



Namibia
Operational Plan Report
FY 2010



Operating Unit Overview

OU Executive Summary

Overview

Namibia continues to experience a severe, generalized HIV epidemic with an estimated 195,000 HIV-infected adults and children. Namibia's HIV prevalence among pregnant women attending antenatal care was 18% in 2008. HIV transmission is largely through heterosexual contact and/or through mother-to-child transmission. Social, economic and cultural factors such as population migrations, disempowered women, alcohol, stigma, multiple concurrent partners, and lack of male circumcision help drive the epidemic. Key to note are the substantial disparities in characteristics of the epidemic and the response by geographic regions.

The Tuberculosis (TB) case rate of 665 cases per 100,000 in Namibia is one of the highest in the world (Ministry of Health and Social Services (MoHSS 2006), with HIV co-infection remaining at an estimated 59%, an increasing number of MDR cases and the emergence of some XDR cases. TB continues to be the leading cause of death for people with HIV/AIDS, even with the availability of antiretroviral therapy. Additionally, Namibia has the world's highest rate of unequal income distribution (Gini Coefficient of 74.3), high levels of poverty and food insecurity, a lack of economic opportunity and vast distances separating segments of the population.

A recent health sector review (MoHSS, Health and Social Services System Review, 2008) found that the Public sector has fewer than two health workers per 1,000 population, a level below the World Health Organization's benchmark of 2.5 workers per 1,000 population. Chronic staff shortages exist, especially in the MOHSS, where the overall job vacancy rate stands at 27 percent. There are marked human resource disparities between urban and rural settings. Only 24% of doctors and 39% of nurses practice in rural areas. This is significant considering that over 65% of Namibia's population resides in rural settings. In addition, the public sector loses up to 5% of its healthcare professionals to attrition each year. Reasons for the HR shortage are varied and include: 1) limited local training opportunities to pursue careers in health; 2) lack of incentives to practice in rural settings (there is no longer a 'deprivation package' for workers in rural settings); 3) lack of HR retention strategies and an implemented performance management system; 4) long recruitment processes for government positions; 5) staff burnout due to high disease burdens and workloads; and 6) limited career movements, particularly in the public sector.

As mentioned, high rates of tuberculosis (TB) and other communicable diseases, especially in the poorer northern regions, place additional strains on the nation's ability to finance the healthcare system. The situation is further aggravated by an unemployment level of over 35 percent and widespread poverty. In 2008, the Central Bureau for Statistics defined 27 percent of the country's population as "poor", and 13.8 percent as "severely poor."¹

Financing for healthcare is driven principally by the public sector (44% of total health expenditures (THE)), followed by donors (25% of THE), then households (23% of THE), and lastly companies (9% of THE).

- The **public sector** provides universal coverage and is predominantly financed through general taxation. With one national referral hospital, three intermediate hospitals, 30 district hospitals, 44 health centers, and 265 clinics, and church managed mission health facilities, the public sector is the lead provider of healthcare.

¹ Central Bureau of Statistics (2008). *A Review of Poverty and Inequality in Namibia*. National Planning Commission, Windhoek.

- The **not-for-profit sector** plays a significant role in health promotion and service delivery. Financed largely by external aid, NGOs are mostly involved in the delivery of community-based healthcare. With the exception of the HIV/AIDS program, NGOs are not typically involved in the MOHSS planning processes.
- The **for-profit sector** provides both comprehensive and partial coverage largely through insurance mechanisms funded by employee and employer contributions. In 2006, there were 844 private health facilities registered with the MOHSS. These include hospitals, primary care clinics, health centers, pharmacies, specialist practices, and offices of private practitioners. The majority of these services are provided in urban areas.

Based on the 2006-2007 Demographic and Health Survey, there are an estimated 250,000 orphans and vulnerable children (OVC) in Namibia, of whom 155,000 are orphans (one or both parents deceased). They represent nearly one third of all Namibia's children (under the age of 18). Approximately half of all orphans in Namibia were orphaned because of AIDS. UNAIDS estimated that approximately 16,000 children were living with HIV in 2008. Only 41% of OVC in Namibia have access to basic materials – defined as a pair of shoes, a blanket and two sets of clothes. In some regions, fewer than one in five has these basic materials. Projections indicate that in 10-15 years orphans will represent up to 50% of the economically active population of Namibia.

Summary of New Program Directions that Respond to the New Vision

COP 2010 represents an evolution in the vision and methods that underpin the planning, organization, and implementation of USG support for HIV/AIDS programs. This evolution will inform a shift in focus and resources within the PEPFAR initiative. As this shift occurs, PEPFAR will build on the sustainable foundation established in Namibia during the “emergency” response of its first five-year period (2004-2008). In coming years, starting with COP 2010, investments will be shifted to further strengthen Namibian capacity and ownership, especially in the areas of human resources, and the financing and operation of national healthcare systems. This evolution will be essential to sustain the important gains made to date. While Namibia's Partnership Framework (PF) will not be finalized until COP 2011, PEPFAR Namibia is moving towards transition now. Examples of activities described in COP 2010 that support the new vision for PEPFAR include:

- Government-to-government engagement and technical assistance (TA) to support GRN-led processes and activities (examples: day-to-day TA in multiple program areas, national costing exercises, jointly implemented PHE's, central TA support for PwP, alcohol interventions and evaluations, and a blood utilization quantification exercise, to name a few)
- Direct TA for jointly prepared Global Fund applications, National Strategic Framework, National Prevention Strategy, MC Policy, and Treatment guideline revision
- Increased support for long-term training of Health Care Workers
- University of Namibia (UNAM) MPH program strengthening for long term capacity-building in SI, Nutrition, and Public Health Leadership
- Support to Polytechnic of Namibia for Namibia's first lab technologist training program
- Pre-service and in-service clinical training for public and private providers through MOHSS training infrastructure, and UNAM
- Direct mentoring for capacity-building for operational research (Institutional Review Board training and support, formal public health evaluations, and data triangulation exercises)
- Direct TA and support for Prevention Strategy development, Prevention Technical Advisory Committee, and Prevention Coordinator
- Implementation and documentation of cost recovery models for sustainability at National Institute of Pathology (NIP) and Namibia Blood Transfusion Service (NAMBTS)



- Annual joint supportive supervision of HIV Programs led by GRN (not a parallel PEPFAR-only process)
- Continued support for GRN strategy to recruit, train and deploy necessary HCW and lay workers
- Continuing and intensified focus on task shifting (IMAI site expansion, community counselors, case managers, expert patients)
- Lab services fully integrated with national laboratory network (no parallel HIV/TB lab infrastructure)

The PF, which will support and strengthen the GRN's capacity to plan, oversee, manage and, eventually, finance the national HIV/AIDS response, will build on the substantial gains and strengths in Namibia. Currently, the GRN contributes a sizeable 48 percent of total HIV/AIDS expenditures. The PF will support a steady increase of GRN financial contributions to HIV/AIDS response over time. Additionally, while the USG is supporting approximately USD 3.7 million in ARV costs, roughly 10%. The GRN pays for about 35% of the total cost of ARVs, and plans to increase its share to 43% by 2010 and 55% by 2015. In the same period the Global Fund contribution will decrease from 42% in 2010 to 38% in 2015.

To this end, the GRN is currently exploring ways to decrease costs related to ARV and plans to: (1) assess the country's first ever HIV/AIDS subaccount in October 2009, (2) cost the upcoming National Strategic Framework, (3) develop a healthcare financing strategy, and (4) develop a resource mobilization and sustainability plan.

In COP2010, the USG will review both the PEPFAR-funded portfolio for readiness to transition and a financial strategy assessment to help inform the best way forward in supporting the GRN's increased contributions.

Program Areas

Prevention:

Prevention activities outlined in COP 10 have been developed in close consultation with the GRN through the development of the PF. Core to the prevention strategy is a focus on the known epidemic drivers, scaling up prevention interventions, addressing the drivers with evidence-based interventions, and intensifying work with vulnerable and most at risk populations. In recognizing our need to prevent new infections, the national strategy and the PF focus on a combination of behavioral, biomedical, and structural interventions. In COP10 Namibia will continue to enhance and expand multi-level and multi-channel prevention programs. Prevention is Namibia's top priority in the new National Strategic Framework (NSF). In support of Namibia's national plan and the new vision of PEPFAR, COP activities for prevention will focus on:

- Provision of technical assistance to the GRN to finalize its Prevention Strategy and to implement programs that are evidence-based and focused on the drivers, with outreach to include most at risk and vulnerable populations
- Continued direct government-to-government technical and financial support to design, implement, and evaluate high-quality prevention interventions that are fully integrated with GRN systems. The USG is collaborating with MOHSS, the Ministry of Information and Communication Technology's (MICT) Take Control program, and MOE's school-based programs to strengthen implementation and coordination.
- Support for planning and transitioning increased responsibility to the GRN
- Support for long-term capacity development, including training and support for task shifting efforts
- Support for combination prevention activities that address individual behavior change, underlying structural factors and biomedical interventions.



- Support for collaboration, coordination and capacity building with the GRN, local civil society and private sector partners

PEPFAR resources will have supported expanded PMTCT services to all clinics, reaching approximately 42,300 women and providing 10,835 HIV-positive pregnant women with a full course of anti-retroviral drug (ARV) prophylaxis, by FY 2010. In the coming year, the USG will further align its activities with the MOHSS through completion and implementation of the PF and Partnership Framework Implementation Plan (PFIP). The PF, aligned closely with the NSF, identifies PMTCT as a key objective in the prevention of HIV/AIDS. The PF aims to transition programs to the GRN and shift USG focus to TA and capacity building. While the Government of Namibia's ability to assume financial support for several cadres of worker who are currently supported fully by the USG represents a significant challenge, the PF has identified the following areas of focus for the USG strategy:

- Provide GRN with TA for costing of PMTCT programs
- Provide TA for operational research to improve PMTCT program efficiency
- Support recruitment of nurses who will support both PMTCT and ART provision to strengthen follow-up and care for HIV-infected mothers and their HIV-exposed babies. Ultimately, these nurses will be absorbed in the newly restructured Health Systems Review
- Support for the implementation of a roadmap to accelerate the reduction of maternal and neonatal morbidity and mortality

Treatment, Care, and Support:

Consistent with the Partnership Framework, the USG will continue to leverage its resources for care and treatment services with those of the GFATM, MOHSS, the Clinton Foundation and other development partners. All partners will continue to strengthen linkages between non-ART care, CT, and referral services.

In support of the PF the MoHSS will gradually absorb staff required to maintain service delivery, while the USG will commit to handing off direct services over time and instead providing technical assistance (TA) to define an appropriate and comprehensive model for pre-ART and a minimum service package. In 2010 PEPFAR activities will emphasize: support for training, support for a portion of bio-clinical monitoring costs for pre-ART and ART clients, the provision of TA to pilot a Food by Prescription program, strengthening of bi-directional referrals between facility and community-based services, and integration of palliative care into home-based care services.

The USG will support clinical care for PLHIV to include pain and symptoms management, and continued support of the Namibian Integrated Management of Adolescent and Adult Illnesses (IMAI) palliative care toolkit, as well as the integration of palliative care into the UNAM School of Nursing curriculum.

The USG will continue to support a high-quality improvement program in health facilities, managed and supported by the MOHSS. In COP10, training and mentorship activities will strengthen HCW capacity to use performance data to improve the quality of care.

TB activities will focus on the integration of HIV/TB services by increasing HIV testing of TB patients and TB testing of ART patients, and by improving bi-directional linkages to HIV/TB care and treatment. Other TB/HIV activities will help improve timely detection and treatment of TB by strengthening linkages between laboratories and health facilities, and by increasing DOTS service points to improve adherence to TB treatment.

In COP10, PITC services will be expanded throughout the MOHSS network from the limited settings where they are currently offered, with support from PEPFAR. The USG will provide technical support to MoHSS for the piloting of different PITC implementation strategies and the phased roll out of successful



strategies. PITC for children will receive greater emphasis in COP10.

Based on the overwhelming success of previous national testing days in Namibia, PEPFAR will support the addition of semi-annual testing events, including an event linked to World AIDS Day, and themed events targeting youth and men.

Lastly, based on the portfolio review recommendations, the GRN, with support from the USG, will complete work on a national HCT strategy and vision, which will be aligned with the NSF and PFIP commitments with an emphasis on cost efficiency. The role of low volume, high cost stand-alone CT facilities will be reviewed and some sites could be considered for closure where other mobile HCT services are available.

With approximately 250,000 OVC in Namibia, PEPFAR will continue to support the GRN's and civil society's implementation of the OVC National Plan of Action (NPA) 2006-2010, and development of a follow-on plan of action. Under the PF, the USG has committed to supporting OVC programming with technical assistance and sustainable service delivery.

The USG will continue to build the planning, monitoring and human resource capacity of the Ministry of Gender Equality and Child Welfare (MGECW) as the focal ministry for OVC, and will support improved coordination mechanisms between ministerial and civil society stakeholders. USG support will also emphasize strengthening CBOs and Namibian NGOs to deliver services to children and their caregivers in all seven service areas prioritized by PEPFAR.

In COP 10, the USG will continue its ongoing efforts to forge Public Private Partnerships (PPPs) with Olthaver & List and Coca Cola/Namibia Beverages to support job creation for vulnerable youth, while also linking USG-funded education, microenterprise and life skills programs for OVC to jobs based on market needs and demand in Namibia.

Health System Strengthening:

Health Systems Strengthening, including Human Resources for Health, will play an increasingly important role in PEPFAR as Namibia begins the transition to a government-owned and led process. Namibia's total investment in healthcare is significant, averaging US\$276 per capita (including public, private and donor spending), accounting for approximately 8.3 percent of the country's GDP (National Health Accounts, 2005-2006). The MOHSS Health Systems Review in 2008 identified two areas of structural weakness within the GRN (public sector) healthcare system: Unequal access to health facilities and human resources. Addressing these weaknesses will be priorities for the GRN with support through the PFIP.

The PF development process in COP10 will include an assessment of the PEPFAR portfolio to inform strategies for transitioning USG-funded programs to the GRN. Emphasis will be on:

- Programs funded by the USG, but implemented by local NGOs, the national private sector or the GRN.
- USG-funded programs implemented by external (not-for-profit and/or for-profit) partners

Given the GRN and USG shared commitment to evidence-based programs, and recognizing the constraints of the current global financial environment, the assessment described above will identify a range of options, including, but not limited to:

- Projects which could be immediately transitioned to and absorbed by the GRN;
- Projects which could benefit from a phased transition or streamlining to achieve greater cost efficiencies;



- Projects which would be best suited to continue under the leadership of local NGOs or the Namibian private sector, with technical and/or financial assistance from either the USG or GRN; and,
- Projects which could be terminated without sacrificing patient care or critical prevention services.

In addition, a financial assessment will be conducted in COP10, utilizing TA, to more closely understand Namibia's current financial situation and identify strategies to support the GRN's capacity to assume an increasing percentage of financial contributions over time, as USG and other donor contributions decrease.

In COP 10 specific activities that support HSS and HRH include: investing in a variety of *pre-service* training programs for numerous health worker cadres, including nurses, public health specialists, public health managers, pharmacists, and medical technologists; strengthening the use of HRH data for policy and management decisions and linking the HRIS with existing systems such as the private sector NAMA system, the TB registry, I-Tech's in-service training database, health professionals council system, and public sector systems such as the Ministry of Finance and the Office of the Prime Minister; and, transition from short term HR strategies (such as rapid staffing utilizing outsourced human resources) to long-term sustainable plans.

Other Costs:

The USG will continue to support the MOHSS in its monitoring and evaluation of the national HIV/AIDS response through technical assistance and material support. In COP10, the USG and MOHSS are planning a population-based AIDS Indicator Survey (AIS) for the collection of behavioral and sero-status data. The USG Strategic Information (SI) team will continue working with the MOHSS, UNAIDS and the Global Fund, to further develop the M&E plans for the PF and to build on substantial gains made thus far in harmonizing indicators in support of the Three Ones.

Programs addressing cross-cutting issues in the government and civil society will continue to emphasize gender, human rights, and reduced stigma and discrimination.

Scholarships for Namibian students will be sustained at a high level in the continuing effort to alleviate Namibia's severe human resource shortages in medical and allied health professions. The integration of HIV/AIDS programs into existing pre-service training programs for health care workers and continued use and expansion of digital video conferencing (DVC) that reduces costs of expanding training for new and existing health care providers.

Government and business partners will expand workplace HIV/AIDS programs, while national and local HIV/AIDS umbrella organizations representing both public and private sectors will be strengthened in order to expand their reach and effectiveness in reaching PLWHA, fighting stigma and bringing HIV/AIDS issues to a national constituency.

Administrative costs will support an increased focus on the provision of TA to the GRN to plan, oversee, manage and, eventually, finance the national HIV/AIDS response.

Other Donors, Global Fund Activities, Coordination Mechanisms

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is the second largest donor to Namibia (behind the USG) in the fight against HIV/AIDS, and Namibia is currently utilizing a round two, phase two grant of \$47 million while awaiting a decision on the Rolling Continuation Channel (RCC) application submitted this year, expected in November 2009. Other development partners include the European Union, the GTZ, and the UN Joint Team. GFATM funding supports ART and care services, OVC programs, workplace HIV programs, support for community-based care, TB control, CT, PMTCT-



Plus and community outreach services. The USG co-chairs the HIV/AIDS Partnership Forum, which provides an HIV/AIDS partner coordination mechanism among development partners and the GRN, and is a member of the Global Fund's Country Coordinating Mechanism, and its sub-committee on Budget, Finance and Audit.

The USG also sits on the National AIDS Executive Committee (NAEC), chaired by the Deputy Permanent Secretary of MOHSS, which coordinates implementation of HIV/AIDS activities throughout Namibia. The National Multi-Sector AIDS Coordinating Committee (NAMACOC), supported by the National AIDS Coordination Program (NACOP) as Secretariat, is responsible for multi-sector leadership and coordination. Membership of the committee consists of the Permanent Secretaries of all government ministries, major development partners, NGOs, FBOs, trade unions and private sector organizations. The USG team will continue to work with the Namibian government and other development partners to maximize resources, ensure coordination of HIV policies and programs, reduce redundancies and promote sustainability of programs.

Program Contacts: Ambassador Denise Mathieu, DCM Matthew Harrington, and Emergency Plan Coordinator Dennis Weeks

Time Frame: FY 2011 - FY 2012

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV						
Adults 15-49 HIV Prevalence Rate						
Children 0-14 living with HIV						
Deaths due to HIV/AIDS						
Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of pregnant women in the last 12 months						
Estimated number of pregnant women						

living with HIV needing ART for PMTCT						
Number of people living with HIV/AIDS						
Orphans 0-17 due to HIV/AIDS						
The estimated number of adults and children with advanced HIV infection (in need of ART)						
Women 15+ living with HIV						

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

Redacted

Public-Private Partnership(s)

Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
Media Cost Share	13448:Prevention Alliance Namibia	TBD, Namibian Broadcasting Corporation			Cost share for health communication
PPP for Health	14306:Health	New Partner,			COP 12 will be year

Systems	Systems Strengthening (TBD)	Containers to Clinics, Global Alliance for Improved Nutrition			two of a three year partnership that will leverage at least \$1,387,509 in total from the private sector. This PPP GDA aims to strengthen the Namibian public health system and its capacities for achieving its maternal and child health and nutrition targets.
Sponsorship of helpline	12721:Strengthening HIV/AIDS Responses in Prevention and Protection (SHARPP)	MTC Namibia, Leo, Telecom Namibia			Provide calls to the Child Helpline, which we operate free of charge to all their customers.
Support for vocational training	13120:Self-Development and Skills for Vulnerable Youth	ELMA Foundation, Namibia Training Authority (NTA)			"The ELMA Foundation supports Economic Opportunities for Youth (EOY). For KAYEC, ELMA are interested in vocational training and jobs for youth graduates. NTA is a Namibian state-owned entity that funds KAYEC for the delivery of

					vocational training services. "
Training providers to delivery HIV services	10386:The Capacity Project	Oshakati Pharmacy, Sanofi Aventis, RanBx			Support to HIV clinicians society to train and build capacity of private and public providers to provide quality services to PLWHA. Includes training, annual conference, meetings, speakers, and updates.

Surveillance and Survey Activities

Name	Type of Activity	Target Population	Stage
Alcohol counseling intervention outcomes	Evaluation	General Population	Implementation
Alcohol use estimation	Population-based Behavioral Surveys	General Population	Publishing
AND and PMTCT data comparison	Evaluation of ANC and PMTCT transition	Pregnant Women	Planning
ART outcomes	Evaluation	General Population	Planning
Behavioral surveillance survey	Population-based Behavioral Surveys	Female Commercial Sex Workers, Male Commercial Sex Workers, Men who have Sex with Men	Implementation
HIV drug resistance monitoring	HIV Drug Resistance	General Population	Planning
HIV prevalence survey among military	Surveillance and	Uniformed Service	Other



personnel	Surveys in Military Populations	Members	
Improving Clinical Outcomes through Patient Education - NA.09.0251	Evaluation	General Population	Implementation
Multi Country PHE: Development, Implementation, and Evaluation of a Comprehensive Prevention Intervention for HIV Care and Treatment Settings - NA.07.0199	Evaluation	General Population	Data Review
PHE: Changing Gender Norms that Support HIV Risk Behaviors among Young Men in Namibia - NA.07.0214	Evaluation	General Population	Publishing
PHE: Compliance to Guidelines and Evaluations of Medicines Prescriptions - NA.08.0097	Other	Other	Development
PHE: Evaluation of the Impact of Adherence Interventions - NA.08.0098	Evaluation	Other	Data Review
PHE: Understanding and Reducing Sexual vulnerability of Adolescent OVC - NA.09.0222	Other	Other	Other
Population size estimation	Population size estimates	Female Commercial Sex Workers, Male Commercial Sex Workers, Men who have Sex with Men	Development
Venue-based risk estimation	Population-based Behavioral Surveys	General Population	Implementation



Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHCS (State)	GAP	GHCS (State)	GHCS (USAID)	
DOD			2,652,150		2,652,150
HHS/CDC		1,500,000	42,920,752		44,420,752
HHS/HRSA			5,290,610		5,290,610
PC			1,992,400		1,992,400
State			540,772		540,772
State/AF			25,000		25,000
USAID	300,000		43,112,497		43,412,497
Total	300,000	1,500,000	96,534,181	0	98,334,181

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency								Total
	State	DOD	HHS/CDC	HHS/HRSA	PC	State/AF	USAID	AllOther	
CIRC		150,000	743,772	200,000			794,026		1,887,798
HBHC		162,000	1,877,822	574,792	10,000		3,806,770		6,431,384
HKID					10,000	25,000	8,086,902		8,121,902
HLAB		225,000	1,461,975						1,686,975
HMBL			1,000,000						1,000,000
HMIN							900,000		900,000
HTXD			1,879,596						1,879,596
HTXS		450,000	10,724,680	1,414,550			3,174,492		15,763,722
HVAB		262,150	4,160,430		10,000		3,784,222		8,216,802
HVCT		450,000	3,282,042	380,924			3,062,415		7,175,381
HVMS	540,772	305,000	3,693,926		1,942,400		7,682,112		14,164,210
HVOP		300,000	1,645,751	200,000	20,000		3,320,797		5,486,548



HVSI		128,000	3,006,350	725,000			785,770		4,645,120
HVTB		80,000	1,651,003	287,500			1,229,980		3,248,483
MTCT			1,898,583	359,240			2,078,455		4,336,278
OHSS		140,000	3,761,388	597,985			3,347,110		7,846,483
PDCS			1,795,741	224,597			663,620		2,683,958
PDTX			1,837,693	326,022			695,826		2,859,541
	540,772	2,652,150	44,420,752	5,290,610	1,992,400	25,000	43,412,497	0	98,334,181

Budgetary Requirements Worksheet

(No data provided.)



National Level Indicators

National Level Indicators and Targets

Redacted



Policy Tracking Table

(No data provided.)

Technical Areas

Technical Area Summary

Technical Area: Adult Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	6,431,384	
HTXS	15,763,722	
Total Technical Area Planned Funding:	22,195,106	0

Summary:

Context and Background

Provision of an adult care, treatment and support program is one of the major objectives of the Partnership Framework (PF) between the USG Namibia and the Government of the Republic of Namibia (GRN) which is closely aligned to the National Strategic Framework (NSF). These objectives include a range of pre-ART, ART, and community and home based care services. The PF builds on the strong accomplishments by the GRN's efforts to plan, oversee, manage and, eventually, finance the national HIV/AIDS response. The GRN, supported by the PF, will work to continue to take on increasing responsibility for the Care and Treatment portfolio. USG commitments through the PF will support this transition and focus, in part, on:

- TA for the implementation of PEPFAR-supported Human Resource transition to GRN
- TA to strengthen the existing procurement and logistics systems
- GRN with continued TA for costing of Treatment Programs
- TA to Develop guidelines for mainstreaming nutrition into the HBC package
- TA to support an enabling environment for palliative care implementation
- Conduct a Public Health Evaluation on HBC provision in Namibia

Approximately 195,000 Namibians are living with HIV. The UNAIDS Spectrum Model estimates (2009) 65,000 adults will need treatment. More than 80% of these patients will be managed within the public healthcare sector. To date, ART coverage in Namibia is approaching the universal access target of 85%. The male-to-female ratio of those in care and treatment is 1:2, highlighting gender disparities in accessing HIV/AIDS services. Adult ART in Namibia started in 2003 at major hospitals and was rolled-out rapidly to all 35 district hospitals by 2005. By FY09, ART services were offered in 141 sites, including clinics staffed by physicians, as well as Integrated Management of Adult and Adolescent Illnesses (IMAI) facilities staffed by nurses trained in ART, and through outreach visits by ART teams from main sites.

Namibia revised its ART Guidelines in 2007, and will revise them again in light of the proposed WHO Guidelines revision due in October 2009. The Technical Advisory Committee (TAC) that advises MOHSS on HIV/AIDS recommended lowering the threshold for initiating ART to CD4 counts <350. It is also considering including tenofovir (TDF) in the preferred first line HAART regimen. Final decisions will be aligned with the WHO guidance and an on-going costing exercise.

The key elements of the care and support program in Namibia are:

- Early identification of HIV-infected persons; referral to and retention in care
- Reduction of HIV-related morbidity and mortality (e.g., TB, malaria, nutrition)



- Improved quality of life through pain management and psycho-social support
- Reduction in the transmission of HIV from HIV-infected persons to the uninfected.

Namibia's ART program uses a public health approach that includes simplified clinical decision making, standardized ART regimens, task-shifting to IMAI trained nurses, and use of lay community counselors for treatment and adherence counseling, as well as centralized monitoring and evaluation. Bio-clinical monitoring is provided through the Namibia Institute of Pathology (NIP), a parastatal which operates on a fee-for-service basis. First-line treatment failure is detected using clinical, immunological and virological suppression to VL<1000c/ml 6 months after initiating treatment. In addition, Namibia has instituted HIV-drug resistance surveillance using PEPFAR-approved methodologies, including the WHO HIV drug resistance surveillance strategies for both transmitted and acquired drug resistance. Lab services costs are supported through PEPFAR, the Global Fund and the MOHSS. MOHSS staff, in conjunction with all treatment partners, conducts annual supportive supervision visits to treatment sites to monitor scale-up of treatment services and identify programmatic successes and challenges. An important PEPFAR supported strategy to build competencies and expertise of clinicians in HIV/AIDS care and treatment has been the deployment of clinical mentors. These experienced clinicians provide hands-on mentoring to clinical staff thus empowering them with the skills needed for successful program scale-up. Additionally, Digital Video Conferencing (DVC) is utilized to quickly disseminate revisions to national care and treatment guidelines, and to address critical clinical questions and challenges experienced by staff in distant sites in Namibia.

However, there are challenges relating to the decentralization of services (to expand access to clinical and laboratory services) and task shifting to address chronic shortages of trained healthcare workers.

The package of care currently provided at ART facilities includes voluntary counselling and testing, registration in pre-ART, screening for TB and other opportunistic infections (OIs), bio-clinical monitoring and follow up (including ART initiation), isoniazid preventive therapy (IPT) and cotrimoxizole preventive therapy (CPT), nutritional assessment and referral for psychosocial and other support services, as needed. This package will be standardized using relevant best practices identified in Namibia and elsewhere.

Community home-based care, palliative care, and social and legal supports are largely addressed by a wide variety of civil society organizations (CSOs), faith based organizations (FBOs) and NGOs, most of whom receive USG and GF support. There is a need for better integration of these community services with the MOHSS network, and improved collaboration (including bi-directional referrals) between community-based partners and the MOHSS. The GRN is in the process of establishing a cadre of health extension workers who would be critical to strengthening linkages and absorbing the responsibilities of the current USG-supported community counsellors and community based health care workers. Building these relationships will improve access to a comprehensive continuum of care services (including TB/HIV screening and treatment) and strengthen geographical and target group coverage.

Accomplishments since last COP

By the end of June 2009, a total of 73,674 adult and pediatric patients were receiving ART in the public sector. Approximately 88% were adults and 12% were children. This represents an estimated 72% coverage of adults and almost 100 % of children in need of treatment, according to UNAIDS Spectrum Model estimates (June 2009). The number and coverage of pre-ART and ART clients receiving CPT and IPT has been gradually increasing as more training and mentoring are conducted collaboratively by USG and MOHSS teams.

USG supported a national Adult Treatment and Care Portfolio Review in collaboration with the MOHSS. Specific findings, reflected in COP10, include:

- Emphasize community linkages
- Increase food security for ART clients
- Pursue long-term human resources solutions



- Integrate and improve health information systems
- Increase decentralization and task shifting using the IMAI model
- Expand quality improvement and increase training

Other accomplishments in COP09 include:

- Renovation of at least six public ART clinics.
- In-service training of 1551 HCW in adult care, treatment and support
- 728 PEPFAR supported clinical and support staff transitioned to MOHSS contracts in response to new Labour Law (see MOHSS HTXS, HBHC, PDCS, PDTX, and HVTB budget code narratives)
- Laboratory services expanded in sub-national facilities and increased efficiency of laboratory services (e.g., turnaround time for results)
- ePMS information system updated to enhance patient management and performance monitoring
- ART costing project continued
- Operational guidelines for Food by Prescription Program piloted in eight ART sites
- Integration of nutrition assessment education and counseling (NAEC) into ART sites
- Strengthening of palliative care within home-based and facility-based care
- Strengthening of linkages between home-based care organizations and facilities through memoranda of understanding (MOU)

The USG also supported the development and implementation of adherence interventions in which treatment literacy materials were piloted in six ART sites, and an adherence monitoring module for WHO HIV Drug Resistance Early Warning Indicators that was included in the electronic dispensing tool.

Goals and Strategies

Consistent with the Partnership Framework, the USG program will continue to leverage its resources for care and treatment services with those of the MOHSS, GFATM, the Clinton Foundation and other development partners.

As part of the Partnership Framework (PF), the MoHSS will gradually absorb staff required to maintain service delivery, while the USG will commit to handing off direct services over time and instead focus on providing technical assistance (TA) to define an appropriate and comprehensive model for pre-ART and a minimum service package. Support for training, supportive supervision and clinical monitoring for quality HIV treatment and care services will continue in COP10. PEPFAR will continue to support a portion of bio-clinical monitoring costs for pre-ART and ART clients (see also, HLAB), and a portion of basic equipment and supplies for the provision of quality services.

