to obtain HTC services. Regarding quality of HTC services, a major cause identified was adolescents who test HIV positive and are referred but do not the referral points. This was linked to the lack of integrated HTC and ART services, which services were sometimes provided on different days or at different sites.

**Corrective actions**

Proposed strategies to address availability of VMMC commodities was to train staff and introduce stock-management systems. This was also suggested for HTC commodities. Similarly, training of health staff on VMMC was suggested, including incorporating VMMC training at the pre-service level. This was linked to increased accessibility, as having more trained staff would facilitate having staff based at the sites. Schools and communities and awareness programmes targeting adolescents were proposed as a strategy for increasing utilisation of VMMC services. There was a proposal to revise the age of consent for VMMC to increase utilisation of the services. To address the identified data gaps, there were proposals to revise the existing data-collection tools to capture referrals, post-operative visits and clients aged 10-14. In addition, Omusati proposed including VMMC in the existing quarterly data review meetings.

For HTC, implementation of the AFHS guidelines at all levels was proposed as a strategy to address accessibility of AFHS, which would in turn create a demand for AFHS training. Omusati recommended adolescent participation at health facility level, as this would create demand and feedback on the AFHS situation in the region. Omusati also proposed adolescent-focused messages and messages
targeting parents of adolescents to support HTC among adolescents. Another proposal was to align the age of consent for all reproductive health services by integrating the services. Similarly, integration of HIV and ART services was proposed for addressing linkage between the two services.

**Regional micro-plans**

The corrective actions from the causality analysis were used to formulate Omusati’s action plan. This action plan had two objectives – one for each intervention.

**First objective:** Coverage of VMMC among adolescents aged 15-19 increased from 7% 12 to 65%13 by December 2017.

**Corresponding outputs:**
- Proportion of sites providing VMMC reporting any stock-out of essential commodities in the last three months reduced from 52% to 0%.
- Proportion of sites not providing VMMC services to adolescents reduced from 42% to 20%.
- Among the adolescents males estimated to be in need of VMMC, the proportion that did not receive VMMC services reduced from 68% to 35%.
- Improvement of the collection and management of data to inform provision of VMMC services to adolescents.

**Second objective:** Coverage of HTC among adolescents aged 10-19 increased from 29% to 80% among females and 14% to 70% among males by December 2017.

**Corresponding outputs:**
- Proportion of health facilities reporting any stock-outs of HTC commodities over the last three months reduced from 98% to 20%.
- Proportion of health facilities providing HTC that do not have adolescent-friendly services reduced from 60% to 30%.
- Proportion of adolescents aged 15-19 who did not test for HIV or did not receive their test results in the last 12 months reduced from 86% to 40% among males and 71% to 30% among females.
- Proportion of adolescents (aged 15-19) who tested positive for HIV and were not enrolled in HIV care services (Pre-ART or ART) in the last 12 months reduced from 54% to 20%.

### 3.4.5 Otjozondjupa Region

**Selected interventions and geographical locations**

Otjozondjupa Region selected HTC as its intervention. Like Erongo, this region initially selected Prevention of Teenage Pregnancy as well, but dropped it due to lack of determinant indicators. The selected geographical site was Otjiwarongo Health District.

**Determinant analysis**

Availability of commodities was at 20% across the five HTC sites. Availability of human resources was at 60%, representing the number of sites with at least one health worker trained in AFHS. On accessibility, none of the sites provided AFHS. Graph 15 shows the supply-side determinants of HTC for adolescents, and Graph 16 shows the demand-side determinants.

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13 Target according to VMMC strategy.
As mentioned earlier under other regions, national data was used for utilisation and continuity indicators, showing utilisation at 25% and 42% and continuity at 14% and 29% for male and female adolescents (aged 15-19) respectively. For quality, 100% of the HIV-positive male adolescents and 57% of the HIV-positive female adolescents had been linked to treatment and care services. However, the sample for male adolescents was very small, which was a limitation.

From this determinant analysis, the prioritised bottlenecks were:
- **Commodities**: 80% of health facilities currently providing HTC services reported stock-outs of HIV test commodities in the last 3 months.
- **Accessibility**: None (0%) of the health facilities currently providing HTC have Adolescent/Youth Friendly Health Services (as per national guidelines).
- **Continuity**: Only 14% of male and 29% of female adolescents aged 15-19 tested for HIV and received their test results in the last 12 months.
- **Quality**: 36% of adolescents aged 15-19 who tested positive for HIV were not enrolled in HIV care services (pre-ART or ART) in the last 12 months.

**Causality analysis**

The low availability of commodities was associated with poor stock management, which in turn was related to low human capacity as well as changes in HTC protocol which led to changes in procurement procedures. The low provision of AFHS was attributed to lack of implementation of the AFHS guidelines, the underlying cause being that the AFHS standards were not regarded as a priority at all levels. Low continuity of HTC services was attributed to fear of HIV-positive results, the underlying cause being adolescents’ uncertainty of parental support, which stems from their fear of their parents knowing that they are sexually active. The identified cause of low continuity in utilisation was that HTC services were not being provided in community settings, as there was no cadre that provided HTC services outside the health facility setting. The poor linkage of HIV-positive adolescents from HTC to ART services was attributed to the flow of services not being systematic as there was no monitoring of referral from HTC to ART.
Corrective actions

Proposed strategies to address availability of commodities were national-level training of regional-level staff on stock management and consultations before implementing significant changes such as the HTC protocol. A suggested strategy to address AFHS provision was on-the-job training of health workers, implementing the AFHS guidelines and incorporating AFHS aspects into the current supervisory tool to monitor and evaluate the AFHS services at facility level. Similarly, inclusion of HTC services in the current outreach services was proposed as a strategy to address low continuity of HTC. Another strategy proposed was involving youth clubs in outreach programmes to reach out to adolescents with HTC messages. To address linkage of HTC and ART services, a proposed strategy was to integrate HTC and ART services at facility level and to monitor this linkage regularly.

Regional micro-plans

Objective: Coverage of HTC among adolescents aged 15-19 increased from 29% among females and 14% among males to 50% among both sexes by December 2017.

Corresponding outputs:
- Proportion of health facilities currently providing HTC services reporting stock-outs of HTC commodities reduced from 80% to 0%.
- Proportion of health facilities currently providing HTC that do not have adolescent-friendly services reduced 100% to 40%.
- Proportion of adolescents (aged 15-19) who did not test for HIV or did not receive their test results in the last 12 months reduced from 86% among males and 71% among females to 50% among both.
- Proportion of adolescents (aged 15-19) who tested positive for HIV and were not enrolled in HIV care services (pre-ART or ART) in the last 12 months reduced from 36% to 0%.

3.4.6 Zambezi Region

Selected interventions and geographical locations

The selected interventions for Zambezi were ART for ALHIV and Prevention of Teenage Pregnancy. The selected location was Katima Mulilo, being the only health district in the region. Determinant analysis was conducted for key ART supply, demand and quality indicators. There were no available indicators on teenage pregnancy, so determinant analysis was not conducted. However, causality analysis was conducted and corrective actions were formulated for this intervention.

Determinant analysis

For supply-side determinants, availability of ART commodities was 97% as only one of the 29 sites had reported a stock-out in the last three months. Only 28% of the sites had trained health workers on AFHS, and only 31% of the sites provided AFHS. Graph 17 shows the supply-side determinants.

Graph 17: Supply-side determinants of ART to adolescents in Zambezi Region
For demand-side determinants, initial utilisation was above 100% for adolescent boys and girls aged 10-14 and for girls aged 15-19. This was attributed to clients being tested elsewhere and then being initiated on ART in Zambezi. In contrast, utilisation among adolescent boys aged 15-19 was notably low, at 67%. Continuity, which measured retention, was 100% among adolescent boys and girls aged 10-14 and among boys aged 15-19, and 60% among adolescent girls aged 15-19. There was no data on viral load suppression, which was the quality indicator. Graph 18 shows the demand-side determinants for adolescents aged 10-14 and 15-19 respectively.

From this determinant analysis, the following bottlenecks were prioritised:

- **Commodities**: 3% of the health facilities offering HIV treatment reported stock-outs of ART commodities in the last three months.
- **Human resources**: 72% of the health facilities that offer HIV treatment do not have at least one health worker trained in Adolescent/Youth Friendly Health Services (as per national guidelines).
- **Accessibility**: 69% of the health facilities that offer HIV treatment do not have adolescent-friendly health services.
- **Utilisation**: 33% of boys aged 15-19 tested positive for HIV and were not initiated on ART in accordance with the nationally approved protocol in the last 12 months.
- **Continuity**: 40% of girls aged 15-19 are not alive or not on treatment 12 months after ART initiation.
- **Quality**: Data gap in quality indicator – viral load monitoring.

**Causality analysis**

The causality analysis was conducted on all bottlenecks identified above. Unavailability of stock was linked to a limited number of trained pharmacists and procurement procedures. Causes of the lack of human resources were high turnover of health workers and a long recruitment process. High staff turnover was also linked to low accessibility of services together with lack of infrastructure attributed to budgetary constraints. Low initial utilisation was linked to fear of the unknown as well as lack of knowledge among adolescents regarding HIV, and poor attitudes among health workers. Low continuity was attributed to migration, fear of disclosure, and cultural beliefs. There was a data gap for quality, which was attributed to lack of adherence to guidelines for viral monitoring.
Causes attributed to teenage pregnancy were early sexual debut, intergenerational sex and early marriages which were linked to poor parenting skills and socio-cultural issues.

**Corrective actions**

The proposed strategy to address low availability of ART commodities was improvement of stock-control systems. Capacity development of health workers was proposed to address availability of human resources. Strengthening the existing youth multipurpose centre was proposed to address accessibility of AFHS services. Proposed strategies for continuity were establishment of teen clubs to promote retention of adolescents on ART, new disclosure guidelines, and improvement of the procedures for tracking ART clients who missed their appointments. Implementation of adherence to viral load monitoring guidelines was proposed to address the data gap on quality of ART.

Proposed strategies to address teenage pregnancy included using the LSBE curriculum in schools and using sports for development.

**Regional micro-plans**

Zambezi’s action plan has two objectives – one for each intervention.

**First objective:** Coverage of ART services among adolescents in Zambezi Region increased from 49% to 80% by December 2017.

**Corresponding outputs:**
- Proportion of ART sites reporting stock-out of commodities reduced from 3% to 0%.
- Proportion of health facilities that do not have at least one health worker trained in AFHS reduced from 72% to 30%.
- Proportion of health facilities currently providing ART sites that do not have Adolescent/Youth Friendly Health Services (as per national guidelines) reduced from 69% to 0%.
- Proportion of adolescent boys aged 15-19 who tested positive for HIV and were not initiated on ART in accordance with the nationally approved protocol in the last 12 months reduced from 33% to 10%.
- Proportion of adolescent girls aged 15-19 who are not alive or not on treatment 12 months after ART initiation reduced from 40% to 15%.
- Data improvement plan: Conduct viral load monitoring for 100% of adolescents on ART as per the guideline by December 2017.

**Second objective:** Teenage pregnancy in Zambezi Region reduced from 28% to 14% by the end of December 2017.

**Corresponding output:** Proportion of adolescents aged 10-19 falling pregnant in Zambezi reduced from 28% to 14% by the end of December 2017.
3.4.7 General observations across regions having similar interventions

**ART**

Only Kavango and Zambezi selected ART as a priority intervention.

In both of these regions, availability of ART commodities was high, with Kavango reporting 100% and Zambezi 97%. However, availability of human resources for Adolescent Friendly Health Services (AFHS) and accessibility of AFHS services were low in both regions.

For demand-side determinants, utilisation was above 100% for both boys and girls aged 10-14 years in both regions. However, in Zambezi there were disparities in utilisation among females and males aged 15-19, with males at 67% and females at over 100%.

