
# PEPFAR NAMIBIA
# REGIONAL STAKEHOLDERS CONSULTATION MEETINGS

## FEBRUARY 21, 2017 - Ongwediva
## FEBRUARY 22, 2017 - Otjiwarongo

## MEETINGS SUMMARY

The purpose of the regional consultations was to engage with different stakeholders and get their ideas on priority activities, challenges and opportunities to be focused on for the U.S Government's (USG) Country Operational Plan for fiscal year 18 (COP17). The participants were engaged to provide new ideas and innovation for the Country Operational Plan, to give information about existing activities to avoid overlap and to verify and validate proposed ideas. The meeting consisted of presentations giving an overview of the COP; a session on data review of the region by looking at the 90-90-90 UNAIDS targets; and group work to identify gaps and opportunities for COP17.

The meetings were attended by representatives from Government Ministries, implementing partners, non-governmental organizations and private sector.

**Ongwediva, Tuesday, February 21, 2017**

**Team members:**
Vaino Tauya (MOHSS/CDC Program Assistant)
Selma Amakali (MOHSS DSP Resource Mobilization and Development Coordinator)
Naemi Shoopala (CDC Service Delivery)
Rachel Coomer (CDC Health Policy and Communications)
Sirka Amaambo (PEPFAR Small Grants and Communications)
Tara O'Day (USAID Health Office Director)

## 1. Summary

Thirty-three participants from the Oshana, Omusati, Oshikoto, and Ohangwena regions attended the meeting. Ms. Johanna Haimene, the Regional Health Director in Oshana region and the Regional Director for Oshikoto region, Mr.Peter Angala attended the consultative meeting.

## 2. Welcome, introductions and opening remarks

Ms. Johanna Haimene, the Regional Health Director in Oshana region, gave the opening remarks for the meeting.[1] She stated that the country has moved from emergency activities to developing targeted programs and that the Namibian Government understands that in order to achieve a continuum of the response, there needs to be shared responsibility with civil society organizations, and the different communities across the country. She stressed the importance of COP planning in assisting Namibia to achieve epidemic control. She also emphasized the importance of strengthening care among key populations and acknowledged the vital role donors play in Namibia.

## 3. Presentations

### 3.1 COP Overview

Ms. Tara O'Day (USAID) presented the COP overview and processes; the importance of stakeholder engagement; and their role in the COP 17, which requires innovative and creative initiatives to work on a long-term sustainability plan.

### 3.2 Data review of the regions: 90-90-90

Ms. Naemi Shoopala (CDC) presented on progress made in fiscal year 2016 and highlighted the importance of developing evidence based interventions and using data to guide implementation

[1]Remarks included in Annexure

through strategic planning. She gave particular emphasis to data from the regions attending the consultation.

*Discussions*

- Involving men who have sex with men (MSM) in HIV prevention, treatment and care: One participant was not aware that men who have sex with men are present in the northern regions. How do you get data on MSMs if you are not aware of their existence?
    - **Response:** Clarity was given to explain that the data presented was from the Integrated Biological and Behavioral Surveillance Survey (IBBSS) and discussion ensued on how the data can be used to guide interventions targeting Key Populations (KP).

- Raising awareness on availability of Pre-exposure Prophylaxis (PreP) treatment: Not everyone is at risk so those who are not sexually active do not need to get PrEP. How do you decide who gets PrEP?
    - **Response:** Risk reduction is part of HIV counseling; consideration can be case-by-case.

- HIV testing: Has data looked at why testing in certain regions is low?
    - **Response:** One of the contributing factors is human resources for health (HRH) which remain an issue especially in hard-to-reach areas. Transportation also remains a challenge, which makes it hard to get to those people. Interventions need to be targeted, depending on available resources.

- Partner Index data accuracy: Namibian lifestyle trends indicate that people have multiple partners, especially in the villages.
    - **Response:** Programs should package the Partner Index in a way that reflects what is actually happening on the ground.

- Adolescent Girls and Young Women (AGYW): The data show that older positive men are infecting young people. One participant highlighted the fact that a certain percentage of young people are born with HIV. Some are on treatment but may not know why. How will programs address this challenge?

- The point was made that consultations with the community are needed to understand the specific issues that are faced so that interventions can be tailored.