There is a critical human resources gap in Namibia. The lack of pre-service training institutions in Namibia contributes to a chronic shortage of health professionals. As described in the PFIP, in the short term PEPFAR will continue to fund MOHSS staff to provide HIV services. Concurrently, the USG will support MOHSS strategies and plans that absorb a greater number of positions. The GRN will continue to emphasize the development and implementation of broad-based task shifting and decentralization strategies. USG will provide technical assistance to boost pre-service training programs in pharmacy, medical laboratory and public health in Namibia for undergraduate and graduate students. The GRN recognizes that investing in health facility infrastructure will increasingly become its responsibility. Nevertheless, the USG will continue to play a role in supporting infrastructure renovations to improve the quality of services and infection control in facilities offering care and treatment services. In COP10, PEPFAR will support the renovation of one ART site.

USG will provide TA to pilot a Food by Prescription program for eligible PLHIV clients at eight ART facilities. Health care providers at these facilities will be trained on appropriate Nutrition assessment, education and counseling. PEPFAR will work with MOHSS to strengthen bi-directional referrals between facility and community-based services, and to integrate palliative care into home-based care services. Special focus will be given to finalize the Home-Based Care Standards, guidelines, training curriculum, and tools for community based health care providers caring for pre-ART, ART and bedridden clients as well as HIV positive children.



The Case Management Program initiated in COP08 will be continued to enhance facility-based care and support and strengthen linkages between facility- and community-based services (See HTXS, HBHC, PDCS, PDTX, and HVTB budget code narratives). Case managers will work closely with “expert patients” and community counselors to assist PLHIV and their families. Case manager duties include:

- Counseling patients on adherence, Positive Prevention, and disclosure/partner referral
- Tracing treatment defaulters
- Facilitating PLHIV support groups
- Referring patients to other services (e.g., drug/alcohol abuse, mental health, domestic violence, income-generating programs)
- Encouraging men to seek services and support their partners and children.

USG will support clinical care for PLHIV to include pain and symptoms management, and will also continue supporting the Namibian Integrated Management of Adolescent and Adults Illnesses (IMAI) palliative care toolkit, as well as the integration of palliative care into the UNAM School of Nursing curriculum. A team of HCW and program managers will be identified for palliative care training, with the goal of improving service delivery and enhancing policy development. The USG will facilitate creation of a National Task Force for Palliative Care. End-of-life care, including hospice care, will be reinforced in HCW training.

The USG will continue to support a quality improvement program in health facilities managed and supported by the MOHSS. Training and mentorship activities will strengthen HCW capacity to use performance data to improve the quality of care. A pilot program for consumer advisory boards at two public hospitals will be launched. This exciting new initiative will train PLHIV in quality management techniques and management skills necessary to organize and implement the advisory boards.

Namibia is one of three countries participating in two centrally-funded initiatives targeting PLHIV. One project will be implemented in care and treatment settings; the other will be community-based. Positive Prevention will be integrated into work with PLHIV support groups, community home-based care organizations, and post-test clubs at stand-alone VCT sites.

PLHIV involvement in treatment, care and adherence support programs will be further enhanced through support for PLHIV to, address community forums, work as community counselors, and participate in a network of PLHIV that advocates for improvements in community- and facility-based care. With USG support, clergy from faith based facilities will support the spiritual component of basic care for PLHIV and their caregivers.

USG will continue to actively participate in the MOHSS Care and Treatment TAC, particularly in the review of treatment guidelines in line with international standards.

USG will provide TA to CSOs in organizational management. This is aimed to improve their capacity to manage and expand home-based care services to include 1) early identification of HIV status; 2) referral to care and treatment; 3) adherence support for ART and CPT; 4) nutritional assessments and referrals; 5) support for safe water, sanitation and hygiene; 6) malaria prevention; and 7) integrated family planning services.

Cost modeling for Care and Treatment Programs scale up

The adoption of cost efficient processes in treatment and care programs will take on increasing priority in COP10. USG will work with the MOHSS to finalize a comprehensive costing exercise related to the NSF. While Namibia plans for increased GRN financing of the HIV/AIDS response, detailed cost information and contributions for all program areas, including care and treatment, will be identified through this exercise. Specific attention will be paid to the potential impacts on costs if Namibia broadens eligibility criteria for ART. Changes to first-line drug regimens will also influence cost estimates in COP10 and beyond.



Technical Area: ARV Drugs

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	1,879,596	
Total Technical Area Planned Funding:	1,879,596	0

Summary:

Context and background

Since inception of the PEPFAR program in Namibia, the Ministry of Health and Social Services (MOHSS) has been using its Central Medical Stores (CMS) for procurement of ARV in the public sector. This procurement is done either by tender or by emergency buy-out. The buy-out method, through local or international vendors, is used when there is insufficient time to complete a tender process, particularly if stocks are unexpectedly low. Data have demonstrated that the buy-out method has increased the total cost to purchase various medicines and commodities compared to better planned forecasting and regularly scheduled procurements.

The successful, rapid roll out of antiretroviral treatment in Namibia has partly been made possible by an uninterrupted supply of antiretrovirals (ARV) using a procurement system that has increasingly been strengthened since the inception of PEPFAR. Since 2003, enrollment in the ART program has steadily increased. As of March 2009, 64,000 adult and pediatric patients were receiving treatment in 141 sites, up from 101 sites in September 2008. Approximately 88% were adults and 12% children. This total represents an estimated 80% coverage of adults in need of treatment and almost 100% coverage of children in need of treatment, according to estimates derived from the UNAIDS Spectrum Model (June 2009). To date no stock-outs have been reported in any of the 141 sites.

As part of its strategic plan to sustainability and in line with the Partnership Framework (PF) now under development, the Government of the Republic of Namibia (GRN) has committed to funding the procurement of ARV medicines for all clients receiving ARV in the public sector. This cost absorption is scheduled to be done gradually. The estimates in 2010 of contribution to the ARV procurement envelope indicate that the MOHSS pays 47% while USG and Global Fund (GF) contribute with approximately 16% and 37% respectively (Section 4.6 Global Fund-RCC Proposal). GRN plans to increase to their contribution to 55% in 2015.

In addition to ARV procurement, the USG is supporting the CMS in strengthening their system through human resource support and infrastructure upgrading to cope with increasing need of storage for HIV/AIDS commodities. (See also OHSS TAN).

Accomplishments since the last COP

In order to ensure a sustainable supply of ARV drugs, a joint procurement plan was developed in 2007, led by the MOHSS and implemented by all involved partners. This plan consolidated ARV procurement through the CMS with each stakeholder contributing to the ARV envelope.

During FY09, CMS has successfully ensured routine distribution of ARV drugs to District Hospitals. With support from USG, the CMS and regional medical stores (RMS) have received technical assistance on quantification, forecasting, inventory control and warehouse management, as well as upgrades to the information systems used to manage distribution logistics. As a result of the joint procurement plan and technical assistance, costs have been stabilized and no stock outs have been reported in FY09.



In line with the PF, the MOHSS commitment to absorbing costs of ARVs previously paid through the Global Fund and USG will increase country ownership of the ART program.

The USG will support the GRN's continued efforts to plan, oversee, manage and, eventually, finance the national HIV/AIDS response with commitments outlined in the PF including TA to strengthen the existing procurement and logistics systems, and continued TA for costing of Treatment Programs.

During FY09, USG Namibia received a team from OGAC who performed a treatment and care portfolio review. Recommendations were made regarding improving the program performance as well as improving the ARV procurement systems.

Goals and strategies for the coming year

The USG announces its budget for ARV annually and this budget will continue to leverage the resources of the MOHSS, the Global Fund and the Clinton Foundation. The latter continues its focused support to pediatric and second line treatment commodities. The USG ARV budget will decline annually beyond 2011. In COP10, the MOHSS will receive approximately \$1.2 million from the USG for ARV drug procurement for FDA-approved products through the CMS.

Currently, the government pays for about 37.6% of the total cost of ARVs and this will increase to 47% by 2010 and 55% by 2015 as per the current commitment. In the same period Global Fund contribution will remain at approximately 37% to 2015.

Namibia has standardized first and second-line regimens. Currently, 71% of adults on first-line regimens are currently on stavudine/lamivudine/nevirapine (d4T/3TC/NVP) or zidovudine/lamivudine/nevirapine (AZT/3TC/NVP); 21% are on stavudine/lamivudine/efavirenz (d4T/3TC/EFV) or AZT/3TC/EFV; and; 8% are on a tenofovir (TDF) containing regimen. Only 2.4% of patients on ART were on second-line regimens in June 2009. Namibia is poised to revise its treatment guidelines to align with the expected WHO recommendation that treatment begin at CD4 counts <350 copies/ul, potentially resulting in a notable increased demand for treatment.

The MOHSS Technical Advisory Committee (TAC) has already recommended the adoption of the lower threshold, and the addition of a TDF-based first line regimen (see Adult Treatment TAN). All final decisions will be aligned with the WHO guidance and informed by an on-going TAC costing exercise. Given that countries pay varying prices for ARV drugs based on a range of factors that include the procurement mechanism, USG will continue to support the joint procurement plan developed in 2007 with the Global Fund. Strengthening the role of the CMS as Namibia's primary source of ARV drugs is a key sustainability objective. USG partners will continue to provide TA to CMS in support of this strategy to confirm country ownership of the ARV drug procurement system and improve efficiencies. Where appropriate, external development partners will support the GRN in price negotiations with drug vendors. During FY09, 83% of the drugs procured with PEPFAR funds were FDA-approved generics and 17% FDA-approved branded products. Funds from MOHSS and other donors will continue to be used to procure non-FDA-approved products until full absorption of all cost by the MoHSS.

In moving forwards, USG will continue to strengthen the supply chain for ARVs and related drugs, and support quantification and forecasting. As per the recommendations of the treatment and care portfolio reviewer, the USG will utilize the best supply chain expertise available to assist the MOHSS in achieving the best value for money on tenders for ARVs and limit the use of buy-outs. USG partners can help guide/advise GRN to make the best possible future tenders for HIV-related and other health commodities.

In order to ensure better understanding of current cost profile in Namibia, and provide estimates of future resource needs and requirements, and to identify any funding gap, the USG will provide TA to the MoHSS to finalize the cost modeling for ART scale up initiated in FY09. (For additional details on USG TA for pharmaceutical supply chain management see the OHSS TAN.)

Technical Area: Biomedical Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	1,887,798	
HMBL	1,000,000	
HMIN	900,000	
Total Technical Area Planned Funding:	3,787,798	0

Summary:

Biomedical prevention activities include male circumcision (MC), blood safety, and injection safety. PEPFAR does not support injecting or non-injecting drug user programs in Namibia.

MALE CIRCUMCISION (MC)

Context and Background

Currently, an estimated 20% of Namibian men are circumcised. MC services are primarily supported by PEPFAR funding. In 2007, the MOHSS created a MC Task Force to develop a national MC strategy and policy. In 2008, the MC Task Force conducted a national situation assessment based on the WHO MC Situation Analysis Toolkit to determine the status of MC activities and map a strategy for scale-up of MC. The assessment consisted of four components:

1. A desk review of existing MC literature and research;
2. A qualitative study on perceptions and attitudes toward MC;
3. A facility readiness survey (infrastructure and human resources), and;
4. A cost analysis of scaling up MC services.

A stakeholders' meeting was held in August 2008 to share the results of the assessment, build consensus, and inform the development of a draft MC policy and action plan.

Based on initial drafts of the MC policy and action plan, COP09 included the following activities: (1) training of MC service providers; (2) development of an information, education, and communication (IEC) strategy and materials; (3) procurement of supplies and commodities; and (4) hiring of a National MC Coordinator and health care staff to perform MC. These activities will continue in COP10.

MC Accomplishments since last COP

In June 2009, the MC Task Force began to pilot activities at selected sites. Three public sector sites (Windhoek Central, Oshakati, Onandjokwe) and two military sites (Grootfontein and Windhoek) were identified. In July 2009, the first MC training course took place. Seventeen providers from the five pilot sites (10 doctors and seven nurses) participated. The course was organized by PEPFAR using the WHO/JHPIEGO manual for MC under local anesthesia, and served as a train-the-trainer activity. A second course taught primarily from individuals trained at the first course is scheduled for October 2009. In total, approximately 40 providers will be trained in 2009.

As of October 2009, three of the five sites provide MC on a consistent basis. The sites provide MC once a week, and serve between two and 10 individuals. By October 2009, approximately 170 men had received elective MC. All men were offered HIV testing, with approximately 95% accepting the test. Adverse reactions to MC have been moderate, including two cases of excessive bleeding (which were resolved)



and three cases of insufficient foreskin removal.

A communication needs assessments was conducted, and materials were developed for health care providers, clients, the media and politicians. Many PEPFAR partners have already included MC-related educational messages in their activities. Some HIV counseling and testing (HCT) sites have also incorporated MC counseling.

MC Barriers

One of the most significant barriers to the roll out of MC is human resource capacity. Currently, only doctors can perform MC in Namibia, but many doctors are overwhelmed with other clinical responsibilities. Consultations are planned with the Nursing Board to enact task shifting of MC to nurses. Additional challenges include the need to start a facility-based neonate MC program as well as strengthen linkages between MOHSS and traditional circumcisers.

MC Goals and Strategies

Overall, PEPFAR will increase MC funding by over \$800,000 in COP10. Additional funds were allocated to human resources and procurement. The primary goal for COP10 is to roll out MC to additional sites in Namibia. At a minimum, 80 clinicians will be trained in MC procedures. HCT counselors will be trained to educate and refer clients for MC services. The MOHSS is considering additional scale-up strategies, such as utilizing visiting foreign MC providers and task-shifting to nurses. In 2010, the MC Task Force will consider piloting neonate MC services. Additional communication materials will be developed, including materials for demand creation. The Department of Defense (DOD) is adding MC activities, including: a) procurement of equipment and supplies for military sites; b) training nurses and counselors; c) establishing supportive supervision and quality assurance systems within Ministry of Defense healthcare facilities, and; d) incorporating MC education into risk reduction counseling.

Documentation of key strategic information (SI) on MC services and demand will be essential to guide and monitor additional scale-up. As services are rolled out, MC indicators will be incorporated into routine monitoring and evaluation (M&E).

It is expected that the MC policy and action plan will be approved by MOHSS and Parliament in 2009. MC is also an integral part of the prevention approach outlined in the National Strategic Framework (NSF), the National Prevention Strategy, and the Partnership Framework (PF).

MC Links to the Partnership Framework

COP10 MC activities will support the following 5-year USG commitments:

- Implementation of the National MC policy, action plan, and operational guidelines
- On-going TA to the MC Task Force, including IEC, pre-service training, and quality assurance/quality control
- Strengthening of local communications capacity and demand creation for MC
- Evaluation to inform evidence-based MC models and the national MC program

BLOOD SAFETY

Context and Background

Blood safety has been part of the USG prevention strategy in Namibia since 2004. PEPFAR funds have supported the Blood Transfusion Service of Namibia (NAMBTS), a non-profit corporation with a legal mandate to collect, screen, and distribute safe blood and blood products throughout Namibia. Under PEPFAR I, USG also supported technical assistance (TA) from WHO, however, TA concluded in COP09. In COP10, NAMBTS may request TA from CDC Headquarters through a new task order mechanism. (NB: Funding for all blood safety TA will be centrally managed. It is not reflected in the Namibia COP.)

The NAMBTS national transfusion center operates in a modern facility leased from the MOHSS. A cost-recovery system is in place. NAMBTS supplies blood and blood products to 41 health facilities which



perform blood transfusions. All donated blood is collected from voluntary, non-remunerated blood donors (VNRD), and is tested for HIV, Hepatitis B, Hepatitis C, and syphilis. Since 2005, NAMBTS has contracted blood screening services from the South African National Blood Service (SANBS). This arrangement has proven to be both cost-effective and efficient. Given the shortage of laboratory staff in Namibia, this outsourcing model has allowed NAMBTS to access high-quality and reasonably priced testing services (including individual nucleic acid testing for HIV). Cost savings have allowed NAMBTS to devote resources to increasing blood component production and improving access to compatibility services at facilities that transfuse blood. In COP09, NAMBTS will conduct a bi-annual assessment of the SANBS contract to review costs and services.

Due to improved planning, component preparation (e.g., pediatric red cell units), and scaled up blood collections, NAMBTS has met all blood requests in the past 12 months and will collect in excess of 20,000 units of blood in 2009.

With PEPFAR support, blood utilization guidelines were published in 2006. A National Blood Policy was developed in 2007. A strategic plan linked to blood policy was released in June 2008. Training has promoted the implementation and enforcement of these policies and guidelines.

Blood Safety Accomplishments since last COP

In COP09, NAMBTS launched a new blood donor recruitment strategy to increase donations from in-school youth (ages 16-25). This "peer promoter" program was rolled-out in nine high schools in Windhoek. NAMBTS also provided training focused on HIV prevention and general health promotion. These messages are reinforced by volunteer student ambassadors. In COP10, this program will be expanded to 17 additional high schools in six cities. The "peer promoter" concept will also be fortified with materials from the Red Cross "Pledge 25" program. Other accomplishments include:

- Continued low prevalence of HIV among blood donors (<0.40%).
- >56% of all blood collected is Group O, ensuring availability of universal donor blood at facilities without cross-matching capacity.
- Expanded access to compatibility services and cold chain storage at facilities in northern Namibia.
- Continued training in blood bank management for clinical ward staff.

Blood Safety Barriers

The recruitment and retention of regular VNRD remains a challenge, especially with younger donors. The "peer promoter" program is designed to address this barrier and double blood collections from youth (aged 16-25) over the next five years. Cold chain transport and storage is a challenge in remote areas. As a nongovernmental organization (NGO), NAMBTS also has limited authority to supervise transfusion services in hospitals. The slow implementation of hospital-based transfusion committees is a symptom of this lack of authority.

Blood Safety Goals and strategies for the coming year

In COP10, funding for NAMBTS will be managed by CDC Namibia, through a new sole source cooperative agreement. COP10 activities will focus on developing skills in quality management, component production, and counseling of donors with HIV reactive results. Other emphasis areas will include training and support for supervisory skills and cost-effectiveness assessments for blood collections, screening and distribution. NAMBTS will also continue to diversify its funding sources, including conducting outreach to the private sector for in-kind donations, as well as negotiations with pharmaceutical firms regarding the potential sale of excess plasma. PEPFAR TA to NAMBTS will support evaluations aimed at quantifying demand for blood and blood products and tracking trends in blood utilization (e.g., among ART patients).

Blood Safety links to the Partnership Framework



The PFIP calls for increasing the impact of HIV/AIDS investments across the Namibian healthcare system. NAMBTS sits at a cross-roads between HIV prevention and clinical healthcare services, especially for maternal and child health. The PFIP includes the following five year commitments by the USG in support of blood safety:

- Continued TA to support costing reviews of the blood screening contract with SANBS
- TA to strengthen linkages between NAMBTS and clinical consumers of safe blood (e.g., maternity wards)
- TA as liaison between NAMBTS and universities to facilitate practical training for graduate students in laboratory services, pathology and transfusion medicine
- TA to promote NAMBTS as a regional center of excellence
- Support for NAMBTS public-private-partnerships and other commercial ventures to strengthen its cost recovery system

INJECTION SAFETY

Context and Background

PEPFAR has supported injection safety (IS) and waste management (WM) in Namibia since 2004. A national working group has been established to oversee all aspects of IS and WM. Infection control (IC) guidelines are finalized and a draft medical waste policy has been developed. All health facilities have adopted needle stick prevention procedures and MOHSS now quantifies its need for safety boxes, which are produced in Namibia.

PEPFAR continues to work with the MOHSS Quality Standards Department (QSD) to build capacity so that MOHSS can take over both IS and WM activities. PEPFAR has also supported a “care of caregiver” training programs in six districts, as well as efforts to make post exposure prophylaxis (PEP) available to healthcare workers (HCW) and efforts to make safety equipment and supplies available to HCW. Despite staff shortages in the MOHSS, some IS and WM activities will transition to MOHSS during COP10 as planned. Please see the OHSS TAN for additional information on waste management.

Injection Safety Challenges

Despite progress, continued PEPFAR support is needed due to staff shortages in the GRN and limited facility-based capacity to implement IS, WM, and IC activities. Facility-level implementation of IS and WM is not consistent. Insufficient or broken incinerators and a lack of trained staff to operate them remain challenges. Additional communication work with HCW and the general population to reduce demand and reliance on medical injections is needed. Despite progress in the public sector, IS needs and practices in the private sector have not been fully addressed.

Injection Safety Accomplishments Since Last COP

In COP09, the IS program transitioned from Track 1 to a field-funded activity. PEPFAR supported GRN programs on blood-borne IC, airborne IC, as well as pharmaceutical and facility-wide WM efforts. An IC and WM guideline was finalized. PEPFAR continues to make IS, WM and protective clothing available to HCW and waste handlers. PEPFAR supported PEP services for HCW and to victims of rape. PEPFAR facilitated the implementation of PEP using trained HCW and conducted a review of incinerator readiness and usage patterns.



Injection Safety Goals and Strategies for the Coming Year

PEPFAR will continue to collaborate with the MOHSS to transition IS activities to the GRN. Broader WM, IC, IS, and PEP efforts require continued PEPFAR investment in COP10, including:

- Provision of TA to MOHSS to disseminate and implement new IC guidelines and WM policies
- Assistance with establishing or strengthening IC committees to ensure availability and use of IC guidelines and the development of regional and district IC plans
- Assistance with instituting standard precautions such as hand hygiene, prevention and management of injuries from sharp instruments, early detection of disease and isolation precautions, and immunization of health care workers
- Assistance with ensuring there are PEP protocols in all facilities, including awareness creation, availability and compliance with PEP guidelines, availability of starter packs, IEC materials, and linkages with other programs
- Facilitation of the transition of the procurement and supply of sharp waste containers to MOHSS.
- Assistance to MOHSS with the procurement and maintenance of incinerator
- Development of training and training manuals for healthcare workers on IS and WM

Linkages to the Partnership Framework

Investments in IS, WM, and PEP in the Partnership Framework Implementation Plan (PFIP) include the following commitments:

- ? Integration of PEP into all health facilities offering ARV services, and expansion of access to PEP beyond HIV/AIDS programs
- ? Support for in-service and pre-service training on PEP, IS and WM.
- ? Expanded collaboration between PEPFAR IS/WM activities and those funded and/or implemented by other development partners for other programs (e.g., immunization).

Technical Area: Counseling and Testing

Budget Code	Budget Code Planned Amount	On Hold Amount
HVCT	7,175,381	
Total Technical Area Planned Funding:	7,175,381	0

Summary:

Background and Context

Namibia ascribes to the UNAIDS and WHO goals of universal access to HIV prevention, care and treatment, and has significantly expanded testing and counseling services, through traditional voluntary counseling and testing services (VCT) for people who seek to know their HIV status. USG Namibia's HIV counseling and testing (HCT) portfolio supports the Government of the Republic of Namibia's (GRN) HCT objectives as described in the Third Medium Term Plan (MTP3), the National Strategic Plan on HIV/AIDS (2004-2009), and the new National Strategic Framework (NSF) for HIV/AIDS (2010-2015). The NSF is a multi-sectoral framework that provides policy guidance on the planning and implementation of the national multi-sectoral HIV/AIDS response. The GRN's capacity to plan, oversee, manage and, eventually, finance the national HIV/AIDS response will be strengthened by the Partnership Framework (PF) which will include commitments from the USG and GRN based on the "priority actions" described throughout the NSF. Counseling and Testing is one of the key priority actions included in prevention, which has been highlighted as Namibia's top priority against the HIV/AIDS epidemic. Key areas of USG focus over the life of the five year PF will include but not be limited to: the establishment of a plan to transition funding from



USG to GRN for Rapid Testing Kits (RTK) procurement and improved human resource capacity; provision of technical assistance will be provided to enhance the quality of HCT programming in all public, uniformed services, correctional facilities, civil society and private health facilities, in outreach and other community models; support for long term human resource capacity development for HCT will be available and will include formalizing task shifting and pre-service training within host country training institutions.

Since COP04, HCT activities have included technical assistance to the Ministry of Health and Social Services (MOHSS) at the national level. A CT Technical Advisor supports the MOHSS in the development and revision of national CT guidelines, rapid HIV testing standard operating procedures, curricula and training, as well as the establishment and scale up of rapid HIV testing and quality assurance (QA). Additional assistance to MOHSS has included health management information system (HMIS) support, health facility renovations, and the procurement of CT test kits and consumables. Namibia's HCT program has been successful in scaling up rapid HIV testing (RT), providing same-day results and facilitating referrals to care and treatment services. By September 2009, about 306 public health facilities were offering HCT services with 200 facilities using rapid HIV tests. Additionally, 18 New Start sites (12 community-based and 6 health-based facilities), four Ministry of Defense (MOD) and six Ministry of Safety and Security (MOSS) sites were offering rapid HIV testing.

The HCT program has experienced a number of challenges including, but not limited to, a shortage of human resources, a lack of appropriate infrastructure for HCT services, and low uptake of couples and male clients. Current data from New Start sites show a male uptake of VCT varying between 30 to 40% and only 8% being tested as couples.

Human resource constraints are addressed by the GRN-approved task-shifting of HCT activities to lay community counselors (CC), who are certified to conduct RT upon completion of a 12 weeks training course (six weeks of didactic, and another six weeks of practical training, including training in rapid testing). QA results for CC thus far show nearly 100% concordance with ELISA. In COP10, refresher trainings for the deployed CC will be enhanced to include positive prevention, couples counseling, pediatric counseling, and training in the revised PMTCT guidelines. In COP 10, the USG will continue to support this innovative strategy. The introduction of CC in mid-2005 has been a major boost for integrated provider-initiated CT (PITC) services, as well as VCT in community-based centers. Nurses, who supervise CC, as well as CC, will continue to receive refresher trainings in HCT, with particular focus on supervision and advanced HCT skills such as couples, family, and child counseling. HCT is now routinely offered to pregnant women; TB and STI patients in hospitals, health centers, and clinics; and, increasingly, to patients with suspected HIV-related symptoms. In COP10, PITC will expand to include outpatient and inpatient services for adults and children, and will also be aggressively pursued within birthing settings, where about 19% of pregnant women present for delivery with unknown HIV status.

Accomplishments since last COP

The GRN and USG have broadly scaled up CT activities in community based facilities, public health facilities, and in the uniformed and correctional services. From October 2008 to August 2009, MOHSS facilities had tested and returned results to 111,611 clients with the New Start Centers testing 53,000 new clients. The ratio of male: female persons accepting testing is about 40:60, reflecting some gender inequity to accessing services for men (similar trends have been obtained in care and treatment settings, as well as PMTCT; where, in the latter, only 4% of men accept testing). Combined with the national testing day event, a total of 193,822 clients were tested and received their results, an increase from 138,830 during the same reporting period last year. This 28% increase can be partly attributed to the national testing day event, rapid HIV testing scale up, and training and deployment of more CC.

The USG and WHO, in 2009, supported the GRN in reviewing the HCT guidelines and align them with the new NSF and PF, and enhancing the integration of PITC for adults and children. The alignment process was informed, in part, by a USG CT program portfolio review.



Also in COP09 was the successful transitioning of the management and supervision of CC from the Namibia Red Cross Society (NRS) to the MOHSS in March 2009. This transition was driven by recent changes in the national Labor Law and has resulted in the community counselors becoming official cadres of the MOHSS, a significant step towards the sustainability of the program.

As noted above, Namibia held its second successful national testing event in 2009. A total of 82,211 people were tested and received their results over five days. About 70% of the clients reported being first time testers, and men represented about 40% of those tested. Given the success of the national testing event, COP10 funding will support the promotion of two HCT events, one coinciding with World AIDS Day.

Outreach/mobile services are critical to providing HCT and other services. The MOHSS approved guidelines for the provision of outreach CT activities soon after the national testing event in 2008. However, implementation challenges have slowed the scale up of this activity. In accordance with the new NSF strategy, COP10 funding will support the provision of mobile outreach CT services, and upgrade the knowledge and skills of nurses and counselors deployed to outreach or mobile TC services, so they understand the unique characteristics of the populations they are targeting.

Unlike the HCT sites integrated in MOHSS facilities, stand-alone, community-based facilities are sometimes faced with low uptake of services. In COP10, USG-supported, community-based testing partners will continue to implement a focused community mobilization and a behavior change communication strategy targeting first time testers, couples, and male testing. Trained community mobilizers will use Interpersonal Communication (IPC) skills and materials, as well as other promotional activities, to motivate clients living near centers to utilize HCT services. In COP09 this strategy showed promise as a means to increase community uptake of HCT.

USG support for community-based centers is complemented by funding from the Global Fund (GFATM), which has supported an assistant HCT coordinator in the MOHSS to work with the National HCT Program Coordinator and the USG Technical Advisor.

Members of the military and other uniformed forces have been identified as populations at greater risk of HIV than the general population. In COP06, the Namibian Ministry of Defense, with support from the USG Department of Defense, initiated HIV testing within the military at two sites. In COP09, military HCT services were extended to an additional two sites.

Increasing education and communication on male circumcision (MC) in Namibia, a number of New Start sites have incorporated MC counseling in their risk reduction plans making the CT an entry point to voluntary medical MC.

Namibia's commitment to quality HCT services is unparalleled, with clear policy documents and standardized training offered to counselors. Stringent external quality control mechanisms for rapid HIV testing strengthen the national HCT response. Because of excellent external QA results, the MOHSS reduced the RT QA for retesting from 10% to 5%. As part of the 2009 portfolio review, strengthening QA for both counseling and testing was identified as a priority for COP10. A comprehensive QA structure was established in 2009. This national HCT QA program is overseen by a QA officer based at the MOHSS headquarters, and implemented by 13 regional QA officers who are responsible for enforcing adherence to MOHSS protocols and guidelines, data management, supportive supervision, site inspections and certifications. Community-based facilities coordinate with the MOHSS QA team through regional supervisors. The Namibia Institute of Pathology (NIP) provides technical assistance and support for the laboratory QA program.



Goals and strategies for the coming year

As part of the portfolio review recommendations, the HCT program will create a National Quality Improvement Team (NQIT) as a subcommittee of the HCT technical working group (TWG). The proposed role of the NQIT will be to ensure consistency and coordination in the national HCT QA system. Specific areas of emphasis will be enforcing adherence to national HCT guidelines and standards for testing, counseling, data management, logistics and referrals. Through the NQIT, regions and districts will be empowered to initiate QA activities using a standardized national toolkit.