Continuity, which here refers to retention in ART after 12 months, was above 100% among girls aged 10-14 years in both regions, and at 100% for boys aged 10-14 in Zambezi, whereas in Kavango, the rate among boys in this age group was much lower, at 67%, hence there is a gender disparity in this regard in Kavango. There were also notable gender disparities in the 15-19 age group in both regions. In Zambezi, continuity among males was higher, at 100% compared to 60% among females. In Kavango, continuity was higher among females, at 81% compared to 60% among males. Both regions identified fear of disclosure as a cause of the continuity bottleneck, and it is noteworthy that Zambezi also identified cultural beliefs whereas Kavango identified parental consent and perceived lack of parental support as underlying causes of this bottleneck. This observation highlights the gender dynamics in the causes of bottlenecks, which is a crucial factor to consider when planning implementation.

Similarly, gender disparities were observed in quality in Kavango, with 63% of males reporting viral suppression compared to 47% of females. Zambezi had a data gap for this indicator so it is not possible to compare this indicator across the two regions. Kavango attributed the low virological suppression rates to poor adherence.

**HTC**

Five regions selected HTC as a priority intervention – all regions except Zambezi.

There were large disparities across these regions with regard to commodities. This was partly due to the timelines selected by different regions. Kavango, Khomas and Erongo used the previous MoHSS quarter, being April to June, with 100% availability reported for Kavango and Khomas and 92% for Erongo. Omusati opted for a six-month timeline, i.e. January to June, the rationale being that they had used that timeline for VMMC which was their other priority intervention. Omusati reported that they had experienced stock-out of commodities for both interventions during this six-month period, which had adversely affected services in the region. Availability of HTC commodities was at 2% during this period. All five regions reported that there had been a nationwide stock-out situation of HTC commodities in the period January to March 2016 due to the change in HTC testing protocols. However, Omusati participants noted that although the stock-out of HTC commodities had been nationwide and was resolved by April 2016, the region had experienced residual effects thereafter, such as stock-out of pipettes, thus they felt that it was crucial to address availability of commodities to avoid future disruption of services. Otjozondjupa selected the most recent three months, being June to August. Notably, by this time the nationwide stock-out of HTC commodities had been resolved, thus the availability of stock in only 20% of their sites might be attributable to regional issues.
Accessibility relating to provision of AFHS was identified as a bottleneck in all five regions. Notably, although Khomas and Otjozondjupa reported having trained health workers in AFHS in 100% and 60% of their health facilities respectively, AFHS was provided in 8% and 0% of the health facilities in these regions. This suggests that AFHS implementation requires much more than trained human resources.

Initial utilisation and continuity indicators were national indicators, and coverage of both was low, hence all five regions identified continuity as a bottleneck for HTC.

All regions except Erongo identified quality as a bottleneck, the causes of which were associated with separate data systems for HTC and ART and the linkage not being monitored.
Section 4
LESSONS LEARNT

This section describes the process and programmatic lessons learnt from the in-depth analysis. It further outlines the challenges faced.

4.1 Process

The assessment was undertaken through:
- an orientation workshop involving national and regional stakeholders;
- a data-gathering process and analysis and planning; and
- a validation workshop.

Orientation workshop

- The multi-sectoral Task Team is crucial for bringing together the mandates and responsibilities of the different stakeholders.

- Selection of the right participants at both national and regional level in terms of capacity and mandate is critical for ownership and success of the regional workshops and for the entire BNA exercise.

- Regional profiles facilitated a deeper understanding on the part of regional participants regarding the adolescent situation in their respective regions.

- Plenary presentations, discussions, group work and hands-on exercises with the assessment tool were very effective methods of facilitation in the orientation workshop.
Data gathering, analysis and planning

- The regions led the data-gathering process with the support of the national consultant. This served to build data-gathering capacity and ownership of the data-gathering process, while also ensuring accuracy of data gathered.

- In the data-gathering process, the regions had an opportunity to use their own programmatic data. This highlights the link between data and programming, and stimulates data demand and utilisation at regional level.

- Having a good mix of data and programme people during the BNA process was crucial to linking the data to the programme context.

- The BNA process provided a platform for regions to raise awareness of the existing data gaps and the need for more robust M&E and reporting processes in the programmes at regional level. This bottom-up approach could address data-quality issues while also facilitating development of more responsive M&E systems.

- Participation of key government ministries and CSOs at regional level is crucial for making the BNA exercise more meaningful.

- Meaningful involvement and participation of adolescents is crucial. For example, having adolescents and young people as a separate group in causality analysis and generating solutions enabled them to fully participate and provide their perspectives.

- The review workshop after the first cluster of regional workshops provided an overview of the BNA regional fieldwork, and was an opportunity to incorporate lessons learnt for the next regions.

- Cluster teams comprising national and regional multi-sectoral stakeholders provided support to the regional BNA workshops. The cluster approach enabled concurrent support of two regional workshops in the BNA process, which was an efficient strategy.

- The composition of the cluster teams was multi-sectoral, which provided for more insight on the HIV programme context and the existing opportunities for integrating activities.

- The consolidation of corrective actions into regional work plans at the regional workshops offered a seamless process from in-depth analysis into the evidence-informed planning and monitoring which constitute the third phase of the rapid country assessment.

- Costing of plans should have been done in the regional workshops and not as an afterthought.

Validation workshop

- Provided a forum for all seven regions to present their regional plans and obtain peer review.

- Provided an opportunity for regional and national participants to share best practices on key actions and strategies.

- Created a platform for regional and national stakeholders to explore and get clarity on key policy issues such as AFHS, Integrated School Health, and the Eastern and Southern Africa Ministerial Commitment (ESA) to Comprehensive Sexuality Education (CSE).

- Provided an overview of the adolescent HIV programme component situation at regional level in the different regions.
• Provided an opportunity to further refine the micro-plans, cost them and include M&E plans.
• Offered an opportunity to begin to mobilise resources.
• Provided an opportunity for government, implementing partners, donors and representatives of adolescents and youth networks to review, endorse and advance the proposed regional work plans through existing programmes.

4.2 Programmatic

• Several data challenges were common across the seven regions, and partners have an important role in supporting Namibia to address them.

• Although data was available on adolescents in the 10-19 age group for some of the interventions and indicators, the data was often not analysed, disaggregated or reported routinely at national and regional level in the format required.

• There were data gaps related to the representation of adolescents in surveys (i.e. ethical issues and sampling), especially for those aged 10-14 years.

• There was no data on adolescent key populations, even though this was recognised as a key issue in some regions.

• Some existing policies and guidelines are not implemented at the regional level. For instance, the national MoHSS team reported that they were in the process of revising the current AFHS training curriculum, which would inform the new AFHS guidelines. Most regional participants had not even seen the current AFHS guidelines, which were introduced in 2011. In addition, the lack of provision of AFHS in regions where there are AFHS-trained health workers indicates that there is a need to address this issue with more than training.

• There are existing initiatives at national level, but implementation at regional level is fragmented. The existing initiatives include teen clubs for adolescents living with HIV (ALHIV), Integrated School Health, and the ESA commitment initiative for CSE.

• Availability of commodities is a key factor in service delivery. The unavailability of commodities across most interventions indicates challenges related to stock management. In addition, the disparity in availability of similar commodities in different regions may indicate gaps in stock management in the medical stores and the health facilities.

• Lack of linkage and integration of services across most interventions is evident. For instance, the linkage between HTC and ART across most regions was not well co-ordinated, yet the aim of HTC is to identify HIV-positive clients in order to link them to treatment in a timely manner. The fact that this linkage is not monitored indicates lack of identification of the leakage points in the HIV treatment and care cascade. Similarly, lack of linkages begets missed opportunities for adolescents to access other services. HTC should provide an entry point to other SRH and HIV services, such as family planning, STI and VMMC services. Similarly, these services provide opportunities for Provider-Initiated Testing and Counselling (PITC) when taking into account adolescent health-seeking behaviour.

• Co-ordination for adolescent response is critical for achieving the maximum benefits of the existing synergies within the MoHSS and across other sectors. The Ministry needs to strengthen multi-sectoral collaboration and planning, with an emphasis on integrated delivery of services for adolescents. This will require effective linkages with all stakeholders regarding ongoing
strategies. For instance, most regions reported that they conduct school health activities, but they had limited knowledge about the National Integrated School Health Programme which was being rolled out in all regions. Similarly, the MoHSS national level reported that they had funding for teen clubs for ALHIV, yet most regions did not have funding to run the activities.

- Adolescent participation and consultation is critical in the country assessments, and also in the implementation phases. The disconnect observed between adolescents and other stakeholders in the assessment of the enabling environment in Namibia indicates lack of adolescent and youth engagement in policy formulation and implementation.

4.3 Challenges

- There were constant changes of MoHSS lead persons due to staff turnover, which resulted in gaps in ownership and continuity of the process.

- It was difficult to secure the full commitment of Task Team members to participate for the whole period of four weeks, and this resulted in higher workloads for the fewer participants in the cluster teams.

- The absence of key sectoral stakeholders such as the education and gender directorates in some of the regional workshops affected the quality of the BNA process in the relevant regions.

- Competing priorities in the regions resulted in absence of strategic regional MoHSS participants, which impacted on the regional-level capacity in planning. As a result, two regions selected only one intervention.

- Unavailability of global indicators on teenage pregnancy hindered effective BNA of the pregnancy prevention intervention. For Namibia, teenage pregnancy is one of the most pressing needs, and most of the seven regions identified it as an intervention for further analysis, yet there were no indicators to guide such analysis.

- In order to estimate the percentage of adolescents in need of VMMC, it is first necessary to obtain data to determine the current prevalence of circumcision among adolescents.
The purpose of the country assessments is to facilitate (a) the identification of gaps affecting adolescent HIV programming and (b) the definition of priority actions to address these gaps. This section outlines the recommendations for a successful BNA process, and also programmatic changes required for strengthening the adolescent component of Namibia’s national HIV response.

5.1 Process

- The mix of programme and data people throughout the BNA process is critical to the success and ownership of the process. This also ensures capacity building at regional level for data demand and utilisation for evidence-informed planning.

- The selected interventions in the regions should guide the identification of participants for the BNA process. This would ensure that all the right people participate and provide the insight and knowledge required for an effective BNA process.

- Having strategic people from both the regional and national levels at the validation workshop is crucial. Such people include Directors at regional and national level who, as policy makers, would provide a policy overview while also having the mandate to align the corrective actions into existing governance and accountability frameworks.
• The timing of the BNA process should be planned to avoid the peak period of the year when strategic people at the government and stakeholder levels have conflicting schedules. A suitable time would be at the beginning of the financial year (April to June).

• Including a practical session in one region during the orientation workshop would be beneficial to build capacity of all of the Task Team members to support the regions to conduct an effective BNA process.

• Engaging at least two consultants to support the regional BNA process would ensure continuity in supporting the regions, and would mitigate the unavailability of key Task Team members in all regions.

5.2 Programmatic

AFHS training

Provision of AFHS is a key component of the efforts to strengthen the adolescent component of HIV programmes. In addition, AFHS should be aligned with new policy changes such as disclosure and NIMART in order to ensure more adolescent-focused services. There is a need to establish a system to manage and track staff trained in AFHS. This requires conducting training-needs assessments, and having training plans and updated records of staff who are trained in order to meet staffing needs while also mitigating staff turnover.

AFHS trainings and follow-up activities need to be built in by both the training institutions and the government regional directorates to ensure implementation of post-training plans, and also for adequate support of the trained staff in the field.

AFHS provision

The lack of provision of AFHS despite having trained staff in some regions underscores the need for management and supervisory support to ensure that the knowledge and skills acquired in the trainings are utilised in the field. AFHS provision requires implementation of policy and guidelines. Hence there is need to have supportive supervision for regular assessment of the quality of AFHS provided. This could be integrated into the Primary Health Care (PHC) package to prevent viewing AFHS as a stand-alone programme.

