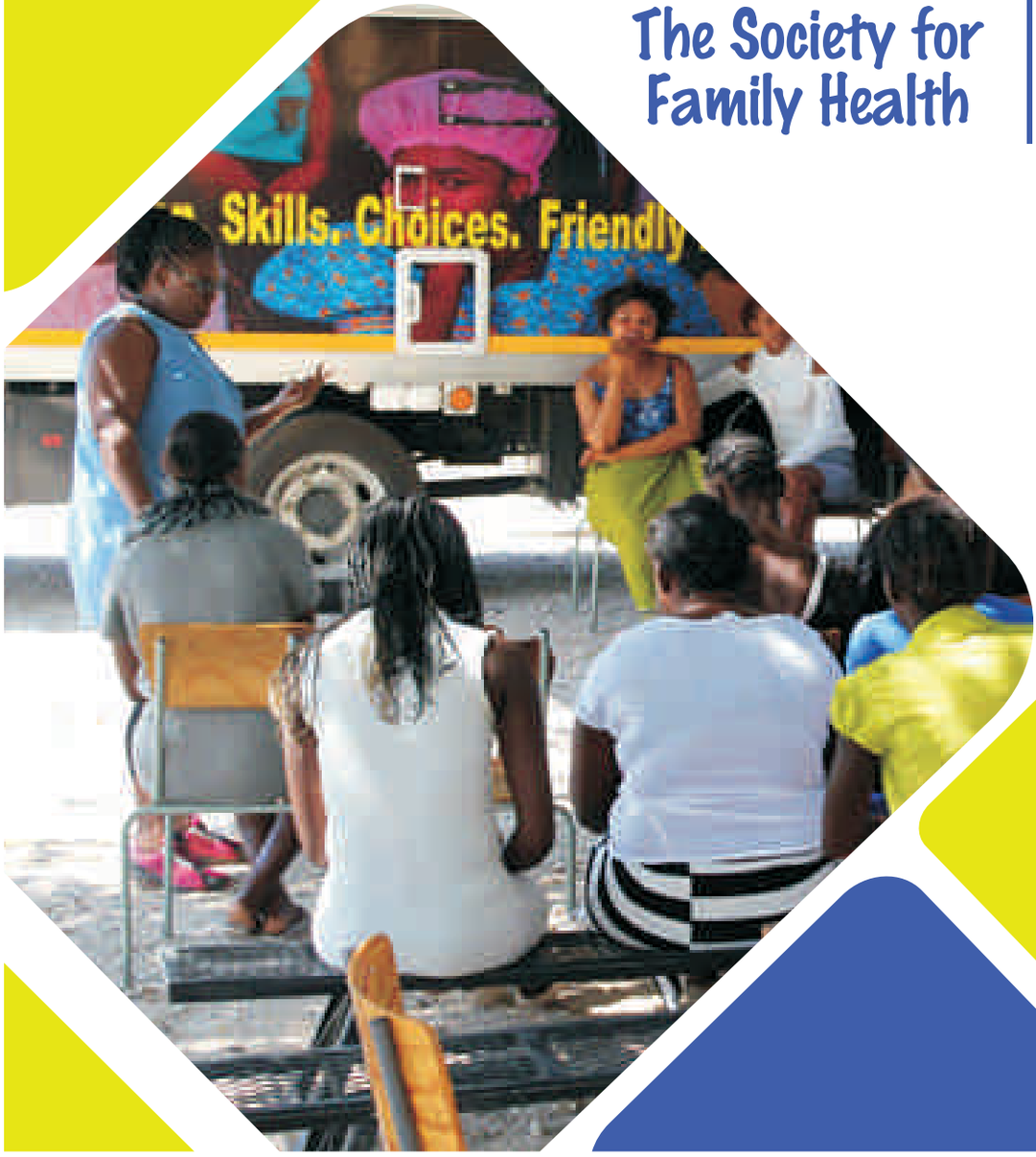
The Society for Family Health

ANNUAL REPORT 2017

ANNUAL HIGHLIGHTS



THE SOCIETY FOR FAMILY HEALTH

ANNUAL REPORT 2017 HIGHLIGHTS

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SFH
THE SOCIETY FOR FAMILY HEALTH
20 YEARS

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ACRONYMS AND ABBREVIATIONS

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CBOs	Community Based Organizations
CHCs	Community Health Consultants
CHFL	Caprivi Hope for Life
CHWs	Community Health Workers
CM	Case Management
CSE	Comprehensive Sexuality Education
DQA	Data Quality Assessment
DOD	Department of Defense
FBOs	Faith Based Organizations
GBV	Gender based violence
GP	General Population
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IBBSS	Integrated Biological Behavioural Surveillance Study
KDO	King's Daughters Organization
KP	Key Population
MAPP	Military Action Prevention Programme
MCH	Maternal and Child Health
MER	Monitoring, Evaluation and Reporting
MoEAC	Ministry of Education, Arts and Culture
MoHSS	Ministry of Health and Social Services
NANASO	Namibia Network of AIDS Service Organisations
NAPPA	Namibia Planned Parenthood Association
NCDs	Non-Communicable Diseases
NGO	Non- Governmental Organization
NUST	Namibia University of Science and Technology
ORN	Out-Right Namibia
RnRT	Rights not Rescue Trust
PHC	Primary Health Care
PrEP	Pre-exposure Prophylaxis
PMTCT	Prevention of Mother-To-Child Transmission
PSI	Population Services International
REDCap	Research Electronic Data Capture
SBCC	Social and Behavior Change Communication
SFH	Society for Family Health
SMA	Social Marketing Association
STIs	Sexual Transmitted Infections
SRH	Sexual and Reproductive Health
TB	Tuberculosis
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHT	Voice of Hope Trust
VMMC	Voluntary Medical Male Circumcision
WASH	Water, Sanitation and Hygiene
WBCG	Walvis Bay Corridor Group
WinS	Water, Sanitation and Hygiene in School

Message From SFH's Board Chairman

This year marks exactly 20 years of existence of the Society for Family Health (SFH) in Namibia since 1997.

Starting from humble beginnings, SFH has steadily grown over the years, now having a core staff complement of 53 and over 300 community health workers across our 9 regional offices. SFH has always worked hand in hand with government structures and in line with national policies and strategies, in order to complement government's efforts in delivering a broad range of public health programmes. Some of these programmes include HIV prevention and care services for key populations and other vulnerable populations such as adolescent girls and young women, school health promotion, malaria prevention and treatment, sanitation and hygiene interventions. All these programmes would not have been possible without the support from the Ministry of Health and Social Services, Ministry of Education, Arts and Culture, Ministry of Gender Equality and Child Welfare, Regional Councils, and our development partners such as the USAID, US Department of Defense, Global Fund to fight AIDS, TB and Malaria, and UNICEF.

Throughout our 20-year journey, SFH has had to continuously adapt its business model. We adapted from being a highly centralized to a decentralized NGO, to be closer to our communities. Additionally, we adapted from being a process-driven to a results-driven organization.

Throughout this process, we have strived to provide excellent services while ensuring financial soundness at all times, even in the most financially constrained environments. This report presents our 2017 achievements, challenges, lesson learned and emerging opportunities. These accomplishments were achieved through evidence-based interventions, advocacy, policy and enabling environments, service delivery, capacity strengthening, and community mobilization. However, we still have much to do. As our communities aspire to prosper, they will be met with new health challenges, be it the re-emergence of old diseases or emergence of new diseases. The prosperity of these communities is dependent on the extent to which NGOs, government and development partners prepare them to survive adverse situations.

We will constantly rethink our tools, our systems and our responses. We will seize the windows of opportunities for strengthening existing partnerships and creating new ones. Above all, we will continue to be at the center of social transformation, and contribute to improving health outcomes for the most vulnerable groups. In that way we remain true to the founders of SFH and we remain an NGO fit for the 21st Century.

Finally, we remain focused on our grand vision of being a leading national public health NGO that strives to deliver greater results for various under-served groups. To this end, we remain committed in mobilizing support and partnerships with different actors to ensure that the most vulnerable groups are empowered to reduce HIV infections and access needed health services. This in return will improve health outcomes. We remain grateful to our communities for their support in making the dreams of many beneficiaries a reality.

Dr. Kalumbi Shangula
SFH Board Chair, Namibia

Acknowledgements

SFH is indebted to various actors for the 2017 achievements. We appreciate the technical and financial support from the US government through the President's Emergency Plan for AIDS Relief (PEPFAR); US Aid for International Development (USAID); US Department of Defense (DOD); Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); Namibia Network of AIDS Service Organizations (NANASO) and the Ministry of Health and Social Services (MoHSS), Ministry of Education, Arts and Culture (MoEAC), and the Ministry of Gender Equality and Child Welfare (MGECW).

Furthermore, SFH recognizes the invaluable commitment, enthusiasm and expertise of different duty bearers from Government institutions and Non-Government Organizations. Our work on the ground would not have materialized without ongoing support and collaboration from the Government in particular the Ministry of Health and Social Services, Ministry of Education, Arts and Culture, and the Ministry of Gender Equality and Child Welfare.

Our contributions and participation at various platforms is evident that NGOs have a major stake in collectively contributing to the achievement of the objectives of the national agenda.

Reaching members from the key populations would not have been possible if it was not for strategic partnerships built over time with key population-led organizations and NGOs and community-based service providers namely the Walvis Bay Corridor Group (WBCG) and Namibia Planned Parenthood Association (NAPPA).

Despite the absence of favorable legal instruments for key populations, the KP-led organizations and networks (Out-Right Namibia, Voice of Hope Trust, Rights not Rescue Trust, Caprivi Hope for Life, Kings Daughters Organization) have been instrumental in being the champions for mobilizing, educating and reaching out to key populations for HIV prevention, care and treatment.

In addition, we would like to register our gratitude to the communities we serve and their leadership, active participation and contribution to the planning, implementation and monitoring of interventions.

Finally, SFH board and staff are indebted to the right's holders (beneficiaries) who justify our existence. Thank you for sharing your voices and experiences that shape the design and implementation of programmes. You provide hope to the current and future generations.

About SFH

The Society for Family Health is a registered trust operating in Namibia since 1997 as a Non-Governmental Organization (NGO). SFH is an independent member of the international global network of Population Services International (PSI) and was formally known as Social Marketing Association (SMA) from 1997 to 2011.

Our Vision

We are a recognized leading public health NGO empowering communities with health promotion interventions aimed at reducing health disparities and improved health outcomes in Namibia.

Our Mission

Promote and protect health and well-being for the most vulnerable populations

Our Core Values

- Integrity and confidentiality
- Partnership
- Innovation
- People-centered
- Results driven

Our work areas

In collaboration with Government and other stakeholders, our work focuses on the following areas:

- Capacity enhancement of Key Populations in HIV prevention, care and support;

- Enhancing capacity of uniformed personnel to implement HIV prevention, care and support services for their staff and families;

- Empowering adolescent girls and young women with life skills education in the context of HIV
·prevention and sexual and reproductive health and services;

- Equipping adolescents living with HIV with knowledge and skills on positive living and nurturing them to grow into aspiring, productive and successful citizens;

- School health promotion to ensure that learners and teachers have a conducive environment for effective school attendance, learning and teaching; e.g. building capacity to promote water, sanitation and hygiene practices;

- Empowering communities with knowledge and skills on maternal and child health issues;

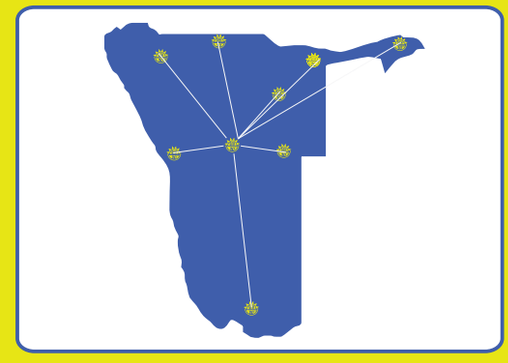
- Educating communities on the prevention of non-communicable diseases (e.g. diabetes, hypertension, etc.) and promoting health seeking behaviors;

- Consultancy Services, Research and Publication: We provide a high level of professional services in various areas to government and private sectors; technical assistance, public health policy and program development, monitoring and evaluation, training and research.

These programmes are operational in all 14 regions of the country.

SFH has (9) nine regional offices namely in

- Walvis Bay (Erongo)
- Rundu (Kavango East)
- Windhoek (Khomas)
- Outapi (Omusati)
- Oshikango (Ohangwena)
- Ongwediva (Oshana)
- Grootfontein (Otjozondjupa)
- Katima Mulilo (Zambezi)
- and Keetmanshoop (Karas)



BOARD OF DIRECTORS

Dr Kalumbi Shangula (Chairman)

a renowned medical practitioner who is currently serving as the Assistance Pro-Vice Chancellor for the Health Sciences campus of the University of Namibia (UNAM). He poses extensive leadership skills at executive levels where he served in various public service positions since 1990, including Permanent Secretary of the Ministry of Health and Social Services and Permanent Secretary of the Ministry of Environment and Tourism. Dr Shangula holds a MD, MSC (Med) and a Master of Business Administration from Maastricht School of Management (Netherlands). He as well serves on a number of public and private sector boards.

Anna Ipangelwa,

an Entrepreneur Consultant and holds a Bachelor of Education degree from the University of Namibia (UNAM), Masters of Education degree from Rhodes University, South Africa and is currently enrolled for a Masters of Business Administration (MBA) degree. Anna has managed educational programs for the United States Peace Corps for 5 years, and was the country director of the International Foundation for Education and Self-Help (IFESH) for 6 years. Ms Ipangelwa has extensive experience in business related research, education program research, product sales and specializes in project implementation, business development and monitoring and evaluation of projects. Recently, Ms Ipangelwa headed the Business Development division of the UNAM Central Consultancy Bureau for years.

Sakkie Kaulinge

an entrepreneur who is currently serving as the Namibian Director to Basil Read Mining and Construction Namibia (PTY) Ltd Boards of Directors. He previously served as Secretary to the Presidency and First National Coordinator for the Vision 2030 Project. Before this He served as the Permanent Secretary of the Ministry of Information and Broadcasting, and subsequently as Permanent Secretary of the Ministry of Agriculture, Water and Rural Development then later as the Secretary to the Cabinet (1996-1999). Previously, Mr Kaulinge spent 15 years at Consolidated Diamond Mines of De Beers, while being seconded from Anglo American corporation, to the position of Senior Human Resources Manager and subsequently Head of Department at Namdeb (CDM) mines in Oranjemund. His qualifications include a Master's Degree in Public Policy and Administration from the University of Namibia (UNAM) and a post-graduate Diploma in Human Resources Management from the University of Stellenboch.

BOARD OF DIRECTORS

Judi Heichelheim

a senior regional director for Population Service International (PSI) Southern Africa and has previously served across Eurasia and Eastern Europe, Africa and Latin America and the Caribbean. Judi has over 20 years of experience working in design, implementation and management of global health programs, with a focus on sexual and reproductive health and social marketing. Judi's role at PSI include providing technical assistance to country programs particularly focused on HIV prevention among most-at-risk populations, and in expanding access to family planning. Judi has a master's in international health and development from George Washington University's Elliot School of International Affairs.

Matilda Jankie-Shakwa

a legal practitioner with over 16 years' experience. She is a graduate of the University of Namibia (UNAM) Law School with a Baccalaureus Juris (B Juris) and a Bachelor of Law (LLB) degree. After graduating from UNAM, Matildah worked in different capacities including Principal Legal Officer in the Office of the Prosecutor General, Senior Litigating Lawyer and as Director and Head of Commercial and Conveyancing Department with Sisa Namandje Inc & Co. She also served as a legal practitioner into the High Court of Namibia in 2004 and has been a High Court Accredited Mediator since 2014. Ms Shakwa sits on a number boards in the private and public sector.

Agai Jones

holds a BSc degree in Chemistry from Morehouse College and an MBA from the Ross School of Business. Agai has served as a Peace Corps Volunteer, in Luderitz, Namibia and has worked in HIV prevention, training and development in 14 countries in east and southern Africa. In the US, Agai has worked in Project and Program Management with American Association for Retired Persons (AARP), the William Davidson Institute and Population Services International. Agai is currently a Vice President of Sales and Marketing for a US based beauty company.