In COP10, PITC will be scaled-up throughout the MOHSS network. PEPFAR will support the expansion of PITC services from the limited settings where they are currently offered, e.g., TB clinics, STI clinics and ANC facilities. The USG will provide technical support to MOHSS for the piloting different PITC implementation strategies and phased roll out of successful strategies. Emphasis will be placed on ensuring that all trained health care providers include HCT as part of the routine standard of care and providing in-room testing, particularly for inpatients and PITC for children. In keeping with the PEPFAR emphasis of placing pediatric care and treatment in dedicated separate pediatric COP program areas, and the PEPFAR re-authorization mandate that USG-supported programs provide care and treatment services to children with HIV in proportion to their percentage within the HIV-infected population, PITC for children will receive greater emphasis in COP10. This will include training of both lay counselors and health workers in performing rapid HIV tests on children, as a way of increasing children's entry into care and treatment. This strategy will be critical to ensure that all children presenting to MCH facilities, other outpatient and inpatient facilities have their HIV-exposure status determined at first contact with a health facility, and get an opportunity to have further definitive tests to confirm their HIV status. The MOHSS has already started training healthcare workers, including CC, on PITC for both adults and children, and will pilot point of care testing models in limited sites. Some of the challenges affecting implementation of PITC are ideal space in delivery points, especially at out patient's departments (OPD), lack of male-friendly services, lack of youth-friendly testing points, inadequate staffing levels and time constraints. Lessons learned at these sites will help inform and direct the national scale-up. Additionally, support will be given to provide HCT for all clients seeking MC services.

Success of the two previous national testing events will result in PEPFAR supporting the addition of semi-annual events, including an event linked to World AIDS Day, and themed events targeting youth and men. These national events will be integrated with mobile HCT activities offered by the MOHSS, community groups and the private sector. The MOHSS will assess the mobile outreach program in hopes of expanding it in COP11. To date, the limited use of mobile HCT and outreach services has proved to be an effective means of reaching youth and men, two important target groups not effectively served by fixed sites. COP 10 funding will support maintenance for four mobile/outreach vans, the procurement of related equipment and consumables, and personnel. More importantly, USG will support the MoHSS to work with IntraHealth supported New Start Centers in expanding outreach HCT services using static facilities.

In addition, more emphasis will go into creating linkages between testing sites and care and treatment services, to prevent attrition through referred clients failing to reach the intended treatment sites. It is critical to ensure that CT site patients are offered testing as part of their medical encounter, are referred for care and treatment and follow through with the care and treatment referral. USG will continue to support functional referral systems to care and treatment sites in COP10. The CT program will also ensure that post-test counseling for all persons will include specific prevention education and counseling based on the person's HIV test results and risk behaviors, emphasizing couples counseling and testing, and disclosure of HIV status to sexual partners. Support for persons after they have received their test results will be intensified through formation of post-test clubs, and those who test HIV-negative will be supported in COP10 to maintain their HIV-negative status.

Finally, based on portfolio review recommendations, the GRN, with support from the USG, will complete



work on a national HCT strategy and vision, to be aligned with the NSF and PFIP commitments. The role of certain low volume, high-cost, standalone CT facilities will be reviewed, with some sites possibly considered for closure where other mobile HCT services are available. The national CT TWG will also be strengthened by encouraging participation from a wider stakeholder base.

Technical Area: Health Systems Strengthening

Budget Code	Budget Code Planned Amount	On Hold Amount
OHSS	7,846,483	
Total Technical Area Planned Funding:	7,846,483	0

Summary:

Context and Background

A strong health system is critical to sustaining the effectiveness of the National HIV/AIDS response as well as a substantial focus of the development and implementation of Namibia’s Partnership Framework (PF) Agreement.

Health System Strengthening (HSS) Assessment

The Government of Namibia (GRN) has embarked on a major HSS initiative. The process began in 2008 with a comprehensive health systems assessment supported by stakeholders, including the USG. This assessment provided a status report on five HSS focus areas: Governance, Human Resources (HR), Service Provision, Infrastructure, and Health Financing. Recommendations were outlined and published in the Ministry of Health and Social Services (MOHSS) “Health and Social Services System Review”. This document in turn informed the MOHSS “Strategic Plan 2009-2013.”

GRN and Partner HSS Efforts

The MOHSS is now operationalizing the HSS recommendations and working towards the following HSS objectives (PEPFAR-specific activities will be emphasized in subsequent sections.):

1) Governance

- Responsive legislation and policies
- Improved stakeholder relations and coordination
- Strengthened stewardship of the MOHSS (to guide the health system) and the National AIDS Commission (NAC) (to guide the National HIV/AIDS response)
- Decentralization-Devolve levels of decision making to appropriate levels

2) Health Financing

- Equitable allocation of resources
- Improved financial management of resources

3) Medical products/technologies and procurement systems

- Efficient and effective system to ensure availability and accessibility of safe and efficacious medical products, vaccines, and technology.

4) HR

- Skilled motivated and sustained workforce to meet health needs

5) Service Delivery

- Implementation of minimum district services package (MDSP)
- Streamlined and harmonized services/programs/functions
- Health facilities responsive to emerging needs



6) Information Systems

- Production of streamlined and integrated data on the health sector

Currently, HSS activities are led by the GRN with support from only a few donors, including PEPFAR. UN agencies (WHO, UNICEF, and UNFPA) offer technical assistance (TA) to the MOHSS on policy issues, assessments, studies, and reviews, but little direct funding. GFATM support for pre-service bursaries, infrastructure and information systems may increase if Namibia's RCC application is approved in 2010. The MOHSS is also pursuing HSS partnerships with the private sector (e.g., business associations, insurance schemes) and civil society. Some partnerships are being piloted (e.g., workplace outreach) or implemented on a limited scale (e.g., new insurance schemes for low-income workers).

In its annual management work plan, the GRN (largely MOHSS) has prioritized the following activities for the coming fiscal year.

Governance

The MOHSS will establish a policy review core team to update health policies, including those related to decentralization. The MOHSS also plans to step up its coordination role among public, private and donor health stakeholders. Associated activities may include annual health assemblies, stakeholder satisfaction surveys, and a national mapping exercise to reduce programmatic duplication. Other governance systems strengthening activities include plans to align GRN ministries' roles and responsibilities with the proposed enhanced stewardship role of the NAC, an oversight body that will be based in the Office of the President. A work plan associated with this restructuring will be developed in conjunction with the passage of the National Strategic Framework (NSF) in 2010.

Health financing

The MOHSS will establish, with USG support, a task force on equitable resource allocation. To contribute to this effort, the MOHSS is conducting a National Health Accounts (NHA) estimation that includes for the first time a focused HIV/AIDS expenditure review (with USG support). Goals of this estimation include improving access to up-to-date finance information, informing resource allocation decisions, and institutionalizing a resource tracking system. The GRN is incorporating a decentralized approach to budget formulation with greater input from the district level. Finally, the MOHSS will develop a health care financing strategy and support costing exercises for the human resources for health (HRH) plan and MDSP.

Medical Products/ Technologies and Procurement Systems

The MOHSS will build on existing procurement and distribution strengths in its Central Medical Stores Division. Continuing USG TA may further strengthen quantification and forecasting capacity and support implementation of the National Pharmaceutical Master Plan. GRN will also seek technical assistance to strengthen the regulatory framework for essential medicines, and draft revised standards and norms for pharmacies. On-going outreach to the private sector may produce proposals to build pharmaceutical production capacity in Namibia.

Human Resources

To address the HRH workforce shortage and respond to the dynamic needs of the national response, Ministries (including the MOHSS and the Ministry of Gender Equality and Child Welfare (MGE CW)) are developing comprehensive national HR plans (supported by PEPFAR). Specific GRN HR activities include strengthening of local pre-service and in-service training programs, opening of the country's first medical school, bursary support for students (to study in Namibia and abroad), greater understanding of the HR workforce situation through the roll out of an HR Information System (with support from USG), and increased attention on recruitment and retention (including task shifting) strategies.

Service Delivery

The MOHSS is establishing a task force to revise and cost the minimum district services package for its



facilities. This body will also develop harmonization plans to address fragmentation and expand access. To allow further absorption of community-based health care workers (HCW) by the MOHSS, a new category of HCW will be created: Extension Healthcare Workers. As resources are identified, linkages between the HIV/AIDS response and maternal and child health will be strengthened. Investments are also planned in healthcare system infrastructure and information systems.

Information Systems

The MOHSS aims to develop an integrated and linked information system so that data on service utilization, HR, epidemiology, and finance can be analyzed in an integrated manner. To do so, the MOHSS is rethinking its HR structure for health information systems (HIS) and aims to establish a core team for health management information systems (HMIS) (currently information systems personnel are scattered across several directorates and departments) and develop a strategy for the integration process.

HSS Accomplishments under PEPFAR

Under the first phase of PEPFAR, USG HSS investments were largely 'spill-over' effects from HIV/AIDS-focused activities. Specific accomplishments include:

1. Governance

- Increased opportunities for civil society and PLWHA to participate in GRN planning.
- Current health sector reforms (e.g., decentralization, streamlining of GRN functions, increased investment in HRH and infrastructure) driven by recommendations from USG-sponsored health systems review.

2. Finance

- First comprehensive review of HIV/AIDS expenditures (public, private, and donor) in the context of the overall health system (National Health Accounts).
- Implementation of innovative cost-recovery models to diversify local funding sources, e.g., reimbursements from private insurance.

3. Medical products/technologies and procurement systems

- Strengthened Central Medical Stores and pharmacies. In COP 09, unlike prior years, there have been no ART stock outs.
- Strengthened health care centers' laboratory and infection control systems through cross-cutting investments in HIV and TB services.

4. Human Resources

- Increased HRH workforce capacity through USG bursary support and strengthening of local training institutions
- Increased awareness of human resource needs and informed planning decisions based on data from a USG developed - human resource information system and an Office of the Prime Minister impact assessment that examined workforce constraints due to HIV/AIDS.
- Plans for GRN absorption (into new extension worker category) of USG-sponsored community workers

5. Service Delivery

- Rapid scale up of clinical and logistic support services for ART and PMTCT services.
- Cost and time efficiencies achieved through technical assistance, supportive supervision and effective use of monitoring and evaluation data to strengthen laboratory, palliative care, and TB/HIV services.

COP10 HSS Focus Areas

Building on the accomplishments above, COP 10 investments will target HSS more directly than before. This will mean an increase in 'targeted leveraging' activities. In addition, COP10 signifies a transition year



in the PF process. The USG will use this transition phase to build an evidence-base on which sustainable engagement and transition plans may be developed.

USG activities to this end will target all six building blocks of the health system (with increased attention to governance, finance, and information), in the public and private sectors as well as the national and community levels. For the public sector, there is a clear vision and plan for each health system block, and the USG will work jointly with the MOHSS to identify areas that could benefit from USG support. For the private sector, the USG will play a greater role in facilitating links between the for-profit, not-for-profit sectors and the GRN. At the community level, the USG will work to strengthen the involvement and linkages between communities, facilities, health and social workers, small businesses, and social support programs. Specifically, the USG plans to support the following HSS activities:

1) Governance:

- Strengthening civil society's capacity to contribute to planning, advocacy and oversight of the national HIV/AIDS response. Technical assistance will support leadership, strategic planning, financial, administrative, and HR management capacity, as well as program planning, networking, and grant management. (spill over)
- Operationalizing the Road Map for Maternal and Newborn Health. Direct USG support for "mainstreaming" will leverage HIV/AIDS investments to benefit maternal and child health. (targeted leveraging)
- Strengthening the GRN's stewardship and coordination role through support for the NSF and the new NAC (see above). (targeted leveraging)
- Strengthening community level involvement through USG support to NGOs to facilitate, strengthen, and integrate linkages between communities and GRN services. (targeted leveraging)

2) Finance:

- ? Institutionalizing expenditure tracking as a routine function of government through USG support of a donor-NGO resource tracking database (to replace one-off surveys), the inclusion of financial indicators in the country's HMIS, posting of resource use data on a website to foster transparency and accessibility by all stakeholders (targeted leveraging)
- ? Increasing financial accountability - by strengthening civil society's ability to understand and use national data on expenditures (targeted leveraging), strengthening local NGO financial management and reporting capabilities (spill over),
- ? Establishing equitable and efficient resource allocation criteria and process through USG technical support to MOHSS task force on resource allocation (targeted leveraging)
- ? Developing a national resource mobilization and sustainability plan—through the provision of technical support to the GRN in collaboration and consultation with other national stakeholders (targeted leveraging).

3) Medical products/technologies and procurement systems

- Improving governance and the regulatory framework of the pharmaceutical sector through technical support to the Namibia Medicines Regulatory Council; transferring therapeutics information and pharmacovigilance centers to the MOHSS; supporting the implementation of the national pharmaceutical management plan (targeted leveraging)
- Strengthening pharmaceutical services through curriculum development at the University of Namibia. (targeted leveraging)
- Strengthening procurement, logistic, quantification and warehousing management systems through technical assistance and direct support to the MOHSS Central Medical Stores. (spill over)

4) Human resources: Details of COP10 HRH activities are provided in the HRH TAN. Specific investments to strengthen HR systems will include:

- Support for administrative systems and categories to allow the gradual absorption of USG-supported staff into the GRN civil service, or as GRN-funded contractors.
- Strengthening and integrating the HR Information System with other clinical and administrative data sources.



- TA for costing exercises and the development of national HR plans (for MoHSS and MGECW) based on the costing data. (targeted leveraging)
 - Continued investments in curriculum development, faculty, and infrastructure at Namibian universities. (targeted leveraging)
 - Support to GRN to develop sustainable recruitment and retention strategies
- Systemic barriers to achieving PEPFAR health worker goals are also described in detail in the HRH TAN, as are the proposed USG strategies and commitments to address them.
- 5) Information systems:
- Integrating GRN information systems (e.g., MEDITECH, laboratory information systems, HRIS) in accordance with the national M&E plan (targeted leveraging)
 - Supporting the GRN to develop an integrated HIS plan (targeted leveraging)
- 6) Service Delivery:
- Support for task-shifting to promote the expansion and mainstreaming of GRN HIV services, e.g., training community counselors to support immunization outreach. (targeted leveraging)
 - Leveraging investments in HIV prevention, e.g., documenting the impact of access to safe blood on patient outcomes for non-HIV conditions such as nutritional or pregnancy-related anemia. (targeted leveraging)
 - Continued support for Central Medical Stores as the primary GRN agent for procurement. Additional TA and investments to build GRN capacity to maintain capital infrastructure and improve capital replacement planning. (targeted leveraging)

Monitoring HSS

COP10 activities will emphasize baseline monitoring of HSS activities. An upcoming GFATM HSS study will be leveraged in support of this objective. In addition, the USG will review and identify all HSS activities across all budget codes. These will be categorized according to the HSS building block addressed and by the type of PEPFAR engagement (focused, spill over, leveraging). Impact evaluations will be conducted using tools from the GFATM Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening (Feb. 2009).

Technical Area: Laboratory Infrastructure

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	1,686,975	
Total Technical Area Planned Funding:	1,686,975	0

Summary:

Context and Background

The USG Namibia Laboratory Infrastructure capacity building effort is designed to support the GRN's national HIV/AIDS response. USG support is delivered through the Namibia Institute of Pathology (NIP), a parastatal organization, which has been authorized by the GRN to provide laboratory services for the public healthcare sector. NIP also provides services to the private sector as part of its cost-recovery strategy.

COP 10 activities will focus on strengthening the delivery of laboratory services, as well as structural issues related to the implementation of the commitments described in the Partnership Framework Implementation Plan (PFIP) and the new National Strategic Framework for HIV/AIDS (NSF). Special emphasis will be placed on improving access to laboratory services, the quality of laboratory services, and strengthening MOHSS' oversight capacity to better direct and monitor NIP's activities on behalf of the public sector.



Accomplishments Since Last COP

1. Training. The NIP training policy was finalized and training needs were assessed. Trainings on chemistry, hematology and TB culture for 25 staff were conducted with assistance from the American Society of Clinical Pathology (ASCP) and the American Society for Microbiology (ASM). The Clinical and Laboratory Standard Institute (CLSI) conducted training on quality systems improvement and accreditation for 24 laboratory staff.

2. Bio-clinical monitoring. More than 600,000 tests were performed for bio-clinical monitoring, including biochemistry, hematology, CD4, and viral loads as well as over 9,000 DNA PCR for Early Infants Diagnosis (EID). Turn around time of laboratory results was improved in most testing centers.

3. Technical Assistance (TA). The PEPFAR Laboratory Advisor continued to strengthen the relationship between MOHSS and NIP. He contributed to improving NIP program reporting and helped manage the first Namibian TB Drug Resistance Survey. The Laboratory Advisor also worked closely with MOHSS, NIP and other GRN partners to assess the feasibility of establishing a Namibian public health laboratory system to help address shortcomings in public health related disease detection and surveillance, reporting, and management. There are already several other laboratories beside NIP that have competencies in public health-related disease detection in Namibia. A Namibian public health laboratory system would establish a link between all these laboratories with the MOHSS leadership. The USG Laboratory Advisor will continue to provide technical assistance to address NIP and MOHSS human capacity weaknesses identified in prior years.

4. Decentralization of TB diagnostic services to the sub-national level. TB culture capacity was expanded to two more regional laboratories (Oshakati and Walvis Bay). Fluorescence microscopy for TB microscopy was introduced in the reference TB laboratory in Windhoek and is being decentralized to Walvis Bay and Oshakati laboratories. EID services were also expanded and the median age of babies tested decreased.

5. Drug resistance monitoring. The MOHSS and WHO have adopted the WHO strategy for HIV drug resistance surveillance. Early warning indicators were collected for the first time in COP09 and NIP began drug resistance testing of specimens from newly enrolled ART patients.

Activities for COP10

Expanding Early Infant Diagnosis. With support from the USG Laboratory Advisor, NIP's capacity to perform HIV DNA PCR for EID and viral load assays has been enhanced in the central laboratory. A national policy was adopted by MOHSS to regulate and monitor the use of these assays. Clinicians may request DNA PCR for symptomatic and HIV-exposed infants from birth up to 17 months of age. Viral load testing may be requested when drug resistance is suspected, and for all patients six months after initiation of HAART. In COP10, antibody testing for symptomatic and HIV-exposed infants older than nine months will be rolled out to cut costs and associated cost savings will be assessed. A review and close monitoring of the viral load testing done at six months after initiation of HAART will also be implemented.

Strengthening TB Diagnostic Capacity. Building local expertise in TB testing, and expanding access to TB testing facilities is critical. In COP10, PEPFAR will support continued expansion of NIP's TB diagnostic services. This support will include quality assurance (QA) and assistance with results monitoring, as well as surveillance for drug-resistant TB.

Bio-clinical Monitoring. Supporting ART adherence and effectiveness through bio-clinical monitoring remains the cornerstone of the USG laboratory support program. USG funds will improve NIP staff performance and skills through training and supportive supervision. NIP laboratory staff will continue to



serve on the front-line of the ART service program, providing rapid, accurate results to physicians and patients. USG support for this activity is complemented by the MOHSS, which contributes funds through the NIP cost-recovery strategy. To support and coincide with the “mainstreaming” objectives outlined in the PFIP and in the NSF, NIP will be encouraged to cross-train laboratory staff to support other prevention and diagnostic activities, such as TB and STI screening. Also in line with the commitments described in the PFIP, PEPFAR will support an assessment of NIP’s bio-clinical monitoring program and practices. The assessment findings will be used to identify cost savings through efficiencies and other programmatic changes. This assessment will also inform any changes to NIP’s bio-clinical monitoring program that may be required if Namibia updates its ART eligibility criteria.

Training. In COP10, PEPFAR will continue to assess training needs and design appropriate training courses to respond to these needs. Trainings will be supported for NIP technical and managerial staff at central and peripheral laboratories. These activities will continue to focus on laboratory management, strategic planning, and the appropriate and efficient use of resources. The USG will continue to work with the International Lab Consortium Partners (ILP) to deliver training. In addition to short-term training, the USG will also support the Polytechnic of Namibia’s Medical Technology School through a twinning program with the American International Health Alliance (AIHA) and the University of Arkansas. This project is described in detail in the OHSS technical area narrative.

Drug Resistance Surveillance. In COP10, NIP and the MOHSS will continue to implement the WHO strategy for monitoring HIV drug resistance at selected ARV sites. Specific assistance in this area will include TA in strategy implementation, data capturing and analysis, and review and updating of the strategy.

Laboratory Logistics. In COP07, the Partnership for Supply Chain Management Systems (SCMS) facilitated the design of a new laboratory logistics management system for NIP. This design was developed in close collaboration with all key stakeholders, including USG-funded implementing organizations, other donor organizations and the Global Fund. In COP10, this activity will continue with a focus on strengthening the effectiveness and efficiency of NIP’s laboratory supplies logistics system, and assessing areas where SCMS activities may be transitioned to NIP or the MOHSS. The MOHSS Central Medical Stores will continue to manage and oversee the procurement of laboratory supplies, consumables and equipment. The strength of this national procurement system will be periodically assessed by the Laboratory Advisor, with support from USG health communication advisors, to identify and share best practices with other program areas.

Ministry of Defence. The Namibian Ministry of Defence (MOD) and National Defence Force (NDF) uses NIP laboratory facilities for all laboratory testing needs. Emphasizing the unique nature of the military and the issue of confidentiality of data, the MOD has expressed the need to establish its own laboratory facilities within the military hospitals where ART services will be provided. The first MOD laboratories were established in COP08 and COP09. In COP10, NIP will continue to support these initiatives with technical assistance and other support.

Infrastructure and Transportation. NIP is a national network of 36 laboratories. These laboratories cover the whole country but are only located in the main hospitals. The central reference lab is in the capital, Windhoek; regional labs are based in Oshakati (northwest) and Rundu (northeast); 33 sub-regional laboratories are distributed nationwide in district hospitals. To improve the quality of services delivered by this network, and to reduce turnaround times for results, PEPFAR will support the strengthening of transportation and laboratory information systems (LIS) at sub-national facilities. Special attention will be placed on reducing the turn-around time for results and the management of data in remote locations. To this end, more facilities will be connected to the USG-supported LIS at NIP (MEDITECH). Expanding the electronic information network will speed up the delivery of results to remote facilities. It will also improve data sharing and access to datasets which may be compared or tracked over time. NIP staff will



participate in PEPFAR-initiated Public Health Evaluations (PHE), and will have regular meetings with clinical staff to review the quality of data. These data will be used to develop evidence-based strategies to improve services. As noted in the PFIP, the USG will also participate in MOHSS-led discussions about the development of a national specimen transportation system. A variety of transport vehicles should be considered for this system, including motorcycles, all-terrain vehicles and automobiles.

These transportation and LIS activities will also be coordinated and aligned with the 2010 implementation of the National Decentralization Policy.

Human Resources. Namibia faces major challenges related to laboratory services including the lack of qualified Namibian laboratory professionals. This shortage is amplified by poor working and living conditions for medical staff in remote areas. Another challenge has been the rapid roll-out of care and treatment services to the whole country without commensurate decentralizing of laboratory services. To begin addressing some of these weaknesses, a National Laboratory Strategic plan will be developed with assistance from the Association of Public Health Laboratories. The partnership with international institutions, the planned medical technologists training program at the Polytechnic of Namibia and the development of a NIP training policy, will also assist Namibia to develop, train and deploy Namibian laboratory professionals.

Other Activities. PEPFAR will support the development of a strategic plan for national laboratory services, a feasibility assessment for establishing a national public health laboratory, monitoring of testing technologies and instrumentation, and quality systems for TB and opportunistic infections (OI).

Supportive Supervision and Sustainability. As noted above, NIP is a parastatal institution and its financing strategy is designed to generate its annual budget through a cost-recovery mechanism. This mechanism uses service fees and other charges to recoup costs from clients in the public and private sectors. The MOHSS is the largest contributor from the public sector. PEPFAR support to the MOHSS partially offsets these contributions. Reducing direct PEPFAR support for MOHSS payments to NIP is a key objective for the five year PFIP strategy. In COP10, PEPFAR will assist the MOHSS in completing a ministry-wide costing exercise, which will include an analysis of the current structure of payments from MOHSS to NIP. This health systems strengthening activity will be supported by TA from the USG Laboratory Advisor. In addition to increasing country ownership, the primary five year objective in this area is to strengthen MOHSS oversight of NIP's laboratory activities, especially in the area of bio-clinical monitoring.

Related to this objective, special attention will be paid in COP10 to strengthen NIP's ability to meet its responsibilities to the public sector, while expanding its engagement with the private sector. USG technical assistance will focus on achieving and sustaining an appropriate balance between using cost-recovery as a sustainability tool, and using it as a mechanism for profit.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	14,164,188	
Total Technical Area Planned Funding:	14,164,188	0

Summary:
(No data provided.)



Technical Area: OVC

Budget Code	Budget Code Planned Amount	On Hold Amount
HKID	8,121,902	
Total Technical Area Planned Funding:	8,121,902	0

Summary:

Context and Background

Approximately 250,000 Namibian children under 18 (28.2%) are classified as orphaned or vulnerable (DHS 2006). Of the 155,000 that are orphans, half are believed to have lost a parent due to HIV/AIDS. Poverty is a key factor in exacerbating the problems faced by OVC and their caregivers and is also the most significant underlying cause of vulnerability. The proportion of OVC is highest (34%) in the lowest wealth quintile, and child malnutrition among OVC is higher than the national average.

The Namibian national OVC response is described in the National Plan of Action for Orphans and Vulnerable Children 2006-2010 (NPA), which supplements and makes operational the National Policy on OVC of 2004. The NPA embraces a multi-sectoral approach in five strategic areas: Rights and Protection, Education, Care and Support; Health and Nutrition, Management, and Networking. The Ministry of Gender Equality and Child Welfare (MGECW) leads the implementation of the NPA and hosts the OVC Permanent Task Force (PTF) which brings together key government ministries, development partners, including USG, and civil society organizations for a coordinated response. All USG OVC activities are in line with the NPA.

Accomplishments since the last COP

During FY 09 USG contributed to significant progress in systems strengthening, service provision, strategic planning, and improved quality of programming. At the system level, USG provided technical assistance (TA) to the MGECW and the Ministry of Education (MoE). With MGECW, USG strengthened the Directorate of Child Welfare (DCW) to follow up on a Human Resources Gap Analysis by creating a new cadre of government-funded Community Childcare Workers (CCW) who received training with USG funds and have started to replace volunteers previously recruited by the USG. Through the volunteers and increasingly the new CCW, the government was able to scale up the processing of welfare grant applications, which now reach 105,000 children. The Directorate also recruited a monitoring and evaluation (M&E) officer who is being mentored by USG TA to manage the national OVC data warehouse and to use it for tracking and mapping of service delivery to OVC.

The DCW was supported to conduct its first strategic planning exercise, which resulted in national-level and regional-level annual plans. Joint support from USG and UNICEF led to the compilation of the first report on the NPA, as well as a review of modalities to strengthen sub-national coordination bodies (Regional and Constituency OVC Committees).

Policy issues around alternative care for orphans were addressed with USG support to finalize and launch Standards for Residential Child Care Facilities, on which all social workers were trained. Initial registration and inspection of facilities is now in progress. National standards for the different OVC service areas were developed and launched in a participatory process involving NGOs and line ministries.

PEPFAR Namibia supported the fostering of Public-Private Partnerships (PPPs) with Standard Bank, De Beers Foundation and Namibia Dairies to improve nutritional support to OVC. This support benefits 800 children and has improved the nutritional status of OVC in sites supported by this intervention. In addition, Standard Bank builds on the USG Ambassador's Girls Scholarship Program by providing scholarships for



secondary education to the vulnerable girls who graduate from the AGSP program, as well as to support a boys' scholarship program. This partnership benefits about 2000 learners.

In FY09, a desk analysis on OVC research was conducted to identify research gaps. The USG also supported the MGECW to conduct a baseline assessment on human trafficking. This study reported that trafficking of persons, especially children, transnationally and nationally occurs in Namibia. The study recommended a coordinated approach to prevention, developing a legal framework, and protection of victims.

The MoE was assisted to finalize and roll-out a school-based OVC register, which will enable better evidence-based planning of educational and other services provided to vulnerable children. USG also supported the MoE in the development of tools and manuals used for training of teachers on the identification, counseling and referral of OVC. Additional USG support increased effectiveness in the delivery of the government's school feeding program and provided assistance to the education sector's HIV workplace program.

At the community level, the USG worked through civil society organizations to deliver targeted community-based services in education, psychosocial support, nutrition, shelter and care and protection. For caregivers, livelihoods were supported through training and support for a broad range of income generating activities, including microfinance. Economic strengthening activities were conducted in conjunction with parenting training.

Between October 2008 and March 2009, 56,097 OVC received direct support from the USG.

Inter-ministerial coordination at all levels, and continued low MGECW staffing levels (shortage of social workers), as well as systemic level challenges to school-related costs continue to present challenges. Policies providing for exemption of vulnerable children from financial contributions are frequently ignored by schools that rely on income from school development funds for many basic school supplies. Critical gaps remain in the affordability and scale of educational services available for young children (e.g., Early Childhood Development), as well as vocational training for out-of-school adolescents. The care and support needs of some categories of vulnerable children are inadequately addressed, such as HIV-infected children or children in improvised school boarding facilities.

Further challenges lie in the sustainability of USG-supported, community-based OVC service programs through community-based organizations (CBO) and faith-based organizations (FBO). Although support to OVC community initiatives includes income generating activities, their scope is often limited given the low economic development in rural communities, natural conditions (e.g. lack or cost of water for market gardens) and low educational levels of caregivers and project members.

Goals and strategies for the coming year

During COP10, the USG OVC program will continue to support the GRN and civil society implementation of the OVC NPA 2006-2010, and develop a follow-on plan of action. Support for the NPA will also contribute to the impact mitigation objectives in the multi-sectoral National Strategic Framework for HIV and AIDS 2010–2015 (NSF), in particular, the objectives related to comprehensive care and support for OVC and economic coping abilities of households with OVC. Under the Partnership Framework, the USG has committed to supporting OVC programming with an emphasis on technical assistance and sustainable service delivery.

The USG will continue to build the planning, monitoring and human resource capacity of the MGECW as the focal ministry for OVC, and will support improved coordination mechanisms between ministerial and civil society stakeholders. USG support will also emphasize strengthening CBO and Namibian NGO to deliver services to children and their caregivers in all of the seven service areas prioritized by PEPFAR.



Evidence-based programming will seek to address GRN and civil society's advocacy and planning capacity for delivering services to groups of OVC whose educational and care and support needs have not been addressed at scale and who have not benefitted from strong development partner interest. Examples include early childhood development for 0–5 year olds and vocational opportunities for out-of-school adolescents, as well as children living with HIV. HIV prevention education and life skills will be integrated into all USG OVC programming with children, adolescents and caregivers.

In COP 10, the USG will continue its ongoing efforts to forge PPPs with Olthaver & List and Coca Cola/Namibia Beverages to support job creation for vulnerable youth as well as linking USG funded education, microenterprise and life skills programs for OVC to jobs based on market needs and demands in Namibia.

Priority Actions

Evidence-based strategic planning:

The USG will support policy makers and service providers to utilize and analyze data from national M&E systems, such as the OVC data base and the school OVC register. A USG M&E advisor will support the MGECW to extend the use of the OVC database to civil society. The USG will also continue to second a senior OVC advisor to the MGECW, who will extend strategic planning support from the Community Welfare Directorate to the Directorates of Community Development and Gender.

The Directorate of Community Development will be supported to develop scale-up plans for early childhood development services in select regions.

To develop better systemic procedures for strengthening the overall use and administration of the government cash transfer system for OVC, USG and UNICEF have already conducted a grant effectiveness study, and USG will provide technical support to the government to analyze and implement the recommendations of this study.

With PHE funding from COP09 (and proposed for COP10) the USG will also embark on quantitative longitudinal research to understand the social and economic determinants of OVC sexual vulnerability to HIV, and the effectiveness of current interventions to reduce this vulnerability. HIV prevalence data will be collected as part of the research.