In addition, there is a need to explore available opportunities for meaningful adolescent involvement and participation at health facility level. Optimal AFHS implementation should ensure that:

• adolescents know about, and are able and willing to obtain, the health services that they need;
• service providers are non-judgmental and considerate in their dealings with adolescents, and deliver the required services in the right way;
• health-service delivery points are welcoming and appealing to adolescents, and provide the health services that adolescents need; and
• community members are aware of the health-service needs of different groups of adolescents, and support their provision.

Stock management

There is a need for better stock-control management to address availability of commodities across all interventions. This will require building staff capacity as well as systems at all levels including procurement procedures. Supervisory support should be built in to address stock control across
different cadres of health workers, including their roles in ensuring availability of commodities at all levels. Addressing stock management at all levels would benefit not only HIV interventions but all health services for the whole population.

**Integrated HIV services**

Provision of HIV and related sexual and reproductive health (SRH) services should be integrated to facilitate access to services regardless of the entry point. HTC and ART should be provided to allow for a seamless flow in order to avoid missed opportunities, especially with regard to referrals. Adolescent clients should be supported to navigate these systems in order to access the available services. Linkages between services should be explored, strengthened and monitored to ensure that adolescent clients are provided with the services that they need.

**Multi-sectoral and intra-sectoral co-ordination**

Co-ordination for adolescent response is critical for achieving the maximum benefits of the existing synergies across different sectors. The MoHSS needs to strengthen multi-sectoral collaboration and planning, with an emphasis on integrated delivery of services for adolescents. This will require effective linkages with all stakeholders regarding ongoing strategies such as the ESA commitment to CSE. Similarly, the Ministry should strengthen the link between the national and regional levels. This involves having implementation and support mechanisms in place to ensure that national guidelines on interventions and treatment, such as those on AFHS and viral load monitoring, are translated at regional level. In addition, the national level should ensure that available funds for implementation are not locked up at national level.

**Age of consent**

The age of consent needs to be explored and aligned in the statutes pertaining to SRH and HIV interventions as well as other statutes. This alignment is needed for facilitating access to services, which is presently hindered by the varying ages of consent. Where parental consent is required, parents should be targeted to ensure that they too facilitate their adolescent children’s access to these services.

**Parental and community support**

Parental and community involvement is crucial for adolescent health-seeking behaviour and efficacy for accessing available services. Community involvement and dialogue in CSE will provide more knowledge and understanding of adolescent developmental stages, which could help to address some of the cultural barriers to facilitate support for adolescents’ SRH and HIV needs.

**Adolescent-focused messages**

Adolescent-focused messages in HIV interventions are needed for reaching out to adolescents to access the available services. There is a need to address knowledge among the adolescents on SRH issues including the available services. This requires provision of information to adolescents in schools, communities and other places where adolescents gather. This can be done by targeting adolescents with clear and specific messages in the media, community meetings and specific curricula in the schools. Use of peer educators to reach out to adolescents and provide accurate information to them would ensure a continuous and available pool of knowledgeable adolescents in all localities. The peer educators could be adolescents and young people in school clubs, teen clubs. NGOs, etc.
LSBE needs strengthening at both school and community level. This would ensure that adolescents are provided with comprehensive knowledge on prevention of HIV/STIs and availability of services. In addition, LSBE would empower the adolescents to demand services.

**Meaningful adolescent engagement**

There should be meaningful engagement of adolescents in updating programmes, to make the communication and delivery models more relevant and acceptable to adolescents. The adolescent participation and consultations in the ALL IN process has provided great insight from a user’s perspective, including insight regarding the challenges that adolescents face in accessing services.

**Scaling up best practices**

The country assessments have identified best practices that can be taken to scale for better adolescent programming. Such practices include the teen-club approach, SRH/HIV integration and AFHS. In Namibia since 2011, teen clubs for ALHIV have been rolled out from 8 to 15 facilities in order to reach more adolescents. The teen-club approach has been shown to facilitate a reduction of loss to follow-up, and has increased the number of boys and girls with full disclosure. The teen clubs have also been instrumental in the provision of psychosocial support for both adolescents and parents, including addressing depression and hopelessness among ALHIV. Consequently, there is a need to roll out teen clubs at all of the ART sites in order to reach ALHIV, especially with regard to the test-and-treat approach for ART. Similarly, integration of SRH/HIV services has been piloted in seven health facilities in Namibia, and has been shown to promote and increase access to SRH and HIV services in these health facilities, which underscores the need to roll out this practice to other health facilities.

**Adopting BNA methodology for future planning**

The BNA methodology has proved to be very useful for in-depth analysis and subsequent evidence-based planning at regional level – this being a bottom-up approach. Building regional capacity to conduct the BNA methodology across all programmes would promote data use for programming at regional level, which in turn would promote data demand as well as facilitate improvement of data quality. In addition, using programmatic data at regional level provides a more regional context, which in turn generates more appropriate region-specific corrective actions. Thus the BNA methodology should be adopted as a best practice for performance monitoring and programme management.

**Integrating adolescent-disaggregated data into routine monitoring**

The Namibia country assessments showed that there is much programmatic data at both regional and national level. However, this data is not easily accessible and is not well analysed. The BNA process demonstrated efficient use of the available programmatic data, including identification of data gaps in the routine monitoring data at regional level. In addition, the BNA process formulated data improvement plans to address the data gaps. The proposed data improvement plans include revision of data-collection tools and strengthening of data review processes at regional level. There is a need for the national level to support the implementation of these plans by building the capacity of regional staff to pilot-test the plans in their regions, and then to institutionalise and scale them up appropriately. This capacity building would provide an opportunity for the integration of sex- and age-disaggregated data into routine monitoring processes to facilitate evidence-based planning for better adolescent programming.
A Bottleneck Analysis (BNA) methodology was used for identifying bottlenecks in priority HIV and Sexual and Reproductive Health (SRH) interventions for adolescents in Namibia.

The key bottlenecks identified were:
- unavailability of essential commodities for all interventions;
- lack of implementation of Adolescent Friendly Health Services (AFHS);
- lack of integrated SRH/HIV services; and
- lack of parental and community support, including disclosure support and parental consent.

Similarly, data gaps, especially for the 10-14 age group and adolescent key populations, were identified across most of the interventions. Corresponding key corrective actions, including data improvement plans, were formulated into regional action plans which were then validated. The validation process also recommended costing of the regional plans.
The successful implementation of the regional plans depends on their alignment with national processes. The end-of-term review of the National Strategic Framework for HIV and AIDS Response in Namibia (NSF) provides an opportune platform for the ALL IN country assessments to inform the next NSF in order to have a more robust focus on the adolescent component of the national HIV response. The findings from the ALL IN process resonate with the national plans for accelerating HIV prevention, care and treatment among children and adolescents. The current NSF and national plans identify national-level co-ordination, identification of infected children and adolescents and sub-optimal documentation and data management as major areas requiring improvement. The recommendations included increasing availability of quality AFHS and strengthening the Health Management Information System to better capture paediatric and adolescent HIV care. The ALL IN process provides a regional overview and offers a bottom-up approach to addressing these issues, through embedding the regional plans in existing regional and national plans and the Ministry’s strategic plans including the new NSF (2017-2021).

Other priority actions for implementation include:

- integrating the regional micro-plans into regional annual plans;
- resource mobilisation through existing mechanisms such as PEPFAR/CDC CoAg and the Global Fund, and provision of technical assistance to the MoHSS on a regular basis;
- creating advocacy through the upcoming National AIDS Conference, World AIDS Day activities, etc.;
- monitoring the implementation of the plans through regular regional meetings; and
- incorporating these plans as a standing agenda item in the national-level Technical Advisory Committee meetings.

The costed regional plans provide an overview of the resources required for implementation. This is a key step to engage donors to support the implementation of the action plans through upcoming platforms such as the Adolescent and Young Women (AGYW) initiative supported by the Global Fund. In addition, the co-ordination mechanism of the government, civil society, adolescent networks, donors and UN agencies can be drawn upon to provide a platform for advocacy to support and monitor the implementation of the regional plans. This advocacy would also ensure that the ALL IN process becomes a platform for generating data that feeds into ongoing programmes. Finally, the ALL IN process provides an opportunity for implementation science to build partnerships to develop modelling for identification and retention of adolescents in HIV care and other services. This could be a good strategy for Namibia as an upper-middle-income country, and is also pertinent as the country gears into the test-and-treat strategy.

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## Appendix 1

### LIST OF TASK TEAM MEMBERS

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<th>ORGANISATION</th>
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<tr>
<td>Dr Ndapewa Hamunime</td>
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<td>MoHSS</td>
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<td>MoHSS</td>
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<tr>
<td>Michael De Clerk</td>
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<tr>
<td>Marcus Betts</td>
<td>UNICEF</td>
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<tr>
<td>Jacqueline Kabambe</td>
<td>UNICEF</td>
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<tr>
<td>Ernst Mbangula</td>
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<tr>
<td>Tharcisse Barihuta</td>
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<tr>
<td>Mohamed Turay</td>
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<tr>
<td>Grace Hidinua</td>
<td>UNFPA</td>
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<tr>
<td>Aina Heita</td>
<td>UNESCO</td>
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<tr>
<td>Patricia Komu</td>
<td>Consultant</td>
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</tbody>
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## Appendix 2
### INDICATOR DEFINITIONS AND DATA SOURCES

**Indicators used for Antiretroviral Treatment (ART) for Adolescents Living with HIV**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Determinant</th>
<th>Indicator Definition</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply</td>
<td>Commodity</td>
<td>Proportion of ART sites offering HIV treatment with no stock-out of any recommended ARVs in the last three months</td>
<td>Number of ART sites offering HIV treatment with no stock-out of any recommended ARVs in the last three months</td>
<td>Number of ART sites offering HIV treatment</td>
<td>Pharmacy Stock Cards April-June 2016</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Human Resources</td>
<td></td>
<td>Proportion of ART sites offering HIV treatment with at least one health care worker trained in Adolescent Friendly Health Services</td>
<td>Number of ART sites offering HIV treatment with at least one health care worker trained in Adolescent Friendly Health Services</td>
<td>Number of ART sites offering HIV treatment</td>
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</tr>
<tr>
<td>Accessibility</td>
<td></td>
<td>Proportion of ART sites offering HIV treatment that have Adolescent/Youth Friendly Health Services (according to national norms / local definitions)</td>
<td>Number of ART sites offering HIV treatment that have Adolescent/Youth Friendly Health Services (according to national norms / local definitions)</td>
<td>Number of ART sites offering HIV treatment</td>
<td>PHC Facility Records August 2016</td>
</tr>
</tbody>
</table>
| Demand        | Initial Utilisation | Proportion of adolescents aged 10-19 years who tested positive for HIV and were initiated on treatment in accordance with nationally approved guidelines in the last 12 months | Number of adolescents aged 10-19 years who tested positive for HIV and were initiated on treatment in accordance with nationally approved guidelines in the last 12 months | Number of adolescents aged 10-19 years who tested positive for HIV and were initiated on treatment in the last 12 months | Numerator: EDT Data
Denominator: EPMS Data
Jan-Dec 2015                                               |
|               |             |                                                                                       |                                                                            |                                                                            |                                                          |
| Continuity    |             | Proportion of adolescents aged 10-19 years who tested positive for HIV, were initiated on treatment, and are alive and on treatment 12 months after initiation | Number of adolescents aged 10-19 years who tested positive for HIV, were initiated on treatment, and are alive and on treatment 12 months after initiation | Number of adolescents aged 10-19 years who tested positive for HIV and were initiated on treatment in the last 12 months | EDT Data
January-March 2015 cohort at April 2016                     |
| Quality       |             | Proportion of adolescents aged 10-19 years initiated on treatment who are virologically suppressed (viral load below 1 000 copies) at 12 months after initiation | Number of adolescents aged 10-19 years initiated on treatment who are virologically suppressed (viral load below 1 000 copies) at 12 months after initiation | Number of adolescents aged 10-19 years who tested positive for HIV and were initiated on treatment in the last 12 months | EDT Data
Jan-March 2015 cohort                                        |
## Indicators used for HIV Testing and Counselling (HTC) for Adolescents