- The rate of HIV children was discussed. The PMTCT program has been successful. The problem remains with children infected before the PMTCT was implemented. This is the group programs need to focus attention on.

- How can MSMs and female sex workers (FSW) benefit from PrEP: Guidelines not specific on how MSM and FSW can benefit from PreP. It will be difficult to target them without knowing where to find them and they might even be in the group with the highest prevalence rate.
    - **Response:** It is important to work with organizations that are already working with MSM and FSW. Even with service provision, people will not come out identifying themselves as MSMs or FSWs due to stigma. The guidelines do not say ‘do not provide’ so it is crucial to design interventions that are targeted and strategic.

**Group breakout sessions**

The breakout session was introduced and the group process and instructions were explained. The participants were divided into three groups:

1. Prevention
2. Treatment
3. Care

Each group also included discussions about gender-based violence (GBV), monitoring and evaluation, the needs of children 10 – 14, the needs of adolescents and young women, human resource challenges and other cross cutting elements.

**Group 1. Prevention**

| AREA FOR DISCUSSION | CHALLENGES/GAPS | OPPORTUNITIES |
|---|---|---|
| HIV testing in children | • Healthcare workers (HCW) turning down children who want to be tested | • Integrate testing into school health programs<br>• Accommodate testing after school hours<br>• Include HIV counselling and testing (HCT) in the health extension worker (HEW) program |
| VMMC | • Health Extension Workers (HEW) have limited knowledge of VMMC<br>• Myths about VMMC influence the public | • Train HEW & field officers on mobilization messages<br>• Address the myths<br>• More male health workers are needed in VMMC |
| PrEP for sero-discordant couples | • Health Care Workers (HCW) do not know about this option<br>• People at risk do not know about this service<br>• Limited documentation | • Train HCWs on PrEP<br>• Inform the public<br>• Actively offer to people at risk<br>• Document and report |
| PMTCT | • HCW not up to date, don't know the guidelines,<br>• Clients are not informed<br>• Pregnant women missing appointments | • Facilities to refer lost to follow up (LTFU) patients to HEW/field officers to follow up in community<br>• Train HCW, HEW, field officers on guidelines |
| Family Planning | • HCW approach to youth is not friendly<br>• Youth not informed on family planning (FP) and HIV transmission | • Raise awareness that FP does not substitute for condoms<br>• Train HCW on adolescent friendly services |

| | | |
|---|---|---|
| ANC | • Women not coming for ANC | • Find out why and develop strategy to address |
| HIV testing (men) | • Men do not want to wait for testing<br>• Men fear knowing their status (have pregnant partner test to find out their own status) | • Educate men on HIV testing<br>• More outreach/ community testing options<br>• Make sites man-friendly (accommodating hours) |
| Children (10-14) and young people (15-24) | • Few teen clubs operating to discuss their issues<br>• Lack of funds to make sites youth friendly<br>• Health facilities do not know organizations working with youth<br>• Poor communication structures | • Teen clubs at facilities (provide ART); facility to provide space<br>• Facilities to have list of referral sites for youth<br>• Peer educators<br>• Strengthen communication through youth structures to include them<br>• Train HCW how to engage youth<br>• Train parents on disclosure<br>• Link youth to friendly support groups |

*Discussions*

- PMTCT: Mother baby follow up: Is there a tool that collects data for children aged 0 to 14 who are HIV positive?
    - Data is not available. NAMPHIA survey is an opportunity to get information.
    - In addition, currently, at national level data is obtained from the Namibian Institute of Pathology (NIP). These come from the lab requisition form that is completed at site level and submitted with specimen to the lab. This data is entered in the early infant diagnosis (EID) database at the national level as well as mother-baby pair follow-up registers at the facility level.
    - For testing among infants more than 9 months, this information is available and extracted from the voluntary counseling and testing (VCT) database.
- We need to make the ANC clinic friendly to men and adolescents. Lessons learned; the male champion campaign to increase male involvement in PMCTC only increased the number of women who come for ANC in the first trimester. But did not improve male partner testing.
- Is there a PrEP tool that can be used as a follow up on clients?
    - No, but once demonstration project are completed the SOP and tools will be availed

