Strengthening the Adolescent Component of National HIV Programmes through Country Assessments

SUMMARY OF THE REPORT ON PHASE 2 OF THE NAMIBIA “ALL IN” COUNTRY ASSESSMENT 2016
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SUMMARY OF THE NAMIBIA “ALL IN” COUNTRY ASSESSMENTS REPORT 2016

Ministry of Health and Social Services
Joint United Nations Programme on HIV/AIDS
United Nations Children’s Fund

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ABBREVIATIONS

AADM Adolescents Assessment and Decision Maker’s
AFHS Adolescent Friendly Health Services
AIDS Acquired Immune Deficiency Syndrome
ART Antiretroviral Treatment/Therapy
BNA Bottleneck Analysis
CSE Comprehensive Sexuality Education
HTC HIV Testing and Counselling
LSBE Life Skills Based HIV Education
MGECW Ministry of Gender Equality and Child Welfare
MoEAC Ministry of Education, Arts and Culture
MoHSS Ministry of Health and Social Services
MSYNS Ministry of Sports, Youth and National Service
NDHS Namibia Demographic Health Survey (2013)
NSF National Strategic Framework (for HIV and AIDS Response in Namibia)
SRH Sexual and Reproductive Health
STI Sexually Transmitted Infection
UNAIDS Joint United Nations Programme on HIV and AIDS
UNICEF United Nations Children’s Fund
VMMC Voluntary Medical Male Circumcision
WHO World Health Organization
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7 REGIONS STUDIED

OMUSATI  OSHIKOTO  OSHANA
KUNENE

OMUSATI  OHANGWENA  KAVANGO

OTJOZONDJupa  ERONGO  KHOMAS

OMAHEKE

KHOMAS  KAVANGO  ZAMBEZI

KUNENE  ZAMBEZI

Atlantic Ocean  Botswana

South Africa  Angola  Zambia
Introduction

Globally, adolescents (persons of ages 10-19 years) are the only demographic group in which AIDS-related deaths are not decreasing.\(^1\) In Africa, AIDS is the leading cause of death among adolescents.\(^2\) ALL IN is a platform for action and collaboration to drive better results with and for adolescents (10-19 years) through critical changes in programmes and policy. It aims to unite actors across sectors to accelerate reductions in the numbers of 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 AIDS epidemic among adolescents by 2030.

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Namibia is one of the 22 countries which are globally implementing the ALL IN initiative. This initiative supports countries in identifying gaps and defining priority actions to accelerate the HIV response for adolescents and to reach targets by 2020. These aims are achieved through a three-phase country assessment. Phase 1 was 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-performing interventions (i.e. the rates of service provision are low). Phase 2 was an in-depth analysis of gaps and bottlenecks that hamper coverage in the high-burden locations identified in Phase 1. The third phase harmonised decisions 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 (regional) level.

Results of Phase 1 – the rapid national assessment

The rapid national assessment was conducted through review and analysis of data on adolescents and HIV/SRH from multiple data sources. The government-led process involved consultations with multi-sectoral stakeholders and adolescents, including adolescents living with HIV. This first phase provided a detailed profile on adolescent HIV in Namibia, and facilitated the identification of low-performing indicators among adolescents in comparison with adults and younger age groups.

Key findings included the following:

- Adolescents represent about a quarter (23%) of the total Namibian population.
- There are more adolescent girls living with HIV than boys. In 2014, the estimated number of adolescents living with HIV in Namibia was 11 035, comprising 6 087 girls and 4 948 boys.
- 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. (In the 2013 NDHS, the rates were at 59% among females and 40% among males.)
- ART coverage among adolescents aged 15-19 years is at 61% among girls and 76% among boys, which is low in comparison with 92% among girls and 94% among boys in the 10-14 age group. This sharp decline in the 15-19 age group continues further in the 20-24 group, with 39% among females and 14% among males. This declining ART coverage with age and corresponding low HIV testing rates indicate challenges in ART initiation among newly infected adolescents and young adults, and in retention of patients on ART as they transition into adulthood.
- Condom use is at 61% and 75% among female and male adolescents respectively, these rates being below the national target.
- Comprehensive knowledge of HIV coverage is at 56% among girls and 51% among boys, which is very low compared to the 90% national target. In addition, the older males (ages 20-24) are no more knowledgeable than the younger ones, as is indicated by this rate of 51% compared to 68% among their female counterparts.