NGOs/CBOs implementing OVC interventions with PEPFAR funds will be supported to use results-based management techniques, and to evaluate outcomes by using measuring tools such as the Child Status Index (CSI).

Improve quality of programming:

The USG will continue to work through existing local structures such as community-based and faith-based NGOs to continue to deliver services at child level, including nutrition, education, care and psychosocial support. At the household level, caregivers will be targeted with training and microfinance for economic strengthening activities.

In COP10, protection services will be strengthened through support for improved counseling of child victims and follow-up support and referrals by the government's Woman and Child Care Protection Units (WCCPU) in five regions. Community engagement on violence prevention will also be stressed.

Promising practices that target HIV infected and affected children with child-to-child support methodologies will be scaled up, e.g. child support groups.



The USG will provide technical strengthening to local sub-grantees for setting outcomes-based objectives, and to follow national and international service standards in care and support for OVC. These organizations will also be assisted to employ cross-cutting strategies such as stakeholder and child participation, child protection and gender sensitivity, to integrate HIV prevention skills into OVC programming and to conduct referrals.

Organizational development support to local grantees will include stronger emphasis on sustainability, including income generation and leveraging partnerships with local businesses. Stronger emphasis will be placed on advocacy to leverage government budget allocations, for instance in the case of school children residing in improvised and unregistered school hostels.

Promote coordination of care at all levels:

The USG will strengthen the national OVC PTF to enable it to transition from an information-sharing forum to a more action oriented coordination and task monitoring body. USG will continue supporting the functionality of OVC forums in eight regions and support regional councils and constituency to delineate and coordinate the roles of different sub-national coordination bodies, such as Regional AIDS Coordination Committees (RACOC), Constituency AIDS Coordination Committees (CACOC) and regional ECD and protection committees.

The capacity of local sub-grantees to liaise with government offices and facilities will be strengthened by trainings on government responsibilities and regulations.

Address policy issues and strengthen national and local social service systems:

The USG will support the implementation of key aspects of the forthcoming Child Care and Protection Act and of regulations related to alternative care in residential facilities. The USG will assist the MGECW to review and streamline regulations related to social welfare grants and to engage other ministries to ensure that the waiver procedures for fees related to schools and clinics are enforced for grant recipient families and children.

In key areas related to child protection, the USG, through its partners, will help to document emerging policy advocacy needs, such as those related to gender-based violence and child trafficking.

Address human resource needs:

Developing sustainable human resource levels to support OVC programs has been analyzed through a USG-supported human resource and capacity gap analysis. To implement the findings of this study, the USG will support the MGECW to review its overall staff structure and position descriptions, develop training plans, and develop an overall HR structure for all Directorates, including national and regional positions. Special emphasis will be placed on strategies to recruit and retain social workers and on optimal use of field-based cadres across the directorates of Child Welfare (responsible for grants) and Community Development (responsible for ECD). To alleviate the social worker shortage, the USG will continue to support student social workers with bursaries and experiential internship support.

In order to scale up the processing of social welfare grants, the USG funded 150 volunteers for MGECW in 2008/9, which was scaled down to 60 in 2009/10 with the creation of the new government position of CCWs. As MGECW manages to fill all 100 positions for CCWs, the USG will be able to phase out volunteers. Many of the volunteers who meet the requirements have already been recruited into the government cadre.

Technical Area: Pediatric Care and Treatment



Budget Code	Budget Code Planned Amount	On Hold Amount
PDCS	2,683,958	
PDTX	2,859,541	
Total Technical Area Planned Funding:	5,543,499	0

Summary:

Background and Context

Namibia’s HIV/AIDS epidemic is generalized and fueled by heterosexual transmission. An estimated 16,000 of 195,000 PLHIV are children less than 15 years with MTCT being responsible for more than 90% of the cases. The comprehensive care, treatment and support needs of HIV-infected children are key focus areas in the Partnership Framework (PF) between the USG and the Government of the Republic of Namibia (GRN). The PF builds on strong accomplishments and supports the GRN to lead, manage and, eventually, finance the national HIV/AIDS response. The GRN leverages resources for pediatric treatment and care services from the USG, Global Fund (GF), Clinton Foundation, UNICEF and other bilateral donors.

The package of pediatric care and treatment services being supported by USG includes:

- Early identification of HIV-infected persons and referral linkages to and retention in care.
- Anti-retroviral therapy (ART) for all infected infants and eligible children, and support for treatment adherence.
- Regular clinical follow-up and bio-clinical monitoring, including CD4 counts.
- Nutritional assessment, growth monitoring and promotion.
- Infant and Young Child Feeding (IYCF), counseling and food supplementation.
- Co-trimoxazole Preventive therapy (CPT).
- Opportunistic infection prevention diagnosis and treatment.
- Linkages to immunization and other child survival services.
- Pain assessment, management and psycho-social and spiritual support.

By March 2009, 12.4% (7,997/64,000) of all patients on ART were children, reflecting 100% coverage of those estimated to be in need (UNAIDS 2008 EPP). However, the GRN has expressed concern that the projected number of children in need of ART is unrealistically low. Nonetheless, gaps remain in covering all HIV-infected children in Namibia. Some of these challenges, such as human resource (HR) shortages, inadequate infrastructure, and gaps in accessing laboratory services, are common. Additionally, the unavailability of pediatricians in most facilities results in pediatric treatment often being provided by non-specialists. Lack of confidence among health care workers (HCW), coupled with the complexities of pediatric care, are also challenges. While ART is currently being provided at 141 service points (outreach and health facilities) only 35 district hospitals provide care and treatment to HIV-infected children. Current data do not suggest any gender inequality in pediatric access to care and treatment services.

At the community level, the limited capacity of home-based caregivers to identify children eligible for referrals compounds the low number of children seen in facilities.

The increased numbers of children and adolescents in care and treatment programs have created additional challenges for supportive and communication interventions related to disclosure, positive prevention and counseling on sexual and reproductive health.

The GRN is currently revising the counselling and testing guidelines to include provider- initiated testing and counselling (PITC) for children to increase early identification of HIV- exposed and infected children.



In addition, the Reproductive and Child Health Policy is currently being revised to integrate HIV pediatric care and treatment within maternal and child health services.

Community home-based care (CHBC), palliative care, and psychosocial support are provided through USG- and GF-supported civil society organizations (CSO). The MOHSS provides coordination and standards for CHBC and support with home-based care (HBC) kits. Still, bi-directional referrals between health facilities providing pediatric ART and CSO are weak and need strengthening. There is also a need to strengthen the pediatric care component of HBC services.

Achievements since COP09

Based on recent prevalence estimates among adults and pregnant women (2008 HIV Sentinel Survey), the MOHSS estimates that 7,700 children under 15 years currently require ART. According to these estimates, Namibia is meeting the estimated pediatric demand for ART.

Namibia was one of the first PEPFAR-supported countries to implement an early infant diagnosis (EID) program and has revised its EID algorithm to lower the age for HIV antibody testing from 12 to nine months, in line with WHO recommendations. With USG support, the Namibia Institute of Pathology, a fee-for-service parastatal, provides lab services to the Ministry of Health and Social Services (MOHSS) for all diagnostic and bio-clinical monitoring tests associated with providing care and treatment to HIV infected clients, including DNA PCR testing of all exposed children. (Refer HLAB TAN.) In FY09, 12,271 DNA PCR tests were performed with 7.5% of the first testers (PMTCT babies) testing positive. Because Namibian women overwhelmingly practice breastfeeding, the majority of infants who test HIV negative on a PCR at six weeks will receive a second DNA PCR test at least two months after their last breastfeeding to determine if they seroconvert due to breast milk transmission. A confirmatory antibody test is also done on all HIV-exposed infants at 18 months.

In FY09, the MOHSS National Health Training Center (NHTC) trained 446 HCW in dried blood spot (DBS) collection techniques. The EID training curriculum has been combined with PMTCT training to ensure that all PMTCT nurses are competent in this technique and provide appropriate infant follow-up. The curriculum also addresses provision of Co-trimoxazole prophylaxis, infant feeding counseling, assisting women with disclosure to partners, and encouraging male partners to assume more responsibility for the care of HIV-exposed children.

With technical assistance (TA) from the USG, MOHSS developed a pediatric ART curriculum for clinicians with some experience managing ART patients. PEPFAR has supported 241 HCW who have been trained on this curriculum. Additionally, a cumulative total of 865 community based care providers and nurses have been trained in palliative care.

The MOHSS and the Nursing Council are reviewing the nurses' scope of practice and may allow integrated management of adolescent and adult illness/integrated management of childhood illness (IMAI/IMCI) trained nurses to initiate ART. This task-shifting would facilitate the expansion of services for children, as all health centers and clinics have nurses. Currently, nurses can only provide referrals for early care and treatment, treat HIV-related conditions, and continue repeat ARV prescriptions.

PEPFAR supported the development of nutrition-related job aids and training materials for health care workers in ART sites, and started a pilot food-by-prescription (FBP) program in eight ART sites. HCW at these sites and regional program managers were trained on nutrition assessment education and counseling (NAEC). Models to link pediatric HIV clients and other OVC with clinic- and community-based food and nutrition services were also developed.

COP10 GOALS AND STRATEGIES

Through the PF, the GRN will assume increasing responsibility for the pediatric care and treatment



portfolio. In COP10, USG commitments through the PF will support this transition and focus, in part, on:

- TA for evaluation of the EID programs
- TA to develop a model for mother-baby follow -up
- TA for nutrition support for HIV-exposed babies after weaning, and for infected children
- TA for the implementation of PEPFAR-supported HR transition to GRN
- TA to strengthen the existing procurement and logistics systems
- TA to the GRN for continued costing of treatment programs

In COP 10 there will be continued support for the implementation and evaluation of the EID program. To boost early identification of HIV-exposed children, the Primary Health Care Child Health Passport (under-5 card) was revised to include PMTCT, nutrition, and HIV information in COP09 (with support from UNICEF). Utilization of the revised passports will start in COP10. Detailed PMTCT, nutrition and HIV documentation in the passport will support identification of children needing CPT, HIV DNA PCR testing and nutrition supplementation. Use of the passports is also expected to improve the early referral of infected children to care and treatment. Activities will support the follow-up of HIV-exposed children and mother-baby pairs at the community level

With PEPFAR support, the NHTC will continue to train HCW with the integrated EID/PMTCT and IMCI curricula. USG will continue to expand HCW training in IYCF. These trainings will cover nutritional assessments of HIV-exposed children; counseling of caregivers of HIV-exposed children (6–23 months old) on optimal IYCF; management of acute malnutrition; micronutrient supplementation; sanitation and hygiene; links with livelihood support and food assistance; and follow-up of mother-infant pairs to monitor their implementation of chosen infant feeding methods.

Namibia revised its ART treatment guidelines for children in June 2008 and adopted the WHO recommendations to initiate life-saving ART in all HIV-infected infants less than 12 months of age regardless of clinical staging or immunological status (CD4 cell count). Studies have shown that this strategy has reduced pediatric HIV-related mortality by as much as 76%. The USG will continue to support internships in pediatric centers of excellence within the region. Staff exposed to these internships will, in-turn, provide mentorship and training to other HCW in pediatric care and treatment.

In COP10, the USG and the MOHSS will increase support for task shifting by improving and supporting nurses' skills in pediatric HIV care management. Community counselors in ART facilities will provide adherence counseling for children and assist with referrals to other services.

With USG support, the pilot FBP program will be evaluated in COP10. Results will inform further programming decisions. The FBP program provides food supplements for infected and affected children and will leverage support from the Clinton Foundation. PEPFAR will support the MOHSS in expanding and ensuring the quality and sustainability of NAEC and provision of specialized food products to treat acute malnutrition in children. PEPFAR will continue to provide TA to strengthen referrals of malnourished children to HIV testing and acute malnutrition treatment sites.

USG will continue to support communication interventions to ensure that parents and communities understand how to access available pediatric care and support services. In addition, USG will support printing of information education and communication materials on maternal nutrition and IYCF in the context of HIV for distribution at ART/PMTCT sites.

PEPFAR partners and the MOHSS will provide palliative care training using the Namibian curriculum for in-service training, training of trainers and supportive supervision. USG will support an ongoing review of training materials and the essential medicines list, and provide technical assistance to the MOHSS, where needed, to revise policies to increase availability and accessibility of palliative care medicines for children. COP10 will see further strengthening of the overall preventive care package for HIV-infected children,



including malaria prophylaxis and treatment, and insecticide-treated bed nets for children under five. This initiative will be leveraged with GF resources.

Following MOHSS leadership, the USG will support strengthening of bi-directional referrals between health facilities and community-based services. To ensure continuity of care, HIV positive children in care and on ART will need linkages to OVC service providers for psychosocial, spiritual, social and other preventive support. In addition, systems that link OVC to health facilities will be strengthened to ensure that OVC who are beneficiaries of social welfare grants are accessing pediatric care and treatment services, and vice versa.

With USG support, the minimum package for prevention with PLHIV that will be rolled out at treatment facilities and within community care settings will include testing for the children of all registered pre-ART and ART adults. The referral system will be strengthened by ongoing training, monitoring and evaluation efforts, as well as regular coordination meetings between representatives from facility and community-based service delivery points. These meetings will strengthen the relationships between communities and health facilities and are integral to the MOHSS decentralization initiative.

As increasing numbers of HIV-positive children reach adolescence in stable health, issues of disclosure of HIV status and coping with sexuality become paramount. The USG will support the development of a strategy to address the needs of HIV-positive adolescents. Health workers will be trained to communicate with and counsel HIV-infected adolescents and children using the child counseling curriculum developed in COP08. MOHSS will be supported to develop a package of child-friendly services that will address adherence and facilitate open communication between young patients and providers.

TB case finding and provision of TB Isoniazid preventive therapy will be scaled up for HIV-infected children in whom active TB disease has been excluded, as well as for children of sputum-positive contacts. More details about TB/HIV linkages are highlighted in the TB/HIV TAN.

Other aspects of quality care for the HIV-infected child, such as pain and symptom control, as well as psychosocial and social support, will be provided in a holistic manner. Caregivers of HIV-infected children suffer tremendous stress and will be supported spiritually and psychologically to help ensure adherence to treatment for the HIV-infected and affected children in their care.

With PEPFAR support, the MOHSS will expand the quality improvement (QI) program to all 34 districts of Namibia (Refer HBHC/HTXS TAN). QI will be expanded to include pediatric care and treatment indicators in COP10. In addition, HCW in the public and private sectors will continue to receive training updates on pediatric clinical skills through the HIV Clinicians' Society and other USG partners.

The continued roll-out and refining of the electronic patient management system to improve data capture, analysis and transmission from peripheral to central levels, (Refer to HVSI TAN) as well as bi-directional feedback between national and regional levels, will be supported. Lessons learned will be disseminated during quarterly partner meetings in-country and shared in regional and international meetings.

Technical Area: PMTCT

Budget Code	Budget Code Planned Amount	On Hold Amount
MTCT	4,336,278	
Total Technical Area Planned Funding:	4,336,278	0



Summary:

Context and background

Namibia's ANC sero-prevalence of 17, 8% in 2008 remains one of the highest worldwide and poses a real challenge to efforts to control pediatric HIV. The country, in collaboration with donors, is currently undertaking a review of its five-year strategic plan for HIV/AIDS, and is developing a framework to guide implementation of the multi-sectoral response to the HIV/AIDS epidemic; the National Strategic Framework (NSF). PMTCT as an entryway to care, treatment and support for HIV positive pregnant women and their families is one of the key prevention objectives of the Partnership Framework (PF) between the USG and the Government of the Republic of Namibia (GRN), which is closely aligned with the NSF.

The Ministry of Health and Social Services (MOHSS) started PMTCT services as a pilot in 2002, and has rapidly scaled-up to 242 (95%) of the 256 ANC facilities (Namibia has 335 health care facilities in total, of which 114 facilities offer regular Labor and Delivery (L&D) services. Currently more than 95% of women attend an ANC clinic, while 81% deliver with assistance by skilled birth attendants (SBA). This figure of 81% conceals significant regional variations, and through the MOHSS Roadmap for the Acceleration of the Reduction of Maternal and Newborn Morbidity and Mortality, the GRN has made improving access for more women to give birth with a SBA a key objective. As geographic access expands and becomes more equitable, these percentages should increase.

It is anticipated that 61,000 women will become pregnant in COP 10, and that more than 95% will accept to be tested for HIV. More than 80% of the estimated 10, 970 HIV positive pregnant women; and greater than 95% of their HIV-exposed infants will receive ARV prophylaxis. Without this high uptake of PMTCT services, an estimated 3, 291 (30%) of children would likely become HIV infected in Namibia.

Namibia has used combination ARV prophylaxis for PMTCT since August 2008. HIV-positive pregnant women who do not meet criteria for initiating HAART receive AZT from 28 weeks gestation, sdNVP and AZT/3TC at the onset of labor, followed by a 7 day 'tail' of AZT/3TC. The HIV-exposed infant receives sdNVP within 12-72 hours of delivery, followed by a 7-day 'tail' of AZT and 3TC. With this regimen for PMTCT, MTCT should be reduced to less than 10%. Furthermore, Namibia's PMTCT guidelines will be revised in 2009 to add emphasis to the provision of highly effective prophylaxis or HAART throughout the antenatal, labor and postpartum risk periods to align with anticipated revised WHO guidelines expected end of 2009.

National scale-up

In COP10, USG will continue to support PMTCT as a priority program area to reach all 256 ANC facilities, and provide at least 90% of all pregnant women with ANC care, regardless of HIV status. USG will contribute to the safe motherhood goals by supporting expanded access to a basic package of ANC services for all pregnant women. The package includes access to HIV testing using the 'opt-out' strategy, hemoglobin and syphilis testing, urine examination, and blood pressure checks. Provider-initiated testing and counseling (PITC) will encourage more women and family members to seek HTC. In addition, all HIV-positive pregnant women will receive; infant feeding counseling; referral to pre-ART registration; assessment for ART eligibility; longitudinal HIV care; Cotrimoxazole Preventive Therapy (CPT); TB Isoniazid Preventive Therapy (IPT), and malaria Intermittent Preventive Therapy and impregnated bed nets if in malaria-endemic areas. Partner testing and disclosure will be emphasized and supported. Pregnant women who test HIV-negative will be encouraged to remain negative and to use condoms with every sexual contact. In addition, repeat HIV testing in pregnant women who initially test HIV-negative will be performed at 36 weeks gestation to take account of the possibility of incident HIV infection; while continued counseling will be given to women who initially decline HIV testing.



Health workers will be trained in the revised PMTCT/EID curriculum to equip them with skills to deliver the above package; as well as to give infant ARV prophylaxis and to follow-up HIV-exposed infants.

Namibia ascribes to the WHO's four-pronged approach to PMTCT that recognizes PMTCT as a bridge between the national HIV/AIDS response and primary healthcare. The four "prongs" are:

1. Primary prevention of HIV
2. Prevention of unintended pregnancies among HIV-infected women
3. Prevention of HIV transmission from mother-to-child
4. Provision of care, treatment and support for HIV-infected mothers, their partners and families as appropriate

In response to the "mainstreaming" vision described in the NSF and the Partnership Framework documents, renewed emphasis will be directed towards "prong #2."

Specifically:

- Linkages with family planning services will be strengthened; including co-locating PMTCT and SRH/FP services during ANC and postpartum periods;
- FP providers will be trained on PMTCT;
- Support for the provision of FP commodities in the postpartum period and beyond;
- Incorporating emergency obstetric care and neonatal resuscitation into PMTCT training

In FY10, USG will provide targeted assistance to the emergency obstetrical care as per the funding gap analysis performed as part of the MOHSS Roadmap for the Acceleration of the Reduction of Maternal and Newborn Mortality.

Accomplishments since last COP

It is projected that 61,000 women will become pregnant during the period covered by COP10. In the GRN FY '08, 59,666 pregnant women presented for first ANC visit, of whom 3,578 (6%) already knew they were HIV positive. 52,822 (96%) of pregnant women with unknown status accepted an HIV test. Of the women who were tested in ANC, 6,140 (12%) were HIV-positive and 5,308 (86%) of these received post-test counseling. Of the 6,140 women testing HIV-positive in ANC, 5,676 (92%) had a CD4 count done. Of these HIV-positive women, 1,042 (18%) had a CD4 count of less than 250, making them eligible for ART.

47,190 women delivered in health facilities. Of these, 42,092 (89%) knew their HIV status. Furthermore, 8,565 of those who knew their status on admission were HIV positive. Of the 4,057 women of unknown HIV status on admission to maternity, 1,730 (42%) accepted testing at delivery, with 712 (41%) testing HIV-positive. This figure highlights the need to increase access to rapid testing in labor ward to minimize missed opportunities for women of unknown HIV status. Adding the women with a prior HIV-positive diagnosis who presented to the labor ward, to the number that newly tested HIV-positive at delivery, a total of 9,277 women were HIV-positive at labor and delivery. Of these, 84% had taken ARV prophylaxis for PMTCT, while 88% of all HIV-exposed infants received PMTCT prophylaxis.

Since PMTCT program inception, 3,488 health care workers have been trained in PMTCT. In COP09, the PMTCT curriculum was revised to include Early Infant Diagnosis (EID), and 167 health care workers have been trained since then.

Goals and strategies for the coming year

Technically over the next year, USG will strengthen testing in labor wards and postpartum counseling and



testing, to minimize missed opportunities for PMTCT. Counseling on safe infant feeding options will be provided to newly identified HIV-positive mothers. Women identified as HIV-negative in ANC and at or after delivery will receive intensive counseling to encourage them to remain negative. Those who are HIV-positive will receive prevention with persons living with HIV/AIDS (PLWHIV) package. This includes counseling on family planning and promotion of condom use as a second method of contraception, i.e. dual contraception, to prevent unintended pregnancies as well as STIs and HIV re-infection.

USG will continue to support training of health care workers (HCWs) to adequately equip them to provide quality PMTCT services. Support for Digital video conferencing (DVC) facilities will be continued as a way to complement in-service and pre-service training courses. Training in the revised PMTCT/EID curriculum will be intensified in COP10. The child health card revised in FY09 with support from UNICEF to include HIV-specific information that facilitates early identification of HIV-exposed infants eligible for CPT and DNA PCR testing will be rolled-out in COP 10. PITC will also be expanded to include children. HIV rapid tests will be offered to children at nine months in keeping with WHO recommendations. To minimize costs, children who are between nine and 18 months will have an HIV DNA PCR test only if they have an HIV-positive antibody test.

PEPFAR will also support pre-service and in-service training in PMTCT/EID, leveraging resources from the Global Fund. MOHSS' M&E efforts will be strengthened to improve the capacity for data management and utilization of District Health Information Systems (DHIS) routine PMTCT, as well as EID data, to both guide future programming and assist with evaluations.

In COP10, community counselors (CCs) will receive updated training to improve their skills in counseling pregnant HIV-positive women on adherence and safe infant feeding options. In addition, CCs will be trained to improve their capacity to provide preventive counseling to pregnant women who test HIV-negative to remain negative. This support will also include counseling on disclosing their HIV-status to their partners. Case managers and CCs will help initiate support groups for mothers, assist with partner testing, and referral and follow-up of mother-baby pairs. This initiative will enhance linkages with community-based organizations to assist pregnant and postpartum women with follow-up and on-going HIV care and treatment.

Laboratory capacity will be strengthened to facilitate CD4 count testing for all HIV positive women and increase access to ART for eligible patients. In COP10, turnaround time for CD4 will be reduced by utilizing point-of-care CD4 testing, improving transportation between laboratories and clinical sites, and adding CD4 testing capacity to more laboratories.

Doctors and nurses trained in the Integrated Management of Adult and Adolescent Illnesses (IMAI) will prescribe ART to ensure pregnant women receive appropriate therapy. Not only will expanding access to ART target HIV-positive women most likely to transmit HIV to their babies; it will also improve health outcomes and survival, and lessen the risk of them developing ARV resistance. HIV-positive women and their HIV-exposed babies who are not yet eligible for ART will be enrolled in longitudinal care and receive ARV prophylaxis for PMTCT.

Safer infant feeding practices will be promoted through better infant feeding counseling and practical demonstrations of infant feed preparations in health facilities. The Nutrition Department in the PHC will update Infant and Young Child Feeding guidelines based on WHO guidance.

Infants' health will be maximized by incorporating growth monitoring and promotion, anthropometry, and nutritional counseling and support for all HIV-exposed children 6-24 months. USG will support the establishment of, and strengthen existing linkages to OVC support and nutrition programs. In COP10, 10% of HIV-positive pregnant and lactating women will get nutritional supplementation. Current M&E tools will be revised to capture data on the nutritional status of pregnant and lactating women, and their HIV-



exposed children.

The HIVQUAL quality improvement program covers all 34 district hospitals in Namibia, and will expand to include PMTCT indicators to assist facilities to utilize data to improve the quality of their PMTCT efforts.

Gender-based violence, stigma, and discrimination remain barriers for some women to accept HIV testing, or disclose their status to partners and families. To address this, managers from the PMTCT program will engage communities through meetings facilitated by local leaders. These forums will provide opportunities for dialogue, promotion of PMTCT and HCT services and help to increase male involvement in PMTCT. In February 2008, Namibia hosted the first National Male Leaders Conference on HIV/AIDS; and similar meetings at community level will be replicated to sensitize men about issues of gender-based violence; the importance of supporting women in PMTCT and HIV/AIDS care; and dispel myths that perpetuate the subjugation of women by men.

The PMTCT program will also be linked with other PEPFAR program areas, e.g. HVCT, HVAB, HVOP, CIRC and HMBL, to promote standardized data collection methods and systems. Where appropriate, support for health information system (HIS) will emphasize inter-programmatic data sharing and communications.

To maximize cost savings, the PMTCT team will work with other program areas teams to identify training, logistics, infection control, waste management, referral, data management and supervisory tasks that may be shared or combined to avoid duplication.

Funding issues and Sustainability

The major partner in PMTCT is the MOHSS, which provides all operational costs to state and faith-based facilities. In addition to MOHSS contribution, other contributions during COP10 will come from GF RCC; nevirapine from Boehringer-Ingelheim and Determine rapid test kits from Abbott. The Clinton Foundation will continue to provide support for up to 20,000 HIV DNA PCR test kits, as well as Ready to Use Therapeutic Foods (RUTF) for eligible pregnant and lactating women and their HIV-exposed babies. These contributions clearly demonstrate public-private partnerships.

In the coming year, the USG will further align its activities with the MOHSS through the completion and implementation of the PF and PFIP. A major challenge will be the Government of Namibia's ability to transition financial support to several cadres of health care workers that are currently supported fully by the USG; in support of this transition, USG will provide:

- TA support for evaluation of the PMTCT and EID programs
- Ongoing TA support to scale-up PMTCT implementation
- TA support to develop a model of Mother-baby follow-up, leveraging resources with UNICEF
- Provide GRN with support for continued costing of PMTCT

This transition process is expected to occur over the next five-years with clearly defined benchmarks annually.

Technical Area: Sexual Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVAB	8,216,802	
HVOP	5,486,548	
Total Technical Area Planned	13,703,350	0



Funding:		
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Summary:

Context and Background

Profile of the Epidemic

Namibia is one of the countries in the world most affected by HIV and AIDS. With approximately two million citizens, Namibia has a generalized HIV epidemic widely dispersed across the country. According to estimates derived from UNAIDS models, Namibia's national HIV prevalence for adults in 2006 was approximately 15%. Adult prevalence estimates have been decreasing since 2002, from 17% to 15%, mirroring a national decline in prevalence among pregnant women.

HIV prevalence among pregnant women attending ANC peaked at 22.0% in 2002 and declined to 17.8% by 2008. HIV prevalence among young pregnant women (15 to 24 years) declined significantly from 15.2% in 2004 to 10.6% in 2008. HIV prevalence in pregnant women is not equally distributed across Namibia's 13 regions. The highest burden of HIV is in Katima (32%). Although overall prevalence estimates are declining, troubling increases have been observed in some Northern areas (Nyangana and Okahao).

In 2008/9 there were approximately 195,000 adults and children living with HIV and AIDS (PLHIV) in Namibia.

Description of Major Epidemic Drivers

In 2008 the National Prevention Consultation, with USG support, identified the following key drivers of the epidemic in Namibia:

- Lack of male circumcision
- Multiple concurrent partnerships
- Inconsistent condom use, especially among married and cohabiting couples
- Excessive alcohol use
- Intergenerational sex
- Transactional sex
- A lack of HIV testing and public awareness of HIV serostatus

Populations of Persons Engaged in High Risk Behaviors

The majority of prevention efforts in Namibia are focused on the general population. PEPFAR-supported HIV prevention efforts have focused on averting new infections among HIV-negative individuals. Recent cross-cutting efforts have included prevention with HIV-positive individuals, helping HIV infected individuals protect themselves and avoid spreading HIV to others.

Groups of "most at risk populations" (MARPs) have also been identified:

- 1) Persons engaged in commercial sex work (CSW), and their clients, and
- 2) Men who have sex with men (MSM).

Injection drug users, often considered a MARP, are not common in Namibia.

USG support for the GRN's sexual prevention strategy will include appropriate assistance related to legal and policy barriers to prevention, care, and treatment services for these groups. Other populations with increased vulnerability to HIV due to a combination of behavioral, social, or environmental factors include:

- 1) Military and other uniformed services
- 2) Men and women engaging in transactional sex
- 3) Incarcerated persons



- 4) Mobile populations (e.g. migrant workers, truck drivers, seafarers)
- 5) Street and other vulnerable youth,
- 6) Persons who engage in alcohol-associated HIV sexual risk behaviors

Male and Female Condoms

According to the 2006 National Demographic and Health Survey (NDHS), 41% of women, and 57% of men, reported using condoms the last time they had sex. Similarly, 62.1% of women and 78.3% of men aged 15-49 who had sexual intercourse in the last 12 months (prior to NDHS) with non-marital, non-cohabiting partners, reported using a condom. The majority of condoms in Namibia are financed by the Global Fund (GF), which provides support for production of the MOHSS Smile brand of male condoms, and for Femidom female condoms. The Namibian Defense Forces support a Camo brand of condom for uniformed services. Condoms are distributed free of charge to health facilities and to the community. In 2010, Namibia will procure 20 million condoms. GF will fund 13 million condoms, USG six million, and the GRN one million. Regional condom distribution is not always consistent with population needs and requires strengthened logistics and distribution strategies to improve accessibility.

Prevention and Namibian National Strategies

The PEPFAR prevention priorities outlined in COP10 and in the Partnership Framework, were developed in consultation with the GRN. Special emphasis has been placed on aligning PEPFAR activities with the National Strategic Framework (NSF). The GRN is developing a comprehensive, evidence-based National HIV Prevention Strategy focused on known epidemic drivers, scaling-up prevention interventions, and intensifying work with vulnerable groups and MARP.

The USG collaborates with GRN stakeholders (e.g., MOHSS, Ministry of Information, Communication, and Technology (MICT), Ministry of Education (MOE) and other government entities), as well as UNICEF, UNAIDS, WHO, GTZ and civil society partners including organizations serving PLWHA.