**Group 2. Treatment**

| | CHALLENGES/GAPS | OPPORTUNITIES |
|---|---|---|
| Supply Chain | • Communication between national and regional level (multi-regional) | • Decentralize to regions<br>• Improve updates on stock status<br>• Decentralize pharmaceutical health system |
| Community-based ART (CBART) outreach model | • Transport<br>• Staff shortage<br>• Services not integrated | • Look at alternative models of CBART |
| ART and TB service integration (facility and community) | • No integration of services at community level directly observed treatment (DOT) points<br>• Staff rotation at hospitals<br>• Misunderstanding between clinicians and pharmacy staff | • Establish clubs/refill points for ART<br>• Train more staff on NIMART<br>• Provide clear guidance/SOP on ordering drugs |
| Workload | • Not enough staff at facilities<br>• Concept that 'the problem is beyond us' | • Participants are hoping that the MoHSS restructuring process will be completed soon |
| Pediatric ART and NIMART | • Staff not confident to initiate pediatric ART<br>• Frequent visits for pediatric needs can be a challenge for patients | • Mentoring and refresher training<br>• Decentralize to NIMART/CBART sites<br>• Targeted health education for children |
| Maximizing retention | • Electronic Dispensing Tool (EDT)/electronic patient monitoring system (ePMS) need to be inter-linked<br>• Decentralize services | • Activities to address retention are in place |

*Discussions*

- Community based ART challenges can be addressed by having community ART mobilization groups. It is however different from clubs which are for stable patients.
- EDT systems: clients who go to external pharmacies cannot be traced
- Pediatrics: integrating them into community based ART means staff members will attend to the children and reduce the distance that has to be covered in reaching them.

**Group 3. Care and Support**

| | CHALLENGES/GAPS | OPPORTUNITIES |
|---|---|---|
| **CARE AND SUPPORT** | | |
| | • Insufficient support to caregivers<br>• Lack of accessibility to health services/lack of youth involvement<br>• Lack of youth services in rural areas<br>• Need to harmonize existing program to avoid duplication<br>• Nutritional issues | • Existing youth clubs<br>• Strengthen current offer of service to youth<br>• Establish youth centers<br>• Regular stakeholder meetings to coordinate<br>• Expand provider-initiated testing and counseling (PITC) to schools<br>• Drought relief<br>• School feeding programs<br>• Social grants |
| Children 10-14 | • Lack of family support<br>• Information not reaching the community<br>• Disclosure issues<br>• Lack of targeted interventions | • Index model<br>• Disclosure process |

*Discussions*

- What happens to people who were sent away because test and treat was not being implemented in the beginning?
  - Make test and treat services widely available, and advertise on radio to make sure everyone gets the message. Currently, it is not widely advertised.
  - PrEP – we cannot introduce PrEP to some and not to all.
- Is test and treat available, accessible and affordable? Avoid creating demand and not manage to continue providing it. It can also promote 'misbehavior'.
- Adolescent girls and young women (AGYW): Make waiting areas more interesting for young people. Install television sets and display information material they can read while waiting.
- Come up with income-generating projects to help young people
- Have a workshop for guardians on how to take care of adolescents living with HIV
- Is there an intervention for caregivers?
  - There is a National Disclosure Program with trained staff in the regions. It is still being rolled out but a curriculum has been developed.
  - Even though health staff has been trained, some families do not want to disclose. So a support system is needed.
  - Sometimes, those living with the children are not the parents so those guardians do not want to be the ones to disclose this information.
- The problem of religious teaching that HIV can be healed through prayer was discussed. The group felt this issue should be addressed at the national level.
- Can PEPFAR and other donors take up Health Extension Workers? They were bringing a lot of change in the communities but now they have been stopped.

See Appendix C for additional notes on the group discussions

**Next steps for COP**

Tara O'Day thanked the participants for their contributions and summarized the next steps for PEPFAR to remain in communication with the stakeholders. She also encouraged continuous dialogue to address the noted challenges.

**Closing:**

Ms. Haimene thanked all the participants and stressed that the stakeholders' engagement was a good opportunity to come together, deliberate and exchange ideas on the way forward. It also served as a good learning opportunity.

The meeting adjourned at 15:30.