These results showed gaps in the adolescent component of the national HIV response. As mentioned earlier, the aim of Phase 1 was to inform the in-depth analysis to be undertaken as Phase 2 of the ALL IN process. This required defining:

- priority adolescent populations (i.e. the most vulnerable or most at risk) on whom to focus the programme response;
- high-impact HIV programmes and cross-sectoral opportunities to accelerate results in adolescents; and
- high-burden locations in which to focus programme interventions for maximum impact.

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3 MoHSS and Namibia Statistics Agency (NSA), *Namibia Demographic and Health Survey 2013*. 
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.

Objectives of Phase 2 – the in-depth analysis

The overall objective was to conduct an in-depth analysis of bottlenecks and gaps limiting effective coverage of priority HIV and SRH programme interventions among adolescents, in order to identify corrective actions to address these bottlenecks and gaps. In addition, the corrective actions would be formulated 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.
Section 2
METHODOLOGY

The assessment was undertaken through the following steps:
1. A meeting led by the MoHSS to introduce and launch the process and engage a Task Team.
2. A review of documentation to determine the availability, access and utilisation of the selected interventions in the selected regions. This also included mapping of service delivery platforms of the selected interventions.
3. Reviewing and validating the indicators for the in-depth analysis to ensure alignment with the country context and service delivery platforms.
4. An inception report detailing the process, methodology, activities and timelines for the assessment.
5. An orientation workshop, 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, CSOs, UN partners and representatives of adolescents and youth networks.
6. Formation of cluster teams composed of representatives of the MoHSS (national and regional levels), other government ministries, CSOs and UN partners.
7. Data gathering at regional level with the participation of different sectors and implementers.
8. Conducting in-depth analysis through consultative and participatory regional workshops with the support of the cluster teams.
9. Validation of the in-depth analysis results with the regional teams, government ministries, CSOs and development partners.

Research design

The in-depth analysis was conducted in selected health districts in the identified regions using a rapid assessment methodology in order to identify priority programme gaps and bottlenecks of the selected interventions. Both quantitative and qualitative data-collection methods were used for the in-depth analysis. This included facilitated workshops, focus-group discussions and in-depth interviews with key stakeholders including representatives of government, CSOs and adolescents, in alignment with the national multi-sectoral response. In addition, a desk review of policies, strategic plans, health surveys, guidelines and programme reports relating to adolescent-focused HIV and SRH interventions was conducted.

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 1.
Table 1: 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>

Data collection

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

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

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

Determinant analysis

The first step was to select and define the indicators to be used to conduct an 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.

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. However, the targets in the VMMC strategy are for the 15-49 age group. Consequently, the target for the 15-19 age group had to be obtained from the proportion of male adolescents aged 15-19 years among the 15-49 age group in 2015 population projections. Another case was for ART demand and quality indicators, the denominator for which 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 timelines of the indicators. 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”.

Key data sources were the 2013 NDHS, health facility records, programme records, District Health Information Systems and electronic national data systems. The data collected was then entered into the Adolescent Assessment and Decision Maker’s Tool (AADM) used in Phase 2. The AADM generated graphs depicting availability of commodities, human resources and access, as well as 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 data was qualitative, and was collected using a highly participatory approach in the regional workshops, through adolescent consultations, group discussions and consensus building to explore immediate, underlying and structural causes of the observed bottlenecks. This was critical in identifying the main factors contributing to low coverage of interventions. Figure 1 shows the format used to explore the multiple causes of the identified bottlenecks.

**Figure 1: 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><strong>Intervention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Identification of corrective actions

This third step built on the previous steps and used the same participatory approaches in the same regional workshops to formulate solutions for the identified multiple causes of the bottlenecks.

This involved prioritisation of the solutions and strategies, with the focus on what can be done with available resources and what is applicable to the regional context.

The guiding questions in formulating solutions were:
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 2: 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: 1.1</td>
<td>Why 1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Why 2:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Why 3:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INTERVENTION: 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, responsible person/institution to oversee 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 one and two of the country assessment.