MANAGEMENT

Taimi Amaambo, Country Director:

Public Health Specialist with extensive work experience with the Ministry of Health and Social Services, Family Health International, UNICEF and the World Health Organization in the area of adolescent health, maternal health, prevention of mother to child transmission, voluntary medical male circumcision, and HIV prevention, care and treatment. Qualifications include Nursing and Midwifery Science from the University of Namibia, Master of Public Health (MPH) from the University of South Carolina, a post-graduate certificate in Integrated Marketing Communication for Behavioral Impact in Health and Social Development from New York University, post-graduate certificate in Social and Behavioral Research from Harvard University, and currently completing a Doctoral Degree in Public Health (DrPH) from the University at Albany, State University of New York.

Steven Hong, Deputy Chief of Party:

Medical doctor trained in the United States, specializing in Infectious Diseases at Tufts University School of Medicine. He has a Masters of Public Health from Columbia University and a Master of Arts in Religion from Trinity Evangelical Divinity School. Since 2009, Steven has worked closely with the Ministry of Health and Social Services in Namibia to develop a strong HIV drug resistance public health surveillance program, along with several operational research studies. He is also a consultant for the World Health Organization global HIV drug resistance surveillance strategy.

Isabel Mendes-Siyamba, Programs Director:

with over 12 years of progressive experience in the social development field; work experience include HIV prevention field, adolescents health and non- communicable diseases. She obtained her Master Degree in Development Studies from the University of Free State, South Africa and a Bachelor of Education (Adult Education and Community Development) from the University of Namibia. Isabel possesses sound knowledge and practical skills in the design and implementation of community-based interventions and coordination of multiple stakeholders from diverse background.

Prince Owusu-Afriyie, Finance and Operations Director:

Extensive years of professional work experience in financial and Operations management with the Non-Governmental organisations. Extensive years of experience in writing and preparation of budget for project proposal, capacity development, donor and management financial reporting, budgeting for public health program design, Human Resource Management, Grants Management and Operations. Qualifications include Bachelor of Arts – Population and Family Life, from University of Cape Coast, Chartered Accountant Certificate from the Institute of Chartered Accountants (Ghana), from University of Professional Studies and a Master of Business Administration (MBA), from Maastricht School of Management.

MANAGEMENT

Ntombizodwa Makurira Nyoni, Community/Public Health Nurse & Officer in Charge for Erongo Region:

Community/Public Health Nurse in charge of the Erongo Regions: holds diverse experience in the area of Public health HIV Prevention strategies and research .She worked for Roman Catholic Hospital.Global Fund VMMC Program as a Clinician. Ntombi published a research on VMMC in Kavango Region. Coordinated a project on Key population size estimation and assisted in the Validation process of HIVST in 2017. She holds an Honours Degree in Nursing Sciences with a speciality in Nursing Education from University of Zimbabwe. Currently undertaking her research project for Masters in Public Health.

Milka Mukoroli, Community/Public Health Nurse & Officer in Charge for North West Offices:

Extensive and progressive experience in the HIV prevention, care and treatment, maternal and child health. Milka has worked with the Ministry of Health and Social Services in various capacities and led teams in carrying out focused managed health care; previously worked with I-TECH through the National Health Training center and led capacity building interventions for health providers in HIV testing services, Prevention of Mother to Child Transmission, Care and treatment and voluntary medical male circumcision. Qualifications include Nursing and Midwifery Science from the University of Namibia, followed by post-graduate Diploma in Health promotion; Clinical diagnosing, treatment and Care, and currently working towards a Master Degree in Public Health.

Agatha Kuthedze: Community /Public Health Nurse & Officer in charge of Khomas and //Karas Offices:

holds vast experience in the HIV Prevention, Care, Treatment, Maternal and Sexual Reproductive Health. Agatha has worked for MoHSS in the Primary Health Care and Specialized Nursing Services especially the Pre - and In-Service training programs of nurses and other Health Care Workers. She has previously served as HIV Counseling and Testing (HCT) Technical Advisor and as a TB/HIV National Project Coordinator in a number of NGOs. Her qualifications includes Bachelor's Degree in Nursing Education and Nursing Administration from the University of Limpopo, South Africa, Diploma in Nursing Science and Midwifery Science from the University of Namibia, She is currently completing her Master's in Public Health (MPH) from the University of Namibia

Mbunga Tughuyendere: Community/Public Health Nurse in charge of the Kavango & Zambezi Regions:

in charge of the Kavango & Zambezi Regions: is a Registered Nurse. His qualifications include Nursing and Midwifery, a certificate in Clinical Management of HIV from the University of Washington, a Bachelor of Science degree from the University of Stellenbosch and currently enrolled for Master of Science in nursing at the University of Stellenbosch. Mbunga has extensive and progressive experience in HIV care and treatment, Malaria, Tuberculosis and Nursing education. He has been a trainer, mentor and coach for health programmes such as HIV/AIDS(including VMMC), Malaria, TB, Integrated management for Childhood illness (IMMCI) and Adolescents Friendly health services with the MoHSS as well as a number of development agencies and NGO., I-TECH-Namibia, Global Fund and CDC.

MANAGEMENT

Nashilongo Gervasius Nakale, Communication Specialist:

is a trained journalist with over 10 years experience in Media/ journalism and communication. Nashilongo has a combined 5 years, experience in the NGO sector. She has experience in Policy Analysis, Stakeholder engagement, Public Policy advocacy and the academia. Her qualifications include Masters in Information and Communication Technology (ICT) and the Knowledge Society, a Post Graduate Diploma in Leadership Development in ICT and the Knowledge Society as well as a Bachelor Honours Degree in Journalism in Communication Technology from (NUST).

5. ADOLESCENT GIRLS AND YOUNG WOMEN PROGRAMME

IN THEIR OWN WORDS – BENEFICIARIES

"I was born with HIV and lost both my parents due to AIDS-related diseases. I have also been in a relationship for over 5 years with a girl, who at some point put me in a very difficult situation as she had demanded that we start having sex without using a condom. I became very confused and did not know what to do. After this situation I decided to go talk to the Community Health Facilitators whom I was introduced a month earlier to help me deal with my situation. The community health facilitators listened and made an appointment with the social worker and the nurse who helped prepare me for disclosure. I am a bit relieved because I now feel I am ready to tell my girlfriend and I continued to take my ARVs strictly".
**Anton Johannes from Kavango West region*

** name not real*

**Simon, 13 years old is an orphan born with HIV. He is from a village near Okalongo. Simon lived with his aunt who is an alcoholic. His aunt never paid attention to Simon, and does not provide him necessary food and support to take his ARV medications. On the first day of the teen club meeting, One could see that Simon was not happy and he appeared weak and sick. This case was brought to both SFH and Okalongo Health Center. SFH and MoHSS officials stepped in and SFH investigated Simon's situation. An analysis from his medical records, found that Simon had a high viral load. After thorough investigation in conjunction with Ministry of Gender Equality and Child welfare, it was established that Simon`s aunt was negligent in her guardianship responsibilities. Simon was taken from his aunts to live with his cousin where his twin brother also lives. His situation is getting better now and adhering to his ARVs. By the end of the 3rd meeting of the club, Simon was one of the boys who was always optimistic and eagerly to share his experience in the past weeks.*

**name changed to protect his identity – Story shared by SFH's CHC, Omusati Region.*

Chaze, is an 11 year old young girl from Zambezi region who was born with HIV and never took treatment. Her mother suspected that her daughter may be HIV positive, but never went to confirm it because she feared about what people could say and how to handle the situation if she was HIV positive. When she heard about SFH Mobile Van coming to their village, she decided to take the little girl for an HIV test. The girl was tested was found HIV reactive. The mother counseled together with the girl and accepted the results and indicated that she understood and she has also heard that some children are born with HIV. The girl was referred to the health facility for treatment. The girl is currently taking her ARV medication with the support of her mother.

Story narrated by SFH's, CHC Zambezi Region

5. ADOLESCENT GIRLS AND YOUNG WOMEN PROGRAMME

The Society for Family Health (SFH) is among the implementing agencies for the Adolescent Girls and Young Women (AGYW) initiative with funding from Global Fund. This initiative started in the last quarter of 2016 and is being implemented in selected schools and health facilities in Kunene, Omaheke, Zambezi, Omusati, Kavango East and Kavango West.

The Namibia Population and Housing Census of 2011 indicate that the country has a relatively young population, where 66% of the population is below the age of 30 years. Young people below the age of 25 makes up 58% and adolescents (10-24 years) constitute 33 % of the total population. The vulnerability of the young people is a concern in the context of Namibia with % of new infections occurring among 15-29 of age. As women age, HIV prevalence increases with the highest prevalence observed in 20-24-year-old at 9.3 %.

Women and girls, and poor women specifically are particularly vulnerable to HIV infection due to gender inequality and gender based violence. Women's economic marginalization forces them to depend on men, increasing the likelihood of involvement in "transactional and inter-generational sex, both key drivers of the epidemic".

Overall aim of this initiative is to reduce vulnerability of adolescent girls and young women to HIV infection, unintended pregnancies and related social determinants. Therefore interventions are designed with the objectives of:

1. Ensuring that adolescents complete schooling, avoid pregnancies and HIV infection

2. For adolescent and young women already living with HIV, supporting them with life skills education and related services for positive living

3. Ensuring greater access to comprehensive adolescent-friendly and adolescent-centered sexual and reproductive health services It is clearly known that traditional biomedical interventions serve only as one piece of the solutions to HIV infection in adolescent girls and young women.

Other structural drivers of risk for HIV infections be it from legal, economic and social factors fall outside the health and education sectors. These factors are not included in this initiative and should be highly considered as the program expands.

The current AGYW program is designed around the following interventions:

- Promoting adolescent-friendly sexual and reproductive health services that address the barriers to care faced by women and girls;

- Educating and mobilizing young boys and men for HIV testing services and linkage to voluntary medical male circumcision;

- The fact that the same girls and young women who are at risk of HIV are also at risk of unintended pregnancy, the program highlights the use of dual protection methods for the prevention of unintended pregnancy and HIV infection;

- Training providers in the provision of care that is adolescent-friendly across a spectrum of services, from HIV testing to violence screening and contraceptive counseling, and the possibility for PrEP provision to young women at substantial risk for acquiring HIV infection.

Challenges Addressed:

- Staff demonstrated that it is possible (and indeed necessary) to genuinely involve and vest leadership in young people in all aspects of project planning and implementation to ensure project success.

- Young people who were not in school often wanted a compelling reason for participating in the SRH sessions. Adjustments during the latter phase addressed many of these challenges; consistently holding sessions at a specific time and location, simplifying messages and ensuring that they spoke to the realities of this population's lives, and in some cases offering small refreshment to encourage participation and retention.

- Multidisciplinary and multifaceted approaches play an integral role in ensuring that those adolescents that are not performing well on ART, root causes are addressed through various actors including parents/guardians, social workers; but most importantly, peer leadership psychosocial activities should be ongoing Club activities.

Year End graduation marking the school' s TEEN Club's on completion

Highlights of Achievements

- Approval was granted by the Ministry of Education, Arts and Cultures through the office of the Permanent Secretary to establish clubs and conduct outreach sessions on SRH in 60 schools in the 6 priority regions namely Kunene, Omusati, Omaheke, Kavango East, Kavango West, and Zambezi. Similarly, MoHSS granted permission to SFH to revive/establish Teen Clubs for adolescents living with HIV at the health facilities in the 6 regions.

- 26 Health Care workers were trained on positive parenting

- 434 AGYW were tested for HIV and received their results; out of which 22 tested positive and have been successfully linked to care and treatment

- 67 AGYW received SRH services including contraceptive

- 60 Teen clubs with a total of 1800 Adolescent Girls were established in schools

- 60 community facilitators were trained as Training of Trainers in SRH and HIV prevention.

- 16 ALHIV clubs have been established in the following regions: Zambezi, Kavango East, Omaheke, Omusati, Kunene region

- 6258 out of school girls were reached with SRH sessions

- 447 young women from tertiary education were reached with SRH sessions

A Community Health Consultant during outreach event by SFH, is seen here providing health education on HIV Counseling and testing

26 Participants at this training include Program Officers from the Society for Family Health, Community Health Facilitators and health providers from the Ministry of Health and Social Services from Omaheke, Zambezi, Kavango East & West, Omusati and Kunene region.

The overall objective of the training was to equip participants with skills on how to build positive relationships with children and adolescents using various communication skills; and to enable them to provide a supportive and user-friendly, client oriented service which respects the privacy of parents and their children including adolescents living with HIV.

- Director of Health in the Ministry of Health and Social Services responsible for the Otjozondjupa region, Maria Kavezembi, joined here by SFH Country Director Taimi Amaambo, SFH's Director of Programs Isabel Mendes and participants of the Positive Parenting Workshop held in Otjiwarongo June 2017.

Lessons Learned

• It is clear that government does not tolerate child exploitation and violation, in this case child marriage. This leadership is critical in sending a signal of the importance of addressing child marriage and other violence against children.

• Strong collaboration and coordination, and open communication, can help to build alignment across sectors and stakeholders to prevent child marriage.

• There are multiple factors impacting on ALHIV poor school attendance and school dropouts. Among these include limited information to and access to sexual and reproductive health services; poverty-fuelled condition.

• The youth facilitators and participants were the key to this project's success. Their enthusiasm, strength, wisdom, and commitment to the project allowed it to flourish and continued in communities.

• Well-trained and supported youth are often the best educators of their peers about reproductive and sexual health issues. Providing them with ongoing support and supervision will ensure that they remain inspired, effective, and not overwhelmed with their responsibility, thus preventing high burnout and turnover rates.

• The monthly assessments of efforts to reach out-of-school youth represented a turning point for the project. It revealed weak points in project implementation especially when disbursement of funding for the project was delayed, and provided an opportunity for the project to modify the strategy for reaching the target population.

Community Facilitator delivering a session on SRH to out-of-school-young-girls

Adolescent School Clubs after their graduation ceremony receiving their certificates of attendance, November 2017

SFH's 5 days session on Youth SRH uncovered Child Bride and led to Arrest

Monica, a 13 years girl was forced to get married in 2016 by her parents who were staying in Usakos. This began when her mother took her to Rundu in the Kavango East region leaving school behind. Little did she know that her parents were planning to give her away in marriage to a 38 year old man. Upon arrival in Rundu, Monica was invited to attend a church service the coming Sunday at a certain church (name of the church known). During the announcement Monica was asked to stand up in front of the pastor and was introduced to her husband. She was then also told to go live with her husband. Monica cried, but there was nothing she could do. From that day, she felt very unhappy and has been thinking of committing suicide. SFH mobilized out of school young women to attend a 5 day sessions on SRH and rights in December 2017.*

When Monica heard about the SRH sessions to be conducted in her community, she decided to attend. After attending several sessions on SRH and a session on the Youth and their Rights in particular, Monica started reflecting on her situation. It was during this time that Monica became aware of her rights and developed courage to talk about her ordeal for the first time. Monica requested the Facilitator if is she could talk to her after the sessions. Monica spoke about what happened to her and her continuous thought of wanting to commit suicide. With help from the Community Facilitator and Project Officer the girl was taken to the Gender Equality and Child Protection Unit for a thorough investigation.

The "husband", parents of the "husband" and the pastor were arrested on 17th December and the girl`s parents were also arrested on 18th December 2017. Bail was denied to those involved in the case pending investigation. The investigation is still underway and the culprits appeared in court in January 2018. Monica was taken to a safe shelter at a different village and started school in January 2018. Our community Health Workers continued to follow up with Monica.
**Name changed to protect identity.*

Teen Clubs for adolescents living with HIV

For many young boys and girls who are living with HIV and on ART often lack strong social networks, the personal relationships they forge at Teen Club are the most invaluable part of initiative. Discussions on reproductive and sexual health, stigma and discrimination, living positively, building healthy relationships, and disclosure of status (among many others) have empower these young boys and girls to engage openly in addressing their concerns as they relate to their status.

Why Teen Clubs for adolescents living with HIV?

- To support adolescents living with HIV (ALHIV) in coping with stressors and to encourage adolescents to develop into healthy, positive adults.
- Provides life skills and positive living education, self-esteem building exercises,
- Support to cope with stigma and misinformation, and a peer support network to assist with some of the mental health and wellness issues that come with adolescence and HIV.
- Provides a social support system of adult volunteers and peer role models that are dedicated to the teens' quality health care and well-being.
- Provides a friendly and open environment wherein its members can momentarily escape the challenges of living in poverty and with HIV infection.
- Enables teens to seek out additional and new information on what it means to live with HIV/AIDS.