<table>
<thead>
<tr>
<th>Domain</th>
<th>Determinant</th>
<th>Indicator Definition</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply</td>
<td>Commodities</td>
<td>Proportion of health facilities currently providing HTC with no stock-outs of HIV test kits* in the last three months</td>
<td>Number of health facilities currently providing HTC with no stock-outs of HIV test kits* in the last three months</td>
<td>Number of health facilities currently providing HTC</td>
<td>Pharmacy Stock Cards April-June 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of health facilities currently providing HTC with no stock-outs of HIV test kits* in the last three months</td>
<td>Number of health facilities currently providing HTC</td>
<td></td>
<td>Health Facility Records April-June 2016</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Proportion of health facilities currently providing HTC that report having at least one health care worker trained in Adolescent Friendly Health Services</td>
<td>Number of health facilities currently providing HTC that report having at least one health care worker trained in Adolescent Friendly Health Services</td>
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<td></td>
<td>Health Facility Records April-June 2016</td>
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<td>Accessibility</td>
<td>Proportion of health facilities currently providing HTC that have Adolescent/Youth Friendly Health Services (according to national guidelines)</td>
<td>Number of Health facilities currently providing HTC that have Adolescent/Youth Friendly Health Services (according to national guidelines)</td>
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<td>Health Facility Records April-June 2016</td>
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<td>Demand</td>
<td>Initial Utilisation</td>
<td>Proportion of adolescents aged 15-19 years who report ever testing for HIV</td>
<td>Number of adolescents aged 15-19 years who report ever testing for HIV</td>
<td>Number of adolescents aged 15-19 years sampled</td>
<td>NDHS 2013 national data</td>
</tr>
<tr>
<td>Continuity</td>
<td>Proportion of adolescents aged 15-19 years who were tested for HIV and received their HIV test results in the last 12 months</td>
<td>Number of adolescents aged 15-19 years who were tested for HIV and received their HIV test results in the last 12 months</td>
<td>Number of adolescents aged 15-19 years sampled</td>
<td></td>
<td>NDHS 2013 national data</td>
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<tr>
<td>Quality</td>
<td>Proportion of adolescents aged 15-19 years who tested positive for HIV and were enrolled in HIV care services (pre-ART or ART) in the last 12 months</td>
<td>Number of adolescents aged 15-19 years who tested positive for HIV and were enrolled in HIV care services (pre-ART or ART) in the last 12 months</td>
<td>Number of adolescents aged 15-19 years who tested positive for HIV in the last 12 months</td>
<td></td>
<td>HTC Register and Pre-ART Register Jan-Dec 2015</td>
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</tbody>
</table>

* HIV test kits include reagents, buffers and pipettes.
## Indicators used for Voluntary Medical Male Circumcision (VMMC) for adolescents

<table>
<thead>
<tr>
<th>Domain</th>
<th>Determinant</th>
<th>Indicator Definition</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply</td>
<td>Commodities</td>
<td>Proportion of health facilities currently providing VMMC with no stock-outs of essential VMMC commodities* in the last six months</td>
<td>Number of health facilities currently providing VMMC with no stock-outs of essential VMMC commodities* in the last six months</td>
<td>Number of sites providing VMMC</td>
<td>DHMIS and District Health Profile</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Commodities</td>
<td>Proportion of health facilities currently providing VMMC with at least one health care worker trained to counsel adolescents on VMMC</td>
<td>Number of health facilities currently providing VMMC with at least one health care worker trained to counsel adolescents on VMMC</td>
<td>Number of sites providing VMMC</td>
<td>Regional VMMC Register</td>
</tr>
<tr>
<td>Accessibility</td>
<td></td>
<td>Proportion of sites that have ever provided VMMC to adolescent males aged 10-19 years</td>
<td>Number of sites that have ever provided VMMC to adolescent males aged 10-19 years</td>
<td>Total number of sites</td>
<td>DHMIS and District Health Profile</td>
</tr>
<tr>
<td>Demand</td>
<td>Initial Utilisation</td>
<td>Among adolescent males aged 10-19 years estimated to be in need of VMMC, the proportion who received VMMC in the last 12 months</td>
<td>Number of adolescent males aged 10-19 years estimated to be in need of VMMC, the proportion who received VMMC in the last 12 months</td>
<td>Estimated number of adolescent males in need of VMMC (according to VMMC implementation plan) in the last 12 months</td>
<td>Regional VMMC Register Denominator: VMMC implementation strategy target (15-49 years); Population and Housing Census modified target for ages 15-19 years</td>
</tr>
<tr>
<td>Continuity</td>
<td></td>
<td>Among adolescent males aged 10-19 years estimated to be in need of VMMC, the proportion who received VMMC, and attended at least one post-operative follow-up visit (routine or emergency) in the last 12 months</td>
<td>Number of adolescent males aged 10-19 years estimated to be in need of VMMC, the proportion who received VMMC and attended at least one post-operative follow-up visit (routine or emergency) in the last 12 months</td>
<td>Estimated number of adolescent males in need of VMMC (according to VMMC implementation plan) in the last 12 months</td>
<td>Regional VMMC Register Denominator: VMMC implementation strategy target (15-49 years); Population and Housing Census modified target for ages 15-19 years</td>
</tr>
<tr>
<td>Quality</td>
<td></td>
<td>Among adolescent males aged 10-19 years estimated to be in need of VMMC, the proportion who received VMMC and were referred to at least one essential service as part of VMMC in the last 12 months</td>
<td>Number of adolescent males aged 10-19 years estimated to be in need of VMMC, the proportion who received VMMC and were referred to at least one essential service as part of VMMC in the last 12 months</td>
<td>Estimated number of adolescent males in need of VMMC (according to VMMC implementation plan) in the last 12 months</td>
<td>Regional VMMC Register Denominator: VMMC implementation strategy target (15-49 years); Population and Housing Census modified target for ages 15-19 years</td>
</tr>
</tbody>
</table>

* Essential commodities include sterile scalpels, local anaesthetic, sutures, dressings and sterile clamps.
## Indicators used for In-school Life Skills Based HIV Prevention and Comprehensive Sexuality Education (LSBE/CSE) for Adolescents (aged 10-14 years and 15-19 years)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Determinant</th>
<th>Indicator Definition</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply</td>
<td>Commodities</td>
<td>Proportion of primary schools with an LSBE/CSE curriculum</td>
<td>Number of primary schools with an LSBE/CSE curriculum for the current academic year</td>
<td>Number of primary schools</td>
<td>MoEAC (HAMU) reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of primary schools with at least one teacher trained on teaching LSBE/CSE</td>
<td>Number of primary schools with at least one teacher trained on teaching LSBE/CSE for the current academic year</td>
<td>Number of primary schools</td>
<td>MoEAC (HAMU) reports</td>
</tr>
<tr>
<td>Human Resources</td>
<td></td>
<td>Proportion of primary schools providing LSBE/CSE for the current academic year</td>
<td>Number of primary schools providing LSBE/CSE for the current academic year</td>
<td>Number of primary schools</td>
<td>MoEAC (HAMU) reports</td>
</tr>
<tr>
<td>Accessibility</td>
<td></td>
<td>Proportion of primary schools providing LSBE/CSE in the fourth year* of primary school within the current academic year</td>
<td>Number of primary schools providing LSBE/CSE in the fourth year* of primary school within the current academic year</td>
<td>Number of primary schools</td>
<td>MoEAC (HAMU) reports</td>
</tr>
<tr>
<td>Demand</td>
<td>Initial Utilisation</td>
<td>Proportion of secondary schools providing LSBE/CSE in the first year of secondary school within the current academic year</td>
<td>Number of secondary schools providing LSBE/CSE in the first year of secondary school within the current academic year</td>
<td>Number of secondary schools</td>
<td>MoEAC (HAMU) reports</td>
</tr>
<tr>
<td>Quality</td>
<td></td>
<td>Proportion of in-school adolescents who know three ways of HIV/STI transmission and two methods of HIV/STI prevention (comprehensive knowledge)</td>
<td>Number of in-school adolescents who know three ways of HIV/STI transmission and two methods of HIV/STI prevention</td>
<td>Number of in-school adolescents</td>
<td>MOEAC (HAMU) reports</td>
</tr>
</tbody>
</table>

* LSBE starts in the fourth year not the fifth year of primary school.
Appendix 3
REGIONAL MICRO-PLANS AND MONITORING AND EVALUATION PLANS

Erongo ................................................................. 50
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### Erongo Regional Micro-Plan

**REGION: ERONGO**

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Baseline</th>
<th>Timeline and Targets</th>
<th>Responsible Person</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 1:</strong></td>
<td>Coverage of HIV Testing and Counselling (HTC) among adolescents aged 15-19 years increased from 14% (male) and 29% (female) to 75% for both by December 2017.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Output 1:</strong></td>
<td>Proportion of facilities currently providing HTC that do not have adolescent-friendly services (as per national guidelines) reduced from 40% to 2% by December 2017.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Activities**

<table>
<thead>
<tr>
<th>Sensitise all four DCCs on AFHS guidelines and policies.</th>
<th>Number of DCCs sensitised</th>
<th>Meeting minutes and attendance register</th>
<th>Once</th>
<th>0</th>
<th>1</th>
<th>CHPO-FH</th>
<th>SHPO-SP</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitise RMT on AFHS.</td>
<td>RMT sensitised</td>
<td>Meeting minutes and attendance register</td>
<td>Once</td>
<td>0</td>
<td>1</td>
<td>CHPO-FH</td>
<td>SHPO-SP</td>
<td>0</td>
</tr>
<tr>
<td>Acquire and distribute guidelines/policies needed for the implementation of AFHS to all health facilities (HFs).</td>
<td>Number of HFs with policy guidance documents needed to implement AFHS</td>
<td>Distribution register</td>
<td>Once</td>
<td>0</td>
<td>26</td>
<td>CHPO-FH</td>
<td>SHPO-SP</td>
<td>0</td>
</tr>
<tr>
<td>Orientate the nurse in charge of facilities on AFHS guidelines/policies during the monthly meetings.</td>
<td>Number of facilities with nurses in charge of facilities oriented on AFHS</td>
<td>In-service training register</td>
<td>Quarterly</td>
<td>TBD</td>
<td>13</td>
<td>Family Health</td>
<td>PHCS</td>
<td>AFHS trained staff</td>
</tr>
<tr>
<td>Nurse in charge of facilities to orientate all HCWs on the job in those facilities on AFHS.</td>
<td>Number of facilities with HCWs oriented on AFHS</td>
<td>In-service training register</td>
<td>Quarterly</td>
<td>TBD</td>
<td>13</td>
<td>RN in charge</td>
<td>Trained staff</td>
<td>0</td>
</tr>
<tr>
<td>Implement AFHS in the HFs.</td>
<td>Number of HFs implementing at least 80% of the selected interventions on AFHS.</td>
<td>Interventions checklist</td>
<td>Ongoing</td>
<td>0</td>
<td>6</td>
<td>5</td>
<td>PHCS</td>
<td>0</td>
</tr>
</tbody>
</table>
### Appendix 3: Regional Micro-Plans and Monitoring and Evaluation Plans

#### REGION: ERONGO

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
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<th>Responsible Person</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor implementation of AFHS at HFs through monthly progress reports and support supervision</td>
<td>Number of visits to monitor implementation of AFHS in four districts</td>
<td>Monthly progress reports and support-visit reports</td>
<td>Quarterly</td>
<td>0</td>
<td>10 6</td>
<td>PHCS CHPO-FH</td>
</tr>
<tr>
<td>Adolescents to form part of the Health Facility/District Committee (HFC)/Hospital Advisory Committee</td>
<td>Number of districts with adolescents on the committee</td>
<td>Committee member list</td>
<td>Once</td>
<td>0</td>
<td>4</td>
<td>PHCS SW MoY</td>
</tr>
<tr>
<td>Train staff on AFHS</td>
<td>Number of facilities with staff trained</td>
<td>District training registers</td>
<td>Biannually</td>
<td>3</td>
<td>8 8</td>
<td>FH PHCS</td>
</tr>
</tbody>
</table>

#### Review of output

**Observation:** monitored quarterly

**Recommendations:**
- National level to train regional trainer of trainers (ToTs) on AFHS.
- National level to introduce AFHS training during the pre-service training in training institutions.