Accomplishments Since Last COP

Namibia prioritized prevention as a key strategy in addressing HIV/AIDS. The GRN, with USG support held the first National Prevention Consultation, appointed a National Prevention Coordinator, and established a National Prevention Technical Advisory Committee (TAC). The GRN is developing a comprehensive, evidence-based National HIV Prevention Strategy to address the known drivers of the epidemic. The preventin TAC and workgroups (e.g., multiple concurrent partnerships (MCP), alcohol and HIV, interpersonal communication (IPC), and prevention for PLWHIV) allowed the USG to provide technical assistance to support coordination and expand prevention activities.

The GRN and USG continued to scale up primary and secondary prevention programs throughout the country. PEPFAR continued support for MICT to target messages on drivers of the epidemic. In COP09, a multi-component package was launched to focus on MCP. The package included mass media as well as complimentary interpersonal communication activities for field-based workers. PEPFAR partners played a key role in message development and intervention delivery. Capacity building by USG to GRN and local partners had an important impact on local capacity to implement higher quality programs.

Interventions targeting youth included the integration of age-appropriate HIV/AIDS learning activities into extra-curricular activities and peer education activities targeted to in-and out-of-school youth. In addition, PEPFAR supported the national scale up of the MOE workplace program.

PEPFAR funded activities for several key MARP and vulnerable populations including the police, transportation workers, seafarers, and persons engaged in transactional sex with ongoing targeted behavior change communication (BCC), condom distribution, and STI and HCT referrals.

PEPFAR has adapted and implemented the evidence-based "Men as Partners" approach as part of



OGAC's global gender initiative. See the Gender TAN. PEPFAR continued to support mainstreaming of gender messaging into programming for clinical and community settings and mass media.

A review of many of the USG-supported partners was completed with specific recommendations and activities to strengthen the quality and impact of BCC programming. Follow-up technical assistance was provided to ensure strong BCC programming within service delivery, mass media communications, and interpersonal communication.

A Namibian organization, with USG support, provided door-to-door prevention services to over 350,000 individuals through 350 trained community-based field officers. These activities were enhanced by placing an additional emphasis on behavior change.

Namibia expanded a facility-based community counselor (CC) program to 650 counselors. These lay counselors provide the majority of HCT services, as well as prevention and treatment adherence counseling to clients. CC were trained on prevention for PLWHIV, as well as male circumcision counseling and referral. CC began operating in correctional facilities.

A case management program with social work professionals complements the CC program. USG conducted a needs assessment to guide the placement of 35 facility-based case managers who will assist with prevention counseling, default tracing, facilitation of support groups, and bi-directional referrals between facility-and community-based services.

In COP09, the USG supported the launch of mobile units offering HIV testing, as well as prevention, care and treatment services, to underserved and difficult to reach populations and MARP.

Namibia participated in two OGAC initiatives that complemented the prevention portfolio: Prevention for PLWHIV and Alcohol-HIV prevention.

The PLWHIV prevention initiative included a pilot training course and support for the implementation of facility-based provider-delivered prevention messages, family planning services, STI services, and testing of partners and children. An assessment of PLWHIV community-based prevention produced recommendations for complimentary community-and facility-based prevention for PLWHIV programming.

A second centrally funded initiative to address the interface between alcohol and HIV was initiated in Namibia in 2009. This multi-component assessment and intervention program includes:

1. Expansion of MOHSS Coalition for Responsible Drinking (CORD) to all 13 regions; support new national alcohol abuse prevention and treatment legislation;
2. Supporting structural interventions to reduce hazardous drinking within alcohol sales venues;
3. Promoting health provider training in alcohol screening, interventions, and referrals to treatment; creating addiction certification training programs through UNAM; and supporting the expansion of Alcoholics Anonymous;
4. Conducting risk assessments and a randomized controlled trial to evaluate evidence-based behavior change interventions related to alcohol use;
5. Supporting the evaluation and revision of existing secondary school alcohol-HIV risk reduction programs;
6. Developing a toolkit of alcohol-related HIV prevention messages and materials.

Challenges

During the development of the NSF, several assessments revealed the following limiting factors among current prevention programs in Namibia:



- Programs not evidence-based, nor focused on behavior change, nor adequately addressing the key epidemic drivers of transmission
- Programs not clearly targeted to high risk geographical areas, MARP and vulnerable populations
- Lack of coordination of HIV prevention efforts
- Poor geographic distribution of intervention coverage and intensity of interventions (dosage) to achieve behavior change
- Lack of M&E capacity support and lack of adequate supportive supervision.
- Lack of updated curricula or IEC materials necessary to work with individuals or groups

In addition, the Regional and Constituency AIDS Coordinating Committees (RACOCs and CACOCs) need to be strengthened to implement the national response.

A USG TA visit reviewed MARP programming and outlined several challenges with current outreach to MARPs. The visit emphasized a renewed focus on MSM, CSW and partners of CSW. In addition, a review of selected community outreach efforts identified weak implementation and the need to focus on dosage/intensity of BCC instead of knowledge/awareness activities, improved linkages to HIV services and stronger M&E of outreach. Further findings indicated that several small activities were highly dispersed across the country.

Goals and Strategies

In COP10, PEPFAR will align its prevention efforts with the NSF and the developing National Prevention Strategy. Both of these documents emphasize combination prevention, which combines behavioral strategies with biomedical and structural interventions.

Most effective behavioral interventions are multi-level and multi-channel, and aimed at multiple behaviors. Structural interventions will be supported, including addressing underlying gender and social norms, economic livelihoods, access to formal and informal education, and mobility.

The USG will collaborate with MOHSS, MICT's Take Control program, and MOE's school-based programs, and other GRN entities. USG supported activities will be coordinated through the prevention TAC, and through relevant workgroups to strengthen collaboration. The USG will continue to invest in local partners and build their capacity to implement evidence-based programs within the National Prevention Strategy.

Namibia will continue to enhance and expand the multi-level programming outlined above. In addition, several follow-on activities will enhance the overall prevention portfolio to address a more strategic mix of methods, dosage/intensity, targeted populations and geographic focus. A redesigned multi-component communications and community outreach activity will focus on strengthening approaches that address key epidemic drivers in the general population. A redesigned education sector program will link with PEPFAR's OVC program to strengthen existing prevention interventions with vulnerable in-school youth and teachers. PEPFAR will expand the scope of community-based, door-to-door prevention services by adding household HCT services. To support USG MARPS programming, research on behavioral practices and size estimations of MSM and CSW populations will be conducted. USG will introduce a program focused on capacity building and delivering tailored prevention packages to CSW, their clients and MSM. The USG will also review and amend existing activities to improve effectiveness and efficiency in materials development, messaging, outreach, linkages to services, and M&E. Expansion of male circumcision services will also take place with COP10 resources (See Biomedical TAN).

Prevention programming for youth has also been identified as a high priority. PEPFAR will add a new intervention to promote positive parenting practices and effective parent-child communication about sexuality and sexual risk reduction for parents and guardians of 9-12 year olds. In addition, PEPFAR will



strengthen and link a peer promoter program to raise awareness about HIV prevention and blood donation among in-school youth with other in-school prevention activities

Sexual Prevention goals linked to the Partnership Framework

Activities for COP10 will support commitments described in the Partnership Framework Implementation Plan currently under development.

USG support will focus on:

- TA to the GRN to finalize the Prevention Strategy and to implement evidence-based programs with a focus on the HIV epidemic drivers, and outreach to MARP
- Continued government-to-government technical and financial support to design, implement, and evaluate quality prevention interventions that are fully integrated with GRN systems
- Support for planning and transitioning increased responsibility to the GRN
- Support for long term capacity development including training and support for task shifting
- Support for prevention activities that merge individual behavior change, structural factors and biomedical interventions.
- Support for collaboration, coordination and capacity building with the GRN, local civil society and private sector partners

Technical Area: Strategic Information

Budget Code	Budget Code Planned Amount	On Hold Amount
HVSI	4,645,120	
Total Technical Area Planned Funding:	4,645,120	0

Summary:

Context and Background

The USG continues to support GRN strategic information (SI) activities, including monitoring and evaluation (M&E), surveillance, and health management information systems (HMIS). The establishment of the Partnership Framework (PF) will further solidify the USG's commitment to build sustainable systems and capacity. Five-year USG commitments include providing TA to support data quality improvement and utilization, supporting follow-on population-based surveys, and developing cost-recovery strategies in support of the research agenda. COP10 activities will focus on training, mentoring, and collaboration.

The PF contains an M&E plan aligned with the Namibian National HIV Strategic Framework (NSF). The NSF's results framework and M&E plan are key instruments for monitoring HIV service delivery and policy reform commitments from all partners. Regular monitoring of the PF's five-year goals, objectives, and commitments via an annual joint review with PF partners and established APR and SAPR monitoring systems will be critical to ensuring that the goals of the NSF are realized.

Namibia's ability to implement the NSF is limited by inadequate human resources, insufficient expertise in SI disciplines, and fragmented information systems. USG activities in COP10 will strengthen Namibian SI capacity through: (1) technical advisors who will work closely with GRN and civil society partners; (2) support for human resources for data entry and management; (3) information technology hardware and software; (4) support for surveys, surveillance, and evaluations, and; (5) other capacity building activities for civil society and GRN ministry personnel. This will include technical support for the University of Namibia's M&E training program, technical assistance via implementing partners, scholarships for M&E workshops, and short courses at internationally recognized institutions in the region.



The USG SI team is working with host country counterparts to prioritize and address SI gaps by building capacity in the use of existing data sources and promoting key surveys to identify population characteristics related to HIV and TB transmission and prevention. The objective is to provide evidence to inform the design of prevention, care and treatment activities, while building local capacity in SI skills. USG representatives sit on the national M&E committee to ensure coordination with government ministries, civil society, and other development partners.

Priorities of the USG SI team are to support and improve the national health information systems (HIS), including the establishment of such systems for the Ministry of Defence/Namibian Defence Force (MOD/NDF). Since 2002, the USG has supported the development of paper-based and electronic information systems that allow calculation of critical HIV and TB indicators. USG is currently recruiting an HIS technical advisor – a position created in COP05 but recently vacated. This advisor will assist the HIS and M&E subdivisions in the Ministry of Health and Social Services (MOHSS).

Accomplishments and Continuing Activities Since Last COP

USG continues to support: (1) The review and revision of the ART clinic-based patient monitoring system (based on the WHO ART card), which included development and roll-out of a locally engineered, computerized system (Electronic Patient Monitoring System) to capture and report on critical indicators; (2) roll-out and enhancement of the ART pharmacy management information system (PMIS) and commodity-tracking system; (3) design and roll-out of the electronic TB information management system, and; (4) design and roll-out of a revised routine HIS that captures key epidemiological outcomes (on HIV/AIDS, TB, mortality, PMTCT, and VCT).

In COP09, USG Namibia continued to harmonize its M&E system with the GRN's, with the strategic goal of reducing the burden of data collection, reporting, and monitoring, and eliminating parallel reporting systems. USG has always relied on GRN health information systems for facility-based data, but community-based partners have reported to USG outside of the GRN's nascent community-based monitoring system. The PEPFAR Next Generation Indicators (NGI) have been integrated into the NSF results framework. The USG plans to be fully reliant on the GRN's HIV reporting system for all PEPFAR reporting needs by the end of COP10. Thus, the USG is working closely with the GRN to improve its health information systems and its community-based monitoring system. To reach this goal, the USG will continue to support the development of HIS programming and architecture, data flow, and data quality. A key challenge continues to be discrepancies between GRN and USG fiscal years and reporting periods.

In COP09, the OVC national data warehouse (based in the Ministry of Gender Equality and Child Welfare, or MGEWCW) was rolled out and is being populated. (Additional details are provided in the OVC TAN.) USG continues to support this effort through technical assistance (via an implementing partner) to MGEWCW.

In COP09, Namibia made significant progress in completing the USG-supported health facility census (with co-funding from Global Fund). At the time of this writing, data collection was approximately halfway done. The final report should be completed by the middle of 2010. Also, a USG-supported situational assessment of palliative care was completed, and progress on several public health evaluation (PHE) protocols was made. Several reports on formative assessments were completed (e.g., the prevention assessment, attitudes toward male circumcision, costing and impact of male circumcision, and alcohol and sexual partnerships).

A USG-supported data triangulation activity was conducted in COP09 through several workshops which built capacity for collating, analyzing, and interpreting data from different data sources. Expertise from local partners supported the interpretations and conclusions. USG will support follow up workshops on how to write up and disseminate the results in COP10. The goal of all these activities is for GRN to lead



the next triangulation exercise proposed for COP10, once upcoming surveys are completed.

Continuing from COP08, the SI team will support the information technology component of the HIV quality-of-care evaluation at the facility level.

As noted above, support for M&E systems is a USG priority. A USG technical advisor for M&E has been seconded to the MOHSS M&E Sub-Division since COP06. Recently vacated, this post is currently being recruited.

Since COP07, the USG has supported 13 regional level M&E officers (one per region), who lead SI activities in each region. In COP10, the USG will continue to support national and regional implementation of the Integrated Action Plan (IAP), with the 13 regional M&E officers playing a pivotal role in data collection, program monitoring, and basic analysis. Under the new Namibian Labour Law, the MOHSS has assumed greater management and oversight responsibilities for these staff. A private firm will continue to provide contract HR services to the MOHSS, e.g., recruitment and payroll.

Capacity building is a central tenet of the IAP. In COP08, the USG supported the development of a Namibian M&E curriculum. In COP09 the USG continued to support the delivery of this curriculum via UNAM. In COP10, the USG will continue to support the revision of this curriculum and its delivery with technical support from UNAIDS, the World Bank, and other development partners. USG COP10 activities will support the development of the annual HIV/AIDS report, the UNGASS report, and quarterly bulletins, among other publications. In addition, building on the data triangulation activity, MOHSS staff will be trained in authoring conference abstracts and manuscripts for peer-reviewed journals.

The USG also supports surveys and surveillance systems to inform the design of prevention, care, and treatment programs; provide inputs for epidemiological projections and monitor progress toward prevention, care, and treatment goals. In COP10 the USG will support the GRN to implement the bi-annual sentinel HIV survey and possible incidence testing on banked samples from the 2006, 2008, and 2010 sentinel surveys. To establish HIV infection levels in the Namibian military, the USG will continue to support a prevalence study that was first funded in COP08. The USG will also continue to support the implementation of an AIDS Indicator Survey (AIS) or other population-based survey with an HIV biomarker to estimate HIV prevalence in the general population. Additional support will be provided for behavioral and prevalence surveys among prisoners. COP10 will provide support for a rapid ethnographic assessment, population size estimation, and bio-behavioral survey of selected most at-risk populations such as MSM, SW, and migrant workers. The USG will also support a survey of TB cases to assess the extent of drug-resistant TB and drug-resistant HIV throughout Namibia. A smaller, less in-depth version of this survey took place in 2007. COP10 will also support an HIV drug resistance threshold survey.

Continuing from COP06, the USG will support training on the use of the EPP/Spectrum software packages to enhance HIV-related projections. Using these and other tools, the USG will assist the GRN in modeling the projected need for clinical, laboratory, and pharmaceutical services through 2014. These projections will be critical to guide costing, policy and other planning commitments described in the PF documents.

In COP10, the USG will continue to support the following PHEs: (1) an ART adherence survey; (2) an evaluation of a comprehensive prevention intervention for HIV care and treatment settings; (3) a quasi-experimental study on the impact of an intervention on changing gender norms that support HIV risk behaviors among men in Namibia; (4) an evaluation of physician compliance to guidelines on treatment and prescription for HIV/AIDS; (5) assessing if clinical outcomes are improved through increased patient involvement and (6) an evaluation of OVC sexual vulnerability. At the time of the COP10 submission, Team Namibia was awaiting word from the PHE review committee regarding the newly proposed PHEs for COP10.



The USG SI team includes the SI advisors for CDC and USAID, the HIV/AIDS project coordinator for DOD, the M&E technical advisor for CDC, the HIS technical advisor (CDC), an SI program assistant at USAID, and the SI liaison at the PEPFAR Coordinator's Office. SI team members communicate daily to support SI activities, and meet weekly.

Goals and Strategies For the Coming Year

In COP10 and beyond, annual and five-year targets will be aligned with the commitments made in the PF and PFIP. For example, PEPFAR service delivery targets will be revised over time as the GRN assumes a greater role in the provision and financing of health services. Likewise, health systems strengthening targets will be revised to reflect increased PEPFAR support for technical assistance. Data on NSF indicators and PEPFAR indicators included in the PF M&E Plan are also collected and monitored on a quarterly basis. Data are reported to HQ and to all PF partners on a semi-annual and annual basis via the existing PEPFAR SAPR and APR structures.

PF progress will be monitored through national-level surveillance, population-based surveys, facility-based surveys, program evaluations, PHEs, and other surveys designed to assess the impact of the national HIV response. These surveys will be planned in accordance with NSF technical priorities and in collaboration with PF partners.

An annual joint review committee (JRC) with representation from all PF partners will review the PFIP on an annual basis, ideally harmonized with the NSF joint annual review and periodic mid-term reviews. Projected financial commitments will be monitored using a simple financial tracking tool. All partners will be required to report annually on annual spending per focus area. Policy reform will be measured using a standardized template. The annual JRC will monitor targets and results, and will be responsible for discussing progress toward annual and five-year targets. The JRC will also identify underperforming projects and/or partners and recommend evidence-based interventions. A narrative report following the M&E plan outline and the updated baseline, target, and results table with integrated annual results will be developed or revised during the annual joint review.

With these commitments, the USG has begun to establish a five-year SI strategy. All commitments listed will require consultation with the GRN and partners before being initiated.

- Provide capacity building for analytic interpretation and use of population-based survey results for program planning
- Develop a surveillance strategy and build GRN capacity to conduct routine surveys
- Improve data quality and integration of various systems by creating a national HIV data warehouse
- Increase M&E capacity in Namibia by supporting UNAM's new international M&E curriculum and assisting UNAM to regularly conduct trainings
- Build M&E capacity by engaging and mentoring GRN M&E staff in all USG-funded evaluations; develop a transition plan for the GRN to assume leadership of major evaluations and surveys
- Support coordination of GRN M&E activities via RM&E and other M&E bodies
- Transition USG-funded positions to GRN or GFATM funding

Technical Area: TB/HIV

Budget Code	Budget Code Planned Amount	On Hold Amount
HVTB	3,248,483	
Total Technical Area Planned Funding:	3,248,483	0



Summary:

Overview

A 2008 WHO Global TB Report estimates that Namibia detected 84% of TB cases in 2007. This exceeds the global target of a 70% detection rate. Over the past 10 years (1998-2008) TB annual notifications increased from 12,286 in 1998 to a peak of 16,156 cases in 2004. Namibia has experienced a gradual decline in the total number of new cases since then. However, with 13,373 cases of all forms of TB, and a case notification rate of 665/100,000 population (of which 4,928 were new smear positive cases reported in 2008) TB remains a major public health problem in Namibia. Additionally, drug resistant TB is on the rise.

Over the past four years Namibia has made progress in scaling-up TB/HIV activities to address co-infection. The increase of HIV counseling and testing (HCT) among TB patients helped draw attention to the magnitude of TB/HIV co-infection. In 2008, 66.9% of notified TB patients were tested for HIV. Of those tested 59% were HIV positive. These data clearly demonstrate the link between TB and HIV. As a result, the national response focuses on TB/HIV co-management and co-implementation of TB/HIV activities.

The treatment success rate for new smear positive TB increased from 70% to 83% between 2004 and 2007, nearly reaching national and international targets. Despite this progress, the emergence of drug resistant TB remains a concern. In 2008, 268 cases of all forms of drug resistant TB were reported. Of those, 23 cases were diagnosed as Extensively Drug Resistant (XDR) TB, 201 cases were diagnosed as Multi Drug Resistant (MDR), and 44 were diagnosed as “poly resistant.”

A well-functioning and well-supported TB program is essential to ensure that appropriate care is available. PEPFAR collaborates with the Global Fund (GF) and the USAID TB Control Assistance Program (TBCAP) to support Namibia’s Directly Observed Treatment Short course (DOTS) program. In addition to PEPFAR, TBCAP is funded through USAID Child Survival and Health (CSH) TB funds, thus leveraging additional sources of support. GF resources focus on strengthening supportive supervision, drug resistance surveillance and monitoring, facility renovation, implementing the Communication for Behavioral Intervention (COMBI) strategy, and ensuring expansion of community-based care. COP10 resources will complement Global Fund Rolling Continuation Channel (RCC) activities, if awarded, by supporting the integration of TB/HIV training, basic community-level TB/HIV care, and community DOTS within USG-supported community and home-based care programs

Current status of national policy, programme activities on TB/HIV and key accomplishments from COP09 The Namibia National TB Control Program’s (NTCP) Medium Term Plan I (MTPI), the National Strategic Plan (NSF) for HIV and national guidelines for the management of TB all contain components that address TB/HIV. The USG and its partners collaborate with the GRN to ensure that all activities are aligned with these national plans, policies and guidelines. The GRN also requires partners to consult national counterparts for guidance on the scale and scope of TB/HIV efforts to avoid duplication, to leverage resources and to maximize efficiencies. Key TB/HIV accomplishments during the last COP include:

a) Provider-initiated HIV counseling and testing (PICT): Namibia’s goal is to achieve HIV testing rates of more than 95% among TB patients. In 2008, 67% of notified TB patients were tested for HIV compared to 54% in 2007. Regionally, the proportion of TB patients with known HIV status ranged from a low of 44% in the Khomas region to a high of 94% in the Kunene region. HIV prevalence in TB patients tested for HIV ranged from a low of 28% in the Omaheke region to a high of 73% in the Caprivi region. HTC with an “opt out option” is mandated by both HIV policy and TB guidelines as a standard of care, and both USG and the GF will continue to provide financial and technical support for this activity. If the GF resources fail to materialize then GRN will be faced with challenges and seek additional USG support.

b) Training: Short in-service trainings for healthcare providers that include TB/HIV were conducted



collaboratively by the USG and MOHSS to improve TB/HIV management. In addition to classroom training, PEPFAR provides clinical mentors who give daily in-service training and support to clinicians in five regions throughout the country.

In terms of HIV care for TB/HIV there have also been nationwide improvements in the delivery of the following services:

a) Cotrimoxazole Preventive Therapy (CPT): Namibia's TB guidelines stipulate that all HIV-positive TB patients should receive CPT. This intervention increased significantly to a current rate of 98% (n=5289) from 31% (n=1495) in 2008. In COP10, PEPFAR will continue to support healthcare provider trainings and guideline review to strengthen this intervention while the GRN will provide consumable commodities and pharmaceutical supplies.

b) ART: PEPFAR and GF support contributed to the significant increase in the number of TB/HIV patients accessing ART from 749 in 2007 to 2,019 in 2008. Thirty-seven percent of HIV-positive TB patients initiated or continued on ART in 2008. The USG will continue to support the scale up of this intervention through health care worker (HCW) training, technical support, and ARV commodity procurement and supply. Continued GF support is critical to this effort.

c) Isoniazid Preventive Treatment (IPT): There was a marked increase in the number of PLHIV started on IPT (6,153 in 2008, up from 4,257 in 2007). Continued national scale-up is still required to ensure adequate coverage. Concerted facility-level strategies for scaling up IPT have been implemented in 16 pilot sites as part of quality improvement projects. The use of pre-ART clinics as an entry point for the roll out of IPT has also proved to be a very promising model for scale up of IPT. Based on this experience, in COP10 the USG and MOHSS will expand this model to high TB/HIV burden areas.

d) TB Infection Control (TB-IC): TB-IC has moved up as a priority for both TB and HIV programs. In 2007 and 2008, the MOHSS requested external international technical assistance for infection control from the US Centers for Disease Control and Prevention (CDC), the Royal Netherlands TB Foundation (KNCV), and the World Health Organization (WHO). This TA provided guidance on the most effective ways to control and prevent X/MDR TB. Based on the TA recommendations, the MOHSS launched TB infection control guidelines in October 2009. In COP10 the USG will continue to support the GRN in implementing TB-IC approaches including:

1. Expansion of Infection Control practices to HIV care and treatment settings.
2. Implementation of new infection control guidelines.
3. Development and implementation of standard operating procedures, ongoing training and supervision.
4. Additional international TA on infection control.
5. Health care facility assessments and upgrades (renovations) to meet international standards for infection control.
6. Implementation of health care worker screening programs.
7. Recruitment of an infection control officer.

e) Intensified case finding: The USG, in collaboration with MOHSS and other partners, will continue to support the expansion of intensified TB case finding in HIV home-based care and treatment settings, HCT and PMTCT settings, and in children less than five years of age. In line with task shifting strategy, community counselors and other community care workers have played a vital role in scaling up this activity. In addition, a health care facility-based case management program will continue to be strengthened, improving HIV and TB bi-directional referrals. In addition, due to previously weak data capture and reporting, TB/HIV data systems will be strengthened in COP10. There is also a need to develop a national M&E program for IPT.

f) Public Private Partnership (PPP) collaboration and coordination: Recently, there has been an increased



focus on private sector participation in TB/HIV collaborative activities. The USG has worked with the Namibia Business Coalition on HIV and AIDS (NABCOA) to strengthen workplace TB/HIV programs. The USG also works with medical associations and HIV clinician associations to engage private medical practitioners and nurses through training aimed at improving the quality of TB/HIV management in this sector.

g) Surveillance and management of drug resistant TB: In COP10, PEPFAR will continue to leverage resources and support MOHSS efforts to improve the management and control of drug resistant TB through:

1. Intensified training of medical officers in designated health facilities identified for the management of drug resistant TB.
2. Revised management of drug resistant TB guidance in terms of case definitions, regimens, case management approaches, prevention efforts through IC, and case finding.
3. Increased interaction with the Namibia Institute of Pathology (NIP) to improve reporting and surveillance of drug-resistant TB using revised request forms.
4. Improved DOT coverage for drug-susceptible TB cases through the development of CB-DOT models for rural, urban and workplace settings.
5. Support for epidemiological assessments and studies to establish possible factors fuelling the rise of DR-TB in Namibia.
6. Support for X/MDR knowledge and skills exchange visits to neighboring countries for doctors and pharmacists.

h) Laboratory support: USG continued to provide financial and technical support to NIP to ensure that all districts have access to smear microscopy services. This support mostly goes towards procurement of equipment, testing, QA, training, and monitoring and evaluation systems. NIP also revised its current recording and reporting system to make laboratories more responsive to the surveillance needs of the National TB Control Programme (NTCP).

Link between COP10 USG Support for TB/HIV and the Partnership Framework. The PF, in line with the NSF, will focus on the following areas in Treatment, Care and Support:

1. Pre-Antiretroviral Therapy
2. TB/HIV Co-Infection
3. Antiretroviral Therapy
4. Care and Support

To reduce TB HIV co-infection, GRN and USG intend to support the broader TB control interventions (CB-DOTS, diagnostic laboratory, nutrition, etc.) by building laboratory capacity, implementing a new testing algorithm for diagnosis, providing long term technical assistance to implement the “3 I’s” (Intensified case finding, Isoniazid preventive therapy, and Infection control) strategy, and providing treatment to all TB/HIV co-infected patients.

FY 2010 proposed activities and priorities for TB/HIV

Namibia has made great strides to ensure universal access to HIV care and treatment for PLHIV. PEPFAR will build on this foundation by providing funding and technical assistance to strengthen TB/HIV interventions. In COP10, the USG will work with the Namibian government and other partners to improve access to, and quality of, TB care for those co-infected with HIV and TB. The USG will strive to transition its scope of work towards the provision of TA and skills transfer where feasible in order to ensure sustainability and ownership of these programs. Similarly, USG partners will work closely with GRN to ensure the gradual absorption of some responsibilities by the GRN and other stakeholders.

In 2009, Namibia revived its National TB/HIV Coordinating Committee to enhance collaboration between



the national TB and HIV programs. Implementation of the WHO-recommended “3 I’s” strategy is a priority for the committee. With PEPFAR support, TB/HIV curricula and training programs will be standardized for healthcare workers and lay counselors at the community and home-based care levels. TBCAP will focus on building the management capacity of the NTCP through training and staff support. The USG will continue to support strengthening of TB infection control as one of the key elements of the 3 I’s.

The USG will continue support to the GRN and community-based organizations to implement integrated TB/HIV activities in health facilities and communities. The MOHSS is exploring the possibility of enhancing nutritional support for TB and TB/HIV patients. Those who meet the criteria will receive nutrition assessment education and counseling and, where necessary, food supplementation with USG support.

In addition, support will be provided for improved and expanded laboratory for TB services. Support will focus on strengthening quality assurance; introducing rapid diagnostic methods for drug resistant TB screening; implementing diagnostic algorithms for TB, smear negative TB, and drug resistant TB; strengthening laboratory surveillance of TB and drug resistant TB; gradual decentralization of Fluorescence microscopy to all districts; and expanding culture capacity to Oshakati and Walvis Bay regional laboratories.

Ensuring Sustainability and transitioning of USG support

HIV and TB care, including co-infected patients, is integrated in the general health care delivery system. First- and second- line TB medicine, as well as most of the laboratory services, is fully funded by GRN, limiting reliance on external support. In line with the new PEPFAR vision, the USG TB/HIV support in Namibia already focuses on technical support. Some USG-supported TA for TB/HIV is co-located with GRN to enhance ownership, skills transfer, and ensure sustainability.



Technical Area Summary Indicators and Targets

Redacted



Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
6459	U.S. Department of State	Implementing Agency	U.S. Department of State/Bureau of African Affairs	GHCS (State)	25,000
7443	Partnership for Supply Chain Management	Private Contractor	U.S. Agency for International Development	GHCS (State)	2,282,062
7622	University Research Corporation, LLC	Private Contractor	U.S. Agency for International Development	GHCS (State), Central GHCS (State)	900,000
9869	Blood Transfusion Service of Namibia	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	1,000,000
9870	APHL	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	150,000
9872	Potentia Namibia Recruitment Consultancy	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	6,285,727

9874	US Health Resources and Services Administration	Own Agency	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHCS (State)	175,676
9876	Namibia Institute of Pathology	Parastatal	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	1,173,000
9877	University of Washington	University	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHCS (State)	5,114,934
9940	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
9942	Ministry of Health and Social Services - Haiti	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	18,125,608
10163	Namibian Social	NGO	U.S. Department	GHCS (State)	562,150

	Marketing Association		of Defense		
10164	University of Washington	University	U.S. Department of Defense	GHCS (State)	1,785,000
10181	U.S. Peace Corps	Implementing Agency	U.S. Peace Corps	GHCS (State)	50,000
10379	Academy for Educational Development	NGO	U.S. Agency for International Development	GHCS (State)	476,696
10381	Abt Associates	Private Contractor	U.S. Agency for International Development	GHCS (State)	971,839
10382	Academy for Educational Development	NGO	U.S. Agency for International Development	GHCS (State)	1,130,000
10386	IntraHealth International, Inc	NGO	U.S. Agency for International Development	GHCS (State)	8,229,420
10387	IntraHealth International, Inc	NGO	U.S. Agency for International Development	GHCS (State)	200,000
10389	Management Sciences for Health	NGO	U.S. Agency for International Development	GHCS (State)	2,869,294
10393	Pact, Inc.	NGO	U.S. Agency for International Development	GHCS (State)	9,256,413
10397	KNCV Tuberculosis Foundation	Multi-lateral Agency	U.S. Agency for International Development	GHCS (State)	950,000
10780	University of Washington	University	U.S. Department of Health and Human Services/Centers for Disease	GHCS (State)	658,000

			Control and Prevention		
11572	HHS/Centers for Disease Control & Prevention	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	3,866,918
12431	ASCP	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	100,000
12432	ASM	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	50,000
12433	Clinical and Laboratory Standards Institute	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	339,655
12434	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and	Redacted	Redacted

			Prevention		
12435	African Palliative Care Association	NGO	U.S. Agency for International Development	GHCS (State)	451,799
12436	Office of the President	Implementing Agency	U.S. Agency for International Development	GHCS (State)	328,700
12437	Church Alliance for Orphans, Namibia	FBO	U.S. Agency for International Development	GHCS (State)	760,000
12438	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12439	Kayec Trust	NGO	U.S. Agency for International Development	GHCS (State)	1,163,750
12440	Lifeline Childline Proposed Voluntary Counseling and Testing	NGO	U.S. Agency for International Development	GHCS (State)	300,000
12441	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12442	Project HOPE	NGO	U.S. Agency for International Development	GHCS (State)	1,221,980
12443	Polytechnic of Namibia	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	302,000
12444	TBD	TBD	U.S. Department	Redacted	Redacted



			of Health and Human Services/Centers for Disease Control and Prevention		
12445	Ministry of Health and Social Services, Namibia	Host Country Government Agency	U.S. Agency for International Development	GHCS (State)	250,000



Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 6459	Mechanism Name: Department of State/African Affairs
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: USG Core
Prime Partner Name: U.S. Department of State	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 25,000	
Funding Source	Funding Amount
GHCS (State)	25,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The State Department Public Diplomacy, Fulbright, and Ambassador's Self Help Program PEPFAR activities are continuing activities from COP09.