6. HIV PREVENTION AMONG KEY POPULATIONS

6. HIV PREVENTION AMONG KEY POPULATIONS

The Society for Family Health serves as a prime recipient for the Key Populations Programtitled, HIV prevention for Key Populations since 2011 with funding from USAID. With 7 sub-recipients predominantly KP-led organizations, the program is implemented in 6 sites – Keetmanshoop, Katima Mulilo, Windhoek, Oshakati, Walvis Bay/Swakopmund and Oshikango.

In Namibia, the data from the Integrated Bio Behavioral Surveillance Study (IBB SS) conducted in 2012/13 suggests HIV prevalence among Female Sex Workers (FSWs) was higher than females in the general population while prevalence among Men who have Sex with Men (MSM) was comparable to men from general population in regions studied except Windhoek were the prevalence was almost double that of men in general population.

The term Key Populations vs Most at risk populations

The term 'key population' has gained more popularity compared to the earlier term - Most at Risk Population (MARPS) that put together sub- groups that were determined to be at a higher risk of HIV infection by the nature of their behavior, lifestyle or circumstances. This new term is viewed as a more accurate and less stigmatizing description because it seeks to describe the risk factor as opposed to population groups.

In this way MSM or 'men who have sex with men' is more accurate than 'Gay men' because one could self-describe as Gay but not necessarily be engaging in high risk behavior. In the context of this KP program, populations that are referred to as key populations herein include, Men who have sex with Men (MSM), Female Sex Workers (FSW) and Transgender (TG) women.

Specific objectives of the program:

Improved access to a core set of HIV prevention, care and treatment interventions to reduce HIV transmission among Key Populations;

The core of KP program is case management which aims to provide holistic and comprehensive care to KPs including effective linkages to services. The Care Cascade ensures comprehensive management of clients seeking services and it enforces the 90-90-90 Global Strategy to reduce HIV Infections and death. This approach is implemented at all sites: Keetmanshoop, Windhoek, Walvis Bay/ Swakopmund, Oshakati, Oshikango and Katima Mulilo.

The following local 7 organizations which are predominately KP-led are the implementing partners:

1. Out-Right Namibia (ORN),
2. Rights Not Rescue Trust (RNRT),
3. Kings Daughters Organization (KDO),
4. Voice of Hope Trust (VHT),
5. Caprivi Hope for Life (CHFL),
6. Namibia Planned Parenthood Association (NAPP A) and
7. Walvis Bay Corridor Group's Wellness Program (WBCG).

Through the process of case management, clients are provided with information about HIV awareness, risk reduction HIV Testing, enrollment on ART and other services, and facilitating a process to ensure they remain negative. Pre-Exposure Prophylaxis (PrEP) provision and HIV Self-Testing are added components to the program as part of the combination prevention approach.

The Key Populations program is helping to achieve HIV epidemic control through the following initiatives

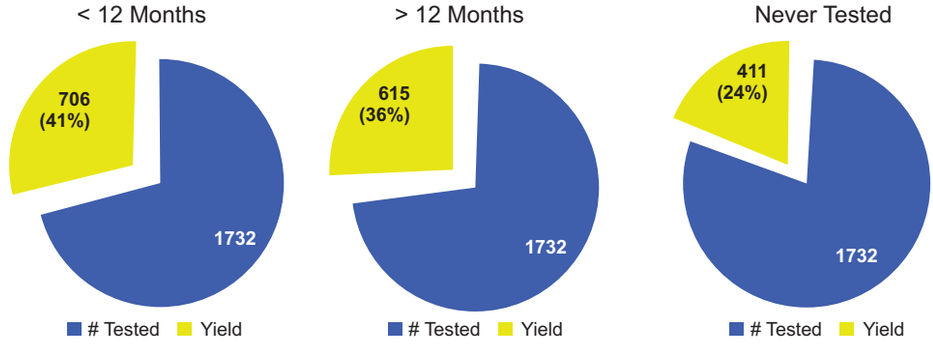
- Expand access, utilization and quality of HIV prevention, care and treatment interventions to achieve HIV epidemic control
- Provide a combination prevention package including sexual risk reduction counseling and condom/lubricant distribution
- Conduct targeted HIV testing and counseling (HTC) services using standard and novel approaches in community and facility settings
- Provide oral pre-exposure (PrEP) and post exposure (PEP) ARV prophylaxis as additional prevention tools
- Ensure Effective sexually transmitted infection screening, diagnosis and treatment services
- Provide Integrated TB/HIV care and treatment including antiretroviral therapy (ART) for intended populations consistent with national guidelines for adults and adolescents
- Assist key population-led local civil society organizations to contribute to HIV epidemic control
- Improve the enabling environment for HIV-related policies, operational guidelines, data collection and analysis and service delivery by all stakeholders of key populations

Highlights of Achievements

- For 2017 over 7,000 key populations accessed HIV testing services and know their status of which 39% are new testers
- Peer-driven outreach activities yield better results in facilitating access and building trust in the program
- Striving towards narrowing the gap between HIV diagnosis and linkage to ART
- Linkage to ART among key populations is almost is above 70% against target and aim to close this gap in the coming year

The chart below indicates that KPs tested for HIV between Oct – Dec 2017, only 159 (9%) out of 1,732 KPs tested positive. Of those that tested 41% tested less than 12 months followed by 36% that tested 12 months ago, while 24% tested for the first time. This data illustrates that more efforts need to be made to find more KPs that have never tested with the purpose of ensuring that they are immediately linked to treatment and other prevention services.

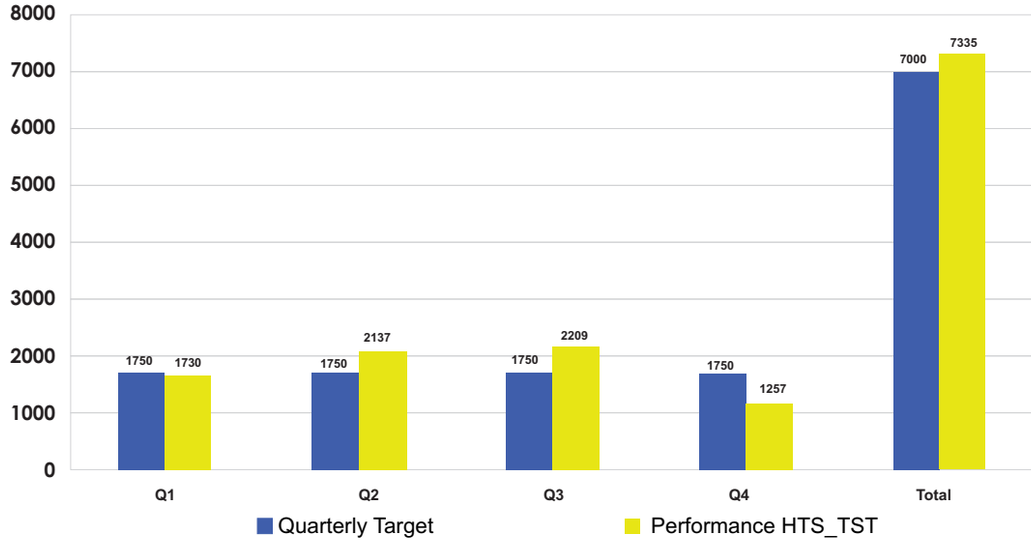
HIV Testing Yield Amongs Kps Oct-Dec 2017 by New/Repeat Testers n=1732; HIV (+) = 159 (9%)



HIV Testing

The graph below shows that over 7,000 KP received HIV Testing Services (HTS) during this period. However, the program will continue to find the best approaches to ensuring that those testing positive are immediately linked to treatment.

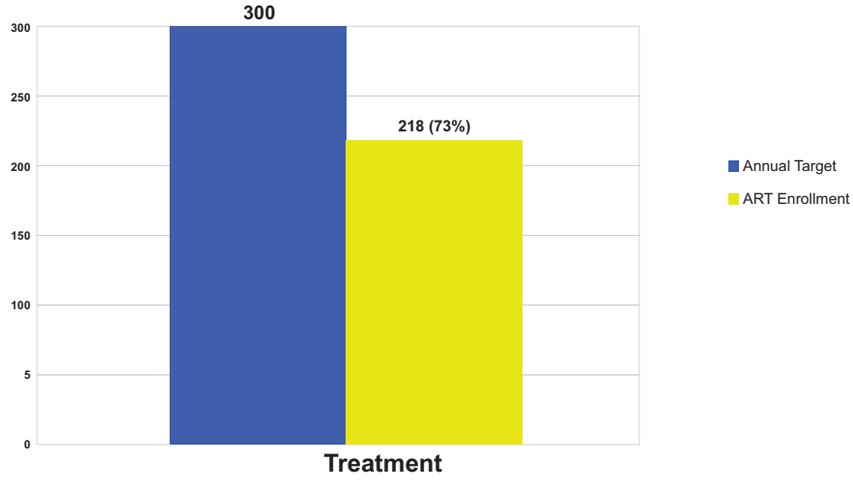
Annual HIV Testing Service Performance Against Quarterly Target, Jan-Dec 2017



Access to HIV treatment

The chart below shows the number of KPs that were enrolled on ART against the target. Performance was below with 27%. Linkage to treatment following diagnosis pose challenges sometimes especially when HIV diagnosis was made through outreach services as clients need to visit the health facility for treatment. Delays in reaching the health facility and loss to follow up (inability to access the clients through mobile contacts provided or incorrect residential area), are some of the contributing factors in ensuring effective and prompt linkage to treatment. Also, ensuring that ART is provided on the mobile van would also increase linkage to treatment.

Annual new enrollment on ART against annual target amongst key populations



Challenges Addressed

- If non-sensitized health care providers engage these referrals, then negative experiences of clinical services by KPs could damage future recruitment and retention. Health care provider training for both sensitization and clinical competency is essential across not only at NAPPA and WBCG but also a select number of public clinics that are serving Kps.

- Meaningful opportunities to have key populations' input in how services are delivered, improved and evaluated – through the national KP Technical working group and the regional stakeholders forums

- Support from trained peers who can help key populations access HIV testing and counseling and other HIV services

Lessons Learned

- Empowered KPs can aid interactions with hidden and hard-to-reach members that have weak or no links to the HIV cascade.

- The introduction of CM implemented through case workers has resulted in steady improvements in HTC, documentation and LTC and enrollment of KPs on ART. Thus CM approach has proved effective in identifying, enrolling and linking KPs to essential services as part of the minimum package

- Scaling up CM through strategic deployment of case workers is needed to facilitate comprehensive HIV services and improve health outcomes for KPs. In order to sustain these efforts, it is crucial to ensure government buy in and support.

Field workers getting ready for outreach activities

6.1 PRE-EXPOSURE PROPHYLAXIS (PrEP)

PrEP Uptake among Key Populations

While Namibia has made strides in reducing new HIV infections, the incidence remains above epidemic thresholds. Use of oral Tenofovir and Emtricitabine as pre-exposure prophylaxis (PrEP) has been shown in clinical trials and demonstration projects to be efficacious in reducing HIV transmission by over 90% when adherence levels are high. Use of oral PrEP as part of combination prevention approaches is an important tool in the HIV prevention packages.

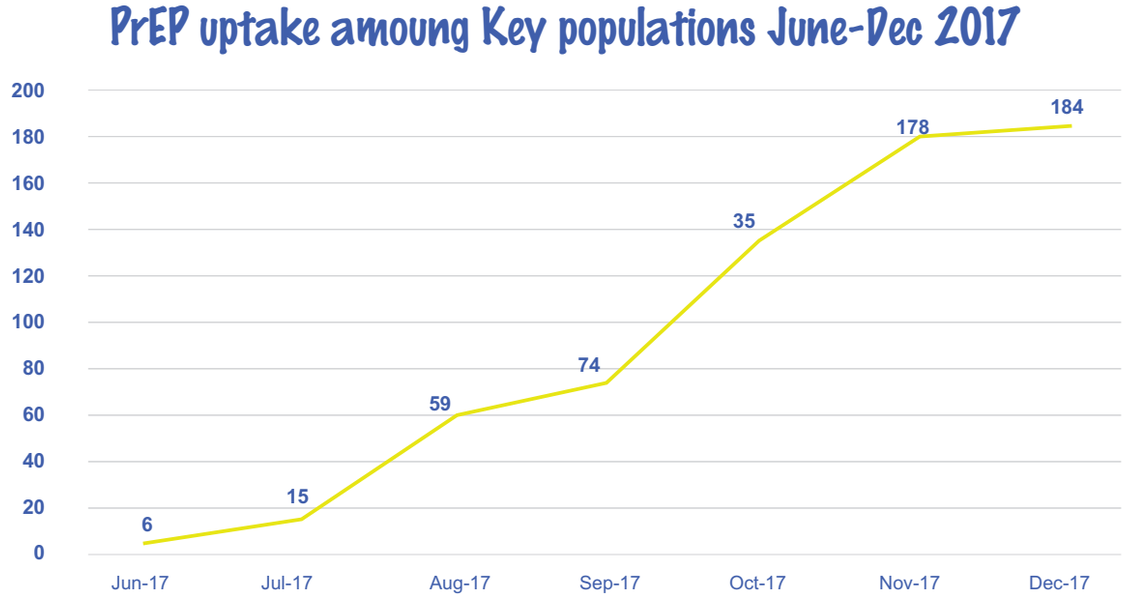
Having laid the foundation in 2016 for the implementation and roll-out of PrEP through a community-based model, in 2017 with support from MoHSS, ANOVA health institute/Equip and USAID, SFH eventually integrated PrEP as an additional HIV prevention tool to the existing program.

SFH with its partners carried the following activities to facilitate PrEP uptake among key populations:

- A series of stakeholders consultations and engagement, this in particular largely focused on KP-led organizations and their communities
- Development and dissemination of PrEP education materials,
- A seminar with the media houses
- An educational seminar with the Namibian HIV Clinicians Society

PrEP uptake

The graph below indicates that by December 2017, 184 key populations were enrolled on PrEP since the start of this service in June 2017. Although this figure is expected to grow over time, clients have an option to take PrEP based on their risk analysis. Some would prefer to cycle on and off and others would take it for a shorter period of time depending on their risk profiles. PrEP is being provided through a community-based model through WBCG wellness program and NAPPA sites.



6.2 MEDIA SEMINAR ON PREP

To facilitate an effective implementation of PrEP, a MEDIA Interactive Seminar targeting different media houses was hosted and attracted over 50 participants. The purpose of the seminar was to arm journalists, presenters and producers with the knowledge and vocabulary to include constructive and accurate messages about PrEP for HIV and to counteract confusion, tackle denial and stigma associated with HIV and AIDS, and increase dialogue with experts and public officials.

Participants had an opportunity to interact with individuals who were already taking PrEP medication and who were able to share their experiences. At the end of the seminar, media houses acquired adequate knowledge to develop quality messages/news coverage about PrEP with accuracy, depth and sensitivity to people using PrEP

Some of the Questions discussed at the seminar

What is the difference between PrEP, PEP and ART ?
All three contain antiretroviral medicines in different combination of different purposes:
PrEP: is a pill that has 2 anti-HIV medicines taken daily to prevent HIV for HIV – negative people
PEP: is taken within 72 hours after exposure to HIV (eg after rape) for 28 days to prevent HIV
ART: is a 3-medicine treatment of HIV positive people to reduce the levels of HIV in a person's body

If I take PrEP, does this mean I have to take it for the rest of my life ?
No. It is important that you take PrEP daily while at risk of getting HIV, but when you feel that you are no longer at risk you can talk to your healthcare provider about stopping PrEP.