**Output 2:** Proportion of adolescents aged 15-19 years who did not test for HIV or did not receive their test results in the last 12 months reduced from 86% among males and 71% among females to 40% among both sexes by December 2017.

#### Activities

1. **Reach adolescents with HIV/HTC and AFHS messages through the health clubs at schools and existing youth forums.**

   - Number of school health clubs reached with HIV/HTC and AFHS messages
   - Monthly and quarterly reports
   - Annually
   - 0 | 30 30 | MoEAC School Health Team SWs | 0 |

2. **Offer HTC to all adolescents as they seek other health services such as family planning, dressings and STI Rx treatment.**

   - Number of Adolescents utilising HTC services
   - HTC monthly reports
   - Monthly
   - Unknown
   - 750 1050 1450 1550 | Facilities staff | 0 |

---

**ABBREVIATIONS USED IN THE ERONGO MICRO-PLAN**

- AFHS = Adolescent Friendly Health Services
- CAA = Catholic Aids Action
- CHPO = Chief Health Programme Officer
- D2D = Door-to-Door
- DCC = District Coordinating Committee
- FH = Family Health
- HCC = Health Care Worker
- HF = Health Facility
- HFC = Health Facility/District Committee
- MoYSNS = Ministry of Youth, Sport and National Service
- NAPPA = Namibia Planned Parenthood Association
- PHCS = Primary Health Care System
- RMT = Regional Management Team
- RN = Registered Nurse
- SHPO = Senior Health Programme Officer
- SP = Special Programme(s)
- STI Rx = Sexually Transmitted Infection Treatment
- SW = Social Worker
- TBD = To be determined

---
### REGION: ERONGO

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Baseline</th>
<th>Timeline and Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide HTC at youth centres / youth gatherings and event commemorations through a mobile clinic.</td>
<td>Number of youth centres and events where HTC is provided</td>
<td>Outreach report</td>
<td>Quarterly</td>
<td>1</td>
</tr>
<tr>
<td>Sensitise the door-to-door (D2D) testers (CAA) on HTC and HIV for adolescents.</td>
<td>Number of D2D testers sensitised on HTC and HIV for adolescents</td>
<td>Meeting report</td>
<td>Once</td>
<td>Unknown</td>
</tr>
<tr>
<td>Provide HTC at schools during the Wellness/AIDS Awareness week or as per request.</td>
<td>Number of HTC provided as requested</td>
<td>Outreach report</td>
<td>Ongoing</td>
<td>Unknown</td>
</tr>
<tr>
<td>Actively reach the adolescents through the D2D and outreach HTC by partners.</td>
<td>Increased number of adolescents utilising HTC services through D2D services</td>
<td>Monthly CAA HTC reports</td>
<td>Ongoing</td>
<td>Unknown</td>
</tr>
<tr>
<td>Discuss the adolescent needs through the existing community meetings/platforms (churches, workplaces, etc.)</td>
<td>Number of meetings/platforms where adolescent needs have been discussed</td>
<td>Outreach report</td>
<td>Quarterly</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

### Responsible Person

- PHCS
- CAA
- MoYSNS
- SHPO-SP
- PHCSs
- CAA
- PHCS
- NAPPA
- CAA

### Budget N$:

- 2 000
- 8 000
- 15 000
- 0
- 20 000

---

**Review of output**

Observation: monitored quarterly.

Recommendations:

1. National level to train regional ToTs on AFHS.
2. National level to develop adolescent-focused messages on HTC and AFHS – posters, leaflets, media inserts, etc.
## Kavango East and West Regional Micro-Plan

### Objective 1:
Coverage of HIV testing and Counselling among adolescents aged 15-19 years increased from 29% to 80% among females and 14% to 70% among males by December 2017.

### Output 1:
Proportion of health facilities currently providing HTC services that do not have Adolescent Friendly Health Services (AFHS) (as per national guideline) reduced from 98% to 30% by December 2017.

### Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain and distribute copies of AFHS National Standard Operational Procedures to health facilities.</td>
<td>Number of copies of AFHS National Standard Operational Procedures obtained and distributed to health facilities</td>
<td>District records</td>
<td>Once</td>
<td>0</td>
<td>SHPO, Family Health</td>
<td>25 000 for printing</td>
</tr>
<tr>
<td>Orientate health workers from all four districts on AFHS during the monthly meetings.</td>
<td>Number of district supervisors and doctors orientated</td>
<td>Attendance register</td>
<td>Once</td>
<td>0</td>
<td>SHPO, Family Health and SP</td>
<td>Staff time</td>
</tr>
<tr>
<td>Implement AFHS in health facilities as per National Standard Operational Procedures.</td>
<td>Number of health facilities implementing AFHS as per national standards</td>
<td>Regional and district records</td>
<td>Throughout</td>
<td>0</td>
<td>SHPO, Family Health</td>
<td>Staff time</td>
</tr>
</tbody>
</table>

### Review of output

**Observation:** Activities to be monitored quarterly by Directorate of Primary Health Care (DPHC) Supervisor.

**Recommendations:** National level to resume AFHS trainings.

### Abbreviations Used in the Kavango Micro-Plan

- **DPHC** = Directorate of Primary Health Care
- **EPMS** = Electronic Patient Management System
- **IMAI** = Integrated Management of Adulthood Illness
- **SFH** = Society for Family Health
- **SP** = Special Programmes
REGION: KAVANGO EAST AND WEST

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output 2:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of male and female adolescents aged 15-19 years who did not test for HIV or did not receive their results in the last 12 months reduced from 86% to 30% among males and 71% to 20% among females by December 2017.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Activities**

- Increase the number of schools reached with the promotion of HIV and SRH interventions targeting adolescents.
  - Number of schools reached with HIV/SRH promotional campaigns
  - Campaign reports
  - Weekly
  - 4 8 16 20 24 28
  - NAPPA

- Conduct radio sessions targeting parents and community leaders on availability of HIV and SRH services
  - Number of radio sessions targeting parents and community leaders on availability of HIV-SRH services
  - Radio reports
  - Monthly
  - 3 6 9 12 15
  - NAPPA

- Provide Comprehensive Sexual Education (CSE) targeting parents and community leaders.
  - Number of CSE campaigns targeting parents and communities
  - Reports
  - Quarterly
  - 1 2 3 4 5
  - NAPPA

**Review of output**

*Observation: Activities to be monitored quarterly.*

*Recommendations: National level to develop HIV and SRH key messages targeting parents and community leaders.*

Output 3: Proportion of adolescents aged 15-19 years who tested positive and were not enrolled in HIV care services (pre-ART or ART) in the last 12 months reduced from 56% to 25% by December 2017.

**Activities**

- Enrol all adolescent who tested positive for HIV care services on the same day.
  - Proportion of adolescents who tested positive for HIV who were enrolled for care and treatment
  - HTC, pre-ART and EPMS registers
  - Daily
  - 44 50 55 60 65 75
  - DPHC focal nurse

## Appendix 3: Regional Micro-Plans and Monitoring and Evaluation Plans

### REGION: KAVANGO EAST AND WEST

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involve partners who are implementing HIV and SRH services in the existing quarterly data review meetings to discuss best practices, challenges and recommendations.</td>
<td>Number of partners involved in quarterly data reviews</td>
<td>Quarterly</td>
<td>Q2 Q4 Q1 Q2 Q3 Q4</td>
<td>DPHC focal nurse</td>
<td>Staff time</td>
</tr>
</tbody>
</table>

### Review of output

**Observation:** Activity 1 should be monitored monthly.

**Recommendations:**
1. MoHSS to monitor and report the number of patients who test positive and are linked to services.
2. Link HTC and ART services and data-capturing tools.

### Objective 2:
Coverage of Antiretroviral Therapy (ART) for treatment among Adolescents Living with HIV (ALHIV) aged 10-19 years increased from 80% to 95% among females and 41% to 80% among males by December 2017.

### Output 1: Proportion of male adolescents who are not on treatment or alive 12 months after initiation reduced from 34% to 25% among those aged 10-14 years and 40% to 30% among those aged 15-19 years by December 2017.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide one-on-one treatment literacy sessions to adolescent ART clients in every visit.</td>
<td>240 240 240 240 240</td>
<td>Staff time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Proportion of adolescent ART clients provided with one-on-one literacy</th>
<th>ART register</th>
<th>Daily on contact</th>
<th>Proportion of adolescent ART clients who defaulted on follow up visits</th>
<th>EPMS</th>
<th>Daily in follow-up visits</th>
<th>DAPP/TCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of</td>
<td>33% 30% 27% 23% 19% 15%</td>
<td>0 240 240 240 240</td>
<td>240 240 240 240 240</td>
<td>33% 30% 27% 23% 19% 15%</td>
<td>DAPP/TCE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Review of output

**Observation:** Partners are not reporting to MoHSS on clients tracked and returned to treatment. It is important to report this indicator in the quarterly data review meetings.

**Recommendations:** National Office to develop adolescent-focused treatment messages for social media.
### REGION: KAVANGO EAST AND WEST

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Q2</td>
<td>Q4</td>
<td>Q1</td>
</tr>
</tbody>
</table>

### Output 2: Proportion of adolescents aged 15-19 years who were initiated on treatment and are not virologically suppressed (viral load below 1 000 copies) at 12 months after initiating treatment reduced from 48% to 35% among those aged 10-14 years and 43% to 30% among those aged 15-19 years by December 2017.

#### Activities

| Conduct disclosure of HIV status to adolescents by their caregivers/parents. | Proportion of adolescents who received disclosure of their HIV status from their caregivers/parents | Disclosure records | Daily on contact | 12 | 15 | 15 | 15 | 15 | 15 | ART Focal Nurse |
| Address adherence and treatment issues and challenges in teen club meetings. | Number of teen club meetings held with available minutes/records | Meeting minutes | Monthly | 3 | 3 | 3 | 3 | 3 | ART Focal Nurse for the teen club |

#### Review of output

**Observations:**
1. Disclosure is captured on EPMS with quarterly monitoring.
2. It is necessary to minute teen club meetings and use a curriculum in the clubs.

**Recommendations:**
1. Teen clubs should be age appropriate – 10-14 years and 15-19 years – in order to meaningfully engage the younger and older adolescents.
2. Integrate SRH and HIV services, especially for adolescents.
## Khomas Regional Micro-Plan

<table>
<thead>
<tr>
<th>REGION: KHOMAS</th>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of data collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget NS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2016 Q2 Q4 2017 Q1 Q2 Q3 Q4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Objective 1: Coverage of HIV Testing and Counselling (HTC) among adolescents aged 15-19 years increased from 29% to 80% among females and 14% to 70% among males by December 2017.

### Output 1: Proportion of health facilities providing HTC that do not have Adolescents Friendly Health Services reduced from 86% to 40% by December 2017.