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

The findings, presented per region in alphabetical order, outline: the selected interventions and geographical locations; findings from the determinant and causality analyses; and the corrective actions identified. In addition, where data gaps were identified, the data-improvement plan is outlined. (The data-improvement plans are included in the regional work plans. The regional work plans are presented in full in the accompanying full report.)

Erongo Region

Erongo Region selected HTC as the priority intervention. The selected geographical sites were Swakopmund and Walvis Bay Health Districts. Similar to the other regions, national data was used for utilisation and continuity indicators for HTC, while the quality indicator was regional data. Graphs 1 and 2 show the results of the determinant analysis.

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.

The low availability of human resources was associated with lack of staff trained in AFHS due to high staff turnover. Low accessibility was linked to lack of knowledge among health workers regarding AFHS guidelines and adolescents’ health needs, and this lack of knowledge was associated with lack of implementation of the AFHS guidelines. Causes of low continuity were associated with low perception of risk and poor health-seeking behaviour among adolescents, linked to perceived lack of parental and community support due to stigma and discrimination.
A proposed strategy to address availability of trained health workers is AFHS training at both pre-service and in-service levels. The trained staff would then orientate other staff members, including identifying individual roles and responsibilities in the implementation of AFHS. Regular monitoring of AFHS implementation through the existing supportive-supervision mechanisms would support this. Continuity would be addressed through awareness raising, adolescent-focused messages and integrated SRH/HIV services.

The objective of Erongo’s work plan is to increase the coverage of HTC among adolescents aged 15-19 years from 14% among males and 29% among females to 75% among both sexes by December 2017.

**Kavango East and West Regions**

The two Kavango regions combined their data, and selected ART for Adolescents Living with HIV and HTC for Adolescents in both Rundu (Kavango East) and Nankudu (Kavango West). National data was used for utilisation and continuity indicators in HTC. Graphs 3 and 4 show the determinant results for ART, and Graphs 5 and 6 show the determinants for HTC.

**Graph 4: Demand-side determinants of ART in Kavango East and West Regions**

**Graph 5: Supply-side determinants of HTC in Kavango East and West Regions**

**Graph 6: Demand-side determinants of HTC in Kavango East and West Regions**
In the Kavango regions, initial utilisation of ART was above 100%, and this was attributed to clients being tested elsewhere and then being initiated on ART in Kavango East/West. (The same applies in Zambezi Region.)

Considering HTC as the entry point for ART, supply-side bottlenecks for HTC were prioritised, as this would address similar bottlenecks of ART. The priority bottlenecks identified 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 1,000 copies) at 12 months after initiating treatment.

The low availability of trained human resources in HTC and ART was linked to high staff turnover with no recent trainings, and was associated with AFHS guidelines not being implemented, which also affected accessibility. Low continuity in HTC was associated with fear of positive results and the need for parental consent for young adolescents, and perceived lack of parental support for older adolescents. The low quality of HTC was attributed to lack of monitoring of the linkage between HTC and ART services. For ART, low continuity was linked to poor parental and community support due to stigma and discrimination. Low quality in ART was attributed to poor adherence associated with poor ARV treatment literacy among adolescents.

Proposed strategies to address availability of human resources in ART and HTC were frequent trainings on AFHS coupled with implementation of AFHS guidelines, which in turn would address accessibility in both interventions. Adolescent-focused messages together with engaging parents and communities to support adolescent health-seeking behaviour could address the low continuity in both HTC and ART, as well as quality in ART. Linking the HTC and ART systems, together with tracking clients across the two interventions, could address quality in HTC.

The Kavango East and West work plan has two objectives – one for HTC and one for ART:
- **Objective for HTC:** Coverage of HTC among adolescents aged 15-19 years increased from 29% to 80% among females and 14% to 70% among males by December 2017.
- **Objective for ART:** Coverage of ART for treatment among adolescents living with HIV aged 10-19 years increased from 80% to 95% among females and 41% to 80% among males by December 2017.