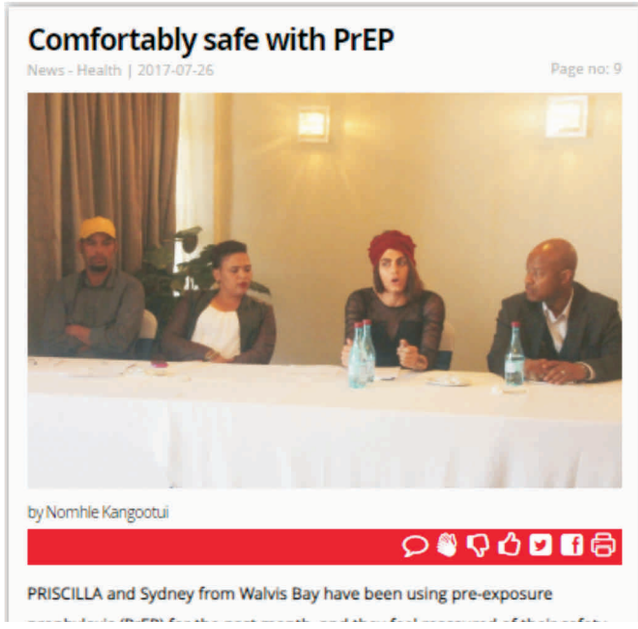
What if I want to stop taking PrEP ?
If you decide PrEP is no longer useful, discuss stopping with a healthcare provider. You will get information for how long after you should continue to make sure you are properly protected.

Does PrEP provide other protection?
No. It only protects against HIV infection. PreP does not protect against pregnancy or other sexually transmitted infections.

Can I use PrEP and contraception together?
Yes, PrEP can be taken with any kind of contraception

Educational Seminar with Namibian HIV Clinicians Society

The purpose of this event was to update members of the Namibian HIV Clinicians Society on PrEP as part of the revised National ART guidelines of 2016, followed by the approval of the use of Maylan's Truvada for PrEP from the Namibia Medicine Regulatory Council in May 2017. An expert from Wits Reproductive Health Institute of Witwatersrand served as the main speaker at the seminar and shared clinical evidence of PrEP, South African experience in implementing PrEP.



Comfortably safe with PrEP

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by Nomhle Kangootui

PRISCILLA and Sydney from Walvis Bay have been using pre-exposure

PrEP is not a cure for HIV: Tobias

25 Jul 2017 19:20pm

WINDHOEK, 2
(NAMPA) - The
Ministry of Hea
and Social Wel
(MoHSS) held
seminar on Tue
to sensitise the
media about th
just-rolled out F
Exposure
Prophylaxis (Pr
medication.
PrEP, taken by
individuals at
"substantial risk" of contracting the Human Immuno Virus (HIV) which causes Aids (Acquir
Immune Deficiency Syndrome), is part of a prevention combination package which include
use of male and female condoms, lubricants, and Antirtroviral Therapy (ART) for HIV-posit
partners, among others.
The Namibia Medicines Regulatory Council approved PrEP in May this year but up till now
not dispensed in public health facilities.
Briefing the media, Control Health Programme Officer in the ministry, Sarah Tobias strongl
advised the public to understand that PrEP is not a cure for HIV nor does it intend to repla
existing evidence based HIV prevention strategies.
"PrEP is one of the additional prevention tools that can be used for people who perceive
themselves to be at substantial risk of HIV infection," said Tobias.

* In September 2017, together with our partners, we celebrated and recognized our efforts in rolling out and availing PrEP to those most risk in a milestone event. The milestone event marking the 100 Key Populations members enrolled on PrEP in Namibia, brought together the Health community in the Erongo region led by the Regional Governor and the US Ambassador in Namibia.

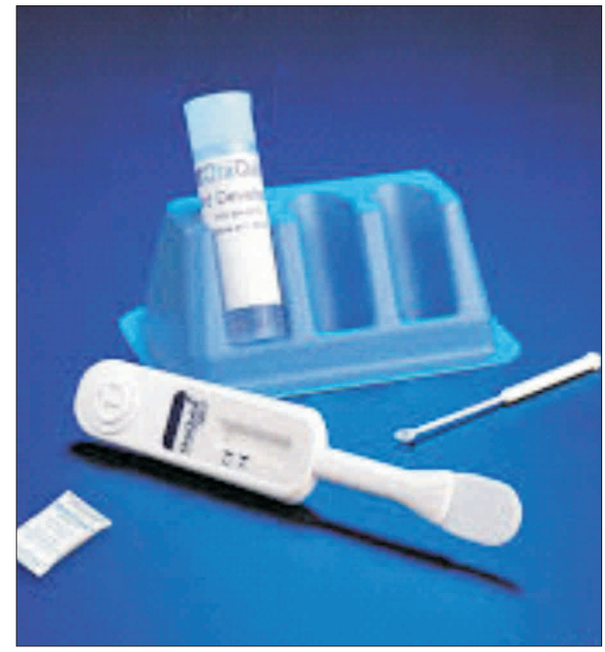
US Ambassador, Thomas F. Daughton, Governor of Erongo Region, Hon Cleophas Mutjavikua, Taimi Amaambo (SFH Country Director), Mr. Zdenek Suda (Acting USAID Country Representative), Lela Baughman – PEPFAR Coordinator, Deputy Mayor of Walvis Bay, Cllr. Hilka Erastus, Edward Shivute (WBCG wellness programme)

6.3 HIV SELF-TESTING

HIV Self-Testing Validation

HIV self-testing (HIVST) has been viewed as an innovative strategy with great potential to contribute to achieving Namibia's 90-90-90 targets by reaching clandestine populations. HIVST refers to a process in which a person collects his or her own specimen (oral fluid or blood) and then performs an HIV test and interprets the result, often in a private setting, either alone or with someone he or she trusts. In line with the Namibia Guidelines for HIV Rapid Testing there is need for a laboratory validation to be conducted on the kit before it can be rolled out in a field.

With support from USAID, the Society for Family Health (SFH) supported the Ministry of Health and Social Services (MoHSS) and the Namibia Institute of Pathology (NIP) to validate OraQuick HIVST kits in August 2017. In this case, the validation focused on oral fluid-based rapid tests through a mouth swab.
The validation was conducted in Katima Mulilo, Walvis Bay, and Windhoek. Samples were obtained from clients identified during the routine outreach services conducted by SFH/partners where HIV testing services are provided. Sample size of n=300 (30 positive).



Objectives of the validation:

- To determine the performance of the OraQuick HIV Test Kits under field conditions in terms of Sensitivity and Specificity when compared to the National HIV Rapid Test (RT) Algorithm, and Automated HIV ELISA. Acceptable Sensitivity and Specificity should be at least 90%

- Determine challenges related to operational logistics: storage, delivery, disposal

	OraQuick SELF interpretation	OraQuick TESTER interpretation	Rapid Test	Laboratory 4th gen test
Number positive	37	37	38	40
Number tested	457	457	457	457
Percent positive	8.1%	8.1%	8.3%	8.8%

Findings:

Out of 457 individuals tested, 40 (8.8%) were identified as HIV-positive by the 4th generation laboratory test. The Rapid Test (RT) Algorithm identified 38 (8.3%) individuals as HIV-positive. The OraQuick test identified 37 (5.1%) individuals as HIV positive (self-tester interpretation & trained tester interpretation). Using the 4th generation laboratory test as a gold standard, the RT Algorithm had a sensitivity of 95 % and specificity of 100.0%. The OraQuick had a sensitivity of 92.5 % and a specificity of 100.0%.

Conclusion:

This validation confirms that HIVST has high acceptability and good performance. The OraQuick test performed similar to reported test characteristics in the literature when used in a Namibian context. HIVST may be an important tool for use in Namibia if utilized as a screening tool or test for triage in the community. Further investigations need to be conducted in Namibia as how to roll out the OraQuick test in clinical settings.

The most important message to the clients seeking HIVST services is that HIVST does not provide definitive HIV-positive diagnosis, but is considered to be a test for triage. A positive HIVST requires further testing and confirmation by a qualified tester. The findings from the validation will help to inform the revision of the National Guidelines on HIV Testing Services

6.4 RAPID ASSESSMENT: PRIORITIES FOR LOCAL AIDS CONTROL EFFORTS (PLACE)

How do we know where to find the Key Population community in Namibia

Priorities for Local Aids Control Efforts (PLACE) is a rapid assessment tool to monitor and improve HIV/AIDS prevention programs in countries with high prevalence of HIV/AIDS coupled with resource constraints such as Namibia. PLACE is ideal for targeting priority areas to prevent new infections and identify gaps in current prevention strategies.

Namibia has a generalized HIV epidemic, but certain populations experience a greater disease burden and risk for infection based on their behaviour. Most notably, female sex workers (FSWs), transgender (TG) women, and men who have sex with men (MSM) have higher prevalence rates compared to the general population. Previous studies have examined these populations through their social networks, but this study used a time-location sampling methodology to:

- Identify places where key populations (KP) socialize and can be reached with outreach services and
- Calculate the size of the populations for FSWs, MSM, and TG women in Windhoek, Namibia. The study was designed to provide results to inform KP programming, both in reach and type.

Field workers posing on the final of PLACE Training

The study design is based on PLACE methodology, which was developed by MEASURE Evaluation, a project funded by the United States Agency for International Development (USAID) and the United States President's Emergency Plan for AIDS Relief (PEPFAR). The methodology is a It is a multistep process:

- The first step is to ask community informants where people go to socialize and meet new sexual partners.
- The second step is to map and verify those spots with informants who are knowledgeable about the spots.
- The last step is to conduct interviews with patrons and workers one by one at those spots and collect data on the respondent's knowledge, attitudes, and behaviour.

Although FSWs, MSM, and TG women were the populations of interest for our study, they were not targeted or asked to self-identify. This allowed for a less stigmatizing process and for data to be collected with the general population at those spots.

Key Findings

- Five hundred and seven (507) community informant interviews were conducted, in which the informants identified 173 unique spots in the nine constituencies of Windhoek where people (notably KPs) socialize and meet sexual partners. Then, 145 of those spots were verified through interviews at 129 spots with spot informants. Afterwards, patrons and workers were interviewed at those same spots.

- Most spots identified by community informants and then verified were bars (both formal and informal), street sites, and shopping centres.

    - According to spot informants, FSWs frequented half of those spots; MSM frequented 28 percent of them; and TG women frequented 61 percent of them.
    - Respondents said that women met new sexual partners at 72 percent of spots and men met new partners at 61 percent of spots.
    - People have sex on-site at 17 percent of spots.
    - At 58 percent of spots there had never been any HIV/AIDS prevention activity.
    - Of the spots that had had any prevention activities in the past six months, for the largest proportion, that activity was condom distribution.
    - Only 6 percent of spots had had HIV testing in the past six months.

PLACE Field workers conducting their activities

- Key population members were identified based on their answers to behavioural questions (e.g., received cash for sex in the past six months) and were identified in the data from 59 spots out of the 129 spots visited for interviews with patrons and workers at those spots.

- Out of a sample of 987 respondents, 42 FSWs, 41 MSM, and five TG women were interviewed.

- Because the size of the sample of TG women was small, it is difficult to generalize about the population of TG women as a whole.

- The largest proportion of all respondent groups visited the interview spot every day, and most said they were there to socialize or drink alcohol.

- A small proportion (17.5 %) was looking for a sexual partner.

- Approximately half of all respondents drank alcohol daily, or almost daily, with FSWs more likely to report daily alcohol use.

- Most respondents had been sexually active in the past 12 months. Female sex workers had the largest average number of partners—16.3 partners, in comparison with 9.5 for MSM and 5.3 for the general population. Female sex workers also most often reported meeting a sexual partner at the place of the interview. FSWs had the highest rates of reporting sex without a condom in the past six months (80 % for vaginal sex and 68 % for anal sex). Sixty-four percent of all respondents had used a condom at last sex. Slightly more than that—70 % —had accessed condoms for free in the past six months.

- Transactional sex was reported by all population groups.
  - One out of 10 respondents had paid a woman for sex in the past six months.

  - One in four MSM had received cash for sex, and 3.4 % of the general population had been paid for sex in the past month.

  - An even larger proportion of all groups except FSWs had received gifts or other goods for sex in the same period. Slightly more than half of FSWs identified themselves as sex workers (55.9 %) whereas 7.6 % of MSM and 0.8 % of the general population see themselves as such did so, despite not engaging in sex work in the past six months.

- Respondents were asked about their health-seeking behaviour.
  - Close to half had been tested for a sexually transmitted infection (STI) in the past year and 13 % had been tested for tuberculosis (TB).

  - Nearly 7 in 10 respondents had been tested for HIV in the past year, with MSM and general population members having the highest rates of testing in the past six months.

  - This study collected only self-reported HIV status. FSWs reported a prevalence of 8.7 %; MSM, 4.4 %; TG women, 0 percent; and the general population, 2.6 %.

- Population size estimates were calculated based on spot-visiting behaviour and network sizes for KPs. The data show size estimates for FSWs ranging from 907 to 3,565. An initial estimate for the MSM population in Windhoek was 529 to 1,063.

These data suggest that:

- FSWs are at greatest risk for acquiring HIV based on individual behaviour, but they also suggest that it is not just KP members who take risks in their sexual behaviour and partnerships.

- These data can help KP programs target their activities to the places where KP members can be found and highlight specific areas where prevention could be improved, such as testing, condom education, and linking to health services.

The findings from this study are currently being used in the program to improve reach and access to services by key populations. For example, new hot spots frequented by key populations are targeted for outreach activities.

7. HIV PREVENTION AMONG SEX WORKERS

7. HIV PREVENTION AMONG SEX WORKERS

Since 2011, the Society for Family Health has been implementing the HIV prevention program for sex workers. The program focuses on HIV prevention and referral services for sex workers, thanks for funding from the Global Fund to fight AIDS, Tuberclosis and Malaria (GFATM) through the primary recipient, Namibia Networks of AIDS Service Organisaton (NANASO). The program is implemented in selected towns and hot spots.

In Namibia, the data from the Integrated Bio Behavioral Surveillance Study (IBB SS) conducted in 2012/13 suggests HIV prevalence among Female Sex Workers (FSWs) was higher than females in the general population while prevalence among Men who have Sex with Men (MSM) was comparable to men from general population in regions studied except Windhoek were the prevalence was almost double that of men in general population.

Due to of high infection rates and large numbers of sexual partners, sex workers have been considered a core group for HIV transmission. In addition, men who engage in both paid and non-paid sex play a major role in bringing HIV infection into the general population. These "bridge" populations are important groups in direct prevention programs. Because of the mobile nature of their work, these groups include for example, military personnel, long-distance truck drivers and migrant workers that are easily identified as potential clients for sex workers.

The intervention HIV prevention package for sex workers, their clients and partners contains at least the following key elements:

- Information and behavior change messages
- Condoms and other barriers methods
- Sexual health services such cervical cancer screening, contraception, etc
- HIV testing services and access to ART PMTCT and support groups
- Importance of VMC, PrEP

The goal of sex work-related STIs/HIV prevention messages is to reduce the health risk, and in particular the risk of STIs/HIV infection, associated with sex work. Basic knowledge of HIV transmission and the protective role of condoms is high among sex workers in most developing countries with a mature HIV epidemic. Therefore, behavior change messages focus on:

- Alternative safe sex practices
- Use and conservation of male and female condoms
- Lubricants
- Symptoms of STIs
- Health-seeking behaviors for HIV testing and ART services and importance of VMMC
- Clarification of misunderstandings and misconceptions about unsafe traditional practices or beliefs

HIV testing is key in diagnosing sero-positive individuals and link them into HIV care and treatment services. SFH built on experiences from the USAID KP funded program to provide a more comprehensive program for sex workers. In accordance with WHO guidance, the 5C's principles (consent, confidentiality, counseling, correct test results and connection to follow up/ linkages to services) will be adhered to in line with national guidelines. In addition, with the expansion of PrEP to other populations at high risk of HIV acquisition in accordance with 2016 National ART guidelines, this is an excellent opportunity to further promote HIV testing services and linkage to care and treatment for sex workers.

Highlights of Achievements

Reporting Indicator Label	Target (Jan-Dec 2017)	Performance (Jan-Dec 2017)	Achievement
#workers who have been reached with individual or small group HIV prevention interventions that address the drivers of the epidemic	4000	3660	91%
# of people in the general population referred to health services who reached referral points (including HCT, PMTCT, ART, MC, STI services	1600	1305	82%
# of people in the general population referred to health services (including HCT, PMTCT, ART, MC, STI services	960	1051	90%

- The introduction of the case management (CM) approach resulted in better targeting of KPs for HTS, improved linkages to care and treatment through the deployment of Junior Case Workers
- Capacity building of all Junior case workers and project staff in HIV counseling and testing, combination prevention and the importance of prompt linkage to treatment and other services
- Community Health Supervisors were trained in HIV counseling and Testing
- Over 1,300 sex workers and other high risk groups were reached with HIV Testing Services (HTS) since June 2017.