#### Activities

- **Conduct an AFHS training need assessment at all HTC sites.**
  - Number of HTC sites assessed
  - Training register
  - Once off
  - 0
  - 14
  - FH
  - 100 000 for fuel and lunch

- **Obtain copies of the AFHS protocol and distribute to all HTC sites.**
  - Number of HTC sites provided with AFHS protocol copies
  - Facility records
  - Once off
  - 0
  - 14
  - FH
  - 25 000 for printing

- **On-the-job orientation for health care providers on AFHS as per the identified need.**
  - Proportion of HTC sites with at least one health care provider trained
  - Training records
  - Once off
  - 0
  - 14
  - FH
  - 15 000

#### Review of output

**Observations:** Quarterly monitoring by Primary Health Care (PHC) supervisor.

**Recommendations:** National level to conduct AFHS trainings.

### Output 2: Proportion of adolescents aged 15-19 years who did not test for HIV or did not receive their test results in the last 12 months reduced from 86% to 30% among males and 71% to 20% among females by December 2017.

#### Activities

- **Conduct schools and community awareness campaign on HTC.**
  - Number of schools and community awareness campaign conducted on HTC
  - Special programme quarterly report
  - Quarterly
  - 0
  - 5
  - 5
  - 5
  - DSP
  - 10 000 for IEC materials and lunch packs

- **Provide HTC mobile health service in secondary schools.**
  - Number of schools with HTC mobile health service provided
  - Special programme quarterly report
  - Quarterly
  - 0
  - 5
  - 5
  - DSP
  - 10 000 For lunch pack

### Abbreviations Used in the Khomas Micro-Plan

- DSP = Directorate of Special Programmes
- FH = Family Health Department
- HAMU = HIV/AIDS Management Unit (MoEAC)
- IEC = Information, Education and Communication
- RACE = Regional AIDS Committee on Education
### Report on Phase 2 of the Namibia “ALL IN” Country Assessment 2016

**REGION:** KHOMAS

<table>
<thead>
<tr>
<th>Output Indicator</th>
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<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain IEC materials from different stakeholders for dissemination in schools and community.</td>
<td>Number of schools where IEC materials have been disseminated</td>
<td>Special programme report</td>
<td>Once off</td>
<td>20 10</td>
<td>DSP and FH</td>
</tr>
<tr>
<td>Conduct ambush theatres with adolescent role models.</td>
<td>Number of ambush theatres with adolescent role models conducted</td>
<td>Special programme quarterly report</td>
<td>One off</td>
<td>5 5</td>
<td>DSP and FH</td>
</tr>
<tr>
<td>Establish boys clubs in all schools in Khomas Region.</td>
<td>Number of schools with boys clubs established</td>
<td>Family Health quarterly report</td>
<td>Once off</td>
<td>4 4 4 4 4</td>
<td>FH and RACE</td>
</tr>
<tr>
<td>Conduct parental meetings and parental youth dialogue on Gender and HIV issues.</td>
<td>Number of parental meetings and parental youth dialogue conducted</td>
<td>Family Health quarterly report</td>
<td>Quarterly</td>
<td>3 5</td>
<td>FH</td>
</tr>
</tbody>
</table>

### Review of output

**Observations:** DSP and FH to monitor activities on a monthly basis.

**Output 3:** Proportion of adolescents aged 15-19 years who tested positive for HIV and were not enrolled in HIV care services (Pre-ART or ART) in the last 12 months reduced from 100% to 40% by December 2017.

### Activities

**Monitor and track referral from HTC to care and treatment services.**

<table>
<thead>
<tr>
<th>Health facility reports</th>
<th>Monthly</th>
<th>0</th>
<th>80%</th>
<th>90%</th>
<th>Staff time</th>
</tr>
</thead>
</table>

**Review of output**

**Observations:** Facility supervisors to monitor monthly and Primary Health Care (PHC) supervisor quarterly.
### Appendix 3: Regional Micro-Plans and Monitoring and Evaluation Plans

#### REGION: KHOMAS

<table>
<thead>
<tr>
<th>Region Indicator</th>
<th>Source of Data</th>
<th>Frequency of data collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 2: Coverage of adolescents aged 10-19 years with Comprehensive Knowledge of HIV increased from 65% among females and 78% among males to 90% among both sexes by December 2017.</td>
<td></td>
<td></td>
<td></td>
<td>MoEAC-RACE</td>
<td>150 000</td>
</tr>
<tr>
<td>Output 1: Proportion of primary schools that have at least one teacher providing In-School Based Life Skills / Comprehensive Sexuality Education (CSE) reduced from 19% to 10% by December 2017.</td>
<td></td>
<td></td>
<td></td>
<td>MoEAC-RACE</td>
<td>Staff time</td>
</tr>
</tbody>
</table>

### Activities

#### Objective 2: Coverage of adolescents aged 10-19 years with Comprehensive Knowledge of HIV increased from 65% among females and 78% among males to 90% among both sexes by December 2017.

- **Train more teachers on Life Skills Education / CSE.**
  - Number of teachers trained on Life Skills Education
  - RACE and NAPPA
  - MoEAC-RACE
  - 150 000

- **MoEAC to liaise with tertiary institutions to offer Life Skills Education as a field of study.**
  - Number of tertiary institutions teaching Life Skills Education
  - MoEAC-RACE
  - Staff time

- **Train primary school teachers to teach the CSE curriculum.**
  - Number of primary school teachers trained in CSE
  - MoEAC-HAMU
  - 70 000

- **Conduct in-service training on Life Skills Education / CSE for new teachers.**
  - Number of new teachers trained on Life Skills Education / CSE
  - Training reports
  - Twice
  - 33
  - MoEAC-RACE
  - 150 000

- **Life Skills Education / CSE TAUGHT BY trained teachers.**
  - Number of teachers teaching Life Skills Education / CSE
  - RACE reports
  - Quarterly
  - 33
  - MoEAC-RACE
  - Staff time

#### Output 2: Proportion of secondary schools that do not provide In-School Life Skills Based HIV Education (LSBE) / CSE in the first year of secondary school reduced from 10% to 0% by December 2017.

**Activity**

- **Train teachers in LSBE/CSE in all secondary schools that are currently not providing LSBE/CSE in the first year of secondary school.**
  - Number of secondary schools providing LSBE/CSE in the first year of secondary
  - RACE Report
  - Yearly
  - 28
  - MoEAC-HAMU
  - 70 000

**Review of output**

*Observations: HAMU to monitor activities quarterly.*
<table>
<thead>
<tr>
<th>REGION: KHOMAS</th>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of data collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2016</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Q2 Q4</td>
<td></td>
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<td></td>
<td>2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q1 Q2 Q3 Q4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Data Gaps: Data-Improvement plan**

Revise reporting tool to capture the number of schools with LSBE/CSE curriculum and Comprehensive Knowledge on HIV among in-school adolescents.

<table>
<thead>
<tr>
<th>Revised reporting tool</th>
<th>HAMU report</th>
<th>Once off</th>
<th>1</th>
<th>Staff time</th>
</tr>
</thead>
</table>

**Review of output**

*Observations:* HAMU to pilot-test the tool before fully adopting.
## Omusati regional micro-plan

<table>
<thead>
<tr>
<th>REGION: OMUSATI</th>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Output 1</td>
<td></td>
<td></td>
<td>2016</td>
<td>2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q2 Q4 Q1 Q2 Q3 Q4</td>
<td>Q2 Q4 Q1 Q2 Q3 Q4</td>
<td></td>
</tr>
</tbody>
</table>

**Objective 1:** Coverage of Voluntary Medical Male Circumcision (VMMC) among adolescents aged 15-19 years increased from 7%1 to 65%2 by December 2017.

**Output 1:** Proportion of sites providing VMMC reporting any stock-out of essential commodities in the last three months reduced from 52% to 0% by December 2017.

### Activities

- **Monitor the availability of commodities at VMMC sites.**
  - **Number of monitoring visits undertaken per site**
    - **VMMC Programme**
      - **Quarterly**
      - **0 1 1 1 1 1**
      - **Regional VMMC Coordinator / Regional Pharmacist**
      - **4 500 for fuel and lunch packs**

- **Train health facility staff on stock management.**
  - **All staff at health facilities trained**
    - **Training register**
      - **Quarterly**
      - **0 0 25 25 25 25**
      - **Regional Director/ Programme Coordinator**
      - **150 000**

### Review of output

**Recommendation:** National level to strengthen the procurement process of VMMC commodities.

**Output 2:** Proportion of sites not providing VMMC services to adolescents reduced from 42% to 20% by December 2017.

- **Train staff in providing VMMC services to adolescents.**
  - **Number of staff trained to provide VMMC services**
    - **Training register**
      - **Quarterly**
      - **18[10 R/N] 9 A/H**
      - **Regional Director/ Programme Coordinator**
      - **550 000**

### Review of output

**Recommendation:** National level to facilitate training of staff.

### FOOTNOTES

1 Proportion reached 2014-2015  
2 Target according to VMMC strategy

### ABBREVIATIONS USED IN THE OMUSATI MICRO-PLAN

- **SP** = Special Programmes
- **FC** = Family Counselling
- **FH** = Family Health
- **SHPO** = Senior Health Programme Officer
### Output 3:
Among the adolescent males estimated to be in need of VMMC, the proportion who did not receive VMMC services reduced from 68% to 35% by December 2017.

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase awareness campaigns on the importance and requirements of VMMC through community meetings and electronic media.</td>
<td>Number of community-based VMMC awareness-raising campaigns undertaken</td>
<td>Quarterly</td>
<td>Q2 Q4 Q1 Q2 Q3 Q4</td>
<td>VMMC Coordinator</td>
<td>50 000</td>
</tr>
<tr>
<td></td>
<td>16 weekly VMMC awareness-raising discussions on radio</td>
<td>Weekly</td>
<td>Q2 Q4 Q1 Q2 Q3 Q4</td>
<td>VMMC/SHPO-FH/SHPO-SP Coordinator</td>
<td>10 000</td>
</tr>
</tbody>
</table>

**Review of output**

**Recommendations:** National level to scale up advocacy for the reduction of the age of consent for VMMC among adolescents.

### Data Improvement plan

**Output 4:**
To improve collection and management of data to inform provision of VMMC services to adolescents by December 2017.

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record the number of adolescents who received VMMC and attended at least one post-operative follow-up visit in the last 12 months.</td>
<td>Number of adolescents who received VMMC and attended at least one post-operative follow-up visit in the last 12 months aggregated</td>
<td>Quarterly</td>
<td>Q2 Q4 Q1 Q2 Q3 Q4</td>
<td>VMMC Coordinator</td>
<td>50 000</td>
</tr>
</tbody>
</table>

**Output 5:**
Improve collection and management of data to inform the estimations of adolescent males in need of VMMC who were referred to at least one essential service as part of VMMC by December 2017.

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review VMMC data-collection tool to capture VMMC referrals to essential service as part of VMMC services</td>
<td>Revised VMMC data-collection tool</td>
<td>Once a year</td>
<td>Q2 Q4 Q1 Q2 Q3 Q4</td>
<td>SHPO-SP/SHPO-FH/VMMC Coordinator</td>
<td>Staff time</td>
</tr>
</tbody>
</table>
## Appendix 3: Regional Micro-Plans and Monitoring and Evaluation Plans

### OMUSATI

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect data on VMMC referrals.</td>
<td>Data collected on number of adolescents who received VMMC and were referred in the last 12 months aggregated</td>
<td>Quarterly</td>
<td>2016 2017</td>
<td>SHPO-SP/SHPO-FH/VMMC Coordinator</td>
<td></td>
</tr>
</tbody>
</table>

**Review of output**

Recommendations:
1. Ensure that VMMC data is included in the ongoing quarterly data review meetings
2. Monitor overall work plan every quarter
3. Increase support from the national level to the regional staff on utilisation of the newly developed VMMC electronic monitoring tool

### Objective 2: Coverage of HIV testing and Counselling among adolescents aged 10-19 years increased from 29% to 80% among females and 14% to 70% among males by December 2017

#### Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor stock management at all health facilities by checking the order books before issuing the commodities.</td>
<td>Pharmacy Assistant, Family Health FP, DPHC</td>
<td>4 500 for fuel and lunch packs</td>
</tr>
<tr>
<td>Number of facilities where stock-taking is done and orders are according to schedule</td>
<td>Stock-taking report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Number of facilities where maximum and minimum levels are adhered to</td>
<td>Stock-taking report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Address the gaps identified from monitoring exercises.</td>
<td>Stock-taking report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Number of facilities where gaps from monitoring activities are identified and addressed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Baseline**
- **2016 Q2 Q4 Q1 Q2 Q3 Q4**
- **2017**
### Review of output

**Observations:** Activities to be ongoing to sustain the intervention.

**Recommendations:** To be monitored monthly.

### Output 2: Proportion of health facilities providing HTC that do not have Adolescent/Youth Friendly Services reduced from 60% to 30% by December 2017.