**Khomas Region**

Khomas selected In-School Life Skills Based HIV Education (LSBE) and HTC for Adolescents, in a single geographical location, namely Windhoek Health District. The MoEAC provides LSBE and the MoHSS provides HTC services. National utilisation and continuity indicators were used for HTC. Graphs 7-10 show the determinant analysis results for these interventions.
Graph 7: Supply-side determinants of In-School LSBE for adolescents (age 10-19 years) in Khomas Region

- Commodity: 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.

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

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

- 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.

Priority bottlenecks identified were as follows:

**LSBE intervention:**
- Commodity: 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.

There were data gaps on LSBE commodities and quality indicators, because they were not regularly monitored. Low accessibility was attributed to low availability of trained LSBE teachers, which was linked to lack of career growth in this field, and low continuity. Low accessibility of HTC was linked to lack of implementation of AFHS, despite having trained health workers. Low utilisation of HTC services was linked to fear of positive results, and lack of parental support and parental disclosure due to stigma and discrimination. Low quality of HTC was linked to separate HTC and ART systems.

Data gaps for commodities and quality indicators would be addressed by revising the LSBE data collection tool to include them. Trainings for LSBE teachers would address low accessibility and continuity. Implementation of AFHS guidelines was proposed to address accessibility in HTC while awareness raising and provision of mobile HTC services was suggested for continuity. Integrated HTC and ART services were proposed to address quality of HTC.
The Khomas work plan has two objectives – one for LSBE and one for HTC:

- **Objective for LSBE:** 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.

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

### Omusati Region

Omusati selected Voluntary Medical Male Circumcision (VMMC) and HTC for adolescents in all four selected locations, namely Oshikuku, Tsandi, Okahao and Outapi Health Districts. As in the Kavango regions, national data was used for utilisation and continuity indicators in HTC. Graphs 11 and 12 show the determinants for VMMC, and Graphs 13 and 14 show the determinants for HTC.

![Graph 11: Supply-side determinants of VMMC for male adolescents (age 15-19 years) in Omusati Region](image1)

![Graph 12: Demand-side determinants of VMMC for male adolescents (age 15-19 years) in Omusati Region](image2)

![Graph 13: Supply-side determinants of HTC for adolescents (age 15-19 years) in Omusati Region](image3)

![Graph 14: Demand-side determinants of HTC for adolescents (age 15-19 years) in Omusati Region](image4)

The priority bottlenecks identified were as follows:

**VMMC intervention:**
- **Commodities:** 52% of the sites providing VMMC services reported stock-out of essential commodities.
- **Accessibility:** Only 58% of the sites providing VMMC 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.

**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.
Unavailability of commodities for VMMC and HTC was linked to poor stock management associated with human capacity and lengthy procurement procedures. Causes of low accessibility were lack of trained staff at health facilities, since an outreach team provided VMMC services. Low VMMC utilisation was linked to age of consent of 18 years, and also the misconception that an HIV test is mandatory for VMMC services. The data gap on quality was attributed to the current VMMC reporting tool. There was no VMMC data for ages 10-14 years. Low accessibility of HTC was linked to lack of AFHS implementation, and low utilisation of HTC was linked to the need for parental consent, a perceived lack of parental support, and poor health-seeking behaviour among adolescents. Low quality of HTC services was linked to lack of integrated HTC and ART services.

The proposed strategy to address commodities for VMMC and HTC were building capacity of stock-management systems. Staff training was proposed for VMMC accessibility. Community and school awareness programmes, and lowering of the age of consent, were proposed to address VMMC utilisation. Revision of the VMMC reporting tool was proposed to address the data gaps. Proposed strategies to increase accessibility of HTC were AFHS implementation to create demand for AFHS training, and increasing adolescent participation at facility level to create demand for and provide feedback on AFHS provision. Other proposed strategies were to align the age of consent in all SRH services, and to integrate HTC and HIV services.

The Omusati work plan has two objectives – one for VMMC and one for HTC:

- **Objective for VMMC**: Coverage of VMMC among adolescents aged 15-19 increased from 7%\(^7\) to 65%\(^8\) by December 2017.
- **Objective for HTC**: Coverage of HTC among adolescents aged 10-19 increased from 29% to 80% among females and 14% to 70% among males by December 2017.