**Otjiwarongo, Wednesday, 22 February 2017**

**Team members:**
Vaino Tauya (MOHSS/CDC Program Assistant)
Selma Amakali (MOHSS DSP Resource Mobilization and Development Coordinator
Naemi Shoopala (CDC Service Delivery)
Rachel Coomer (CDC Health Policy and Communications)
Rosalia Indongo (USAID TB/HIV Advisor)
Cherry Gumapas (USAID Health Office Deputy Director)

## 1. Summary

Twenty-five participants from the Kavango East and West, Zambezi, Otjozodjupa and Erongo regions attended the meeting.

## 2. Welcome, introductions and opening remarks

Dr Patrick Bualya, Regional Chief Medical Officer for Otjizondjupa region formally opened the meeting.[2] Dr Bualya encouraged the group to reflect on the achievements and challenges in the last year and to discuss ideas for what can be done in the coming year. He challenged the group to come up with ideas and plans that will address the negative impact of HIV. He noted the strong youth representation at the meeting and hoped this will help Namibia to work towards a brighter future.

## 3. Presentations

### 3.1 COP Overview

### 3.1 COP overview

Ms. Cherry Gumapas (USAID) presented an overview of the PEPAR Country Operational Planning process. She emphasized how stakeholder input will be incorporated into the planning process and why it is important.

### 3.2 Data review of the regions: 90-90-90

Ms. Naemi Shoopala (CDC) presented on progress made in 2016 and highlighted the importance of developing evidence based interventions and using data to guide implementation through strategic planning. She gave particular emphasis to data from the regions attending the consultation.

*Discussions*

- On the cycle of transmission between young women and older men – young men under 25 years are not listed as 'at risk' in the transmission cycle. They are also at risk because young women are also in relationships with young men.
- Concern that the DREAMS core package focuses on young women only – yet again the young men are left out.
    - Response: When we look at who is infecting young women, the data shows that the majority of people that are infecting them are older men. However it is important to recognize that young men should not be ignored. For example, VMMC is one of the

[2] Dr Bualya did not use a written speech.

interventions in DREAMS to address the needs of young men. Testing and access to ART are integrated into the VMMC services.

- Participants raised their concerns about testing data by district against targets reflected in percentages and not absolute numbers. How have some areas achieved over 100% on testing? Request to have the data presented in actual numbers not percentage of target achieved. The group felt that they were not informed about the targets set. To be addressed in the future, regions want to get their targets so that they know what they are working toward.

**4. Group breakout sessions**

The breakout session was introduced and the group process and instructions were explained. The participants were divided into three groups:

5. Prevention
6. Treatment
7. Care

Each group also included discussion about gender-based violence (GBV), monitoring and evaluation, the needs of children 10 – 14, the needs of adolescents and young women, human resource challenges and other cross cutting elements.

**Group 1. Prevention**

| AREA FOR DISCUSSION | CHALLENGES/GAPS | OPPORTUNITIES |
|---|---|---|
| PMCT | • Recording of data – nurses not doing adequate recording in register<br>• Lack of resources (e.g., cars) to follow up<br>• Delay in getting results - parent may be lost | • Train health extension workers to help with tracing |
| Ante-natal care (ANC) and post-natal care (PNC) | • Not all nurses are trained, not all facilities offer training<br>• Transportation of specimen means samples not taken every day and storage is a problem<br>• Distance to clinic<br>• Lack of capacity at clinic, mother does not action the referral | • Low coverage for PNC but vaccination uptake is good – combine<br>• Strengthen information to mothers –health information is the most important area |
| Family planning | • Some hospitals are faith-based and are not giving out family planning<br>• Lack of information in the community about how to use contraception | |
| Index partner testing | | • Roll out index partner testing country-wide |
| Integrated services | | • Have the services- create one stop centers |
| Adequate nutrition | • Need to identify and support | |
| HIV testing | • Problem linking key populations to health<br>• Need peer-support/civil society organizations to reach this population | • Train health extension workers to initiate more strategic door-to-door testing, including index partner testing |
| VMMC | • Low uptake – culture, tradition, need community engagement with community leaders to explain the benefits | |
| PrEP | • Healthcare sector feels that prophylaxis will be misused<br>• Public and health sector need information –still a new topic | Health workers need to be trained on the standard operating procedure |
| Children and adolescents | • Lack of friendly services<br>• Make friendly services<br>• Involve parents | |