Project staff and community health consultants attending a training on HIV Testing and counseling in July 2017

Challenges Addressed

- The importance to emphasise consistent condom use as the only effective way to prevent HIV infection and other incurable viral STIs in sex work, as PrEP does not protect against other STIs.

- Deliberate and consistent efforts need to take place to ensure that the design of an FSW-tailored HIV prevention package consist of an approach that recognises all levels of risk, and consists of biomedical, behavioural, and structural interventions. The epidemic context in which the sex work occurs is an important determinant of HIV risk, and the importance of sex worker-focused interventions depends on this context.

- Providing combination prevention services (STI screening, ART, PrEP, condoms and lubricant distribution, etc) at outreach points reduces loss to follow up and delayed enrollment on ART. This is in particular valid for migrant sex workers.

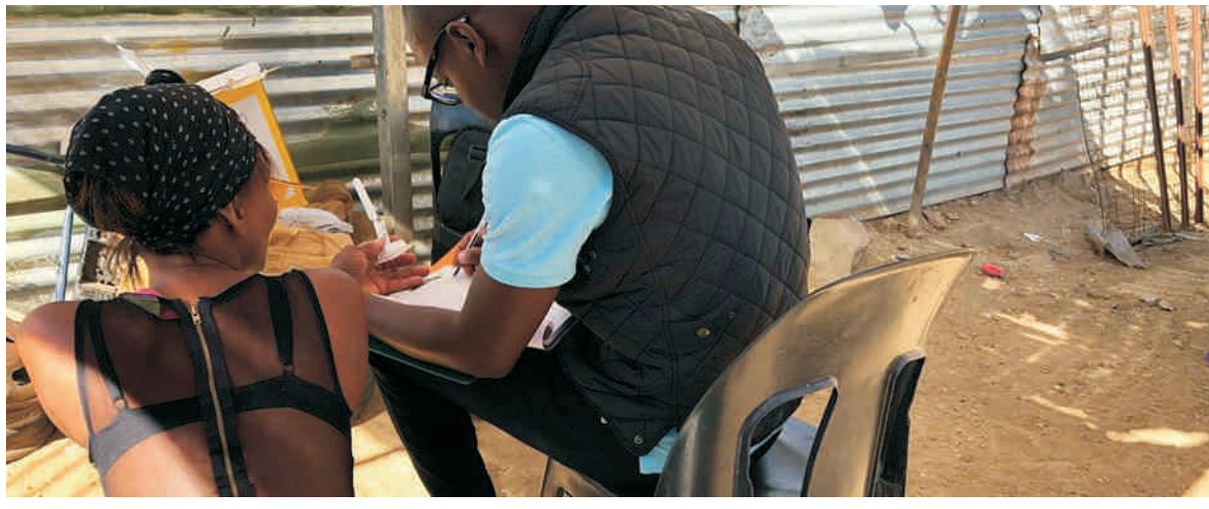
Lessons Learned

- The provision of PrEP as an additional prevention tool attracted a large number of sex workers to the program as HIV testing is an entry point to accessing PrEP.

- The program is demand driven by sex workers as they requested HIV testing services to be conducted at locations they prefer.

- The use of the mobile van for outreach services has facilitated access to services by sex workers and has improved collaboration between SFH and the regional health workers of MoHSS as local health providers joined the mobile team to initiate clients on ART and PrEP in accordance with set guidelines.

- Clinical services for sex workers that include regular screening coupled with prevention messages are likely to increases in condom use and reductions in STI and HIV prevalence



The Society for Family Health

8. Community Based Malaria Prevention

8. Community Based Malaria Prevention

Namibia aims to eliminate Malaria by 2020. Malaria is a serious health problem, especially for children and pregnant women. Although malaria can be severe, early and appropriate treatment is very effective. A failure to recognize danger signs and a delay in treatment often has serious consequences, including death, especially for children.

Based on the End Term Review of the Namibia Malaria Strategic Plan 2010-2017, it is noted that Namibia is seeing a change in the epidemiological context as a result of the increased malaria incidence with outbreaks occurring in 2013, 2014, 2016 and 2017. In part, reasons for these changes are the sub-optimal targeting of Indoor residual spraying (IRS), weak passive and active surveillance systems, limited surveillance data-sharing with neighbouring countries, population movement from high malaria endemic neighbouring countries and climate change. Over 57% of the population at risk of malaria is in the North East of the country bordering the high endemic areas of Angola and Zambia.

As part of a long standing collaborative agreement between the Society for Family Health and the Ministry of Health and Social Services - National Vector-borne Diseases Control Programme (NVDCP) and with funding from Global Fund to fight AIDS, tuberculosis and malaria, SFH implements a community based malaria prevention program in Omusati, Oshana and Kavango East. Since 2003, the malaria program has been in existence in these communities working in close collaboration with community leaders and health facilities supporting prevention activities, surveillance and distribution of mosquito nets. There are over SFH's 130 community health workers (CHWs) and 5 program officers in the regions.

Community Health Worker shows an elder, how malaria is spread and how to protect herself and her family.

The objectives of the program are to:

Increase the utilization of long-lasting insecticidal nets (LLIN)

- Increase timely care seeking for complicated malaria among children under five and pregnant women.
- Strengthen collaboration between health structures and communities through social mobilization and home visits.
- Promote appropriate management of malaria in households and communities

The core functions of SFH's (CHWs) are to:

- Support social and behavior change communication activities in accordance with the national strategy.
- Increase acceptance and utilization of interventions such as mosquito nets.
- Ensure that the community understands the public health benefit of treating all infected persons, regardless of their symptoms more especially during outbreaks.

Highlights of achievements:

Over the recent years, the program has observed remarkable reduction in malaria cases especially in Omusati and Oshana regions. Although Kavango East has also made steady improvements in malaria cases and deaths, these gains are usually derailed because of low coverage of malaria interventions in high malaria endemic neighboring countries and high population movement with increased risk of importation of malaria parasite.

- Approval for community health workers to diagnose malaria and prescribe antimalarial medicines for management of uncomplicated cases was granted by Namibia Medicines Regulatory Council.

- Community health workers (CHWs) continue to reach community members with Malaria messages through household visits and community outreach events.

- Nine (9) community health workers were trained in malaria case management including RTDs

- The Malaria Rapid Test and treatment pilot was carried out in Kangongo Biro clinics, Etilyasa and Onkani district.

Community Outreach in the Kavango West Region, following a Malaria Outbreak in March 2017

SFH - Malaria Suspected 2017		
Total 2017	Total no of Malaria Suspected cases	Total no of people referred
Jan - Mar	164	159
Apr - Jun	48	46
Jul-Sep	38	23
Oct-Dec	13	9
Total	263	237

SFH - Malaria Suspected 2016		
Total 2016	Total no of Malaria Suspected cases	Total no of people referred
Jan - Mar	259	34
Apr - Jun	307	237
Jul-Sep	217	204
Oct-Dec	221	160
Total	1004	635

In the first table above, number of suspected malaria cases was higher (164) as expected during Jan –Mar 2017 with most cases predominantly reported from Kavango east. During the same reporting period, CHWs referred a total number of 159 people with suspected malaria and follow up to ensure access to treatment and compliance with treatment instructions. Compared to the table on the right displaying data for 2016, it is clear that a drastic decrease in malaria cases has been observed which could indicate that malaria interventions efforts are effective.

Reporting Indicator Label	Jan - Dec 17	Performance Jan - Dec 2017
# of malaria household visits conducted by CHWs	86400	95321
# of people (15yrs+) reached with malaria messages through household visits	259200	266447
# of community outreach events conducted by CHWs	11520	12225
# of people reached (15yrs+) with malaria messages through community outreach events	230400	174734

As the MohSS continued to intensify efforts to eliminate malaria in Namibia, SFH will similarly continue to provide support to MoHSS in ensuring that community health workers have capacity to provide diagnosis and treatment of uncomplicated malaria to community members presenting with suspected malaria symptoms. This is in line with the test and treat approach of uncomplicated malaria as approved by the Namibia Medicines Regulatory Council late in 2017.

The table below provides the outcome of the pilot project on diagnosing (through the use of rapid diagnostic test) and prescribing antimalarial medicines for uncomplicated cases in hard to reach areas:

Pilot sites	District	# of clients tested	# of clients tested positive	# of clients tested negative
Biro clinic	Andara district	381	40	341
Kangongo clinic	Andara district	198	57	141
Etilyasa Clinic	Okahao district	213	0	213
Onkani Clinic	Oshikuku district	87	0	87
Total		879	97	782

A total number of 879 people were tested for malaria in 2017 with most people primarily from the Kavango East region. Ninety seven (97) people of the 879 people tested RDT positive. All the 97 people who tested RTD positive were from the Kavango East region.

As the program move forward with the rollout in 2018, methodology and approach for testing and treating uncomplicated malaria in hard to reach areas include:

- House to-house visits will be conducted by the community health workers (CHWs) to determine fever/signs and symptoms of malaria.
- The CHCs will test for malaria with Rapid Diagnostic Test (RDT) and treat individuals with a positive RDT, and no signs of severe/complicated malaria;
- Refer individuals with any sign of severe/complicated malaria and also refer individuals with fever that are negative for malaria.
- Referrals of patients under the age of five and pregnant women to the nearest health facility
- Registration of households for distribution of LLINs
- Distribution of LLINs to households
- Follow up and monitoring of LLIN usage
- Collaboration with the nearest health facility's staff
- Monthly submission of report to health facilities and partner supervisors and wekly reporting.

In this photo a Community Health Worker are conducting a malaria awareness outreach activities at a village in Omusati region.

Challenges addressed:

- Some households are not adequately supplied with mosquito nets due to unclear procedures. Before any distribution is made, there should be clear standard operating procedures (SOPs) and adhered to in ensuring good distribution of the nets.

- Some clients diagnosed with malaria symptoms during household visit do not reach the health facilities when referred due to distance and lack of transport.

- The participation of adults 15years and above during community outreach events continues to remain a challenge due to migration, family and work commitments.

Lessons Learned

- Older community health workers are retained longer in the program compared to the younger community health workers who are constantly in search of better opportunities elsewhere.

- The monthly and quarterly programmatic meetings, quarterly program reviews and on-going support and supervision continues to prove to be effective in improving performance

- Given the use of CHWs within the designated communities is an effective approach to address awareness and health behaviors at the community level especially given limited outreach services from the health facilities.

- Regular home visits allowed CHWs to observe household practices, reinforce good behaviors, and address individual barriers; these visits are especially important to demonstrate and increase LLIN utilization.

- CHWs are also able to provide effective monitoring of sick children and pregnant mother during home visits and ensuring adherence to treatment protocol.

- The practice of health facility workers making counter-referrals to CHWs should be further expanded to ensure proper follow up of serious malaria cases after discharge.

9. MILITARY ACTION PREVENTION PROGRAM (MAPP)

8. MILITARY ACTION PREVENTION PROGRAM (MAPP)

Within the framework of the implementation of the Military Action and Prevention Program (MAPP), the Society for Family Health is tasked with the responsibility of ensuring the capacity enhancement of key military personnel to ensure capacity for HIV prevention, care and support. This program has been receiving financial support from the US Department of Defense since 2003.

For over 17 years, SFH has been working in partnership with the U.S Department of Defense (DOD) and the Namibian Ministry of Defense to implement a Military Action and Prevention Program (MAPP) The organisation works closely with the Ministry of Defense (MoD) to reduce the military personnel's and their families' vulnerability to HIV, while creating a more positive environment for other at risk populations.

The Namibian Ministry of Defense recruits young men and women at a time of their greatest risk to HIV, in the 15 to 25 year age group where 21% of all new infections occurs. The military risk environment is further enhanced by the mobility and absences from home and community that military life demands. The dynamic of transmission could be viewed as similar to that seen in long-distance transport workers and migrants employed in the construction and mining sectors.

The primary objective of this program is to implement a standard package of HIV interventions that intensifies previously implemented activities aimed at providing HIV prevention services to military personnel and their families, especially new recruits, young men and women.

- The package of HIV prevention services included condom demonstration and distribution, HIV risk reduction education, as well as referrals and linkages to health services including HCT, Voluntary Medical Male Circumcision (VMMC), Tuberculosis (TB), STIs screening and treatment, and other sexual and reproductive health services. The programme is implemented in 13 military bases in country targeting all military personnel and civilians at each of the 13 bases.

- To enhance program efficiency and promote ownership, SFH trained peer educators at each of the military bases to support activity implementation and reach out to their peers.

- Training has also been provided to Commanders and HIV unit coordinators.

- The program equally addresses other cross-cutting issues such as gender, stigma and discrimination.

The goal of Military Action for Prevention Program (MAPP) is to support the Ministry of Defense/Namibian Defense Force (MOD/NDF) to implement the standard package of interventions and enabling the MOD to better manage the MAPP activities. Project objectives included:

- Reducing new infections among military personnel and their families
- Strengthening linkages to HIV services for military personnel and their families
- Increasing military personnel and their families' access to condoms

Providing technical assistance and strengthening the capacity of the military to implement the MAPP program including on condom forecasting and distribution plan development and implementation

Highlights of achievements

- A total of 1,920,000 camouflage and flavored condoms were procured and handed over to the Ministry of Defense.
- Although funding from US DoD ceased in the first quarter of 2017, SFH continued to provide technical support to sustain the program. Resource mobilization plan and sustainability plan are being operationalized to ensure that the program continues.

Challenges addressed

- The creation of a follow up and support system for supervision at the regional and base level using newsletters, site visits and condom distribution.
- Increase effectiveness of the peer education approach by providing refresher courses for trainers and peer educators as a forum for sharing experiences and moral support. This approach will ensure that wherever peer educators are redeployed, they will continue to fulfill their roles.

Lessons learned

- Cascade training has proved to be an efficient way of reaching military personnel as it does not involve additional resources after organizing the first ToT workshops. The rest of the cascade training is taken over by the respective military base commanders. The training can also be easily modified for the needs of the audience, taking into consideration culture, religion and language, among other factors.
- The program becomes successful when there is great support from the Battalion commanders and unit commanding officers
- Most military personnel have adequate knowledge when it comes to HIV related matters which they have gained by attending sessions over the years.
- Effective communication cannot be overemphasized as a cornerstone of success even in a program of this nature and it is because of good communication that the program achieved much progress.
- There is a great need for the program to continue more importantly for new intakes as most of them are in their early youth and are more vulnerable.

- Good collaboration with other stakeholders such as Ministry of Health and Social Services (MoHSS) during outreach events leads to a greater outcome such as provision of HTC services and VMMC

- Military personnel more likely to use camouflage military condoms than any other condoms procured by government

- The Ministry of Defense has a forecasting and distribution plan for condoms in place; this resulted in this activity not to be conducted as anticipated.

Col Marriane Muvangua, Head of NDF Special Programmes updating her team on HIV Prevention Activities

10. SCHOOL-BASED WATER, SANITATION AND HYGIENE (WASH) INITIATIVE

10. SCHOOL-BASED WATER, SANITATION AND HYGIENE (WASH) INITIATIVE

With support from UNICEF, the interventions on Water, Hygiene and Sanitation (WASH) was implemented in close collaboration with the Ministry of Education, Arts and Culture and the multi-sectoral support from the Water Sanitation and Hygiene in School (WinS) steering committee. The project was implemented in March 2015 – April 2016 in 100 schools across 7 regions namely, Zambezi, Kavango West, Kavango East, Ohangwena, Omusati, Oshana, and Oshikoto. Although funding for this initiative ceased in 2016, SFH continued to follow up with selected schools to ensure that hygiene conditions and practices and maintained.