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Baseline</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain copies of the AFHS policy and distribute them to all health facility staff.</td>
<td>Number of health facilities with AFHS policy</td>
<td>Distribution list</td>
<td>Once annually</td>
<td>0</td>
<td>Q2/Q4</td>
<td>FH, FC, DPHC</td>
</tr>
<tr>
<td>Orientation of all staff on AFHS in Districts Monthly Meetings</td>
<td>Number of staff oriented on AFHS</td>
<td>Training register</td>
<td>Monthly</td>
<td>0</td>
<td>Q1/Q2/Q3/Q4</td>
<td>FH, FC, DPHC</td>
</tr>
<tr>
<td>Mark all the consulting rooms with numbers instead of the services provided.</td>
<td>% of health facilities with consulting rooms marked with number and not services provided</td>
<td>District and DPHC office</td>
<td>Quarterly</td>
<td>0</td>
<td>Q1/Q2/Q3/Q4</td>
<td>FH, SHPO/SP, DPHC</td>
</tr>
<tr>
<td>Include the adolescents to become members of clinic/health centre committees</td>
<td>% of health facility committees with adolescents represented</td>
<td>District/health centre/clinic register/profile</td>
<td>Once</td>
<td>0</td>
<td>Q1/Q2/Q3/Q4</td>
<td>All health facility committees</td>
</tr>
</tbody>
</table>

### Review of output

**Observations:** Health facilities to report progress monthly in the meetings. Quarterly monitoring by supervisors.

### Output 3: Proportion of adolescents aged 15-19 years who did not test for HIV and receive their results in the last 12 months reduced from 86% to 40% among males and 71% to 30% among females by December 2017.

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Baseline</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct meetings to create demand for SRH services among adolescents in a multi-sectoral approach (MoHSS/MGECW/MoEAC/NGOs, adolescent representatives) through community meetings</td>
<td>Number of meetings conducted to create demand for SRH services among adolescents</td>
<td>Attendance register</td>
<td>Quarterly</td>
<td>0</td>
<td>x</td>
<td>Family Health FC, SP-FC, DPHCs</td>
</tr>
</tbody>
</table>
### Appendix 3: Regional Micro-Plans and Monitoring and Evaluation Plans

#### REGION: OMUSATI

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Develop tailor-made interventions to provide HTC to adolescents in hard-to-reach communities.</strong></td>
<td>Number of communities reached with adolescent-friendly HTC interventions</td>
<td>Outreach schedule programme</td>
<td>Quarterly</td>
<td>0 x x x x</td>
<td>Family Health FC, SP-FC, DPHCs</td>
</tr>
<tr>
<td><strong>Develop messages targeting parents of adolescents to encourage their children’s to go for HTC. (Ensure adolescents are involved in the process.)</strong></td>
<td>Number of IEC materials developed with messages targeting parents of adolescents</td>
<td>Registry of IEC material received and distributed</td>
<td>Twice a year</td>
<td>0 x x x x</td>
<td>Family Health FC, SP-FC, DPHCs</td>
</tr>
<tr>
<td><strong>Target parents of adolescents and community leaders with HTC messages through community meetings, Health Extension Workers and</strong></td>
<td>Number of community-based sessions held to propagate messages</td>
<td>Attendance register for meeting held</td>
<td>Quarterly</td>
<td>0 x x x x x</td>
<td>Family Health FC, SP-FC, DPHCs, Health facility staff</td>
</tr>
<tr>
<td><strong>Conduct community outreach HTC activities targeting adolescents.</strong></td>
<td>Number of community outreach HTC activities undertaken</td>
<td>Outreach schedule programme</td>
<td>Quarterly</td>
<td>0 x x x x x</td>
<td>Family Health FC, SP-FC, DPHCs</td>
</tr>
</tbody>
</table>

### Review of output

**Observation:** Activities to be incorporated in the next quarter activity plan and monitored quarterly.

**Recommendations:** National level to be involved in the development of messages and materials.

**Output 4:** Proportion of adolescents aged 15-19 years who tested positive for HIV and were not enrolled in HIV care services (Pre-ART or ART) in the last 12 months reduced from 54% to 20% by December 2017.

<table>
<thead>
<tr>
<th>Budget N$</th>
<th>NIMART sites in the region</th>
<th>NIMART sites in the region</th>
<th>Progress report for district and region</th>
<th>Quarterly</th>
<th>26</th>
<th>29</th>
<th>31</th>
<th>34</th>
<th>37</th>
<th>40</th>
<th>SP/FC/DPHCs</th>
<th>Staff time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase NIMART sites from 26 to 40 sites in the region.</td>
<td>Number of NIMART sites in the region</td>
<td>Progress report for district and region</td>
<td>Quarterly</td>
<td>26</td>
<td>29</td>
<td>31</td>
<td>34</td>
<td>37</td>
<td>40</td>
<td>SP/FC/DPHCs</td>
<td>Staff time</td>
<td></td>
</tr>
<tr>
<td>REGION: OMUSATI</td>
<td>Output Indicator</td>
<td>Source of Data</td>
<td>Frequency of Data Collection</td>
<td>Timeline and Targets</td>
<td>Responsible Team</td>
<td>Budget N$</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Monitor and track referral from HTC to care and treatment services.</td>
<td>Number of referrals tracked from HTC to care and treatment services</td>
<td>Progress report for district and region</td>
<td>Quarterly</td>
<td>0 1 1 1 1 1</td>
<td>SP/FC/DPHCs</td>
<td>Staff time</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Follow up on adolescent clients who are referred to and do not reach the care and treatment services.</td>
<td>Number of follow-ups of adolescent clients referred to but do not reach care and treatment services</td>
<td>Progress report for district and region</td>
<td>Quarterly</td>
<td>0 3 3 3 3 3</td>
<td>SP/FC/DPHCs</td>
<td>Staff time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Review of output**

*Observation:* Monitor pre-ART and ART registers monthly to track leakages. Use community-based health workers and NGOs to track clients.

*Recommendations:* Ensure linkage of HTC and EPMS data systems to facilitate tracking of patients who tested positive for HIV and were linked to care and treatment.

**Data Gaps: Data-Improvement Plan**

Record all staff trained in training registers and update the registers quarterly.

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of trained staff recorded in the registers</td>
<td>Training register</td>
<td>Quarterly</td>
<td></td>
<td>SP/FC/DPHCs</td>
</tr>
</tbody>
</table>
### Otjozondjupa Regional Micro-Plan

**REGION:** OTJOZONDJUPA

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline</strong></td>
<td></td>
<td></td>
<td><strong>2016</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3 Q4 Q1 Q2 Q3 Q4</td>
<td></td>
<td></td>
<td><strong>2017</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Objective 1:
Coverage of HIV Testing and Counselling (HTC) among adolescents aged 15-19 years increased from 29% among females and 14% among males to 50% among both sexes by December 2017.

#### Output 1:
Proportion of health facilities currently providing HTC services reporting stock-out of HTC commodities reduced from 80% to 0% by December 2017.

**Activities**

- **Conduct on-the-job training for health facility staff on stock management.**
  - Number of facilities where on-the-job training has been conducted
  - Attendance register
  - Once
  - 0
  - 5
  - 19
  - 24
  - 24
  - 24
  - Regional pharmacist and pharmacy assistant
  - 150 000

- **Conduct monthly stock-taking exercise for testing kits and related items at health facilities.**
  - Proportion of health facilities with updated stock cards
  - Stock cards and order books
  - Monthly
  - 0
  - 5
  - 10
  - 9
  - 24
  - Site supervisor/CHPO and PHC supervisor
  - PHC supervisor and regional pharmacist

- **Monitor stock management during supervisory visits.**
  - Proportion of health facilities supervised on stock management during supervisory visits
  - Supervisory report
  - Quarterly
  - 0
  - 21%
  - 63%
  - 100%
  - 100%
  - 100%
  - Regional pharmacist and SHPO/CHPO/FH/PHC
  - 4 500 for fuel and lunch packs

**ABBREVIATIONS:**
- CHPO = Chief Health Programme Officer
- CSE = Comprehensive Sexuality Education
- DCCs = District Coordinating Committees
- ESA = Eastern and Southern Africa Ministerial Commitment
- FH = Family Health
- FHD = Family Health Department
- NHTC = National Health Training Centre
- PHC = Primary Health Care
- SHPO = Senior Health Programme Officer
- SMO = Senior Medical Officer
- SP = Special Programmes
### Review of output

*Observation:* Monitoring to be conducted quarterly.

*Recommendations:* There should be consultation with regions when operational changes in testing occur to allow the regions to adjust accordingly so as not to interrupt service delivery.

#### Output 2:
Proportion of health facilities currently providing HTC that do not have Adolescent Friendly Health Services (AFHS) reduced from 100% to 40% by December 2017.

#### Activities

<table>
<thead>
<tr>
<th>Activities</th>
<th>Baseline</th>
<th>2016</th>
<th>2017</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain and distribute copies of the AFHS standards to health facilities.</td>
<td></td>
<td></td>
<td></td>
<td>FHD</td>
<td>25 000 for printing</td>
</tr>
<tr>
<td>Conduct orientation on AFHS for DCCs.</td>
<td></td>
<td></td>
<td></td>
<td>SHPO/CHPO</td>
<td>Staff time</td>
</tr>
<tr>
<td>Sensitise health facility staff on AFHS through on-the-job training.</td>
<td></td>
<td></td>
<td></td>
<td>PHC supervisor</td>
<td>Staff time</td>
</tr>
<tr>
<td>Monitor AFHS provision during supervisory visits.</td>
<td></td>
<td></td>
<td></td>
<td>SHPO/CHPO</td>
<td>4 500 for fuel and lunch packs</td>
</tr>
<tr>
<td>Sensitise other line ministries on AFHS in Hospital Advisory Committees.</td>
<td></td>
<td></td>
<td></td>
<td>SMO/PHC supervisor</td>
<td>Staff time</td>
</tr>
</tbody>
</table>

**Timeline and Targets**

<table>
<thead>
<tr>
<th></th>
<th>Q3</th>
<th>Q4</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of output</td>
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<tr>
<td>Observation:</td>
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<tr>
<td>Monitoring to be</td>
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<tr>
<td>conducted quarterly.</td>
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</tbody>
</table>
### Appendix 3: Regional Micro-Plans and Monitoring and Evaluation Plans

<table>
<thead>
<tr>
<th>REGION: OTJOZONDJUPA</th>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Baseline</td>
<td>2016 Q3 Q4 2017 Q1 Q2 Q3 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Output 3</strong>:</td>
<td>Proportion of adolescents aged 15-19 years who did not test for HIV and receive their test results in the last 12 months reduced from 86% among males and 71% among females to 50% among both sexes by December 2017.</td>
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<tr>
<td></td>
<td>Activities</td>
<td></td>
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</tr>
<tr>
<td>Provide awareness messages at health clubs; Teenagers Against Drugs, Alcohol and HIV (TADAH) clubs; and youth clubs/forums.</td>
<td>Proportion of health clubs, TADAH clubs and youth clubs/forums where awareness on HIV testing has been provided</td>
<td>Reports</td>
<td>Occasionally or monthly</td>
<td></td>
<td>MoEAC Social worker MoHSS MoSYNS</td>
<td></td>
</tr>
<tr>
<td>Sensitise school boards and school communities on parental involvement in CSE and Life Skills through coordination of the regional ESA sub-committees.</td>
<td>Number of schools that participate in the workshops</td>
<td>Reports</td>
<td>Occasionally</td>
<td></td>
<td>SHPO/CHPO-FH Social Worker</td>
<td>90 000 @ 30 000 per meeting</td>
</tr>
<tr>
<td>Incorporate HTC services into outreach activities.</td>
<td>Number of outreach activities incorporating HTC</td>
<td>Reports</td>
<td>Monthly</td>
<td></td>
<td>SHPO/CHPO SP and FH PHCs</td>
<td></td>
</tr>
<tr>
<td>Provide HTC services at settings where adolescents gather – e.g. Day of the Namibian Child; soccer tournaments; Agricultural Show.</td>
<td>Number of adolescents reached with HTC services in adolescent-friendly settings</td>
<td>Reports</td>
<td>Quarterly</td>
<td></td>
<td>SHPO/CHPO SP MoSYNS MGECW</td>
<td></td>
</tr>
</tbody>
</table>

**Review of output**

*Observation:* Monitoring to be conducted quarterly.