*Discussion*

- Need for early infant circumcision as the cultural factors are going to be difficult to overcome
- Make index partner testing routinely done. Need to be actively looking for the partner. (Just telling the person being tested is not enough)
- Actively assist people to get to the clinics- implementation of assisted patient referrals

*PMTCT*

- Insufficient data to inform the program
    - Program is running but the register not working- register is not completed. Nurses say they do not know how to complete it. Lack of commitment? Poor understanding? The registers are complex. Not user-friendly. Lots of information has to be completed (weight, immunization….. – this information may not all be available). Without completed registers, follow up care not always done. In Oshikoto, it was working well, had support for follow up from UNICEF. In other places, they do not have the money for airtime to follow up patients. No money to conduct review meetings although these meetings helped. Currently, there are no funds to conduct support visits. Only meet patients once/twice a year. Some mothers do not have contact information. Completeness of the register is a problem and the register is not updated.
    - If a baby is HIV negative at six weeks, mothers do not want to come for subsequent tests. Have a strategy but don't have means to follow up. For example, nurses have to use their own cell phones to follow up. Don't have cars to go to patient's home.
    - Mothers are not given enough information during ANC and the need to be told more.
    - Mothers are too far from the clinics –they would love to come but it is too far. Lack of community linkage- need to utilize community health workers.
    - Early-infant diagnosis and mother-baby follow up are linked.
    - Stock management is a problem – cannot give medication (nevaripine)
    - Capacity for testing: Cannot do testing at all facilities, mother gives up if she has to travel too far. Need more community counsellors to do testing. There is a high staff turnover. Mothers are not being tested at 36 weeks despite guidelines.

Opportunities

- Capacitate health extension workers – need task shifting

*ANC*

- Not all facilities can provide option B+.
- Sometimes blood samples are only taken on certain days due to transport issues. Cannot take specimens on a regular basis. Sometimes offered on one day only. Due to staff shortage, sometimes nurses are not willing to offer full services. Also space challenges. Some facilities are missing six weeks testing.
- Not provided during outreach (mobile van for rural areas is not suitable for ANC)

Opportunities

- Well-established programs reaching mothers

- Mothers are coming for vaccinations, capture for post-natal care.

*Family planning*

- Infrequent stock-outs
- In Kavango, faith-based hospitals are not offering family planning (Catholic)
- Staff have not been trained for years. Need guidelines updated with refresher trainings.
- Lack of information given to community. Not enough done to distribute condoms in communities – lack of community linkage. Condom logistic officers were effective.
- Providing family planning Monday-Friday makes it hard to access. Needs to be provided every day in the community
- Adolescent friendly health services (AFHS) are not friendly. Don't want corners (leads to stigma). Want integration

Opportunities

- Regional Aids Coordination Committees (RACOCs), CSOs, individuals –should take on more responsibility for condom distribution. Involve health extension workers.

*HIV testing*

- Problem identifying MSM. Need to improve linkages between MSM/CSOs working in the area and the health sector
- Problem at regional level – MoHSS is not reaching children in schools in some regions. MoHSS and MoE need to work together in some areas. In Okahandja, a written request was submitted to the schools asking for opportunity to capacitate teachers.
- CSOs reaching some children.
- Index partner testing –still at pilot stage. Needs to be rolled out to all regions. Being implemented by CSOs not MoHSS. Want to have health extension workers trained.
- Need to have more HIV testing days

*VMMC*

- Uptake is very low. There is a need for ongoing sensitization.
- Staff shortage – have scaled down number of staff
- Importance to engage the boys, parents. Want to hear the benefits

*PrEP*

- How to introduce without it being misused?
- Gap: Information for staff and community
- Needs to be slowly introduced. Start with key populations and sero-discordant couples.

*Children, adolescents and young women*

- Staff attitude is not friendly enough
- Staff do not know how to deal with young people
- Get the adolescents to the services
- Involve the parents

Opportunities: Strengthen youth centers – Wi-Fi, movies, provide activities. It should not be run by MoHSS – work with organizations that can capture adolescents.