The State Department Public Diplomacy PEPFAR activities are primarily focused on Namibian youth, using grants to various cultural, civil society, and educational groups in Namibia to create and support programming that focuses on the following areas: prevention, reduction of stigma and discrimination, and prevention outreach to youth. In addition, the USG develops programs focused on sending Namibian HIV/AIDS professionals to the US for training and training local media to improve reporting on Namibian trends in the epidemic.

The Fulbright PEPFAR Fellowship will fund the study of Namibian scholars in the fields of public health, medical technology, epidemiology, behavior change, public administration, business administration, nutrition, palliative care, counseling, and others under the Junior Staff Development Program. By selecting outstanding Namibian graduates to pursue master's degrees under the Fulbright Junior Staff Development Program, PEPFAR will greatly contribute to the human capacity development of the nation and its ability to fight the HIV/AIDS epidemic. These scholars will fill key positions in government



ministries and NGOs, to directly carry out the fight against HIV/AIDS, or in academia, to train Namibia's students to carry on the fight.

The Ambassador's HIV/AIDS Self-Help Program will directly reach an average of 100 community members per project through community-based initiatives that: 1) provide care and support for individuals who are infected with, and affected by, HIV/AIDS, and 2) help prevent further spread of the disease. Efforts to leverage resources from other PEPFAR programs (PeaceCorps and State) and an emphasis on building capacity of youth directly contribute to cost savings and sustainability in line with the Partnership Framework. PAO and Self Help have worked with the USG SI team to select appropriate indicators and targets for monitoring and evaluation purposes.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID: 6459			
Mechanism Name: Department of State/African Affairs			
Prime Partner Name: U.S. Department of State			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	25,000	
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details



Mechanism ID: 7443	Mechanism Name: Supply Chain Management System (SCMS)
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Partnership for Supply Chain Management	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,282,062	
Funding Source	Funding Amount
GHCS (State)	2,282,062

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Supply Chain Management System (SCMS) project is a centrally-funded indefinite quantity contract (IQC) managed by USAID/Washington, awarded to the Partnership for Supply Chain Management (PSCM) in October 2005. This is a continuing (third task order) implementing mechanism with three primary objectives under the award, reflecting the project's breadth across technical areas in supply chain management: (1) procurement of HIV and AIDS-related commodities under USAID procurement regulations with a focus on large volumes of antiretroviral drugs and HIV tests delivered at regular intervals, and also including opportunistic infection (OI) drugs, lab consumables, reagents, equipment, and other goods and services in support of HIV and AIDS programs, (2) capacity-building, technical assistance activities aimed at improving the availability of drugs and related medical supplies to patients and clients, and (3) gathering, analyzing, and reporting supply-chain information to inform decision-making, especially in preparation of forecasts for annual budgeting and procurement purposes. In COP09, this IM funded activities under HBHC, PDCS, HVCT, HLAB, HVSI and OHSS. In COP10, HLAB and HVSI are no longer being funded.

The objectives of SCMS are related to all Partnership Framework (PF) goals and benchmarks that include aspects of commodity supplies. Under "Objective 2: Community Home Based Care," SCMS continues to assist the Primary Health Care Directorate (PHC) of the Ministry of Health and Social Services (MOHSS) develop and implement a system for efficient delivery and replenishment of community health based care (CHBC) kits. Under "Objective 3: ART Services", SCMS will assist the MoHSS to "develop short- and long-term plans in view of the integration of ART into primary health care" by helping design and



implement supply systems that maximize the use of existing drug delivery systems and processes for the delivery of ARVs and OI drugs, particularly through capacity building of the Central Medical Stores (CMS) and regional medical stores (RMSs).

SCMS will continue to assist the National Institute of Pathology (NIP) to improve quality services for laboratory testing for patients under care and treatment. SCMS also provides support to the national Quality Surveillance Laboratory (QSL) to improve the lab's ability to ensure drug quality in Namibia through both technical assistance and procurement of supplies and equipment. Under the PF focus area of "Coordination and Management," SCMS broadly supports "Objective 1: Leadership and Governance" by providing data-collection systems that support data-based (evidence-based) decision-making.

SCMS is prepared to strengthen quantification and logistics support of the CMS on commodities related to male circumcision, and food security and nutrition.

SCMS works with several PEPFAR partners to support home-based care and VCT commodities. Cost efficiencies are built in the program and commodity procurement will gradually be transitioned to the MOHSS, and procurement of rapid tests kits (RTKs) will be reduced proportionally to align with the reduction in the number of sites.

SCMS' support to human resources and logistics contributes significantly to MOHSS health system strengthening. SCMS strengthens the selection of appropriate forecasting and budgeting of commodity needs, procurement of commodities, storage and distribution systems, and the collection and analysis of dispensed-to-user data. In line with the PFA, SCMS will work with its stakeholders to develop a transition plan that will ensure gradual take over by MoHSS and NIP as resources declines.

SCMS' coverage is national and contribution is wholly cross-cutting, affecting all programs that rely on continuous supplies of drugs and other commodities.

SCMS will continue to work with MOHSS in the reduction cost in the delivery of goods locally through better long-term planning, permitting the use of less costly transportation and through appropriate local procurement. Success in Namibia's logistics systems will effectively be measured by the reduction in the incidence of stock-outs and through procuring commodities that provide the best value for money. SCMS is well-positioned to further strengthen the CMS to receive the best value on commodities tenders. Where programs are not as fully developed, input indicators such as percentage of sites reporting on time and accurately can track movement towards greater efficacy and efficiency.



Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: 7443			
Mechanism Name: Supply Chain Management System (SCMS)			
Prime Partner Name: Partnership for Supply Chain Management			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	314,828	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	382,205	
Narrative:			
<p>This is a continuing activity from FY09.</p> <p>SCMS works with all IntraHealth and I-Tech VCT (Volunteer Counseling and Testing) sites in its work. The 4 main components are: (1) continued implementation of the VCT systems for the USAID-supported sites of IntraHealth and the DoD/I-Tech-supported Namibian Ministry of Defense (NMoD), (2) procurement of HIV rapid test kits (RTKs) in support of the same sites, (3) improvement of site-level storage for RTKs, and (4) automation of data-collection from VCT sites for IntraHealth.</p> <p>(1) Continued implementation and support of the VCT systems for the USAID-supported sites of IntraHealth New Start standalone and integrated sites, and the DoD/I-Tech –supported Namibian Ministry of Defense sites.</p> <p>In COP07 and COP08, SCMS designed and implemented a system for collecting monthly data on stock levels and consumption of RTKs used at IntraHealth's VCT network sites. The data has been used to</p>			

replenish the entire network (except facility based sites), from small stores to the Council of Churches of Namibia (CCN). This site is managed directly by IntraHealth Windhoek office. SCMS replenishes test kits for DoD/I-Tech, but these sites did not have a regular system for ordering the RTKs until FY09. During FY09, SCMS continued to support IntraHealth's data collection (see activity 4 below) and formalized data collection at NMoD sites. During COP10, SCMS proposes training these organizations to collect and analyze their data and to replenish their sites without assistance from SCMS. SCMS also proposes to roll-out a similar logistics system to MOHSS VCT sites as appropriate.

(2) Procurement of HIV rapid test kits (RTKs). In FY09, PEPFAR funding enabled SCMS to procure RTKs to support testing for 105,964 clients in IntraHealth's 18 fixed and 16 mobile/outreach sites and DOD/I-Tech's 4,000 clients in 4 fixed and 4 mobile/outreach sites using the national testing algorithm. As per the VCT portfolio review recommendations, a number of standalone sites with high costs and low volume and where mobile or facility-based service alternatives are available, might be closing. As a result, the RTKs procured during COP10 will decline.

(3) Improvement of site-level storage for RTKs. During COP08 and COP09, SCMS provided support for improving site-level storage of RTKs. During COP09, SCMS procured cool boxes to support VCT outreach. During COP10, SCMS will continue to provide this support as appropriate.

(4) Automation of data-collection for IntraHealth VCT sites.

During COP07 and COP08, SCMS initiated development of computer software to automate the collection of consumption data from IntraHealth VCT sites, piloting it at three sites. Although the first pilot was successful, SCMS had to convert its data collection from MS Access to the Filemaker database software and retest its functionality since IntraHealth was also separately developing a database for collection of patient data and outcomes. During COP10, SCMS proposes to introduce the stock management module to all IntraHealth sites.

Supportive supervision and QA is measured by the completeness and timeliness of reporting from VCT sites. SCMS will continue to track this as an indicator of the quality of the function of the system.

SCMS' activities contribute to sustainability by building the capacity of each VCT site to manage its stock accurately and ensure routine re-supply of VCT-related commodities. Systematic ordering of routinely used commodities improves use of storage and transportation resources. This more efficient and strengthened system will continue beyond the end of funding.

During COP10, SCMS will measure reporting by sites, timeliness, and accuracy. SCMS will work with IntraHealth to conduct an annual review of actual stock on hand, incidence of over- or under-stocking, stock-out and accuracy of site-level stock management records.



Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	53,917	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	1,531,112	
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7622	Mechanism Name: Health Care Improvement Project, HCI
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: University Research Corporation, LLC	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 900,000	
Funding Source	Funding Amount
Central GHCS (State)	300,000
GHCS (State)	600,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Health Care Improvement Project (HCI) is a continuing implementing mechanism from FY09. HCI provides technical support to the Ministry of Health and Social Services (MOHSS) in implementing



several policy and programmatic interventions to improve medical injection safety and waste management practices in Namibia. During 2010-2011, HCI will focus on building the government capacity and ownership as it expands medical injection safety and waste disposal services to lower level health centers, partnering for comprehensive services, and exploring private public partnerships.

1. HCI has three comprehensive goals and objectives under the award reflecting its breadth across technical areas: 1) provide technical support to the MOHSS to improve the quality of systems, equipment and commodities to ensure safe medical injections and waste management, 2) support MOHSS capacity building efforts for health care to improve the quality of their work with regards to control and prevention of blood borne diseases, and 3) support the strengthening of the National Health Information System to ensure reliable monitoring and evaluation of blood borne diseases and waste management.

2. HCI's work is linked to the Partnership Framework's objectives of developing effective tools for building capacity and collecting data related to post exposure prophylaxis (PEP) from the work place. For example, HCI's work will train health care workers on basic prevention skills in line with the universal precautions, integrate PEP in all health facilities offering ARV services, ART and PMTCT, and support in-service and pre-service training on the provision of PEP.

3. The program will be scaled to cover all 13 regions in the country. Clinical services staff, community members, managerial and support staff will be targeted in each region.

4. The program will contribute towards health system strengthening by a) carrying out project planning in collaboration with regional, district, and facility authorities, which ensures incorporation into their comprehensive health plans. HCI will provide support particularly in the establishment and/or effective functioning of regional or district committees. These committees are entrusted with the strategic planning in their jurisdictions and can promote feasible, sustainable programming within the MOHSS system; b) conducting joint periodic site visits with supervisors (national, regional and district), conducted at least monthly. Visits will be characterized by supportive supervision exchanges with health care workers and meetings with site administration and committees to discuss strengths and limitations in the program with a view to building local capacity; c) training focal persons in regions and districts as Trainers of Trainers; d) supporting regions and districts in proposal writing to solicit funding from both local and external institutions; and e) developing sustainable monitoring and evaluation systems at both the site and national levels for the collection of timely, accurate, and complete data.

5. No cross-cutting programs or key issues are anticipated.

6. The strategies used are designed to be cost efficient in of the following ways: a) URC will go beyond



gap filling of commodities to provide support to improve facility-side functioning for ensuring appropriate forecasting of necessary supplies, improving ordering and follow up with Central Medical Stores(CMS). URC will forge partnerships with CMS and SCMS and will work closely with both organizations to ensure a continuous supply of commodities. SCMS will train facility, district, and regional staff in forecasting and procurement while CMS will work closely with district and regional offices on enhancing communication on orders, supplies and stocks; b) the project will build capacity at the region and district level, thus enabling MOHSS staff to take on routine responsibilities; and c) URC will identify, and jointly with regional and district authorities, approach potential local institutions that could provide support to relevant activities (HIV in the work place, incinerators).

7. URC will partner with the Quality Assurance (QA) office of MOHSS in developing, refining, piloting, and implementing national M&E tools and systems for medical injection safety, infection control and waste disposal. URC will support MOHSS staff to conduct regular site supportive supervision visits - a crucial element in data QA. URC will also strengthen data feedback and dissemination mechanisms with monthly feedback to sites, quarterly/semiannual/annual report sharing at the district, regional and national levels.

May 2010 Reprogramming: \$300,000.00 in supplemental funding was provided to USAID Namibia to enhance the ongoing expansion and technical assistance in the management, prevention and control of blood borne diseases in Namibia. This supplemental funding will be added to the Health Care Improvement Project implementing mechanism (ID# 12175), increasing that implementing mechanism's total GHCS-State funding amount to \$900,000.00. Specifically, the supplemental funding will be added to the HMIN Biomedical Prevention: Injection Safety budget code, increasing the total HMIN budget code amount from \$600,000.00 to \$900,000.00.

Funds will support: partnerships with 34 district health teams to strengthen their capacity in implementing high impact infection prevention and control interventions at community and facility levels; train 200 non-professional staff on infection prevention and control and safe waste management practices; conduct national and regional meetings to broaden support and commitment for infection prevention and control among policymakers and program managers; strengthen capacity of district/regional management teams in monitoring and supervising infection prevention and control interventions using collaborative improvement model; and conduct a 2-day workshop on infection prevention and control in Windhoek by experts from Stellenbosch University, South Africa. These efforts will complement the ongoing work of University Research Corporation and enhance depth in coverage regionally.

Cross-Cutting Budget Attribution(s)



Human Resources for Health	176,268
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Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: 7622			
Mechanism Name: Health Care Improvement Project, HCI			
Prime Partner Name: University Research Corporation, LLC			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	900,000	
Narrative:			
Continuing Activity			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9869	Mechanism Name: Cooperative Agreement 1U2GPS002715
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Blood Transfusion Service of Namibia	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,000,000	
Funding Source	Funding Amount
GHCS (State)	1,000,000



Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a single eligibility follow-on mechanism to replace an expiring Track 1 cooperative agreement with The Blood Transfusion Service of Namibia (NAMBTS). Although this IM is listed as a "TBD partner," NAMBTS will be the only entity eligible for the award. A single eligibility request for proposals (for a five year cooperative agreement) will be issued in November 2009. An award to NAMBTS is expected within the COP10 approval timeframe.

This IM will support activities in the HMBL technical area. However, many of the activities will have cross-cutting impacts beyond the prevention of HIV. Specific HIV prevention objectives for the PEPFAR-supported blood safety program include:

1. Maintaining (and reducing) the low HIV prevalence among voluntary, non-remunerated blood donors. In COP09, HIV prevalence among blood donors stood at <.50%. This will be accomplished through 100% screening of all donated blood for HIV, Hepatitis B and C, and syphilis.
2. Doubling the blood donation rate among youth. In COP09, less than 15% of all donations were collected from donors aged 16-25.
3. Linking school-based education programs targeting blood donors to broader HIV prevention and healthy lifestyles messaging delivered in schools.
4. Training clinical staff to reduce unnecessary blood transfusions.

Links to the Partnership Framework (PF)

As part of the USG contribution to the PF goal of "enhancing prevention," the USG commits to support NAMBTS as the GRN-authorized partner responsible for the safety and adequacy of the national blood supply. USG commitments in the PF are aligned with the HIV prevention priorities described in Namibia's National Strategic Framework for HIV and AIDS 2010-2015 (NSF).

1. Social and Behavior Change
2. HIV Counselling and Testing (HCT)
3. Prevention of HIV among Most-At-Risk and Vulnerable Groups
4. HIV Prevention Involving PLWHA
5. Medical Male Circumcision
6. PMTCT
7. Post-Exposure Prophylaxis
8. Condom Social Marketing and Distribution
9. Prevention of Sexually Transmitted Infections
10. Blood Safety



With funding through this new IM, NAMBTS will directly contribute to the Blood Safety objectives and commitments described in the PF documents and in the NSF. As noted above, PEPFAR investments in blood safety will also have a number of cross-cutting benefits, including indirect contributions to HCT and PMTCT by referring blood donors with HIV reactive test results to HCT and PMTCT services. As the sole entity responsible for supplying hospitals and clinics with blood for transfusion, NAMBTS directly contributes to strengthening the broader primary healthcare system. Since a substantial proportion of the nation's blood supply is consumed by children (malaria anemia) and pregnant women (post-partum hemorrhage), PEPFAR investments in blood safety directly contribute to improving maternal and child health outcomes (MCH).

Coverage and Target population

The activities supported through this mechanism are national in scope. NAMBTS supplies screened blood and blood products to 41 hospitals and clinics in all of Namibia's 13 regions. With PEPFAR support, NAMBTS has expanded access to blood transfusion services by pre-positioning Type O (universal donor) blood at facilities that lack cross-matching capacity. In COP10 PEPFAR will support and evaluate this strategy, and support improvements in local cross-matching capacity where cost effective.

Health Systems Strengthening

The blood safety program also invests in capital infrastructure at the facility level (e.g., ward-based cold chain) and in training for clinicians in the appropriate use of blood. NAMBTS also trains laboratory technicians in the proper handling of blood and the production of quality-assured blood products (e.g., packed red cells, platelets). In COP10, NAMBTS will work with CDC and the MOHSS to create training internship opportunities for laboratory technician students at the Polytechnic of Namibia.

Cross-Cutting Programs and Key Issues

Access to safe blood can improve maternal and child health outcomes. In COP10, CDC and NAMBTS will work with the MOHSS Directorate for Primary Health Care to track blood utilization patterns and measure the impact of safe blood on clinical outcomes. This evaluation will also look at blood utilization among ART patients. Investments in laboratory technician training opportunities will also build Human Resources for Health.

Cost Efficiencies Over Time

An innovative cost-recovery system currently provides a sustainable source of funding for NAMBTS. Through this system, NAMBTS is reimbursed by public and private insurance programs. NAMBTS is also engaged in negotiations with private sector pharmaceutical companies in South Africa regarding the potential sale of plasma. Supporting Namibia as an exporter of plasma to the South African and, potentially, global, plasma markets would substantially enhance NAMBTS's ability to sustain itself over



the long-term. PEPFAR will continue to support quality assured laboratory practices during the accreditation process with the South African Bureau of Standards.

Monitoring and Evaluation Plans

NAMBTS will maintain, expand and align the M&E system developed under the Track 1 cooperative agreement. NAMBTS will submit bi-annual reports on all of its indicators. These reports will indicate any changes to the M&E system during the reporting period. As noted above, an impact evaluation will be conducted on the clinical use of blood.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	100,000
Human Resources for Health	400,000

Key Issues

- Child Survival Activities
- Safe Motherhood

Budget Code Information

Mechanism ID: 9869			
Mechanism Name: Cooperative Agreement 1U2GPS002715			
Prime Partner Name: Blood Transfusion Service of Namibia			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	1,000,000	
Narrative:			
This is a continuing activity from COP09. Activities implemented by the Blood Transfusion Service of Namibia (NAMBTS) in COP10 will focus on the following four areas:			
1) Blood Collection			
2) Blood screening			
3) Blood utilization			

4) Policy and Sustainability

NAMBTS has been a PEPFAR Track 1 partner since 2004. In COP 2010, the management of the CDC cooperative agreement with NAMBTS will transition to the CDC country office from CDC headquarters. This transition is part of a broader expansion of the former Track 1 blood safety program beyond the original 14 Focus countries. As part of this expansion, COP10 blood safety budgets for the former Focus countries were reduced and redistributed to support expanded blood safety investments in non-Focus countries. In Namibia, this reduction and redistribution strategy resulted in a 30% budget cut for NAMBTS. Within this context, NAMBTS will continue to implement the comprehensive blood safety program described in prior years. Specific activities will include:

1) Blood collection. NAMBTS will work to Retain current blood donors, expand recruitment activities to schools, and conduct ongoing surveillance of transfusion transmissible infections (TTI) among donors to identify lowest risk sub-groups

2) Blood screening. NAMBTS will maintain a contract with the South African National Blood Service (SANBS) for all infectious disease screening (including nucleic acid screening for HIV). This arrangement is subject to a bi-annual sustainability review, which is scheduled to occur in March 2010. If necessary, based on the findings of that review, this narrative will be updated to reflect any changes in the NAMBTS screening policy.

3) Blood utilization. NAMBTS will continue training for clinicians in the rational clinical use of blood. This training is designed to minimize wastage, reduce patients' risk of transfusion-associated reactions, and preserve scarce stocks of blood. Within this activity category, NAMBTS will also work with the MOHSS Department of Clinical Services and NIP to expand and strengthen the national network of blood banks and compatibility testing laboratories, with an emphasis on supervision and quality assurance. Other activities will include: Support to MOHSS to draft legislation to regulate blood transfusion nationwide; conduct assessments to define the level of transfusion services to be provided at Namibian hospitals; procure appropriate reagents and equipment for all hospital blood banks; train hospital blood bank staff on cross-matching, quality, and cold chain management; continue to advocate for implementation of a national hemovigilance program; strengthen hospital therapeutic/transfusion committees; conduct blood bank and hospital audits to ensure conformity with best practices; expand access to cross-matching services to northern Namibia, specifically in Rundu and Oshakati.

a. Policy and Sustainability. NAMBTS will continue to participate with the MOHSS and relevant legislative branch offices to advocate for the passage of a new national Blood Bill. Finalization and passage of this bill has been pending since 2006.

b. Advocate for the finalization and passage of the new national Blood Law. Passage of the Blood Bill will allow implementation of the National Blood Authority. Other activities will include: Defining criteria for the import and export of blood and blood products, and continuing negotiations on the potential sale of plasma to a commercial pharmaceutical firm;



implementing a quality management system for the entire blood program

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9870	Mechanism Name:
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: APHL	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 150,000	
Funding Source	Funding Amount
GHCS (State)	150,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES The International Laboratory Branch (ILB) consortium partners' main goal is to strengthen laboratory systems through technical assistance to the Namibia Institute of Pathology (NIP). NIP, in turn, provides quality laboratory services to MOHSS HIV, TB and OIs programs.

To achieve this goal each of the four ILB consortium members provides technical assistance in specific areas. For the Association of Public Health Laboratories (APHL), those objectives include:

- 1- Conducting an assessment of existing laboratory services and providing recommendations to strengthen the national laboratory system.
- 2- Assist MOHSS and NIP to develop a national laboratory strategic plan.
- 3- Provide laboratory management trainings.

This will work will be coordinated with similar assessments and trainings provided by other members of the ILBC.

How the Implementing Mechanism is linked to the Partnership Framework goals and benchmarks over



the life of its agreement/award:

Through support for quality bio-clinical monitoring and training, this implementing mechanism is key to the USG commitments related to the PF goal of "scaling up and enhancing the antiretroviral treatment services as well as reducing TB/HIV co-infection" The technical assistance delivered through this IM will specifically aid the GRN and the USG to meet the following PF objectives:

- 1) Enhance the quality of ART care through quality assured bio-clinical monitoring.
- 2) Expand coverage of screening for TB/HIV co-infection.

The implementing Mechanism's geographic coverage and target population:

This mechanism is designed to provide national coverage through the NIP network of laboratories. APHL will work with NIP and other partners to provide training to staff working in all of the NIP laboratories. The gap analyses and mentoring assistance will be rolled out in a targeted manner, depending on identified needs.

Key contributions to Health System Strengthening:

Strengthening laboratory capacity for the public healthcare system assures that services are accessible, equitable, effective, affordable, and of high quality for all. Strategic planning has also been identified as a priority for NIP and the Ministry of Health and Social Services (MOHSS) in the new National Strategic Framework for HIV/AIDS (NSF). Direct TA to NIP staff will build local human resource capacity, another key objective in the NSF.

Implementing Mechanism's cross-cutting programs and key issues:

As noted above, APHL support for strategic planning contributes to key objective in the NSF and in the PF. Support for planning is also expected to improve cost efficiencies over time by reducing duplication and increasing coordination. Human Resources for Health will also be strengthened through direct mentoring and other support provided to NIP staff by APHL consultants.

The Implementing Mechanism's strategy to become more cost efficient over time:

All ILB consortium partners provide short-term technical trainings or consultancy services. NIP manages the logistics of the trainings and consultancies, and, increasingly, provides trainers from its own staff to conduct follow-up mentoring and monitoring. NIP is also responsible for procuring equipment and reagents for the trainings. These procurements, including stock management and delivery, are done through NIP's local ordering system. As indicated above, the training of trainers as instructors and mentors will, over time, reduce APHL's role in Namibia. On that note, APHL's role is already 100% technical assistance. NIP is solely responsible for laboratory service delivery. A USG objective for the next five years is to develop NIP's administrative capacity to allow NIP to contract and fund its own technical relationships, as needed, with IDP consortium members.

Monitoring and evaluation plans for included activities:

All CDC cooperative agreement grantees must submit a detailed work plan with their annual continuation application. This work plan must be based on PEPFAR indicators and aligned with targets set for each country. All IDP consortium members must also submit bi-annual status reports to the IDP program



manager in Atlanta. These reports are shared with CDC program managers in Namibia and used to inform any year-on-year changes to the work plan.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	75,000
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Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9870		
Mechanism Name:			
Prime Partner Name:	APHL		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	150,000	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP 2009. It includes one component: 1) Technical assistance from the Association of Public Health Laboratories (APHL) to the Namibia Institute of Pathology (NIP).

PEPFAR Namibia will support APHL through a cooperative agreement managed by the CDC Global AIDS Program International Laboratory Branch (ILB) in Atlanta. Other partners supported through this mechanism include: the American Society of Clinical Pathology (ASCP), the American Society for Microbiology (ASM), and the Clinical Laboratory Standards Institute (CLSI). ASM's work is described in the HVTB technical area. CLSI and ASCP are described in separate narratives under HLAB.

In COP10, APHL technical assistance to NIP will include:

- Quality assured laboratory testing, leadership management, strategic planning, and support for plans to establish a Public Health Laboratory System.

Supportive Supervision: APHL experts will provide direct technical assistance and supportive supervision to NIP staff. Additional supervision and mentoring will be provided by laboratory advisors from CDC Namibia. NIP managers and supervisors will provide day-to-day management oversight and supervision.



Sustainability: All ILB consortium partners provide short-term technical trainings. NIP manages the logistics of the trainings to be conducted, and, increasingly, provides trainers from its own staff to conduct follow-up mentoring and monitoring. NIP is also responsible for procuring equipment and reagents for the trainings. These procurements, including stock management and delivery, are done through NIP's local ordering system. The use of training of trainers (TOT) methods will, over time, reduce APHL's role in Namibia. On that note, APHL's role is already 100% technical assistance. NIP is solely responsible for laboratory service delivery. A USG objective for the next five years is to develop NIP's administrative capacity to allow NIP to contract and fund its own technical relationships, as needed, with IDP consortium members.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9872	Mechanism Name: Cooperative Agreement 1U2GPS002722
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Potentia Namibia Recruitment Consultancy	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 6,285,727	
Funding Source	Funding Amount
GHCS (State)	6,285,727

Sub Partner Name(s)

(No data provided.)

Overview Narrative

SUBSTANTIALLY CHANGED FROM LAST YEAR

The HHS/CDC cooperative agreement with Potentia Namibia Recruitment is a continuing mechanism from COP09. The mechanism supports Potentia to perform a limited number of human resource-related



services on behalf of the Ministry of Health and Social Services (MOHSS). These include, administering payroll with a local bank to ensure that electronic funds transfers are completed to MOHSS contract staff on time, and, when requested by the MOHSS, support for recruitment.

This mechanism will expire during the first half of COP10. Because of this, only a portion of COP10 funding will be routed through this existing mechanism. A new, competitive, cooperative agreement will be announced in 2009. A TBD partner will be identified in early 2010 and awarded a five year cooperative agreement to provide these limited human resource services. A TBD IM has been created for this new mechanism.

Objectives: This mechanism has one primary objective: (1) to provide limited human resource services to the MOHSS and other PEPFAR-supported partners. These services, which have been provided since COP05, fill a substantial human resource capacity gap within the MOHSS and the broader GRN civil service. During the first four years of the award, Potentia provided substantial management oversight for staff hired on its contracts. Indeed, during this period, these contractors were employees of Potentia. In COP09, however, a new Namibian Labour Law forced a significant shift in the management of these contract positions. Under the revised law, clients of contract firms were required to establish formal "employee-employer" relationships with contract staff. For the MOHSS, this requirement led to an expansion of human resource (HR) capacity within the Directorate for Special Programmes (DSP). Four HR positions were established under the direction of the Deputy Director of the DSP. These HR specialists now manage the day-to-day relationship between the MOHSS and several dozen contract staff. As noted above, in COP10, Potentia's duties will be restricted to overseeing the electronic payroll transfers from a local bank to the employees' personal bank accounts. Potentia may also provide limited recruiting services to the MOHSS, but this activity, too, has been substantially absorbed by the MOHSS.

Partnership Framework: This mechanism encompasses a broad range of activities and commitments described in the Partnership Framework (PF). Specifically, key objectives are supported under the Coordination and Management thematic area (human resources/human capacity development, and monitoring and evaluation). By linking professionals to MOHSS positions, private HR contract agencies also indirectly support other technical areas (e.g., prevention, care and treatment). However, as the management responsibilities of private contracting firms are increasingly transferred to clients, including the MOHSS, this indirect impact will be minimized.

Coverage: The activities under this mechanism are national in scope. The target clientele includes the MOHSS and other PEPFAR-supported partners (e.g., I-TECH). In COP10, the USG will work with GRN ministries to strengthen the capacity of the civil service to, either, absorb contract staff within the civil service, or manage an outsourcing program for short-term contractors. In COP10, the following



personnel categories will receive limited HR support from Potentia: Physicians, nurses, pharmacists and pharmacy assistants, case managers, training staff, data management staff and supervisors.