## Otjozondjupa Region

Otjozondjupa selected HTC in Otjiwarongo Health District. Like other regions that selected HTC as an intervention, national data was used for the HTC utilisation and continuity indicators, and regional data for the quality indicator. Graphs 15 and 16 show the results of the determinant analysis.

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

- **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.

**Graph 16: Demand-side determinants of HTC for adolescents (age 15-19 years) in Otjozondjupa Region**

The prioritised bottlenecks were as follows:

- **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.

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8 Target according to VMMC strategy.
Otjozondjupa attributed the low availability of commodities to poor stock management, which was linked to low human capacity as well as changes in procurement procedures. Low accessibility was attributed to lack of implementation of AFHS guidelines at all levels. Low continuity was attributed to fear of HIV-positive results, linked to adolescents being uncertain of parental support when their parents found out that they are sexually active. Also associated with low continuity was that HTC services were provided only in health facilities and not in community settings too. 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 referrals from HTC to ART.

The proposed strategy to address commodities availability was staff training on stock management. The proposed strategies to address accessibility were on-the-job training, implementing AFHS and incorporating the monitoring of AFHS implementation into the existing supervisory mechanisms. Provision of HTC in outreach services, and involvement of adolescents in outreach programmes to reach out to their peers, were the strategies proposed for continuity. To address quality in HTC, integration of HTC and ART services, including regular monitoring, was proposed.

The objective of the Otjozondjupa work plan is to increase coverage of HTC among adolescents aged 15-19 from 29% among females and 14% among males to 50% among both sexes by December 2017.

**Zambezi Region**

Zambezi selected ART for adolescents living with HIV and prevention of teenage pregnancy in a single location, namely Katima Mulilo Health District. Determinant analysis was conducted for key ART supply, demand and quality indicators, but there were no corresponding indicators for teenage pregnancy. Graphs 17 and 18 show the determinants. Like in the two Kavango regions, ART utilisation was more than 100%, and this was attributed to clients being tested elsewhere and then being initiated on ART in Zambezi.

**Graph 17: Supply-side Determinants of ART to adolescents in Zambezi Region**

**Graph 18: Demand-side Determinants of ART to adolescents in Zambezi Region**

The prioritised bottlenecks were as follows:

- **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.
Low availability of ART commodities was attributed to lack of trained pharmacists as well as lengthy procurement procedures. Low availability of human resources was associated with high turnover of health workers due to a lengthy recruitment process. Low accessibility was linked to high turnover of staff and lack of infrastructure due to budgetary constraints. Low ART utilisation among adolescent boys aged 15-19 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 associated with migration, fear of disclosure, and cultural beliefs. The data gap on quality was attributed to non-adherence to viral load monitoring guidelines.

The high rate of teenage pregnancy was linked to early sexual debut (e.g. the 2013 NDHS found that nearly half (45%) of all girls aged 15-19 years had already had sex), as well as inter-generational sex and early marriages, poor parenting skills and socio-cultural issues.

Proposed strategies to address ART were capacity building in stock management, establishment of teen clubs, new guidelines on disclosure, and better procedures for tracking ART clients in the community. Proposed strategies to address teenage pregnancy were using the LSBE curriculum in schools and using sports for development.

The Zambezi work plan has two objectives – one for ART and one for teenage pregnancy:

- **Objective for ART:** Coverage of ART services among adolescents in Zambezi increased from 49% to 80% by December 2017.
- **Objective for teenage pregnancy:** Teenage pregnancy in Zambezi reduced from 28% to 14% by the end of December 2017.
A Bottleneck Analysis (BNA) methodology was used to identify bottlenecks in priority HIV and SRH interventions for adolescents in Namibia.

The key bottlenecks identified were:
- unavailability of essential commodities for all interventions;
- lack of implementation of 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 depended on their alignment with national processes. The end-of-term review of the National Strategic Framework for HIV and AIDS Response in Namibia (NSF) provided 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.

Other priority actions for implementation included:
- 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 BNA methodology provides opportunities for scaling up the activities to the regions of Namibia which were not covered in this particular BNA exercise, and opportunities for adopting the BNA methodology as a good practice in performance monitoring and management of programmes.