**Group 2. Treatment**

| AREA FOR DISCUSSION | CHALLENGES/GAPS | OPPORTUNITIES |
|---|---|---|
| Supply chain | • Do not have structures at community level to access medication.<br>• Have TB DOTs and community health workers but there is a breakdown at the end.<br>• No ART DOT points<br>• No ART health points<br>• Some pharmacies refuse to issue ARVs to clinics | • Health extension workers (increase scope of practice)<br>• Outreach services<br>• Outreach health points |
| Community-based ART | • Not enough treatment supporters/groups | • Health extension workers<br>• Many NGOs/CSOs |
| Integration of ART | • Isolated services/fragmented. If at a facility, they have to move from one room to another to get testing, treatment etc | • Services are available, can be integrated to make more user-friendly |
| Integration of pediatric treatment in NIMART sites | • Lack of policy to allow nurses to initiate highly-active ART therapy (HAART) in children<br>• Shortage of medical officers<br>• Inadequate number of mentors | • Mother and child will be present<br>• Nurses are trained in NIMART |
| Maximize retention | • Integrated services<br>• One stop treatment center<br>• Decentralization of integrated services<br>• Occupational nurses at HAART services and tailor-made nurses for services (offer services at times that meet the needs of the community)<br>• Inadequate nutrition | • Existing workplace nurses (farms, mines….) –work with them<br>• Integrate into other NGOs and Government programs e.g., if drought relief is being distributed, integrate |
| Integration of TB and HIV | • TB nurses need to be trained in NIMART<br>• Field officers need to be trained in ART | • These people are in place, need training |
| Needs of AGYW | • Long waiting time for children | • Have a no-waiting policy for children |

*Discussion*

- There are structures in place that can be improved/integrated
- Support for the integration of the private sector. They are not sufficiently involved. How can programs better strengthen the private sector involvement?
- Need to look at the supply chain to understand how we have stock outs.

- Can have staff to do follow up for patient defaulters but if original information is poor/insufficient then patients cannot be followed up. Need to sensitize some field workers on monitoring and evaluation tools that are available.
- Need mentorship on patient documentation – for example capture the person's unique name. The actual patient care booklet is sufficient but must be completed.
- The continued use of the old patients' booklet still circulating in the system contributes to care providers not capturing all the required client information.

**Group 3. Care and Support**

| CHALLENGES/GAPS | OPPORTUNITIES |
|---|---|
| Lack of documents among orphans and vulnerable children (OVC) | Conduct survey to assess needs.<br>Mobile outreach by Home Affairs |
| Misuse of grants by caretakers | Strict monitoring of at community level |
| Street children not registered as OVC | Register street children for grants |
| Lack of co-ordination of stakeholders | |
| Access to services | Strengthen community-based services |
| Lack of parenting skills on the care of PLHIV | Introduce parenting skills for caregivers |
| Lack of services targeting adolescents | Peer education for adolescents (expert patients) |
| AFHS | Special peer educators, school clubs, community services, health facilities, youth centers |
| Poor involvement of men in GBV support groups | Involvement of men in GBV programs and HIV programs |
| Women not free to carry condoms (stigma) | Educate on attitude change (build confidence) |
| | Expand economic strengthening programs<br>Empower women and men in income-generating projects |

*Discussions*

- Women should be empowered to carry condoms – including using female condoms
- There is a lot available that needs to be harmonized
- Need for service providers that can assist with multiple services
- There is a problem that people think that once circumcised you cannot be infected. Need more education
- Flavored condoms are more popular among young people
- People who are testing need to be trained in counselling

**5. Next steps for COP**

Cherry Gumapas summarized the next steps for COP development and for continued engagement between PEPFAR, MOHSS and stakeholders.

**6. Closing**

Dr Bualya thanked the participants for their contributions. He encouraged colleagues to look at the data that is specific for their region to assess what are the particular problems in their regions so that interventions can be targeted.

The meeting adjourned at 15:30.

**Annexes:**

A. Agendas
B. List of participants
C. Additional notes from break-out group discussions
D. COP Overview presentation (separate attachment)
E. Data review of the region: 90-90-90 presentation (separate attachment)
F. Ms. Haimene's speech (separate attachment)