Health systems strengthening: As noted above, this mechanism played an essential role in the successful scale-up of ART services in Namibia. Short-term HR services provided through this mechanism were highlighted as a best-practice for rapidly scaling up ART service delivery (Capacity Project report, 2006). Without the recruitment and HR management services provided by Potentia, weaknesses in the MOHSS HR system would have delayed scale-up and negatively impacted patient care. In the last year, the success of Potentia's support for rapid scale-up has been complemented by the transition to MOHSS ownership driven by the new Labour Law. As the role of private HR service companies evolves, the USG will support the development of HR systems within the GRN civil service. While the USG will continue to support the GRN civil service as the primary public sector employment mechanism, technical assistance will encourage the development of flexible and diverse HR mechanisms within the civil service, including outsourcing.

Cross-cutting/Key issues: This mechanism will contribute to Human Resources for Health objectives through support the development of transparent and flexible HR systems within the MOHSS and GRN civil service.

Cost efficiency: Activities supported under this mechanism are integrated with CDC's technical assistance to the MOHSS, both at the national level and in the field. As Potentia's responsibilities for contract staff have been reduced so, too, have the management fees.

M&E: All CDC cooperative agreement grantees must submit a detailed work plan with their annual continuation application. This work plan must be based on PEPFAR indicators and aligned with targets set for each country. Grantees must also submit bi-annual status reports to program managers in Namibia. Data in these reports may be used inform any year-on-year changes to the work plan.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	6,285,727
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Key Issues

(No data provided.)



Budget Code Information

Mechanism ID: 9872			
Mechanism Name: Cooperative Agreement 1U2GPS002722			
Prime Partner Name: Potentia Namibia Recruitment Consultancy			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	824,057	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09 which supports activities with one main component: 1) Contract human resource (HR) services for physicians, nurses, pharmacists, pharmacy assistants, case managers (CM), and training staff. These services will include: recruitment and hiring (as needed, using MOHSS contracts) and payroll management.

In 2009, a new Labour Law required HR contractors to shift legal responsibility for contract staff from the contractor to the client. This shift was required to establish a clear employee-employer relationship between the client and contract staff. With this change, private HR contractors may continue to provide HR services (e.g., recruitment, payroll management), but may no longer be the formal "employer." All of the contract staff in this program area were affected by this change.

In response to this change, the MOHSS expanded the duties and staff of the Deputy Director of the Directorate of Special Programmes (DSP) to assume direct management of these contract staff. Potentia was previously responsible for this work. This transition represents a significant shift in the day-to-day management of contract staff and is an important step in the development of GRN systems to manage the eventual full absorption and financing of these staff – either as civil servants or as contractors.

These changes have also resulted in cost savings. As the MOHSS has taken on greater responsibility for these positions, Potentia has reduced the management fees associated with these contracts.

Position descriptions:

- 1) Physicians. Medical officers fill gaps in the MOHSS clinical staffing structure and provide a full range of medical services to patients in MOHSS facilities. Services cut across HBHC, HTXS, PDCS, PDTX, and HVTB.
- 2) Registered Nurses. RN will provide advanced clinical nursing services, including palliative and curative care to patients in MOHSS facilities. Services cut across HBHC, HTXS, PDCS, PDTX, and HVTB.
- 3) Licensed Practical Nurses. LPN will support RN staff on clinical wards in MOHSS facilities. They provide services for HBHC, HTXS, PDCS, and PDTX.
- 4) Pharmacists. These staff will manage facility-based pharmacies and dispensaries in MOHSS facilities.

Responsibilities include: Stock management, filling prescriptions, patient counseling, and supervision of pharmacy staff. Pharmacists provide services for HBHC, HTXS, and PDCS.

5) Pharmacist Assistants. Fulfill a task-shifting function by absorbing some stock management, pill counting, filing, data entry tasks from pharmacists.

6) Pharmacist "Hands." Serve a task-shifting function. These positions are also a career entry point for young or inexperienced staff across HBHC, PDCS, HTXS and PDTX.

For accounting purposes across the five technical areas, HBHC funds will support:

- 12 of 65 physicians
- 17 of 76 RN
- 10 of 51 LPN
- 6 of 41 pharmacists
- 9 of 44 pharm. assistants
- 3 of 14 pharm. "hands"

7) Case Managers (CM). COP10 will continue support for 21 CM across HVAB, HVOP, HVCT, HTXS, PDTX, PDCS, HVTB, and HBHC. CM will devote approximately 10% of their time to HBHC. CM have direct contact with newly diagnosed HIV patients, and patients already enrolled in services. A client assessment tool will allow for early recognition of issues that could impact compliance with care and treatment or HIV risk. CM address these issues through an intervention plan. CM also:

- a. Coordinate links to community resources, facilitate social support groups, and psycho-social support for PLWHA.
- b. Assist with treatment defaulter tracing.
- c. Counseling patients on adherence, prevention with positives, Family Planning (FP), STI services and disclosure/partner referral.
- d. Refer patients to other health and social services (e.g., FP, STI services, drug/alcohol treatment and domestic violence).
- e. Encourage men to seek services and to support their partners and children to do the same.

CM work directly with other clinical and lay staff. An assessment will determine the roles and responsibilities of expert patients (e.g., possible default tracing) in support of CM activities.

8) Trainers. One curriculum development officer, one STI trainer, one nurse trainer, and one training manager: These four positions will be based at the National Health Training Center and supervised and managed by the MOHSS.

Supportive supervision: As noted above, the MOHSS now provides additional management oversight and supervision for contract staff.

Sustainability: Changes in the Labour Law have driven an expansion of MOHSS capacity to manage and administer contract staff. USG will continue to advocate for expanded HR management capacity within the MOHSS, and to assist with plans for the full absorption of these staff, either as civil servants or as

contractors funded and managed by the MOHSS. The use of a locally-based HR contractor further builds public and private sector capacity to address Namibia's chronic shortage of healthcare workers.

In line with the Partnership Framework (PF), CDC will support the MOHSS and Potentia to assess sustainability options and develop transition plans for these positions.

CM also contribute to cost containment by identifying clients' issues early and avoiding potentially expensive clinical costs (e.g., drug resistance related to treatment default). Task-shifting from doctors and nurses to CM reduces workloads for medical staff and maximizes their ability to deliver services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	2,587,648	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. Activities will support one component: Contract human resource (HR) services for physicians, nurses, pharmacy staff, district supervisors, and case managers (CM).

These services will include: Recruitment and hiring (as needed, using MOHSS contracts) and payroll management.

In 2009, a new Labour Law required HR contractors to shift legal responsibility for contract staff from the contractor to the client. This was done to establish a clear employee-employer relationship between the client and contract staff. With this change, private HR contractors may continue to provide HR services (e.g., recruitment, payroll management), but may no longer be the formal "employer." All of the contract staff in this program area were affected by this change.

In response to this change, the MOHSS expanded the duties and staff of the Deputy Director of the Directorate of Special Programmes (DSP) to assume direct management of these contract staff.

Potentia was previously responsible for this work. This transition represents a significant shift in the day-to-day management of contract staff. It is an important step in the development of GRN systems to manage the eventual full absorption and financing of these staff – either as civil servants or as contractors.

These changes have also resulted in cost savings. As the MOHSS has taken on greater responsibility for these positions, Potentia has reduced the management fees associated with these contracts.

Position descriptions

1) Physicians. Medical officers fill gaps in the MOHSS clinical staffing structure and provide a full range of medical services to patients in MOHSS facilities. Services cut across HBHC, HTXS, PDCS, PDTX, and HVTB.

2) Registered Nurses. RN will provide advanced clinical nursing services, including palliative and curative

care to patients in MOHSS facilities. Services cut across HBHC, HTXS, PDCS, PDTX, and HVTB.

3) Licensed Practical Nurses. LPN will support RN staff on clinical wards in MOHSS facilities. They provide services for HBHC, HTXS, PDCS, and PDTX.

4) Pharmacists. These staff will manage facility-based pharmacies and dispensaries in MOHSS facilities. Responsibilities include: Stock management, filling prescriptions, patient counseling, and supervision of pharmacy staff. Pharmacists provide services for HBHC, HTXS, and PDCS.

5) Pharm. Assistants. Fulfill a task-shifting function by absorbing some stock management, pill counting, filing, data entry tasks from pharmacists.

6) Pharm. "Hands." Serve a task-shifting function. These positions are also a career entry point for young or inexperienced staff across HBHC, PDCS, HTXS and PDTX.

For accounting purposes across the five technical areas, HTXS funds will support:

- 41 of 65 physicians
- 43 of 76 RN
- 31 of 51 LPN
- 33 of 41 pharmacists
- 18 of 44 pharm. assistants
- 7 of 14 pharm. "hands"

7) Case Managers (CM). COP10 will continue support for 21 CM across HVAB, HVOP, HVCT, HTXS, PDTX, PDCS, HVTB, and HBHC. CM will devote approximately 10% of their time to HTXS. CM have direct contact with newly diagnosed HIV patients, and patients enrolled in services. A client assessment tool allows early recognition of issues that could impact compliance with care and treatment or HIV risk. CM address these issues through an intervention plan. CM also:

- a. Coordinate links to community resources, facilitate social support groups, and psycho-social support for PLWHA.
- b. Assist with treatment defaulter tracing.
- c. Counsel patients on adherence, prevention with positives, Family Planning (FP), STI services and disclosure/partner referral.
- d. Refer patients to other health and social services (e.g., FP, STI services, alcohol treatment and domestic violence).
- e. Encourage men to seek services and to support their partners and children to do the same.

CM work directly with other clinical and lay staff. An assessment will determine the roles and responsibilities of expert patients (e.g., possible default tracing) in support of CM activities.

8) District Health Supervisors (DHS). HTXS will support salaries for TK of 34 DHS nurses. DHS provide supportive supervision and mentoring. They also monitor post-training skill utilization.

Supportive supervision: As noted above, the MOHSS now provides additional management oversight and supervision for contract staff.

Sustainability: Changes in the Labour Law have strengthened MOHSS capacity to manage and administer contract staff. In line with the Partnership Framework, the USG will continue to advocate for expanded HR management capacity within the MOHSS, and to assist with plans for the full absorption of these staff, either as civil servants or as contractors funded by the MOHSS. The use of a locally-based HR contractor further builds public and private sector capacity to address Namibia's shortage of healthcare workers.

CM also contribute to cost containment by identifying issues early and avoiding potentially expensive costs (e.g., drug resistance). Task-shifting from doctors and nurses to CM reduces workloads for medical staff and maximizes their ability to deliver services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	347,966	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. Activities will support one component: Contract human resource (HR) services for trainers and training support staff, quality assurance coordinators, and case managers (CM). These services will include: Recruitment and hiring (as needed, using MOHSS contracts) and payroll management.

In 2009, a new Labour Law required HR contractors to shift legal responsibility for contract staff from the contractor to the client. This was done to establish a clear employee-employer relationship between the client and contract staff. With this change, private HR contractors may continue to provide HR services (e.g., recruitment, payroll management), but may no longer be the formal "employer." All of the contract staff in this program area were affected by this change.

In response to this change, the MOHSS expanded the duties and staff of the Deputy Director of the Directorate of Special Programmes (DSP) to assume direct management of these contract staff. Potentia was previously responsible for this work. This transition represents a significant shift in the day-to-day management of contract staff. It is an important step in the development of GRN systems to manage the eventual full absorption and financing of these staff – either as civil servants or as contractors.

These changes have also resulted in cost savings. As the MOHSS has taken on greater responsibility for these positions, Potentia has reduced the management fees associated with these contracts.

Position descriptions

1. Trainers. HR contract services will support the following training and training support staff: Eight HCT trainers, one driver, one community counselor training coordinator, one specialized counseling trainer, one rapid test training coordinator, and two rapid test trainers. All of these staff will be managed and

supervised by the MOHSS, with input from I-TECH.

2. HCT Quality Assurance Coordinators (HCTQA). Thirteen (13) HCTQA coordinators will be managed and supervised by the MOHSS. One coordinator will be based in each of Namibia's 13 regions. These coordinators support the rollout of HIV rapid testing in Namibia. Specific activities will include:

- a. Support the Namibia Institute of Pathology (NIP) in the certification of regional rapid-test sites and staff.
- b. Conduct supportive site visits to ensure the confidentiality, accuracy, and safety of rapid testing carried out in MOHSS facilities.
- c. Review data accuracy and completeness, and relay findings to appropriate monitoring and evaluation bodies (e.g., Response M&E).
- d. Advise and mentor district Case Management Officers to strengthen the referral mechanisms and ensure continuum of care for tested clients.

3. Case Managers (CM). COP10 will continue support for 21 CM across HVAB, HVOP, HVCT, HTXS, PDTX, PDCS, HVTB, and HBHC. CM will devote approximately 10% of their time to HVCT. CM have direct contact with newly diagnosed HIV patients, and patients enrolled in services. A client assessment tool allows early recognition of issues that could impact compliance with care and treatment or HIV risk. CM address these issues through an intervention plan. CM also:

- a. Coordinate links to community resources, facilitate social support groups, and psycho-social support for PLWHA.
 - b. Assist with treatment defaulter tracing.
 - c. Counsel patients on adherence, prevention with positives, Family Planning (FP), STI services and disclosure/partner referral.
 - d. Refer patients to other health and social services (e.g., FP, STI services, alcohol treatment and domestic violence).
 - e. Encourage men to seek services and to support their partners and children to do the same.
- CM work directly with other clinical and lay staff. An assessment will determine the roles and responsibilities of expert patients (e.g., possible default tracing) in support of CM activities.

Supportive supervision: As noted above, the MOHSS now provides additional management oversight and supervision for contract staff.

Sustainability: Changes in the Labour Law have strengthened MOHSS capacity to manage and administer contract staff. In line with the Partnership Framework, the USG will continue to advocate for expanded HR management capacity within the MOHSS, and to assist with plans for the full absorption of these staff, either as civil servants or as contractors funded by the MOHSS. The use of a locally-based HR contractor further builds public and private sector capacity to address Namibia's shortage of healthcare workers.

CM also contribute to cost containment by identifying issues early and avoiding potentially expensive



costs (e.g., drug resistance). Task-shifting from doctors and nurses to CM reduces workloads for medical staff and maximizes their ability to deliver services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	296,375	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. Activities will support one component: Contract human resource (HR) services for physicians, nurses, pharmacy staff, case managers (CM), and training staff. These services will include: Recruitment and hiring (as needed, using MOHSS contracts) and payroll management.

In 2009, a new Labour Law required HR contractors to shift legal responsibility for contract staff from the contractor to the client. This was done to establish a clear employee-employer relationship between the client and contract staff. With this change, private HR contractors may continue to provide HR services (e.g., recruitment, payroll management), but may no longer be the formal "employer." All of the contract staff in this program area were affected by this change.

In response to this change, the MOHSS expanded the duties and staff of the Deputy Director of the Directorate of Special Programmes (DSP) to assume direct management of these contract staff. Potentia was previously responsible for this work. This transition represents a significant shift in the day-to-day management of contract staff. It is an important step in the development of GRN systems to manage the eventual full absorption and financing of these staff – either as civil servants or as contractors.

These changes have also resulted in cost savings. As the MOHSS has taken on greater responsibility for these positions, Potentia has reduced the management fees associated with these contracts.

Position descriptions

- 1) Physicians. Medical officers fill gaps in the MOHSS clinical staffing structure and provide a full range of medical services to patients in MOHSS facilities. Services cut across HBHC, HTXS, PDCS, PDTX, and HVTB.
- 2) Registered Nurses. RN will provide advanced clinical nursing services, including palliative and curative care to patients in MOHSS facilities. Services cut across HBHC, HTXS, PDCS, PDTX, and HVTB.
- 3) Licensed Practical Nurses. LPN will support RN staff on clinical wards in MOHSS facilities. They provide services for HBHC, HTXS, PDCS, and PDTX.
- 4) Pharmacists. These staff will manage facility-based pharmacies and dispensaries in MOHSS facilities. Responsibilities include: Stock management, filling prescriptions, patient counseling, and supervision of pharmacy staff. Pharmacists provide services for HBHC, HTXS, and PDCS.
- 5) Pharm. Assistants. Fulfill a task-shifting function by absorbing some stock management, pill counting,

filing, data entry tasks from pharmacists.

6) Pharm. "Hands." Serve a task-shifting function. These positions are also a career entry point for young or inexperienced staff across HBHC, PDCS, HTXS and PDTX.

For accounting purposes across the five technical areas, PDCS funds will support:

- 5 of 65 physicians
- 6 of 76 RN
- 3 of 51 LPN
- 2 of 41 pharmacists
- 2 of 44 pharm. assistants
- 1 of 14 pharm. "hands"

7) Case Managers (CM). COP10 will continue support for 21 CM across HVAB, HVOP, HVCT, HTXS, PDTX, PDCS, HVTB, and HBHC. CM will devote approximately 15% of their time to PDCS. CM have direct contact with newly diagnosed HIV patients, and patients enrolled in services. A client assessment tool allows early recognition of issues that could impact compliance with care and treatment or HIV risk. CM address these issues through an intervention plan. CM also:

- a. Coordinate links to community resources, facilitate social support groups, and psycho-social support for PLWHA.
- b. Assist with treatment defaulter tracing.
- c. Counsel patients on adherence, prevention with positives, Family Planning (FP), STI services and disclosure/partner referral.
- d. Refer patients to other health and social services (e.g., FP, STI services, alcohol treatment and domestic violence).
- e. Encourage men to seek services and to support their partners and children to do the same.

CM work directly with other clinical and lay staff. An assessment will determine the roles and responsibilities of expert patients (e.g., possible default tracing) in support of CM activities.

8) District Health Supervisors (DHS). PDCS will support salaries for a percentage of 34 DHS nurses. DHS provide supportive supervision and mentoring. They also monitor post-training skill utilization.

9) Trainers. One curriculum development officer, one STI trainer, one nurse trainer, and one training manager: These four positions will be based at the National Health Training Center. They will be supervised and managed by the MOHSS. PDCS will support a percentage of these positions.

Supportive supervision: As noted above, the MOHSS now provides additional management oversight and supervision for contract staff.

Sustainability: Changes in the Labour Law have strengthened MOHSS capacity to manage and administer contract staff. In line with the Partnership Framework, the USG will continue to advocate for expanded HR management capacity within the MOHSS, and to assist with plans for the full absorption of these staff, either as civil servants or as contractors funded by the MOHSS. The use of a locally-based

HR contractor further builds public and private sector capacity to address Namibia's shortage of healthcare workers.

CM also contribute to cost containment by identifying issues early and avoiding potentially expensive costs (e.g., drug resistance). Task-shifting from doctors and nurses to CM reduces workloads for medical staff and maximizes their ability to deliver services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	426,696	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. Activities will support one component: Contract human resource (HR) services for physicians, nurses, pharmacy staff, district supervisors, and case managers (CM). These services will include: Recruitment and hiring (as needed, using MOHSS contracts) and payroll management.

In 2009, a new Labour Law required HR contractors to shift legal responsibility for contract staff from the contractor to the client. This was done to establish a clear employee-employer relationship between the client and contract staff. With this change, private HR contractors may continue to provide HR services (e.g., recruitment, payroll management), but may no longer be the formal "employer." All of the contract staff in this program area were affected by this change.

In response to this change, the MOHSS expanded the duties and staff of the Deputy Director of the Directorate of Special Programmes (DSP) to assume direct management of these contract staff. Potentia was previously responsible for this work. This transition represents a significant shift in the day-to-day management of contract staff. It is an important step in the development of GRN systems to manage the eventual full absorption and financing of these staff – either as civil servants or as contractors.

These changes have also resulted in cost savings. As the MOHSS has taken on greater responsibility for these positions, Potentia has reduced the management fees associated with these contracts.

Position descriptions

- 1) Physicians. Medical officers fill gaps in the MOHSS clinical staffing structure and provide a full range of medical services to patients in MOHSS facilities. Services cut across HBHC, HTXS, PDCS, PDTX, and HVTB.
- 2) Registered Nurses. RN will provide advanced clinical nursing services, including palliative and curative care to patients in MOHSS facilities. Services cut across HBHC, HTXS, PDCS, PDTX, and HVTB.
- 3) Licensed Practical Nurses. LPN will support RN staff on clinical wards in MOHSS facilities. They provide services for HBHC, HTXS, PDCS, and PDTX.

4) Pharm. Assistants. Fulfill a task-shifting function by absorbing some stock management, pill counting, filing, data entry tasks from pharmacists.

5) Pharm. "Hands." Serve a task-shifting function. These positions are also a career entry point for young or inexperienced staff across HBHC, PDCS, HTXS and PDTX.

For accounting purposes across the five technical areas, PDTX funds will support:

- 5 of 65 physicians
- 9 of 76 RN
- 7 of 51 LPN
- 16 of 44 pharm. assistants
- 3 of 14 pharm. "hands"

6) Case Managers (CM). COP10 will continue support for 21 CM across HVAB, HVOP, HVCT, HTXS, PDTX, PDCS, HVTB, and HBHC. CM will devote approximately 15% of their time to PDTX. CM have direct contact with newly diagnosed HIV patients, and patients enrolled in services. A client assessment tool allows early recognition of issues that could impact compliance with care and treatment or HIV risk. CM address these issues through an intervention plan. CM also:

- a. Coordinate links to community resources, facilitate social support groups, and psycho-social support for PLWHA, especially for care-givers of HIV-positive children.
- b. Assist with treatment defaulter tracing.
- c. Counsel patients on adherence, prevention with positives, Family Planning (FP), STI services and disclosure/partner referral.
- d. Refer patients to other health and social services (e.g., FP, STI services, alcohol treatment and domestic violence).
- e. Encourage men to seek services and to support their partners and children to do the same.

CM work directly with other clinical and lay staff. An assessment will determine the roles and responsibilities of expert patients (e.g., possible default tracing) in support of CM activities.

7) District Health Supervisors (DHS). PDTX will support salaries for TK of 34 DHS nurses. DHS provide supportive supervision and mentoring. They also monitor post-training skill utilization.

Supportive supervision: As noted above, the MOHSS now provides additional management oversight and supervision for contract staff.

Sustainability: Changes in the Labour Law have strengthened MOHSS capacity to manage and administer contract staff. In line with the Partnership Framework, the USG will continue to advocate for expanded HR management capacity within the MOHSS, and to assist with plans for the full absorption of these staff, either as civil servants or as contractors funded by the MOHSS. The use of a locally-based HR contractor further builds public and private sector capacity to address Namibia's shortage of healthcare workers.

CM also contribute to cost containment by identifying issues early and avoiding potentially expensive



costs (e.g., drug resistance). Task-shifting from doctors and nurses to CM reduces workloads for medical staff and maximizes their ability to deliver services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	488,825	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuation of COP09 activities. Activities in this area will support one main component: 1) Contract human resource services for 50 members of the MOHSS Strategic Information (SI) staff. These services will include: Recruitment and hiring (as needed, using MOHSS contracts) and payroll management.

In 2009, a new Labour Law required HR contractors to shift legal responsibility for contract staff from the contractor to the client. This was done to establish a clear employee-employer relationship between the client and contract staff. With this change, private HR contractors may continue to provide HR services (e.g., recruitment, payroll management), but may no longer be the formal "employer." All of the contract staff in this program area were affected by this change.

In response to this change, the MOHSS expanded the duties and staff of the Deputy Director of the Directorate of Special Programmes (DSP) to assume direct management of these contract staff. Potentia was previously responsible for this work. This transition represents a significant shift in the day-to-day management of contract staff. It is an important step in the development of GRN systems to manage the eventual full absorption and financing of these staff – either as civil servants or as contractors.

These changes have also resulted in cost savings. As the MOHSS has taken on greater responsibility for these positions, Potentia has reduced the management fees associated with these contracts.

Position descriptions

1. Facility-based Data Clerks: Twenty-nine facility-based data clerks (including three senior clerks) will focus on ART exclusively to include facilitating data collection, entry and report dissemination for PMTCT, VCT, and TB programs.
2. Regional Data Clerks: These positions are based in each of Namibia's 13 regions. The clerks partner with the regional HIV/TB program administrators to ensure coordinated collation and dissemination of ART/PMTCT/VCT/TB data at the regional level.
3. PCR Data Clerk: This position coordinates data collection for the growing volume of PCR testing for early infant diagnosis. This clerk receives PCR testing results linked to post-natal PMTCT information.

Entry and management of this data enable effective monitoring of the early infant diagnosis program.

4. Data Analysts: Data analysts will provide training and technical support to the data clerks and to coordinate national-level data processing and dissemination. This activity began with one senior and one junior data analyst and expanded to include an additional junior and senior data analyst in COP07. The data analysts are assigned to the head office of the MOHSS National Health Information System in Windhoek.

5. Program Administrators for M&E Unit: These three positions will assist with surveillance, evaluation, database management and compiling and disseminating M&E data from around the country. One will coordinate surveillance efforts called for by the National M&E Plan; the second is in charge of technical evaluations; and the third will assist with database management, data quality assurance, and collecting and disseminating HIV-related M&E data from government sectors outside of health and from NGO partners.

Supportive supervision: As noted above, the MOHSS now provides additional management oversight and supervision for contract staff.

Sustainability: Changes in the Labour Law have strengthened MOHSS capacity to manage and administer contract staff. In line with the Partnership Framework, the USG will continue to advocate for expanded HR management capacity within the MOHSS, and to assist with plans for the full absorption of these staff, either as civil servants or as contractors funded by the MOHSS. The use of a locally-based HR contractor further builds public and private sector capacity to address Namibia's shortage of healthcare workers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	650,694	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES:

This is a continuing activity from COP09 which includes one component: 1) the provision of contract human resource (HR) services for educators and training support staff at the University of Namibia (UNAM), the National Health Training Center (NHTC), I-TECH and selected regional sites. These services include: recruitment and hiring (using MOHSS contracts) and payroll management.

A 2009 new Labour Law required HR contractors to shift legal responsibility for contract staff from the contractor to the client to establish a clear employee-employer relationship between the client and contract staff. With this change, private HR contractors may continue to provide HR services (e.g., recruitment, payroll management), but may no longer be the formal "employer." All of the contract staff in this program area were affected by this.

In response, the MOHSS expanded the duties and staff of the Deputy Director of the Directorate of

Special Programmes (DSP) to assume direct management of these contract staff (Potentia was previously responsible). This transition represents a significant shift in the day-to-day management of contract staff and is an important step in the development of GRN systems to manage the eventual full absorption and financing of these staff – either as civil servants or contractors. UNAM and ITECH have taken similar steps to align their HR practices with the new Labour Law.

These changes have also resulted in cost savings. As the MOHSS has taken on greater responsibility for these positions, Potentia has reduced the management fees associated with these contracts.

Position descriptions:

1. University of Namibia (UNAM) Technical Advisor (TA). The TA will be seconded to the UNAM Nursing School to support the implementation of the integrated nursing curriculum that emphasize the integration of HIV/AIDS modules in the broader curriculum. "Mainstreaming" HIV/AIDS into the broader healthcare system is a key priority for the Partnership Framework.
2. Nursing Lecturers and four part-time Clinical Instructors at UNAM. COP10 funds will support three Nursing Lecturers and four part-time Clinical Instructors at UNAM campuses in Windhoek and Oshakati to support students following their placement in clinical sites to continue to strengthen HIV/AIDS integration into UNAM re-service training. UNAM has increased its intake of nursing students in response to the severe shortage and needs continued support in the classroom and clinical training setting.
3. Ten NHTC and Regional Health Training Center (RHTC) pre-service tutors. COP10 funds will support two pre-service tutors stationed at the NHTC and eight at the five RHTC. These tutors follow up the nursing students in their clinical sites where they learn how to take care for people living with HIV/AIDS (PLWHA). Training for these tutors will be provided by I-TECH.
4. Two HR development staff. COP10 funds will support one HR Development Advisor and one Data Clerk assigned to the MOHSS Directorate of Policy, Planning and HR Development to assist with the management of contract staff, policy development, HR forecasting, management of the staffing database, training strategies and strategic planning, including defining of the expanded roles of nurses and community counselors (CC) in HIV/AIDS care.
5. Fourteen digital video conferencing (DVC) staff. COP10 funds will support one DVC Program Coordinator, one DVC Technologist, and 12 DVC Assistants to ensure the DVC program is coordinated and operational throughout Namibia. The DVC program provides training opportunities such as HIV case conferences, lectures on opportunistic infections and HIV co-morbidities, and video demonstrations of HIV counseling sessions. The DVC program also provides an efficient and cost-effective means of communicating programmatic HIV/AIDS-related information from national to local level, such as technical updates, and provides technical and managerial support to sites as they expand.
6. Two specialized training staff. COP10 funds will support one Training Coordinator and one Clerk assigned to the NHTC to coordinate training activities in PMTCT, VCT, and couples counseling.
7. Fourteen I-TECH/Namibia field office staff. COP10 funds will support the following personnel for I-TECH Central Operations:

- Deputy Director
- Office Manager
- Financial Officer
- Receptionist
- Driver
- Administrative Assistant for the Oshakati RHTC office
- Development Manager to coordinate all major curricula and media products
- Two Training Assistants
- Materials Production Clerk to support training coordination
- Facilities Manager
- Housemother
- Two Cleaners

Supportive supervision: The MOHSS now provides additional contract staff management oversight and supervision.

Sustainability: As noted above, the MOHSS has expanded the duties of the DSP Deputy Director to include direct management and administration of six contract staff and the CC cadre. This transition represents an important step toward the eventual full MOHSS absorption and financing of these staff – either as civil servants or contractors. Long-term cost savings are being achieved through the focus on recruiting and deploying staff within their own communities. CC retention rates are also high, suggesting a high level of morale among this cadre. Also of note, several CC have recently "graduated" to enroll in nursing school and similar transitions will be encouraged throughout the task-shifting initiative.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	271,886	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. Activities will support one component: Contract human resource (HR) services for a National Male Circumcision (MC) Coordinator, and eight specialist physicians (to perform MC). These services will include: Recruitment and hiring (as needed, using Ministry of Health and Social Services (MOHSS) contracts) and payroll management.

In 2009, a new Labour Law required HR contractors to shift legal responsibility for contract staff from the contractor to the client. This was done to establish a clear employee-employer relationship between the client and contract staff. With this change, private HR contractors may continue to provide HR services (e.g., recruitment, payroll management), but may no longer be the formal "employer." All of the contract staff in this program area were affected by this change.

In response to this change, the MOHSS expanded the duties and staff of the Deputy Director of the Directorate of Special Programmes (DSP) to assume direct management of these contract staff. Potentia was previously responsible for this work. This transition represents a significant shift in the day-to-day management of contract staff. It is an important step in the development of GRN systems to manage the eventual full absorption and financing of these staff – either as civil servants or as contractors.

These changes have also resulted in cost savings. As the MOHSS has taken on greater responsibility for these positions, Potentia has reduced the management fees associated with these contracts.