> "I really thank this WASH program for teaching us the basic things about how we as girls can handle our menstruation and to understand how our bodies work. I started with my periods last year and I did not really know much about it at that time. It somehow came as a surprise. Because of this program, we also now can be given pads at school in case if menstruation starts and the girl did not have any pads with her."
> 14 year old girl,
>
> Bagani Combined School,
> Kavango East region, 2016

The project was designed to address needs identified based on a Needs Assessment on WASH in schools led by SFH and partners in 2013/14 which found that one quarter (25%) of the total number of 420 schools surveyed have water piped into the school buildings. Other findings were summarized as follow:

- Non-existent or insufficient water supply, sanitation and hand-washing facilities in some schools;
- Toilets or latrines that are not adapted to the needs of children, in particular girls;
- Broken, dirty and unsafe water supply, sanitation and hand-washing facilities in some schools;
- Children with poor hygiene and hand-washing practices.

Why working with school learners on basic hygiene and sanitation is essential:

- Children are eager to learn. Schools can stimulate and support positive behavioural change in children.
- Children have important roles in household chores related to hygiene.
- Children may question existing practices in the household and become agents of change within their families and communities.
- Children are future parents. What they learn at school is likely to be passed on to their own children.

The overall goal of the project was to promote hygiene and sanitation practices in schools with the objectives to:

- To increase awareness and political support to improve WASH situation in the target regions through advocacy, communication and mobilization.
- To ensure that circuit inspectors, principals and teachers have a basic understanding of WASH concept and how it affects learning and health of learners.

SFH programme Officer Sirrka Mbutu, at a follow up visit to Ondjora Combined school in the Omusati region. Here she is seen assessing Safe Water usage with a student.

How the project was conceptualized

The 100 participating schools were drawn from 7 regions as follow: Omusati region (17), Ohangwena region (17), Kavango East (18) and West (15) region, Zambezi region (17), Oshana region (9) and Oshikoto region (7). These are the regions with low performing indicators on sanitation, safe water supply and prone to floods. Forty-seven schools among the 100 schools were previously supported through the MCA-N WinS project.

At National level, the project was managed by SFH serving as a secretariat to the WinS steering committee while the PQA Director within the MoEAC served as the Chairperson. At these meetings, SFH provided progress update on the project including challenges encountered. Due to competing priorities, the WinS committee only met twice before it was integrated into the broader School Health Task Force led by the Ministry of Health and Social Services (MoHSS) and MoEAC.

At the regional level, SFH regional structures coordinated and collaborated with the regional offices of MoEAC and MoHSS to facilitate project implementation. MoEAC took leadership in identifying the Training of Trainers (ToTs) and participants for the inspectors, school principals and teacher's trainings and sensitization meetings on WASH.

The trainers composed of Education officers, inspectors and selected principals, whilst the trainees were drawn from a much broader cadre – teachers, members of the School Boards, community facilitators and school cleaners.

At the school level, SFH's project officers were responsible for ensuring implementation and monitoring of activities at each school, while the community facilitators assisted schools to establish WASH clubs and providing support in sustaining the clubs. To facilitate ownership and sustainability, community facilitators were identified by the school managements.

Training materials

This training targeted circuit inspectors, principals, teachers, school cleaners and community facilitators from the participating schools. To ensure that the content and quality of training is maintained across all trainings, the WASH Training Guide for Teachers was used. The regional education offices took leadership in providing convenient schedules for trainings and identifying participants as TOTs and trainees. The school boards at each participating school selected community facilitators to assist with project implementation at the school level especially activities related to the creation and sustaining the WASH clubs.

The participants were trained on the content ot the WASH Training Guide for Teachers and how to use it. The purpose of the Guide is to assist teachers in promoting positive behaviour change of learners through increasing their knowledge, skills and practices with regards to the WASH themes, namely water, sanitation and hygiene.

Teachers are expected to help learners practice basic hygiene principles and applying them in different situations and settings including menstrual hygiene and personal cleanliness. They also learned how to keep their environment safe, clean and hygienic through managing the different types of waste material properly.

> "This training has been an eye-opener for some of us. As teachers, we usually do not prioritize activities such as hand washing and hygiene. But having gone through these visual materials and realizing the risk of disease transmission through unhygienic practices, it is a scary thing. At my school it has been a habitual practice just before the school feeding for learners to wash their hands in one large bucket without even soap and even worse, they wipe their mouth with that same water. Imagine what could happen. This is a practice that will be stopped immediately as I return to school. We need to promote good hygiene practices with our learners."
>
> Teacher from lindangungu Combined School, Oshana region, 2016

Highlights of Achievements:

- SFH Continue to give technical support to schools on WASH to ensure that schools maintain their WASH commitments.

- SFH randomly selected 15 schools from the 100 schools that previously participate in the WASH initiative. It was found that 10 out 15 schools are still maintaining good hygiene practices. This pertains in particular to the WASH facilities that are still in good conditions and well maintained. As for some schools and although the toilet facilities are in hygienic conditions, there were no toilet papers available in the toilets. Reasons for these are reported due to budgetary constraints. For the other 5 schools, meetings with the school principals and focal teachers were organized to explore how the schools can revisit their strategies to revive the WASH activities.

Challenges addressed:

- Some teachers reported difficulty in keeping soap by the individual hand washing facilities because of theft. Purchasing soap to supply the hand washing facilities is also a financial challenge for some schools.

- WASH facilities must consider the specific needs of girls. When adolescent girls attend school during menstruation, they need toilets appropriate for girls, and water supply to wash in privacy. Hence the need to also ensure that toilet facilities have (locable) doors and toilet papers are available at all time.

Lessons Learned

- Involving families and communities in WASH in Schools interventions promotes a sense of ownership, which is a necessary prerequisite for sustainability. Examples of involvement include school management committees, parent-teacher associations or committees specifically set up for WASH in Schools.

- The location of the WASH facilities should allow for security to reduce the risk of vandalism, particularly when communal WASH facilities are being installed. Learners or group of learners can be assigned this task.

- Trainings of institutional staff such as cleaners on WASH helped in improving cleanliness and hygienic conditions through the demand and provision of appropriate cleaning and protective materials.

- Schools with active facilitators, focal teachers and principals were observed to have cleaner school environment and learners look neater and tidy compared to others.

11. MAJOR MILESTONES EXPECTED IN 2018

Building on lessons learned and achievements, SFH will continue to strengthen its capacity to improve current program performance, explore new programs as well as opportunities to build alliances with non-traditional partners and stakeholders.

- Contribution to and implementation of the Integrated Bio Behavioral Surveillance Study (IBBSS) to determine size estimates and HIV prevalence and related services among key populations;
- Undertake an analysis of PrEP program data to understand the dynamics around retention, individual and structural barriers and true loss to follow up;
- Ensure improved results for key populations in particular those related to linkage to care and broaden wider participations by key populations;
- Explore innovative ways of engaging vulnerable adolescents and young people to achieve lasting impact in education and health outcomes;
- Broaden collaborative partnerships with local private sectors and other non-traditional development partners;
- In line with the organizational strategic plan, improve organizational capacity for change: increasing change capacity and avoiding change overload through resiliency building;
- Expand our collaboration with academia to jointly define, connect and share new knowledge with local and international partners.

12. APPENDICES

12.1 SFH 20th Anniversary

Official Guests of the SFH's 20th Anniversary Gala Dinner

Ann Singer entertaining the quests at SFH's 20th Anniversary

THE SOCIETY FOR FAMILY HEALTH's 20th ANNIVERSARY
OF PROGRESSIVE WORK IN PUBLIC HEALTH

The Society for Family Health (SFH) recently celebrated its 20th anniversary in a splendid fashion.

Since its establishment exactly 20 years ago SFH Namibia remains committed to empower diverse Namibian communities with health promotion interventions to reduce health disparities and improve health outcomes. We remain grateful to our community of support for making the dreams of many beneficiaries a reality.

SFH's Board Chair, Dr Kalumbi Shangula, Board of Directors, Management and staff, therefore wishes to express gratitude to those who helped us made the event memorable. These are individuals and organisations such as:

1. Honourable Juliet Kavetuna – Deputy Minister of Health and Social Services (represented the Minister of Health, Hon. Dr. Bernard Haufiku and the Right Hon Saara Kuugongelwa-Amadhila, Prime Minister of the Republic of Namibia)
2. Mr Zdenek Zuda – USAID Acting Country Representative
3. Dr Tharcisse Barihuta, UNAIDS Country Director
4. Ms Rachel Odede, UNICEF Country Representative (represented by Ms Jacqueline Kabambe)
5. Ms Dennia Gayle, UNFPA Country Representative (represented by Ms Grace Hidinua)
6. Ms Maria Kavezembi, Director, PHC, Ministry of Health and Social Services
7. Dr. Ndapewa Hamunime – Chief Medical Officer, DSP, Ministry of Health and Social Services
8. Ms Anne-Marie Nitschke, Director, DSP, Ministry of Health and Social Services
9. Brigadier General (Dr) S Ndeitunga, Chief Health Services, Ministry of Defense
10. Cll Marianna Muvangua,, Head of DSP, Ministry of Defense
11. Mr Julius Natangwe Nghifikwa, Deputy Director, Ministry of Education, Arts and Culture
12. All our colleagues and stakeholders in the health, education and private sectors.

Special gratitude for financial support from: Coca Cola Company, Namibia Ports Authority, NamiBRE,Walvis Bay Corridor Group, Dinapama Clothing and Manufacturing.

SFH's Community Health Care Workers presenting their unique diversity Celebration

SFH Board Chairman, Dr Kalumbi Shangula delivering his message to the Health Community

Deputy Country Director Dr Steven Hong, Country Director Taimi Amaambo & Finance Director Prince Owusu Afriyie

Deputy Minister Honourable Juliet Kavetuna with UNAIDS Head Dr Tharcisse Barihuta with Namibia Health Journalist of the Year 1st and 2nd Runner up

35 of the 300 Health Care Workers of SFH also attended the Gala Dinner and Entertained the Guests

Board Member Anna Ipangelwa Delivering a Vote of Thanks

The organization also awarded 6 of their longest serving employees ranging from 14 - 5 years.

Anne Mary Nitschke of the Ministry of Health and a friend with SFH's Deputy Country Director Dr Steven Hong with

USAID Country Representative Mr. Zdenek Suda and UNAIDS Head in Namibia: Dr Tharcisse Barihuta

SFH Board Chairman together with The Deputy Minister of Health – Toast to 2 good decades

12.2 SUCCESS STORIES

The impact of the programs on beneficiaries' lives

Program officer Eileen Louw of the Kings Daughter Organization seen here with program beneficiary Ndapandula (in Red cap) Who narrates the story below

My name is Ndapandula. I am 25 years of age and I would like to share my story so that others in similar situations could learn from it.

I was attending Behavior change communication sessions with one of the Community Health Counselors from Kings Daughters Organization (KDO), in July 2012. After finishing with the sessions, I wanted to know how I can play a role in educating my peers about HIV/AIDS. I spoke to Ndeshi (CHCs) about how to go about it and she took me to the office of King's Daughters Organization.

At the office, I met Ms Eileen Louw, who agreed that I can become one of their CHC's. I started working at KDO in August 2012. I in particularly enjoyed conducting education sessions and referred clients to health facilities for various services. Little did I know that soon, I would need the very same services that I have been referring clients for My partner and I had a good loving relationship and we had earlier planned for a baby. I was three months along my pregnancy when I went for my first antenatal visit. The nurse performed normal check-up and told me that I also need to take an HIV test, because it is compulsory for pregnant women. I got my results that same day, and I was shocked when the results showed positive. I thought that it was the end of my life, was confused and didn't know what I would tell my partner. I was 20 years old and HIV+. I did not even have the confidence to tell my partner about it. I was just devastated. I had no one to turn too, not even my own family members.

A week after that, I went to the office and told Ms Eileen about my fears, my heartache and that I don't want to live anymore. She counseled me and encouraged me, that there was more to life. That was the beginning of my journey with KDO. I immediately went back to the hospital to start with PMTCT program to prevent the virus from getting to my baby.

Ms Eileen walked the path with me, by showing compassion and encouraging me to take my medication on time. I adhere to my monthly visits at the hospital, until I gave birth to a healthy baby boy. My cousin found out my status when my son was seven months old, and she told my mother. My family was shocked, but they supported me too.

I was not put on ARV's right away, because my viral load count was still high. Every month I went for follow ups, and the nurse drew blood after every 3months.
I started ARV treatment in the middle of 2014. At first my body did not adapt with the medication, and I was complaining a lot but Ms Eileen encouraged me to keep on taking the medication on time.
I stacked to my medication, and after three years, in 2017 my viral load got suppressed, which mean that the treatment was working really well for me. I was excited and relieved. My doctor was very happy to break the news about my viral load suppression. The first person I told about my viral load suppression was Ms Eileen. She was pleased too for me. KDO encouraged me to use condoms every time and stay healthy.

I am very happy and now I know that being HIV+ is not a death sentence. One can live healthy, adhere to the medication and have a normal life. My son is 5 years old now, healthy, happy and in pre-school.
I thank God for my life that I can work to give education to my son. I would like to encourage everyone out there who is HIV positive, to adhere to the medication, go for follow-ups and live a healthy lifestyle.

[King's Daughters Organization is one of the implementing partners under SFH's USAID-funded KP program.]

Changing my life, provided a window of hope through community work

"My name is Morina Goreses. I was diagnosed with HIV in 2007 and started taking ARVs in 2008. I was battling with alcohol abuse and could not take my treatment as prescribed. Due to these difficulties worsened by financial problems I decided to drop out from the treatment program. During my struggle I was approached by SFH's Community Health Consultant (CHC) to attend her sessions, where I met fellow Sex Workers who were also attending behavior change communication session. One of the topics for this session focused on ARVs and how to live positively. After the session, the CHC asked the group if there were participants that were willing to share their experiences. At first, I was hesitant, but then I volunteered to share my story. This was the first time I felt comfortable to share my experience since I was diagnosed with HIV in 2007. I shared my life time story to the group and later during the week some participants started to motivate me to go back to treatment. I was escorted by the CHC to the clinic to receive the necessary care and re-initiated on ART. After restarting the treatment, I have not stayed a single day without taking my ARVs on time and thank God my viral load went down.

After this encounter, I was approached by SFH's CHCs to consider helping with the program by serving as a CHC in Erongo region. Following my agreement, I was trained as a CHC in 2017. I received training in the new manual called Taking Care of Business and I was also trained in Case Management. Ever since that training in February, I became a role model to the Sex workers in my community. As a CHC, I conduct education on HIV prevention, risk reduction counseling, HIV counseling, linking clients to care and treatment. I have enrolled clients in case management that I am still following up. I also distribute condoms to Sex Workers during my sessions and also at home to those who urgently need condoms when they run out of condoms.
**Name changed to protect identity*

Changing lives through the Case Management approach

Annalie Visagie is a 37 year old young lady who lives with HIV and enrolled in Case Management Program implemented by SFH with funding from Global Fund through NANASO. Case Management is a project component of the key population project implemented in Namibia, including //Kharas region. One of the services included in the package is linkage to health service, coordination and the facilitation of treatment adherence and psychosocial support.*

SFH Caseworker Katrina Olman met Annalie during her mobilization activities in Karasburg in July 2017. During the intake assessment it was identified that Annalie was a Sex worker who was HIV positive and has also defaulted treatment. The case worker also identify that Annalie had multiple partners and had been battling with alcohol abuse. Annalie also disclosed to the Case worker that she is in a steady relationship and that she has never disclosed her HIV status to her partner. Katrina provided her with psychosocial support and accompanied her to the hospital where Annalie was put back on treatment

Through regular home visits, Annalie was supported and monitored by Katrina who provided her with the necessary support. With the assistance and counseling of the Case Worker, Annalie disclosed her HIV status to her partner who also agreed to be tested for HIV of which he tested HIV negative. The partner accepted Annalie's HIV status and supported Annalie to adhere to treatment. Annalie has been sticking to treatment ever since and has made a commitment to have only one sexual partner.

In November 2017, Annalie got employment and relocated to Aussenkehhr, where she is doing very well. Annalie appreciate what Katrina has done for her at the time when she needed help the most and extended her gratitudes to Katrina.