## APPENDIX A: AGENDAS

**PEPFAR/NAMIBIA REGIONAL STAKEHOLDERS MEETING: Ongwediva**

Tuesday, February 21, 2017 from 10:00 to 15:30

VENUE: Hotel Destiney
Chairs: PEPFAR, CDC, USAID, Peace Corps, MoHSS

**9:30 – 10:15** **Arrivals/Registration/Coffee and Tea**

**10:15 – 10:30** **Welcome, Introductions**
Presenter: Ms. Johanna Haimene, Regional Director, MoHSS

**10:30 – 10:45** **COP overview**
Presenter: Tara O'Day (PEPFAR, USAID)

**10:45-11:15** **Data review of the region: 90-90-90**
Presenter: Naemi Shoopala (PEPFAR, CDC)

**11:15-12:30** **Group Break Out Session: FY16 Lessons Learned & Recommendations for the Development of 2017 Country Operational Plan**

Groups:
1. Prevention
2. Treatment
3. Care

**12:30-13:15** **Lunch Break**

**13:15-14:30** **Break Out Group Report Back**

*SUMMARY: Each group will have 15 minutes report back recommendations using a slide template provided. Plus 5 minutes discussion per group. 15 minutes extra allowed*

**14:30-14:45** **Next Steps in the Development of 2017 Country Operational Plan:**
Presenter: Tara O'Day (PEPFAR, USAID)

**14:45 –15:00** **Close Meeting**
Presenter: Ms. Johanna Haimene, Regional Director, MoHSS

**PEPFAR/NAMIBIA REGIONAL STAKEHOLDERS MEETING: Otjiwarongo**

Wednesday, February 22, 2017 from 10:00 to 15:30

VENUE: C'est Si Bon Hotel
Chairs: PEPFAR, CDC, USAID, Peace Corps, MoHSS

**9:30 – 10:15** **Arrivals/Registration/Coffee and Tea**

**10:15 – 10:30** **Welcome, Introductions**
Presenter: Dr. Patrick Bualya, Regional Chief Medical Officer, MoHSS

**10:30 – 10:45** **COP overview**
Presenter: Cherry Gumapas (PEPFAR, USAID)

**10:45-11:15** **Data review of the region: 90-90-90**
Presenter: Naemi Shoopala (PEPFAR, CDC)

**11:15-12:30** **Group Break Out Session: FY16 Lessons Learned & Recommendations for the Development of 2017 Country Operational Plan**

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1. Prevention
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**14:30-14:45** **Next Steps in the Development of 2017 Country Operational Plan:**
Presenter: Cherry Gumapas (PEPFAR, USAID)

**14:45 –15:00** **Close Meeting**
Presenter: Dr. Patrick Bualya, Regional Chief Medical Officer, MoHSS

## APPENDIX B: ATTENDANCE REGISTERS

| Attendance register; PEPFAR Namibia Regional Stakeholders' Consultative Meeting, February 21, 2017, Ongwediva | | |
|---|---|---|
| **Organization** | **Participant name** | **Email Address** |
| 1.Peace Corps | Yen Nguyen | Nguyen.yen017@gmail.com |
| 2. MOHSS | Vaino Tauya | vainot@nacop.net |
| 3.MOHSS | Karolina Shiyagaya | karolinashiyagaya@yahoo.co.uk |
| 4.MOHSS | Aina Karin Toivo | aktoivo@gmail.com |
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| 7. MOHSS | Dr. Trevor Dzenga | Dr.dzenga@gmail.com |
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| 9.Project Hope | Letho Shapaka | Lshapaka@projecthope.org |
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**APPENDIX C:**
**Additional notes from group discussions at the Ongwediva meeting**

**Treatment Break out Group discussions (Group 2)**

| Challenges | Opportunities/recommendation |
|---|---|
| **Supply Chain**<br>• Recurrent stock out of NVP syrup— Clinics are not informed on time regarding non-availability of ARVs --- communication barriers<br>• Pharmacy department refusing to issue ARVs to the Clinic - Omuthiya<br>• Oshakati multiregional store stock out issues –sometime the Oshakati multiregional store is out of stock but national level has stock yet regions has to wait for the multiregional store to order. Each region must order directly | • Improve updates to regional level on stock levels<br>• Electronic Pharmacy information system must be decentralized to region<br>• Oshakati medical store function needs to be decentralized |
| **Community ART services**<br>• Some patients miss the visit date and wait for the next visit to the community center; some patients still travel far to the CBART<br>• No person identified to keep medications for patients who miss to come on the scheduled date at community site.<br>• Transport to CBART site<br>• Patients go to the CBART sites without being registered, once they learn that there is service available<br>• How integrated are services at CBART sites? Dates are not coinciding? | • Transport need<br>• Cross train all nurses to be able to give ART and other services |
| **Integration of TB/HIV at Community level**<br>• Testing is not integrated in TB DOT points<br>• ART not available at DOT points | • Make DOT point as ART refill center- use field promoter for refill |
| **Workload**<br>• Not enough staff<br>• Can PEPFAR support HR in COP17?<br>• Can there be support for Transport? | • There seems to be no solution, restructuring is taking forever |
| **Integration of Peds. into NIMART sites**<br>• Staff not confident in initiating treatment for Peds, but can do follow-up<br>• Fears of small kids developing side effects<br>• Children treatment not straight forward | • Need more mentorship; aged staff in rural areas hard to trained<br>• Consider peds inclusion in CBARTs |