*Recommendations:* National level to formulate messages and produce IEC materials for adolescents and also parents and community leaders.
### Output 4: Proportion of adolescents aged 15-19 years who tested positive for HIV and were not enrolled in HIV services (pre-ART or ART) in the last 12 months reduced from 36% to 0% by December 2017.

#### Activities

<table>
<thead>
<tr>
<th>活动</th>
<th>指标</th>
<th>数据来源</th>
<th>频率</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Register all clients who test positive for HIV, on the same day.</td>
<td>Proportion of clients tested and registered for pre-ART or ART</td>
<td>ART register book</td>
<td>Monthly</td>
<td>63%</td>
<td>70% 80% 90% 100%</td>
</tr>
<tr>
<td>Monitor linkage from HTC during supportive supervisory visits in the facilities.</td>
<td>Proportion of adolescents registered and put on ART</td>
<td>ART register book</td>
<td>Quarterly</td>
<td>63%</td>
<td>70% 80% 90% 100%</td>
</tr>
</tbody>
</table>

#### Review of output

**Observation:** Monitoring to be conducted monthly by health facility supervisor and quarterly by PHC supervisor.

**Recommendations:** Align the legal age of consent for HTC with other Sexual and Reproductive Health (SRH) services.
# Zambezi Regional Micro-Plan

**Objective 1:** Increase coverage of ART among adolescents in Zambezi Region from 49% to 80% by December 2017.

**Output 1:** Proportion of adolescent girls aged 15-19 years who are not alive and on treatment 12 months after initiation reduced from 40% to 15% by December 2017.

## Activities

<table>
<thead>
<tr>
<th>Activities</th>
<th>Output Indicator</th>
<th>Source of Data</th>
<th>Frequency of Data Collection</th>
<th>Timeline and Targets</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orient health workers on disclosure guidelines.</td>
<td>Proportion of health workers oriented</td>
<td>Attendance registers</td>
<td>Quarterly until all are oriented</td>
<td>0 20 40 60 80 100</td>
<td>MoHSS Zambezi Regional Health Directorate</td>
<td>400 000 @ 80 000 per meeting</td>
</tr>
<tr>
<td>Proportion of nurses oriented</td>
<td></td>
<td></td>
<td></td>
<td>0 20 40 60 80 100</td>
<td>MoHSS Zambezi Regional Health Directorate</td>
<td></td>
</tr>
<tr>
<td>Proportion of doctors oriented</td>
<td></td>
<td></td>
<td></td>
<td>0 20 40 60 80 100</td>
<td>MoHSS Zambezi Regional Health Directorate</td>
<td></td>
</tr>
<tr>
<td>Educate ALHIV, their families and communities on transfer procedure through radio.</td>
<td>Proportion of nurses oriented</td>
<td>SHPO-DSP reports</td>
<td>Quarterly</td>
<td>0 24 24 24 24</td>
<td>MoHSS Zambezi Regional Health Directorate</td>
<td>None</td>
</tr>
<tr>
<td>Proportion of doctors oriented</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MoHSS Zambezi Regional Health Directorate</td>
<td></td>
</tr>
<tr>
<td>Strengthen monitoring process of tracing of ART clients in the region.</td>
<td>Proportion of loss to follow-up cases for whom outcomes are established by TCE workers</td>
<td>TCE register</td>
<td>Quarterly</td>
<td>0 40 60 80 100</td>
<td>MoHSS Zambezi Regional Health Directorate</td>
<td>None</td>
</tr>
<tr>
<td>Constitute and operationalise support groups to deal with issues of disclosure (HIV/AIDS).</td>
<td>Number of support groups formed in the region</td>
<td>SHPO-DSP reports</td>
<td>Quarterly</td>
<td>0 2 2 2 2</td>
<td>MoHSS Zambezi Regional Health Directorate</td>
<td>240 000 @ 60 000 per meeting</td>
</tr>
<tr>
<td>Number of meetings held by support groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MoHSS Zambezi Regional Health Directorate</td>
<td></td>
</tr>
</tbody>
</table>

### ABBREVIATIONS IN THE ZAMBEZI MICRO-PLAN

- DSP = Directorate of Special Programmes
- EDT = Electronic Dispensing Tool
- EPMS = Electronic Patient Management System
- ESA = Eastern and Southern Africa Ministerial Commitment
- NFA = Namibia Football Association
- SHPO = Senior Health Programme Officer
- TCE = Total Control of the Epidemic
**Report on Phase 2 of the Namibia “ALL IN” Country Assessment 2016**

**REGION:** ZAMBEZI

<table>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Output 2:</strong> Proportion of adolescent boys aged 15-19 years who tested positive for HIV and were not initiated on ART in accordance with nationally approved protocol in the last 12 months reduced from 33% to 10% by December 2017.</td>
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<tr>
<td>Activities</td>
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</tr>
<tr>
<td>Identify adolescent expert clients and empower them with skills in peer counselling.</td>
<td>Number of adolescents empowered with skills in peer counselling</td>
<td>Quarterly</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Develop and print IEC materials on adolescent reproductive health, living with HIV and transfer procedures.</td>
<td>Number of IEC materials printed and distributed on adolescent reproductive health and living with HIV in English and Silozi</td>
<td>Monthly</td>
<td>1500</td>
<td>1500</td>
<td>1500</td>
</tr>
</tbody>
</table>

| **Output 3:** Proportion of ART sites reporting stock-out of commodities reduced from 3% to 0% by December 2017. | | | | | |
| Activities | | | | | |
| Conduct quarterly pharmacy supervisory visits for each ART site. | Number of sites without stock-outs at end of each quarter | Quarterly | 0 | 0 | 0 | 0 | Regional pharmacist / PHC supervisor | None |
| Number of sites with at least 4 visits and documented reports by end of Q4 2017 | Once at end of Q4 | | | | | | |
### Appendix 3: Regional Micro-Plans and Monitoring and Evaluation Plans

<table>
<thead>
<tr>
<th>REGION: ZAMBEZI</th>
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<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2016</td>
<td>2017</td>
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<td></td>
<td></td>
<td>Q2 Q4 Q1 Q2 Q3 Q4</td>
<td>Baseline</td>
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</tbody>
</table>

#### Output 4: Proportion of health facilities that do not have at least one health care worker trained in Adolescent Friendly Health Services (AFHS) reduced from 72% to 30% by December 2017.

**Activities**

- **Formulate a region-specific operational plan for AFHS.**
  - **Zambezi AFHS operational plan developed**
  - **DSP Regional Office**
  - Once, in Q2
  - \(x\)
  - MoHSS Zambezi Regional Health Directorate
  - 30 000

- **Relocate the entire NAPPA clinic to the youth centre.**
  - **Functional NAPPA clinic at the youth centre**
  - **DSP Regional Office**
  - Once, in Q3
  - \(x\)
  - MoSYNS
  - None

- **Lobby for 2 containers with furniture from the funders to create space for the NAPPA clinic at the youth centre site.**
  - **An expanded NAPPA clinic at the youth centre**
  - **DSP Regional Office**
  - Once, in Q3
  - \(x\)
  - MoHSS regional team
  - 300 000

#### Data improvement plan

**Output 5: Conduct viral load monitoring for 100% adolescents on ART as per the guideline by December 2017.**

**Activities**

- **Perform scheduled viral load monitoring at 6 and 12 months as per national guidelines.**
  - **Proportion of adolescents viral load monitoring done every 6 months**
  - **HIVQual reports and EPMS database**
  - **Quarterly**
  - 20% 40 60 80 100
  - Clinical mentors and DSP
  - None

- **Conduct refresher trainings for data clerks (13) and counsellors (14) on data quality.**
  - **Number of data-quality refresher trainings provided to data clerks and counsellors**
  - **DSP Regional Office**
  - **Once by second quarter**
  - \(x\)
  - MoHSS national level
  - 80 000

- **Provide acknowledgement for facilities that adhere to monitoring guidelines.**
  - **No. of occasions on which well-performing facilities are acknowledged**
  - **DSP Regional Office**
  - **Quarterly**
  - 1 1 1 1 1
  - Regional Directorate
### REGION: ZAMBEZI

#### Output Indicator | Source of Data | Frequency of Data Collection | Timeline and Targets | Responsible Team | Budget N$ |
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>Baseline</strong></td>
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<tr>
<td><strong>2016</strong></td>
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<td><strong>Q2</strong></td>
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<td><strong>Q4</strong></td>
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<tr>
<td><strong>2017</strong></td>
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<td><strong>Q1</strong></td>
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<td><strong>Q2</strong></td>
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<td><strong>Q3</strong></td>
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<tr>
<td><strong>Q4</strong></td>
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</tbody>
</table>

#### Objective 2: Reduce teenage pregnancy in Zambezi Region from 28% to 14% by the end of December 2017.

#### Output 1: Proportion of adolescents aged 10-19 years falling pregnant in Zambezi Region reduced from 28% to 14% by the end of December 2017.

### Activities

<table>
<thead>
<tr>
<th>Activities</th>
<th>Number of schools that participate in the workshops</th>
<th>Number of workshops organised by the regional ESA sub-committee</th>
<th>FH Regional Office</th>
<th>Regional ESA sub-committee meeting minutes</th>
<th>Quarterly until all schools are covered</th>
<th>Responsible Team</th>
<th>Budget N$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitise school boards and school communities on the parental involvement in CSE and life skills through coordination of the regional ESA sub-committees.</td>
<td>Number of schools that participate in the workshops</td>
<td>Number of workshops organised by the regional ESA sub-committee</td>
<td>FH Regional Office</td>
<td>Regional ESA sub-committee meeting minutes</td>
<td>Quarterly until all schools are covered</td>
<td>Regional Directorate</td>
<td>90 000 @ 30 000 per meeting</td>
</tr>
<tr>
<td>Invite role models to motivate adolescents and promote their self-worth, identity and assertiveness.</td>
<td>Number of schools visited by motivational teams</td>
<td>FH Regional Office</td>
<td>Quarterly until all schools are visited at least once</td>
<td>Regional Directorate</td>
<td>12 000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish and institutionalise the Galz and Goals Sports for Development Programme in the region.</td>
<td>Number of Galz and Goals clubs formed</td>
<td>NFA reports</td>
<td>March to October</td>
<td>MoEAC</td>
<td>120 000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Other key publications relating to adolescents and HIV in Namibia
(PDFs are available on the publishers’ websites.)