**Name change to protect identify*

Adolescent Club rescue girl Child from a sexual predator - AGYW Program

Purowe is a young girl from a school in the Kavango East was spotted by taxi driver who always saw the young girl walking long distance going to school. The taxi driver approached the young girl and indicated to her that he was concerned about her education given her long walk to school and in return offered to drop her to school which the young girl agreed to. After giving her a ride for 3 months, the taxi driver started demanding for sex in exchange of dropping the young to school to which the girl repeatedly refused. Her refusal angered the taxi driver to the point of threatening the young girl and demanding that the girl pays him money for the 3 month trips. The young girl was unable to pay and got very frighten, especially when the demanding messages sent to her cellphone, became non-stop and began to threaten her life.*

She decided to tell her friends who were in the Adolescents club run by SFH's community facilitator. This is when the case was reported to our Community Facilitator in the Kavango East region. After seeking guidance from the Program on how the case should be handled, the regional team was advised to report the case to the Gender Equality and Child Protection Unit for intervention. Both the girl and the Taxi Driver were called in and the case was opened against the Taxi Driver. Thereafter, The program Facilitator continue to follow up on how the girl was doing. The taxi driver has since stopped following the girl and the situation has been normal after the warning from the police and after a series of counseling sessions provided to the girl.

Love can still flourish with Partners in discordant relationship

This is a story of sex worker who was diagnosed with HIV in her early 20's.
One evening, I met with a sex worker at the club. We happened to share different experiences and challenges faced as sex workers and the risks in the business industry. She opened up herself to me and share her story of living with HIV, she also related to stigma as the key challenge of being HIV positive. But gladly, she knew the risk of her job what will come one day. She was 26 years old when she got tested positive for HIV after having sold sex to multiple clients.

Because of her experience finding out that she is HIV positive did made her feel lonely, but after she related her story to me, I told her that i am working with HIV related programs and would be ready to assist her to deal with her situation and get her life back on track. Thereafter, it was clear that we started to gain trust between us as part of building a supportive relationship. She soon realized that it was still possible to lead a healthy life even though being HIV positive.

3 years earlier, she actually met someone she really likes and decided to live together and eventually got a healthy baby-boy. The partner was HIV negative and continued to stand by her side and their child. After learning about PrEP, she asked me to convince her partner to take an HIV test and consider PrEP with the goal to protect him from HIV infection in case if she is not virally suppressed. The partner agreed for PrEP and has been on this medication for the past 3 months.

The moral of this story is that a person living with HIV can still be in a relationship with a negative person and both can be enrolled on ART and/or PrEP.
[Story shared by SFH case worker, Erongo region. Global Fund financed program through NANASO.]

12.3 Schools that participated in the program

AGYW Schools 2016-2017

Omusati Region 10 Schools
Omufitu North Combined School
Omafa Combined School
Ashipala Secondary School
Shedile Junior Secondary School
Pyamukuu Combined School
Ondeka Combined School
Ombuumbuu Junior Secondary School
Onkani Combined School
Mwaala Secondary School
Shaanika Nashilongo Secondary School

Kunene Region 10 Schools
Putuavanga Senior Secondary School
Mureti Senior Secondary School
Outjo Senior Secondary School
Alpha Combined School
Otjerunda Combined School
Elias Amxab Combined School
Kaoko Otavi Combined School
Cornelius Goreseb Senior Secondary School
Kamanjab Combined School
Welwitschia Junior Secondary School

Omaheke Region 10 Schools
Winnie Du Plessis Senior Secondary School
Epako High School
Mokganedi Tlhabanello Senior Secondary School
Johannes Dohren (RC) Senior Secondary
Gustav Kandjii Senior Secondary School
Nossob Combined School
Rietquelle Junior Secondary School
Izak Buys Junior Secondary School
Epukiro Post 3 Junior Secondary School
C.Heuva Junior Secondary School

AGYW Schools 2016-2017

Kavango West 10 Schools
Leevi Hakusembe Senior Secondary School
Kandjimi Murangi Secondary School
Nkerunkuru Combined School
Mupini Combined School
Nakazaza Combined School
Sharukwe Combined School
Kanuni Haruwodi Senior Primary School
Siya Combined School
Bunya Combined School
Kasote Combined School

Kavango East Region 10 Schools
Rundu Senior Secondary School
Dr R. Kampungu Secondary School
Max Makushe Secondary School
Elia M. Nelomba Secondary School
Sauyemwa Combined School
Mashare Combined School
Uvhungu-vhungu Combined School
Kayengona Combined School
Maria Mwengere Senior Secondary School
Shambyu Combined School

Zambezi Region 10 School
Ngweze Secondary School
Simataa Secondary School
Mafwila Secondary School
Mayuni Secondary School
Mavuluma Secondary School
Sangwali Secondary School
Masokotwani Secondary School
Nakabolelwa Combined School
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Barriers to Condom Use Among High Risk Key Populations in Namibia

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Background

- HIV disproportionately affects key populations (KPs) in sub-Saharan Africa, namely female sex workers (FSWs) and men who have sex with men (MSM).
- In Namibia's Integrated Biological and Behavioral Survey (IBBSS), condom use among KPs was inconsistent, especially with non-client sex partners. More data is needed to understand specific reasons for inconsistent condom use among KPs.
- The Society for Family Health (SFH), a local non-governmental organization (NGO) in Namibia conducts a KP program aimed at expanding access, utilization and quality of HIV prevention interventions among KPs to achieve epidemic control.
- This study aims to determine predictors of poor condom use among KPs, as well as describe KP condom use barriers in 11 regions of Namibia.

Methods

- We analyzed data for KPs routinely collected in the SFH electronic case management database from June 2016 to June 2017. Data were cleaned in MS Excel 2015 and analyzed in Stata IC 14.2 using bivariate and multivariate logistic regression models.

Table 1: Client Characteristics

Characteristic	Total n (%)	Consistent Condom Use (Always) n (%)	Poor Condom Use (Sometimes & Never) n (%)	P-value
Total	N = 621	N = 590	N = 591	
Key Populations (KPs)				
Female Sex Workers	432 (69.6)	94 (58.8)	338 (71.3)	
Other KPs (MSM, Other, & n/a)	189 (30.4)	66 (41.3)	123 (26.7)	
Age (years ± SD)	28.5 ± 12.2	28.5 ± 12.6	28.5 ± 12.0	0.94
Sex				
Female	457 (74.6)	98 (61.3)	359 (77.9)	
Male & Other	164 (26.4)	62 (38.8)	102 (22.1)	
Region				
//Karas	117 (22.1)	43 (26.9)	94 (20.4)	
Erongo	78 (12.5)	19 (11.9)	59 (12.8)	
Hardap / Omi	41 (6.6)	0 (0.0)	41 (8.9)	
Kavango West	39 (6.3)	0 (0.0)	39 (8.5)	
Khomas	229 (35.4)	48 (30.0)	172 (37.3)	
Kunene	1 (0.2)	1 (0.6)	0 (0)	
Ohangwena	22 (3.5)	3 (1.9)	19 (4.1)	
Omaheke	1 (0.2)	0 (0.0)	1 (0.2)	
Oshana	48 (7.7)	32 (20.0)	16 (3.5)	
Otjozondjupa	7 (1.1)	0 (0.0)	7 (1.5)	
Zambezi	30 (4.8)	0 (0.0)	30 (6.5)	
Not Available	2 (0.3)	0 (0.0)	2 (0.4)	
Education				0.001
Primary & Primary	155 (25.0)	24 (15.0)	131 (28.4)	
Secondary & Tertiary	466 (75.0)	136 (85.0)	330 (71.6)	
Latest HIV Status				0.001
Positive & Unknown	208 (33.5)	36 (22.5)	172 (37.3)	
Negative & Not Available	413 (66.5)	124 (77.5)	289 (62.7)	
Latest HIV test				0.016
< 30 Days & 1 – 6 months	387 (62.3)	87 (54.4)	300 (65.1)	
6 – 12 months & > 1 Year & Not Available	234 (37.7)	73 (45.6)	161 (34.9)	
Condom-Compatible Lubricant Use				<0.001
Always	84 (13.5)	71 (44.4)	13 (2.8)	
Sometimes & Never	537 (86.5)	89 (55.6)	448 (97.2)	
Ever Treated for an STI				0.054
Yes	163 (23.0)	28 (17.5)	115 (24.9)	
No & Not Available	478 (77.0)	132 (82.5)	346 (75.1)	
Ever Treated for TB				0.070
Yes	89 (14.3)	16 (10.0)	73 (15.8)	
No & Not Available	532 (85.7)	144 (90.0)	388 (84.2)	
Type of Sex				
Genital				0.494
Yes	534 (85.5)	135 (84.4)	399 (86.6)	
No	87 (14.0)	25 (15.6)	62 (13.4)	
Anal				<0.001
Yes	102 (32.5)	45 (28.1)	57 (12.4)	
No	519 (83.6)	115 (71.9)	404 (87.6)	
Oral				<0.001
Yes	179 (28.8)	71 (44.4)	108 (23.4)	
No	442 (71.2)	89 (55.6)	353 (76.6)	
Situations in which you did not use condoms				
Client refused				<0.001
Checked	112 (18.0)	0 (0.0)	112 (24.3)	
Unchecked	509 (82.0)	160 (100)	349 (75.7)	
Client paid extra				<0.001
Checked	133 (21.4)	1 (0.6)	132 (28.6)	
Unchecked	488 (78.6)	159 (99.4)	329 (71.4)	
I refused				0.001
Checked	33 (5.3)	0 (0)	33 (7.2)	
Unchecked	588 (94.7)	160 (100)	428 (92.8)	
I trust the client				<0.001
Checked	140 (22.5)	0 (0)	140 (30.4)	
Unchecked	481 (77.5)	160 (100)	321 (69.6)	
Condoms were not Available				<0.001
Checked	135 (21.7)	1 (0.6)	134 (29.1)	
Unchecked	486 (78.3)	159 (99.4)	327 (70.9)	
Under the influence of drugs/alcohol				<0.001
Checked	156 (24.3)	1 (0.6)	150 (32.5)	
Unchecked	470 (75.7)	159 (99.4)	311 (67.5)	
Afraid of violence				0.005
Checked	24 (3.9)	0 (0)	24 (5.2)	
Unchecked	597 (96.1)	160 (100)	437 (94.8)	
Threat from client				0.009
Checked	25 (4.0)	0 (0)	25 (5.4)	
Unchecked	596 (96.0)	160 (100)	436 (94.6)	
Other				0.117
Checked	7 (1.1)	0 (0)	7 (1.5)	
Unchecked	614 (98.9)	160 (100)	454 (98.5)	

Figure 1: Geographic Location of SFH Sites

11 Regions
//Karas
Erongo
Kavango East
Kavango West
Khomas
Kunene
Ohangwena
Omaheke
Oshana
Otjozondjupa
Zambezi

Table 2: Reasons for Not Using Condoms

Situations in which you did not use condoms	FSW (n, %)	Other KP (n, %)
Total	432	189
Client Refused	103 (23.8)	9 (4.8)
Client Paid Extra	119 (27.5)	14 (7.4)
I refused	18 (4.2)	15 (7.9)
I trust the client	96 (22.2)	44 (23.3)
Condoms were not available	86 (19.9)	49 (25.9)
Under the influence of drugs/alcohol	108 (25.0)	43 (22.8)
Afraid of violence	23 (5.3)	1 (0.5)
Threat from client	24 (5.6)	1 (0.5)
Other	2 (0.5)	5 (2.6)

Results

- Total 621 KP clients were identified with condom use data: 432 FSW and 189 other KPs (MSM and other high-risk clients). Mean age for FSWs was 28.4±12.9 years, and 28.8±10.2 years for other KPs.
- Bivariate analyses identified the following factors associated with poor condom use ("never" and "sometimes" vs "always" used condoms with sexual partners): FSWs (p=0.001), no or only primary education (p=0.001), HIV-positive or unknown status (p=0.001), HIV testing <6 months ago (p=0.016), poor condom-compatible lubricant use (p<0.001), sexually-transmitted infection treatment in the past 3 months (p=0.054), and reporting no anal (p<0.001) or oral (p<0.001) sex.
- In the final multivariate model, factors associated with poor condom use were: FSWs compared to other KPs (OR 1.78; 95% confidence interval (CI)=1.27 to 2.74), primary or no education (OR 2.11; 95% CI=1.29 to 3.43), and an unknown or positive HIV status (OR 1.78; CI=1.16 to 2.72).
- Reasons for not using condoms included: alcohol and drug use (25% FSWs and 23% other KPs), no condom availability (20% FSW and 26% other KPs), clients paying extra (28% FSW), and clients refusing a condom (24% FSW).

Conclusions and Recommendations

- FSWs, less educated, and HIV-positive or unknown KPs report poor condom use. FSWs cited alcohol and drug use, and client preferences as major barriers to condom use.
- Targeted condom use campaigns, education for FSWs, and initiation of PrEP among KPs could significantly reduce HIV transmission.

Acknowledgments

We would like to thank all the staff at MoHSS, SFH, KP organizations, and partners for making this study possible.

SFH often collaborates with MoHSS and partners on conference abstract development and presentation.

HIV Testing Yield in a Key Population Project in Namibia

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Background

- Globally between 40-50% of all new HIV infections in adults occur among key populations (KPs) and their partners. The picture is similar in sub-Saharan Africa with KPs disproportionately affected by HIV.
- KPs are often extremely difficult to reach for critical testing, care and treatment services.
- The Society for Family Health (SFH), a local non-governmental organization (NGO) in Namibia conducts a KP program along with partners Walvis Bay Corridor Group, Namibia Planned Parenthood Association and other KP organizations, and aims at expanding access, utilization and quality of HIV prevention, care and treatment interventions among KPs to achieve epidemic control.
- A mixed HIV testing model approach is implemented by the project including facility-based testing and testing at strategic "hotspots" in the community using mobile van outreach.

Objectives

- We sought to describe the HIV testing yields among KPs (including FSW and lesbian, gay, bisexual, transgender, and/or intersex (LGBTI)/MSM) in our project operating in ten regions in Namibia and compare with GP testing yields in the same regions.

Methods

We analysed secondary data collected from July 2016 to June 2017, captured in the project electronic database. Data were exported, cleaned and analysed using STATA 13.

Figure 1: Geographic Location of SFH Sites

11 Regions
//Karas
Erongo
Kavango East
Kavango West
Khomas
Kunene
Ohangwena
Omaheke
Oshana
Otjozondjupa
Zambezi

Table 1: Characteristics of Tested Individuals

Characteristic	Overall	HIV Positive	HIV Negative	P-value
Sex				0.006
Female	12,159 (53.8)	404 (59.8)	11,755 (53.6)	
Male	10,399 (46.0)	271 (40.1)	10,128 (46.2)	
Transgender	49 (0.2)	1 (0.2)	48 (0.2)	
Organization				<0.001
SFH	2489 (11.0)	100 (14.8)	2,389 (10.9)	
WBCG	7,419 (32.8)	235 (34.8)	7,184 (32.8)	
NAPPA	12,676 (56.1)	338 (50.0)	12,338 (56.3)	
Other	26 (0.1)	3 (0.4)	23 (0.1)	

Table 1: Characteristics of Tested Individuals

Characteristic	Overall	HIV Positive	HIV Negative	P-value
Region				<0.001
Karas	2,036 (9.0)	95 (14.1)	1,941 (8.9)	
Erongo	8,607 (38.1)	138 (20.4)	8,469 (38.6)	
Hardap	13 (0.1)	0 (0.0)	13 (0.1)	
Kavango East	51 (0.2)	5 (0.7)	51 (0.2)	
Khomas	5,433 (24.0)	141 (20.9)	5,433 (24.0)	
Ohangwena	2,741 (12.1)	98 (14.5)	2,741 (12.1)	
Omusati	24 (0.1)	0 (0.0)	24 (0.1)	
Oshana	613 (2.7)	27 (4.0)	586 (2.7)	
Otjozondjupa	88 (0.4)	2 (0.3)	86 (0.4)	
Zambezi	3,003 (13.3)	170 (25.2)	2,833 (12.9)	
Birth				<0.001
Namibia	20,918 (92.5)	594 (87.9)	20,324 (92.7)	
Other	1,689 (7.5)	82 (12.1)	1,607 (7.3)	
Marital Status				<0.001
Cohabiting	1,463 (6.5)	94 (13.9)	1,369 (6.5)	
Divorced/separated	105 (0.5)	3 (0.4)	105 (0.5)	
Married	2,833 (12.6)	94 (13.9)	2,833 (12.6)	
Minor	76 (0.3)	2 (0.3)	76 (0.3)	
Never Married	17,960 (79.7)	472 (69.9)	17,960 (79.7)	
Widowed	86 (0.4)	10 (1.5)	86 (0.4)	
Education				<0.001
None	941 (4.2)	52 (7.7)	889 (4.1)	
Primary	4,946 (22.0)	225 (33.4)	4,721 (21.6)	
Secondary	14,057 (62.4)	361 (53.6)	13,696 (62.7)	
Tertiary	2,578 (11.5)	36 (5.3	2,542 (11.6)	
Last tested				<0.001
1 year or more	7,565 (33.5)	260 (38.5)	7,305 (33.3)	
1-6 months	4,183 (18.5)	111 (16.4)	4,072 (18.6)	
7-12 months	7,761 (34.3)	189 (28.0)	7,572 (34.5)	
Never	3,095 (13.7)	116 (17.2)	2,979 (13.6)	
Population				<0.001
MSM	1,272 (5.6)	46 (6.8)	1,226 (5.6)	
Other	17,718 (78.4)	451 (66.8)	17,267 (78.8)	
FSW	3,612 (16.0)	178 (26.4)	3,434 (15.7)	

Results

- In our KP program, 22,610 clients were tested, 676 (3.0%) HIV-positive and 21,934 (97.0%) negative.
- Amongst all tested, 4,884 (21.6%) were identified as KPs while 17,718 (78.4%) were GP.
- Amongst KPs tested, 3,612 (74.0%) were FSWs while 1,272 (26.0%) were LGBTI/MSM.
- Amongst KPs tested, 224 (4.6%) tested HIV positive compared to 451 (2.6%) among the GP; 46/1,272 (3.6%) LGBTI/MSM tested positive for HIV; 178/3,612 (4.9%) FSWs tested positive for HIV.