| | |
|---|---|
| • Frequent visit for peds is a challenge – affects also visit for guardian | |
| **TB/HIV integration**<br>• Staff in TB clinic not training<br>• Frequent staff rotation, staff trained goes in night duties | • Managers should consider staff skills before rotation to ensure good coverage<br>• Consider training agreement, so that those trained agree to implement upon completion |
| **Retention**<br>• mobile populations<br>• System ePMS and EDT not linked<br>• *Meditech* are linked -ART should learn from that; learn from *Natis* registration system | • Regular screening of the ePMS system to identify the lost to follow and track them early<br>• Improve communication between sites and report patients who are in-transit<br>• Establish support groups with income generating projects |
| **Adolescents**<br>• Staff have poor attitude when talking to adolescents- train Nurses to be more adolescent friendly;<br>• Adolescent has limited knowledge of their treatment | • Educate adolescents about their treatment; disclosure program; separate room for adolescents.<br>• Adolescent friendly services<br>o Separate area; tailored health education<br>o Nurses specialized in adolescents for the hospital--Onandjokwe |
| **There is need to advertise availability of services**<br>• PrEP<br>• Test and Start | |
| **Church influence and changing people mindset regarding treatment**<br>• People joining churches and told not to take their ARVS | |

**Prevention Group:**

*What could be done to make the ANC clinics friendly to men?*

- Male Champions—Oshana experience in using male champion: it has increased # of women starting ANC in the first trimester but did not increase number of partner tested

*What can we do to make the health facilities friendly to adolescent?*

- TV Screens with adolescence friendly messages
- Information corners for Adolescent in clinics
- Income generating projects for youth while engaging them in HIV messaging
- Workshop for guardians on taking care of adolescent who are living with

*Health Extension Workers*

- Training of HEWs is suspend due to funding, can PEPFAR supporting HEWs?

**Group discussion about care**

- DAPP uses a trio method – one HIV positive person is supported by 2 other people. Field officers visit regularly. The same people attend the support groups. This model could be expanded as DAPP continues to find positive people. Currently implemented in 7 regions.
- Problem – people are identified for treatment but do not stay on treatment. DAPP also tracks patients who are lost to follow up
- Need to identify **key populations** and link to existing groups. National guidelines do not give clarity on how to meet the needs of FSWs. Many FSWs also fall into target group of young women (15-19)
- **Young people** are shy, they need more awareness, need to know how to take care, how to prevent infection. Young people don't want to go to workshops, feel stigmatized if they attend so they need to be encouraged to test. There is a need for youth friendly services. AFHS are struggling, they need to be strengthened. Example given from RSA where AFHS are led by youth. MoHSS is currently not integrated with youth forums and they should work with the regional youth forums. Children don't have time to access AFHS – in school. Distance to clinic and attitude of health workers is also a problem. Home-based testing needs to capture youth in the afternoons when they are home from school. School health services do not include HIV testing – which needs to be included.
- Need **guidelines** on PreP
- Need to discuss how to **integrate services** at stakeholder meetings. Bring services to existing groups
- Problem – many children are not told they are HIV positive. We need to support the **caregivers** of OVCs. Testing needs to be targeted for example children who attend the clinic because they are sick, work with MGECW to identify OVCs - use a modification of the index format. Assist with grant registration
- Need to reach rural areas
- Make use of health extension workers
- Hunger is a problem. Expand school feeding to secondary school? Introduce school feeding into AFHS?
- Need to support families and encourage fathers to be part of families (maintenance and care)
- Information is not reaching communities