Conclusions and Recommendations

- By implementing programs targeting KPs, the project is identifying a higher proportion of individuals living with HIV compared to GP testing.
- The program should continue to offer KP-targeted services while utilizing evidence-based and innovative methods to target testing to individuals most at-risk of HIV.

Acknowledgements

We would like to thank all the staff at MoHSS, SFH, KP organizations, and partners for making this study possible.

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Factors Associated with HIV-positive Testing in a Key Population Program in Namibia

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Background

- Closing the HIV testing gap and diagnosing 90% of all people with HIV is critical to the success of the global HIV response to reach epidemic control.
- Despite the annual increase in HIV testing services (HTS) and HIV testing coverage, in many settings HTS is not sufficiently focused. Many of those at highest risk remain unreached.
- In spite of a high prevalence of HIV infection among key populations (KP), including men who have sex with men (MSM) and female sex workers (FSW), uptake of HTS among KP in sub-Saharan Africa remains relatively low among this hard-to-reach population.
- The Society for Family Health (SFH), a local non-governmental organization (NGO) in collaboration with Walvis Bay Corridor Group and Namibia Planned Parenthood Association in Namibia conducts a KP program aimed at expanding access, utilization and quality of HIV prevention, care and treatment interventions among KPs to achieve epidemic control.
- Targeted and high-yield HTS is one of the goals. Therefore, it is important to identify factors associated with HIV-positive testing in order to guide targeted testing.

Objectives

- We sought to describe the population being tested within our KP program in Namibia and to assess factors associated with HIV-positive testing.

Methods

- We analysed routine program data collected from July 2016 to June 2017, captured in the project electronic database. Data were exported, cleaned and analysed using STATA 13.

Photo: SFH Tester in Mobile Van

Table 1: Characteristics of Testers

Characteristic	Overall	HIV Positive	HIV Negative	P-value
Sex				0.006
Female	12,159 (53.8)	404 (59.8)	11,755 (53.6)	
Male	10,399 (46.0)	271 (40.1)	10,128 (46.2)	
Transgender	49 (0.2)	1 (0.2)	48 (0.2)	
Organization				<0.001
SFH	2489 (11.0)	100 (14.8)	2,389 (10.9)	
WBCG	7,419 (32.8)	235 (34.8)	7,184 (32.8)	
NAPPA	12,676 (56.1)	338 (50.0)	12,338 (56.3)	
Other	26 (0.1)	3 (0.4)	23 (0.1)	

Table 1: Characteristics of Testers

Characteristic	Overall	HIV Positive	HIV Negative	P-value
Birth				<0.001
Namibia	20,918 (92.5)	594 (87.9)	20,324 (92.7)	
Other	1,689 (7.5)	82 (12.1)	1,607 (7.3)	
Marital Status binary				<0.001
Cohabiting or married	4,296 (19.1)	188 (27.9)	4,108 (18.8)	
divorced/separated/never married/widowed	18,227 (80.9)	487 (72.2)	17,740 (81.2)	
Education bivariate				<0.001
None or Primary	5,887 (26.1)	277 (41.1)	5,610 (25.7)	
Secondary or Tertiary	16,635 (73.9)	397 (58.9)	16,238 (74.3)	
Last tested new				<0.001
Never or 1 year or more	10,660 (47.2)	376 (55.6)	10,284 (46.9)	
Less than 12 months	11,944 (52.8)	300 (44.4)	11,644 (53.1)	
Population				<0.001
MSM	1,272 (5.6)	46 (6.8)	1,226 (5.6)	
Other	17,718 (78.4)	451 (66.8)	17,267 (78.8)	
FSW	3,612 (16.0)	178 (26.4)	3,434 (15.7)	
Population collapsed				<0.001
KP	4884 (21.6)	224 (33.2)	4,660 (21.3)	
Other	17,718 (78.4)	451 (66.8)	17,267 (78.8)	
Reasons for testing				<0.001
convenience or self-referred	10,222 (45.3)	217 (32.1)	10,005 (45.7)	
referred by healthworker or health issue	12,369 (54.8)	459 (67.9)	11,910 (54.4)	

Results

- In our KP program, 22,610 clients were tested, 676 (3.0%) HIV-positive and 21,934 (97.0%) negative. The mean age was 30 and 54% were female. Nineteen percent were married or cohabiting and 26% had less than secondary education.
- Amongst all testers, 4,884 (21.6%) were identified as KPs. Amongst KPs, 1,272 (26%) were MSM and 3,612 (74%) were FSWs.
- In the final multivariate model, factors associated with a positive HIV test were: female sex (OR=1.21; 95% confidence interval (CI)=1.03 to 1.43), foreign born (OR 1.56; 95% CI=1.22 to 1.99), married or cohabiting (OR 1.70; 95% CI=1.43 to 2.02), education (none or primary) (OR 1.91; 95% CI=1.63 to 2.24), never tested for HIV or tested >12 months ago (OR 1.57; 95% CI=1.34 to 1.84), KP (OR 1.69, 95% CI=1.42 to 2.00), testing because of healthcare referral or health problem (OR 1.67, 95% CI=1.42 to 1.98).

Conclusions and Recommendations

- In order to achieve highest yield in targeted HIV testing, it is important to focus testing resources in populations most at risk.
- In our KP program in Namibia we identified factors associated with HIV-positive testing.

Acknowledgements

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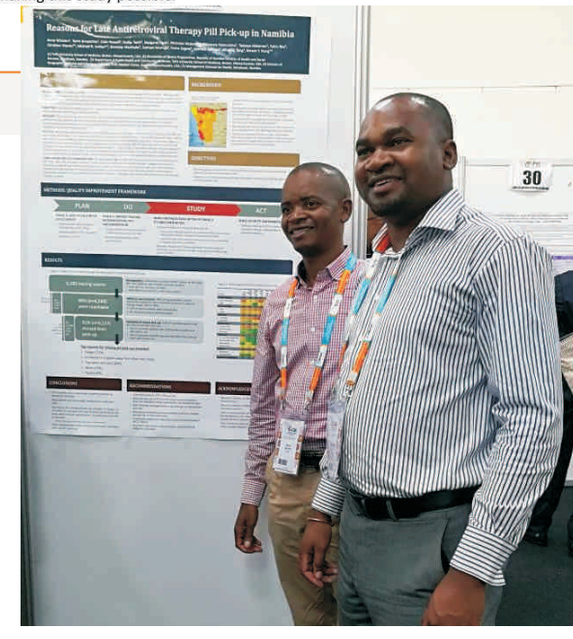

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Reasons for Late Antiretroviral Therapy Pill Pick-up in Namibia

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ABSTRACT

BACKGROUND: In Namibia, 250,000 people (14.3% of the population) are living with HIV as of 2014. Although ART coverage has increased to over 70%, adherence barriers remain and surveillance data have shown poor performance in population-level on-time pill pick-up. These data are concerning as 48-hour treatment interruptions are associated with increased HIV drug resistance. Data characterizing reasons for missed pill pick-ups are lacking.

OBJECTIVES: We aimed to identify patients' reasons for missing pill pick-ups via patient tracing to inform service implementation optimizing on-time pill pick-up.

METHODS: The parent study was a 21-month cluster randomized control trial to assess the efficacy of intensified patient tracing to prevent 48-hour treatment interruptions. One full-time tracer per intervention site (8 sites) conducted phone and physical tracing of patients the day after missed pill pick-ups. We analyzed quantitative and qualitative codes recorded by tracers.

RESULTS: Patients who were traced after a missed pill pick-up (n=5,183) were older (42.7 vs. 39.0 years, p<0.001) and more likely to be male (37 vs. 34% male, p<0.001) compared to a cohort of ART starters at the same ART sites. Tracers were able to contact 88% of patients who missed pill pick-ups or their treatment supporters. Of reachable patients, 91% had missed their pill pick-ups, 6% had picked up at an alternative site, and 3% had in fact not missed their pill pick-ups. The top reasons for missing pill pick-ups included: 1. forgot (22%), 2. in-transit (15%), 3. transport and cost (14%), 4. work (13%), 5. family (8%), 6. too many administrative requirements (7%), and 7. patient was too sick to come or admitted as an in-patient (3%). Of the 15% of patients in-transit, 41% picked up pills at an alternative site.

CONCLUSIONS AND RECOMMENDATIONS: We were able to gain insight into the reasons for missed pill pick-ups at ART sites. Sites demonstrated common trends as well as important site-specific barriers. Targeted interventions should be designed and implemented towards the reasons why people missed pill pick-ups. Such interventions include Short Message Service pill pick-up reminders, a nationally-connected electronic patient record system, community adherence clubs, community-based ART outreach, extended clinic hours, and education on how to stay healthy in transit.

BACKGROUND

Figure 1. Map of Namibia with Intervention Sites Marked

- About 14.3% of the population in Namibia are HIV-positive.
- Antiretroviral therapy (ART) have been provided by the public sector free-of-charge to eligible patients since 2003, with current ART coverage at 70%.
- Increasing ART coverage improves health outcomes but may also increase drug resistance.
- Specifically, 48-hour interruptions in ART adherence are associated with the development or resistance.
- Tracers are standard of care in low- and middle-income countries to contact patients who missed pill pick-ups to reengage them in care. Frequency and tracing varies per country and clinic.

OBJECTIVES

- Identify patients' reasons for missing ART pill pick-ups by analyzing intensified patient tracing implementation data.
- Inform service implementation of intensified patient tracing in order to optimize on-time pill pick-ups.

METHODS: QUALITY IMPROVEMENT FRAMEWORK

PLAN → DO → **STUDY** → ACT

PHASE 1: LOSS TO FOLLOW-UP (LTFU) SURVEY
- Observational cohort study of 524 patients across 7 sites
- Validated patient LTFU outcomes
- Predictors of LTFU

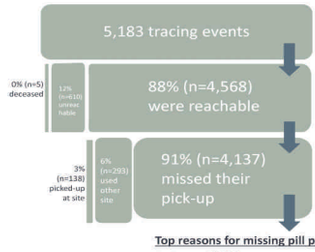
PHASE 2: PATIENT TRACING INTENSIFICATION (PTI) IMPLEMENTATION
- Cluster randomized control trial of ~3,000 patients across 16 sites
- Record implementation and outcome data

MIXED METHODS EVALUATION OF PHASE 2 PTI IMPLEMENTATION
- Evaluate reasons for missed pill pick-ups via:
  - Quantitative data aggregated from worksheets filled out for every tracing event. Analysis conducted using Excel and STATA.
  - Qualitative data from semi-structured tracer interviews analyzed using grounded theory and NVivo.
- Evaluate efficacy of PTI implementation via clinical data on adherence, loss to follow-up, virologic response and mortality using Excel and STATA.

SCALE-UP OF PTI NATIONWIDE
- National scale-up of PTI including evaluation-based implementation recommendations

RESULTS

Figure 2. Flow Chart of Patient Tracing Intensification (PTI) Implementation Results



Demographics: compared to a cohort of ART starters at the same ART sites, patients who missed a pill pick-up were:
- Older (42.7 vs. 39.0 years, p<0.001)
- More likely to be male (37 vs. 34% male, p<0.001)

Ability to reach patients: 88% of traced patients or their treatment supporters were reachable by phone or physical tracing (range: 69% to 99%).
- 12% of traced patients were unreachable
- 0% of traced patients were deceased

Validation of missed pick-ups: 91% of reachable patients had actually missed their pick-ups.
- 6% of reachable patients had in fact picked up pills at an alternative site
- 3% of reachable patients reported they did in fact pick-up their pills at their site

Top reasons for missing pill pick-ups included:
1. Forgot (22%)
2. In-transit in a region away from their site (15%)
3. Transport and cost (14%)
4. Work (13%)
5. Family (8%)

Figure 3. Percentage of Pill Pick-Up Barriers per Site

	Total	Grootfontein	Kavango east	Kavango west	Oshana	Oshikoto	Otjozondjupa	Omaheke	Windhoek
TOTAL	100%	8%	8%	7%	13%	14%	2%	11%	21%
1. Personal Barriers	24%	4%	5%	24%	3%	21%	7%	6%	29%
Forgot appointment	22%	3%	5%	27%	1%	20%	7%	5%	28%
Other	2%	1%	0%	2%	1%	1%	0%	1%	1%
2. Work and Family	20%	25%	19%	31%	13%	28%	28%	35%	28%
Work	13%	15%	16%	23%	4%	12%	19%	7%	22%
Family	8%	4%	3%	10%	9%	8%	8%	8%	6%
3. In-transit	15%	18%	25%	41%	6%	16%	32%	2%	28%
Temporarily	11%	17%	22%	40%	5%	13%	30%	2%	28%
Permanently	3%	0%	3%	1%	1%	2%	4%	0%	0%
4. Access to Care	14%	23%	9%	1%	34%	11%	19%	15%	4%
Transport & cost	14%	23%	9%	1%	31%	11%	19%	15%	4%
Time spent at site	1%	0%	0%	1%	3%	0%	0%	0%	0%
Inconvenient	0%	0%	0%	0%	0%	0%	1%	1%	0%
5. Site Factors	9%	3%	2%	4%	3%	2%	4%	21%	3%
Too many admin. requirements	7%	0%	0%	0%	3%	0%	0%	21%	0%
Site closed when I came	1%	3%	0%	0%	0%	0%	1%	0%	3%
Clinic stock-out	0%	1%	1%	0%	0%	0%	2%	0%	0%
Staff-level factors	1%	2%	2%	4%	0%	2%	1%	0%	1%
7. Medical	3%	1%	3%	0%	2%	3%	1%	4%	3%
Health-related	3%	1%	4%	0%	2%	3%	1%	4%	2%
Medication-related	0%	0%	1%	0%	0%	0%	0%	0%	0%
8. Alternative treatment-seeker	0%	0%	0%	0%	0%	0%	0%	0%	0%

CONCLUSIONS

- PTI is feasible and a unique way to identify pill pick-up barriers in real-time
- Most patients are contactable, however, this varies per clinic
- Top reasons for missing pill pick-ups included: (1) forgot, (2) in-transit, (3) transport and cost, (4) work, (5) family, (6) too many administrative requirements, (7) patient was too sick or admitted
  - Of the 15% in-transit; only 41% picked-up at an alternative site
- Clinics demonstrated some common trends with important clinic-specific variations

RECOMMENDATIONS

- Continued analysis of PTI efficacy data
- National scale-up of PTI incorporating recommendations from the evaluation-based quantitative and qualitative data.
- SMS reminder messages prior to pill pick-ups to reduced late pick-ups
- Nationally-connected electronic patient records to simplify pill pick-ups at alternative sites
- Community Adherence Clubs (CACs) and Community-Based ART (C-BART)
- Extended clinic hours to accommodate work and family obligation schedules

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