Position descriptions:

1. National MC Coordinator. In COP10, PEPFAR funds will continue to support a National Male Circumcision Coordinator based in the MOHSS Directorate of Special Programmes for HIV, TB, and Malaria (DSP). This position is responsible for the development of standard operating procedures for MC and coordinating the implementation of MC in the public sector. Some of the job responsibilities for the MC Coordinator include:

- (a) Coordinating the Male Circumcision task force.
- (b) Collaborating with the MOHSS Division of Primary Health Care (PHC) to explore the expansion of neonatal MC services in maternity wards throughout Namibia.
- (c) Collaborating with PHC to identify traditional circumcisers to be trained and possibly certified to perform MC services.
- (d) Working closely with I-TECH and overseeing the training of health care providers in the public and faith-based sectors.
- (e) Guiding and coordinating MC services in faith-based facilities.
- (f) Liaising with the health facilities and MOHSS Central Medical Stores to ensure that appropriate supplies, commodities, and equipment are available for MC services.
- (g) Working with Nawa Life Trust, the MC Task Force, and other partners in designing and implementing a communications and advocacy campaign.
- (h) Working with the Nursing board to develop a task-shifting strategy for MC.

The MC coordinator may also work with Namibian Medical Aid to include adult MC within its insurance package. Adult MC is currently only covered by national insurance when indicated for medical reasons, and the cost of private MC services is prohibitive for most Namibians.

2. Specialist physicians to perform MC. Eight physicians with expertise and experience in MC will be supported in COP10. This represents an increase of three MC specialist physicians since COP09. The additional providers will be trained by I-TECH and will work closely with the National Male Circumcision Coordinator. As in COP09, all MC physician specialists will be strategically assigned to facilities throughout Namibia to cover the areas with the highest HIV prevalence, lowest MC rates, and anticipated highest demand for MC services. These eight specialist physicians will contribute to an ongoing assessment of task-shifting opportunities for nurses in the CIRC technical area. MC specialist

physicians, nurses and midwives will participate in any eventual planning for task-shifting in MC. The draft national policy includes recommendations on task shifting, including the identification of potential cadres to take up new responsibilities, tasks that could be shifted and training needs.

Supportive supervision: As noted above, the MOHSS now provides additional management oversight and supervision for contract staff.

Sustainability: Changes in the Labour Law have strengthened MOHSS capacity to manage and administer contract staff. In line with the Partnership Framework, the USG will continue to advocate for expanded HR management capacity within the MOHSS, and to assist with plans for the full absorption of these staff, either as civil servants or as contractors funded by the MOHSS. The use of a locally-based HR contractor further builds public and private sector capacity to address Namibia's shortage of healthcare workers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	48,653	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. Activities in this area will support one main component: 1) Contract human resource services for case managers and a National Prevention Coordinator. These services will include: Recruitment and hiring (as needed, using MOHSS contracts) and payroll management.

Because Case Managers do not exclusively provide HVAB services, a portion of the funding to support these positions is reflected in MTCT, HVOP, HTXS, PDTX, HBHC, PDCS, and HVTB. Half of the funding for the National Prevention Coordinator is reflected in HVOP.

In 2009, a new Labour Law required HR contractors to shift legal responsibility for contract staff from the contractor to the client. This was done to establish a clear employee-employer relationship between the client and contract staff. With this change, private HR contractors may continue to provide HR services (e.g., recruitment, payroll management), but may no longer be the formal "employer." All of the contract staff in this program area were affected by this change.

In response to this change, the MOHSS expanded the duties and staff of the Deputy Director of the Directorate of Special Programmes (DSP) to assume direct management of these contract staff.

Potentia was previously responsible for this work. This transition represents a significant shift in the day-to-day management of contract staff. It is an important step in the development of GRN systems to

manage the eventual full absorption and financing of these staff – either as civil servants or as contractors.

These changes have also resulted in cost savings. As the MOHSS has taken on greater responsibility for these positions, Potentia has reduced the management fees associated with these contracts.

Position descriptions

1) Case Managers (CM). COP10 will continue support for 21 CM in eight program areas (HVOP, HVCT, HTXS, PDTX, HBHC, PDCS, and HVTB), including HVAB. These CM will commit approximately 10% of their time to HVAB activities. CM will have immediate contact with newly diagnosed HIV patients, as well as patients already enrolled in care and treatment services. A client assessment tool will allow for early recognition of client issues that could impact compliance with care and treatment. Through an intervention/service plan CM will address issues that place clients at risk of defaulting on HIV care or becoming HIV-infected. CM will:

- Coordinate resources for clients, including links to and facilitation of social support groups, and psycho-social support for PLWHA.
- Assist with treatment defaulter tracing.
- Counsel patients on adherence, prevention with positives, ABC, Family Planning (FP), STI services and disclosure/partner referral
- Refer patients to other health and social services (e.g., FP, STI services, drug/alcohol treatment and domestic violence)
- Encourage men to seek services and to support their partners and children in doing the same.

CM will work directly with other clinical and lay staff. As part of the development of the overall CM program, an assessment will determine the optimal roles and responsibilities of expert patients (e.g., possible default tracing, education, etc) in support of CM activities.

2) Prevention Coordinator. This position coordinates prevention efforts across line ministries and with other stakeholders in the national response. The prevention coordinator leads the National Prevention Technical Advisory Committee, and is leading the development of the National Prevention Strategy.

Supportive supervision: As noted above, the MOHSS now provides additional management oversight and supervision for contract staff.

Sustainability: Changes in the Namibian Labour Law have resulted in cost savings and an expansion of MOHSS's role in the management and administration of contract staff (see above). USG will continue to advocate for expanded management capacity within the MOHSS, and to assist with the development of plans for the full absorption of these staff, either as civil servants or as contractors funded by the MOHSS. The use of a locally-based HR contractor further builds public and private sector capacity to



address Namibia's chronic shortage of healthcare workers.

In line with the objectives described in the Partnership Framework Implementation Plan (PFIP), CDC will support the MOHSS and Potentia to assess sustainability options for these positions. This assessment will inform the development of transition plans for both partners.

CM also contribute to cost containment by identifying and addressing clients' issues early and avoiding potentially expensive clinical costs (e.g., drug resistance related to treatment default). Task-shifting from doctors and nurses to CM reduces workloads for medical staff and maximizes their ability to deliver services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	59,462	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. Activities in this area will support one main component: 1) Contract human resource services for 20 Condoms Logistics Officers, 34 Case Managers, and a National Prevention Coordinator seconded to the MOHSS.

Because Case Managers do not exclusively provide HVOP services, a portion of the funding to support these positions is reflected in MTCT, HVOP, HTXS, PDTX, HBHC, PDCS, and HVTB. Half of the funding for the National Prevention Coordinator is reflected in HVAB.

In 2009, a new Labour Law required HR contractors to shift legal responsibility for contract staff from the contractor to the client. This was done to establish a clear employee-employer relationship between the client and contract staff. With this change, private HR contractors may continue to provide HR services (e.g., recruitment, payroll management), but may no longer be the formal "employer." All of the contract staff in this program area were affected by this change.

In response to this change, the MOHSS expanded the duties and staff of the Deputy Director of the Directorate of Special Programmes (DSP) to assume direct management of these contract staff. Potentia was previously responsible for this work. This transition represents a significant shift in the day-to-day management of contract staff. It is an important step in the development of GRN systems to manage the eventual full absorption and financing of these staff – either as civil servants or as contractors.



These changes have also resulted in cost savings. As the MOHSS has taken on greater responsibility for these positions, Potentia has reduced the management fees associated with these contracts.

Position descriptions

1) Condom Logistics Officers. In COP10, funding will continue to support 20 Condom Logistics Officers at district hospitals to facilitate local supply and distribution from hospital pharmacies to health facilities and PEPFAR-funded nongovernmental organizations (NGO) and faith-based organizations (FBO) who distribute condoms to high-risk people.

2) Case Managers (CM). COP10 will continue support for 21 CM in eight program areas (MTCT, HVOP, HTXS, PDTX, HBHC, PDCS, and HVTB), including HVAB. These CM will commit approximately 10% of their time to HVAB activities. CM will have immediate contact with newly diagnosed HIV patients, as well as patients already enrolled in care and treatment services. A client assessment tool will allow for early recognition of client issues that could impact compliance with care and treatment. Through an intervention/service plan CM will address issues that place clients at risk of defaulting on HIV care or becoming HIV-infected. CM will:

- Coordinate resources for clients, including links to and facilitation of social support groups, and psychosocial support for PLWHA.
- Assist with treatment defaulter tracing.
- Counsel patients on adherence, prevention with positives, ABC, Family Planning (FP), STI services and disclosure/partner referral
- Refer patients to other health and social services (e.g., FP, STI services, drug/alcohol treatment and domestic violence)
- Encourage men to seek services and to support their partners and children in doing the same.

CM will work directly with other clinical and lay staff. As part of the development of the overall CM program, an assessment will determine the optimal roles and responsibilities of expert patients (e.g., possible default tracing, education, etc) in support of CM activities.

3) Prevention Coordinator. This position coordinates prevention efforts across line ministries and with other stakeholders in the national response. The prevention coordinator leads the National Prevention Technical Advisory Committee, and is leading the development of the National Prevention Strategy.

Supportive supervision: As noted above, the MOHSS now provides additional management oversight and supervision for contract staff.

Sustainability: Changes in the Namibian Labour Law have resulted in cost savings and an expansion of MOHSS's role in the management and administration of contract staff (see above). USG will continue to



advocate for expanded management capacity within the MOHSS, and to assist with the development of plans for the full absorption of these staff, either as civil servants or as contractors funded by the MOHSS. The use of a locally-based HR contractor further builds public and private sector capacity to address Namibia's chronic shortage of healthcare workers.

In line with the objectives described in the Partnership Framework Implementation Plan (PFIP), CDC will support the MOHSS and Potentia to assess sustainability options for these positions. This assessment will inform the development of transition plans for both partners.

CM also contribute to cost containment by identifying and addressing clients' issues early and avoiding potentially expensive clinical costs (e.g., drug resistance related to treatment default). Task-shifting from doctors and nurses to CM reduces workloads for medical staff and maximizes their ability to deliver services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	146,484	

Narrative:

NEW/REPLACEMENT NARRATIVE

This is a continuing activity from COP09. Activities in this area will support one main component: 1) The provision of contract human resource services for six members of the MOHSS PMTCT training team based at the National Health Training Center (NHTC). These services will include: Recruitment and hiring (as needed, using MOHSS contracts) and payroll management.

In early 2009, the passage of a new Labour Law required all human resource contractors to revise contractual mechanisms to shift legal responsibility for contract staff from the private contractor to the client. This shift was required to establish a clear employee-employer relationship between the client and contract staff. With this change, private human resource contractors may continue to provide HR services (e.g., recruitment, payroll management), but may no longer be the formal "employer." In this program area, six contract staff were affected by this change. These positions are described below.

In response to this change, the MOHSS expanded the duties of the Deputy Director of the Directorate of Special Programmes (DSP) to include direct management and administration of these contract staff.

Potentia was previously responsible for this work. This transition represents a significant shift in the day-to-day management of contract staff. It is an important step toward the eventual full absorption and financing of these staff – either as civil servants or as contractors – by the MOHSS.

These changes have also resulted in cost savings for the USG. As the MOHSS has taken on greater responsibility for managing these positions, Potentia has reduced the monthly management fees



associated with these contracts.

The following staff are deployed at the MOHSS' National Health Training Center and at Regional Health Training Centers:

(1) Five in-service tutors placed throughout the NHTC network. These tutors provide decentralized training and supportive supervision in PMTCT and dried blood spot (DBS) for DNA-PCR testing for infants. These tutors will conduct at least 50 post-training site visits to reinforce training content and measure utilization of newly acquired skills.

(2) One driver to transport the tutors to training and clinical sites.

Supportive supervision: As noted above, the MOHSS now provides additional management oversight and supervision for contract staff. Additional supportive supervision is provided through I-TECH activities.

Sustainability: Changes in the Labour Law have strengthened MOHSS capacity to manage and administer contract staff. In line with the Partnership Framework, the USG will continue to advocate for expanded HR management capacity within the MOHSS, and to assist with plans for the full absorption of these staff, either as civil servants or as contractors funded by the MOHSS. The use of a locally-based HR contractor further builds public and private sector capacity to address Namibia's shortage of healthcare workers.

USG support for PMTCT training is also leveraged and harmonized with similar support from the Global Fund.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	136,981	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. Activities will support one component: Contract human resource (HR) services for physicians, nurses and a tuberculosis (TB) infection control specialist. These services will include: Recruitment and hiring (as needed, using MOHSS contracts) and payroll management. In 2009, a new Labour Law required HR contractors to shift legal responsibility for contract staff from the contractor to the client. This was done to establish a clear employee-employer relationship between the client and contract staff. With this change, private HR contractors may continue to provide HR services



(e.g., recruitment, payroll management), but may no longer be the formal "employer." All of the contract staff in this program area were affected by this change.

In response to this change, the MOHSS expanded the duties and staff of the Deputy Director of the Directorate of Special Programmes (DSP) to assume direct management of these contract staff.

Potentia was previously responsible for this work. This transition represents a significant shift in the day-to-day management of contract staff. It is an important step in the development of GRN systems to manage the eventual full absorption and financing of these staff – either as civil servants or as contractors.

These changes have also resulted in cost savings. As the MOHSS has taken on greater responsibility for these positions, Potentia has reduced the management fees associated with these contracts.

Position descriptions

1) Physicians. Medical officers fill gaps in the MOHSS clinical staffing structure and provide a full range of medical services to patients in MOHSS facilities. Services cut across HBHC, HTXS, PDCS, PDTX, and HVTB. PEPFAR is working closely with MOHSS and the USAID Tuberculosis Control Assistance Program (TBCAP) to ensure that these physicians are posted where the need is greatest. To this end, one HIV/TB physician will be based at Katatura Hospital. The other will work at Walvis Bay Hospital.

2) Registered Nurses. RN will provide advanced clinical nursing services, including Directly Observe Treatment Short course (DOTS) for patients with TB and TB/HIV co-infection. Nurses will also support surveillance for drug-resistant cases of TB in MOHSS facilities. Services cut across HBHC, HTXS, PDCS, PDTX, and HVTB. Other tasks will include:

- a. Routine counseling and testing for consenting TB patients
- b. Isoniazid preventive therapy for eligible TB/HIV patients
- c. Cotrimoxazole prophylaxis
- d. Linkages of TB with HIV/AIDS services
- e. Provision of ART for eligible TB/HIV patients, including children.

3) TB Infection Control Specialist. This expert will support MOHSS efforts to develop and implement infection control policies and guidelines. These materials will draw on technical assistance from CDC, WHO and other development partners (Netherlands TB control program) The IC specialist will also serve as a focal point for coordination between national TB and HIV programs, especially to support the implementation of the WHO "3 I's": Intensified case finding, Isoniazid preventive therapy, and Infection control.

4) Curriculum Development Manager. HVTB funds will support 100% of this position

5) TB/HIV Curriculum Developer. This individual will work with the National Health Training Center and I-TECH to revise national training curricula on the identification, prevention and management of HIV/TB co-infection. HVTB funds will support 100% of this position.

6) In-service IMAI/TB Trainer. The trainer will provide on-site instruction and supportive supervision to nurses involved with HIV/TB patients. HVTB funds will support 100% of this position.



For accounting purposes across the five technical areas, HVTB funds will support:

- 2 of 65 physicians
- 1 of 76 RN

Supportive supervision: As noted above, the MOHSS now provides additional management oversight and supervision for contract staff.

Sustainability: Changes in the Namibian Labour Law have resulted in cost savings and an expansion of MOHSS's role in the management and administration of contract staff (see above). USG will continue to advocate for expanded management capacity within the MOHSS, and to assist with the development of plans for the full absorption of these staff, either as civil servants or as contractors funded by the MOHSS. The use of a locally-based HR contractor further builds public and private sector capacity to address Namibia's chronic shortage of healthcare workers.

In line with the objectives described in the Partnership Framework (PF), CDC will support the MOHSS and Potentia to assess sustainability options for these positions. This assessment will inform the development of transition plans for both partners.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9874	Mechanism Name: HIVQUAL
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: US Health Resources and Services Administration	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 175,676	
Funding Source	Funding Amount
GHCS (State)	175,676

Sub Partner Name(s)

(No data provided.)



Overview Narrative

HIVQUAL/US Health Resources and Services Administration is a continuing mechanism from COP 09

HIVQUAL/US Health Resources and Services Administration has one comprehensive goal and four objectives across the HTXS, HBHC, PDCS and PDTX technical areas. The main goal is to provide technical assistance to the MOHSS to establish a quality improvement program that allows public health facilities to continuously assess the quality of care they deliver to HIV/AIDS patients. Information from this quality improvement program is used by clinic staff to guide efforts to improve HIV care delivery.

To achieve this goal HIVQUAL has the following objectives:

1. Build capacity for MOHSS program officers and health care providers to become more proficient in using quality improvement tools and methodologies to improve HIV care.
2. Establish a quality of care performance measurement system that monitors to what extent treatment and care provided to patients infected with HIV complies with Namibian National Guidelines for HIV/AIDS care.
3. Establish a system to evaluate the results of efforts to improve the quality of HIV/AIDS treatment and care at all public health facilities.
4. Provide technical assistance (TA) on strategies to develop local, regional, and national consumer involvement processes in HIV/AIDS health care programs.

Links to the Partnership Framework goals and benchmarks over the life of its agreement/award.

This activity closely supports the commitments of the USG in the partnership framework which is currently under development.

As part of the USG contribution to the goal of "enhancing the quality of care" within the partnership framework implementation plan (PFIP), the USG commits through year five to provide TA to enhance quality management and quality improvement of HIV service delivery. In COP10, the USG will support the roll out of structured quality improvement program to all public HIV treatment and care facilities.

The Implementing Mechanism's geographic coverage and target population(s).

In collaboration with USG agencies in Namibia, HIVQUAL will work within the MOHSS to reach out to all public health facilities including those with faith-based affiliations. The target population for the quality improvement program will be all HIV infected children, adolescents and adults receiving HIV care and treatment within all the public health facilities, as well as the health care workers (HCW) staff providing that care.



Key contributions to health systems strengthening

Consistent with the new PEPFAR vision of improving sustainability of national programs, HIVQUAL will support efforts to decentralize program management and build program management capacity at regional, district and other sub-national levels. The HIVQUAL approach emphasizes the development of quality improvement systems and processes involving clinic staff and consumers within the MOHSS and other organizational leadership. These structural features are designed to be sustainable even when staff turnover is high or organizational affiliations support change. Through building capacity at the national and local levels for quality improvement and use of strategic information by providers for program improvement, HIVQUAL will strongly contribute to overall health systems strengthening.

Implementing Mechanism's cross-cutting programs and key issues

In terms of cross-cutting attributions funding for HIVQUAL contributes towards the Human Resources for Health (HRH) component of Performance Assessment/Quality Improvement.

The Implementing Mechanism's strategy to become more cost efficient over time

HIVQUAL values cost efficiency and from the beginning has been working through the structures of the MOHSS, by providing technical assistance through the targeted use of New York-based consultants and the extensive use of USG Namibia technical staff within the program framework. This strategy is consistent with the new PEPFAR vision to ensure cost efficiencies. The MOHSS coordinates the program with other partners in the public sector through its Case Management Unit, and thus is able to expand coverage of the program with low costs. The use of Case Managers also builds human capacity within the MOHSS system. In 2009, the MOHSS took over management of these positions from a private contract firm. This was a first step toward full absorption into the MOHSS human resource system.

Monitoring and evaluation plans for included activities.

The activity itself is primarily focused on the utilization of clinical data for improving quality of care. As such, monitoring and evaluation of clinical services is continual. HIVQUAL is required to submit bi-annual progress reports detailing achievements in terms of PEPFAR indicators and other measures specific to the activities. An independent external evaluation was conducted in 2008.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	70,000
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Key Issues

Child Survival Activities
 Safe Motherhood
 TB
 Family Planning

Budget Code Information

Mechanism ID:	9874		
Mechanism Name:	HIVQUAL		
Prime Partner Name:	US Health Resources and Services Administration		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	18,750	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP2009. It includes five components: (1) Quality Improvement (QI) training; (2) Assessment of quality management programs at participating clinics; (3) Performance measurement (at six-month intervals) on selected core indicators; (4) Ongoing QI coaching and mentoring at participating sites, and; (5) Promotion of patient engagement in HIV care.

Funding for HIVQUAL is split between HTXS, PDTX, HBHC and PDCS because the program focuses on quality improvement of clinical services in all four program areas.

In COP10, the activity will be conducted under the leadership of the MOHSS Directorate of Special Programs (DSP) in close collaboration with CDC Namibia and the US-based HIVQUAL team for technical support. By the end of COP09, the program will have rolled out to all 34 health districts of Namibia, and at least five health centers offering HIV care through the Integrated Management of Adolescent and Adult Illness (IMAI) strategy. Activities in COP10 will focus on quality program implementation in these sites, and expansion to additional health centers.

1) Quality Improvement (QI) training. The USG HIVQUAL team will continue to build capacity for QI among MOHSS staff and healthcare providers in Namibia. Advanced level short term in-service trainings will be provided to staff who have received training in prior years, as well as basic training for new staff. The training activities will be done in collaboration with I-TECH. Specifically activities for COP10 will include Training of Trainers workshops to promote decentralization of QI trainings throughout Namibia, and to support the expanded national quality program.

2) Assessment of quality management programs at the participating clinics. An assessment tool to



measure the capacity of the quality management program at each facility will be used. It will measure the growth of quality management activities as well as the quality of staff members' skills. The findings from these assessments will guide coaching interventions. Aggregated facility-specific data will provide population-level performance data to indicate priorities for national quality improvement activities and campaigns. Similarly, local performance data will be used to improve services at local facilities.

3) Performance measurement (at six-month intervals) on selected core indicators. HIVQUAL will continue to develop providers' skills for collecting and using performance data within their own organizations to improve their HIV treatment and care. Indicators will track the provision of the basic treatment and care package. Selected indicators will include ART services ART adherence, use of Cotrimoxazole prophylaxis, and TB screening. Facility-level data derived from the national health information system will be used to improving quality.

4) Ongoing QI coaching and mentoring at participating sites. In COP10, the program will focus mainly on transferring knowledge and skills to local technical advisors in the MOHSS with the ultimate goal of building country ownership and strengthening sustainability. The transfer of QI skills will be accomplished through coaching and mentoring for MOHSS staff and health care providers.

5) Promotion of consumer engagement in HIV care. HIVQUAL will provide technical assistance to the MOHSS on strategies to develop local, regional, and national strategies and programs to increase consumer (patient) involvement in HIV/AIDS programs. Increased participation by patients and other "consumers" will improve HIV care and treatment services by enhancing the feed-back loop between patients, providers and the MOHSS. Specifically this activity will include working with the MOHSS to devise a written plan for consumer involvement. The plan will outline structures to ensure active participation of people living with HIV/AIDS in the development and improvement of HIV/AIDS programs. This will also include a needs assessment to determine local, regional, and national priorities. Regional civil society groups will be engaged to identify and solicit diverse community opinions.

Sustainability: HIVQUAL values cost efficiency. From the beginning the program has worked within MOHSS structures to provide targeted technical assistance from New York-based consultants and from USG Namibia technical staff. This strategy is consistent with the new PEPFAR vision of enforcing country ownership through responsive technical engagement. The MOHSS coordinates the program with other partners in the public sector through its Case Management Unit, and thus is able to expand coverage of the program with low costs. The use of Case Managers also builds human capacity within the MOHSS system. In 2009, the MOHSS took over management of these positions from a private contract firm. This was a first step toward the full absorption of these into the MOHSS human resource system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	75,601	

Narrative:



NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It has five components: (1) Quality Improvement (QI) training; (2) Assessment of quality management programs at the participating clinics; (3) Performance measurement (at six-month intervals) on selected core indicators; (4) Ongoing QI coaching and mentoring at participating sites; (5) Promotion of consumer engagement in HIV care.

Funding for HIVQUAL is split between HTXS, PDTX, HBHC and PDCS.

In COP10, the activity will be conducted under the leadership of the MOHSS in close collaboration with CDC Namibia and the US-based HIVQUAL team for technical support. By the end of FY 2009, the program will have rolled out to all 34 health districts of Namibia, and at least five health centers offering HIV care through the Integrated Management of Adolescent and Adult Illness (IMAI) strategy.

1. Quality Improvement (QI) training. The USG HIVQUAL team will continue to build capacity for QI among MOHSS staff and providers in Namibia and provide advanced level short term in-service trainings for existing participants, as well as basic training for new participants. The training activities will be done in collaboration with I-TECH. Activities for COP10 will include a Training of Trainers' workshop to enable decentralization of QI trainings throughout Namibia and to support the expanded national quality program.

2. Assessment of quality management programs at the participating clinics. An assessment tool to measure the capacity of the quality management program at each facility will be used to measure both the growth of quality management activities as well as guide the coaching interventions. Aggregated facility-specific data can provide population-level performance data that indicate priorities for national quality improvement activities and campaigns.

3. Performance measurement (at 6-month intervals) on selected core indicators. HIVQUAL will continue to develop providers' skills for collecting and using performance data to improve their HIV treatment and care. Indicators will include assessment of the provision of the basic treatment and care package, including ART provision and ART adherence, Cotrimoxazole prophylaxis and TB screening. Use of facility-level data derived from the national health information system will continue to be an important goal of HIVQUAL. HIVQUAL provides a framework for health services staff and individual health care providers to engage in a participatory process of quality improvement based on evidence and data collected locally. Using the HIVQUAL model, health units, districts, regions and the MOHSS will be able to gauge the quality of clinical HIV services based on national guidelines. Activities will strengthen the provision of quality care and the documentation of key strategic information in health care facilities.

4. Ongoing QI coaching and mentoring at participating sites. In COP10, the program will focus mainly on transferring knowledge and skills to technical advisors in the MOHSS and CDC Namibia with the ultimate goal of ensuring sustainability of the program in the long term. The USG HIVQUAL team will continue to focus on building quality improvement coaching skills among MOHSS staff and provide mentorship to health care providers.

5. Promotion of consumer engagement in HIV care. HIVQUAL develop strategies to enhance local,



regional, and national consumer involvement in HIV/AIDS health care programs to improve the quality of HIV health care provided. Specifically, this activity will include working with the MOHSS (in-country and through US study tours) to devise a written plan for consumer involvement. The plan will outline structures to ensure active participation of PLWHIVA in the continuous development and improvement of HIV/AIDS programs. This includes the development of a needs assessment to determine local, regional, and national priorities. Engagement will be done with regional civil society groups to identify and solicit diverse community members who are interested in pursuing consumer involvement in HIV quality improvement activities.

Special focus within the Pediatric Care and Support area will engage adolescents living with HIV through formation of site specific Young Adults Consumer Advisory Committees (YACACs). Training will be offered to affirm and support the consumer's role in HIV health care and treatment. Qualitative and Quantitative evaluation measures will be developed to evaluate the success of the proposed project. This strategy is aimed at effectively meeting the service needs of pediatric and adolescents living with HIV/AIDS, while addressing ethical issues that may arise. This strategy is also likely to further support adherence to treatment and care by PLWHIA.

Sustainability: HIVQUAL values cost efficiency. From the beginning the program has worked with MOHSS structures to provide targeted technical assistance from New York-based consultants and from USG Namibia technical staff. This strategy is consistent with the new PEPFAR vision of enforcing country ownership through responsive technical engagement. The MOHSS coordinates the program with other partners in the public sector through its Case Management Unit, and thus is able to expand coverage of the program with low costs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	36,250	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes five main components: (1) Quality Improvement (QI) training; (2) Assessment of quality management programs at participating clinics; (3) Performance measurement (at six-month intervals) on selected core indicators; (4) Ongoing QI coaching and mentoring at participating sites, and; (5) Promotion of patient engagement in HIV care.

Funding for HIVQUAL is split between HTXS, PDTX, HBHC and PDCS because the program focuses on quality improvement of clinical services in all four program areas.

In COP10, the activity will be conducted under the leadership of the MOHSS Directorate of Special Programs (DSP) in close collaboration with CDC Namibia and the US-based HIVQUAL team for technical support. By the end of COP09, the program will have rolled out to all 34 health districts of Namibia, and at least five health centers offering HIV care through the Integrated Management of Adolescent and Adult



Illness (IMAI) strategy. Activities in COP10 will focus on quality program implementation in these sites, and expansion to additional health centers.

(1) Quality Improvement (QI) training. The USG HIVQUAL team will continue to build capacity for QI among MOHSS staff and healthcare providers in Namibia. Advanced level short term in-service trainings will be provided to staff who have received training in prior years, as well as basic training for new staff. The training activities will be done in collaboration with I-TECH. Specifically activities for COP10 will include Training of Trainers workshops to promote decentralization of QI trainings throughout Namibia, and to support the expanded national quality program.

(2) Assessment of quality management programs at the participating clinics. An assessment tool to measure the capacity of the quality management program at each facility will be used. It will measure the growth of quality management activities as well as the quality of staff members' skills. The findings from these assessments will guide coaching interventions. Aggregated facility-specific data will provide population-level performance data to indicate priorities for national quality improvement activities and campaigns. Similarly, local performance data will be used to improve services at local facilities.

(3) Performance measurement (at six-month intervals) on selected core indicators. HIVQUAL will continue to develop providers' skills for collecting and using performance data within their own organizations to improve their pediatric HIV treatment and care. Pediatric indicators will track the provision of the basic pediatric treatment and care package. Selected indicators will include ART services ART adherence, growth monitoring, nutrition assessment, immunizations, use of Cotrimoxazole prophylaxis, and TB screening. Facility-level data derived from the national health information system will be used to improving quality.

(4) Ongoing QI coaching and mentoring at participating sites. In COP10, the program will focus mainly on transferring knowledge and skills to local technical advisors in the MOHSS with the ultimate goal of building country ownership and strengthening sustainability. The transfer of QI skills will be accomplished through coaching and mentoring for MOHSS staff and health care providers.

(5) Promotion of consumer engagement in HIV care. HIVQUAL will provide technical assistance to the MOHSS on strategies to develop local, regional, and national strategies and programs to increase consumer (patient) involvement in HIV/AIDS programs. Increased participation by patients and other "consumers" will improve HIV care and treatment services by enhancing the feed-back loop between patients, providers and the MOHSS. Special focus within the Pediatric Care and Support area will be paid on engaging adolescents living with HIV through formation of site specific Young Adults Consumer Advisory Committees (YACACs). Specifically this activity will include working with the MOHSS to devise a written plan for consumer involvement. The plan will outline structures to ensure active participation of people living with HIV/AIDS in the development and improvement of HIV/AIDS programs. This will also include a needs assessment to determine local, regional, and national priorities. Regional civil society groups will be engaged to identify and solicit diverse community opinions.

Sustainability: HIVQUAL values cost efficiency. From the beginning the program has worked MOHSS



structures to provide targeted technical assistance from New York-based consultants and from USG Namibia technical staff. This strategy is consistent with the new PEPFAR vision of enforcing country ownership through responsive technical engagement. The MOHSS coordinates the program with other partners in the public sector through its Case Management Unit, and thus is able to expand coverage of the program with low costs. The use of Case Managers also builds human capacity within the MOHSS system. In 2009, the MOHSS took over management of these positions from a private contract firm. This was a first step toward the full absorption of these into the MOHSS human resource system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	45,075	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes five components: (1). Quality Improvement (QI) training; (2) Assessment of quality management programs at participating clinics; (3) Performance measurement (at six-month intervals) on selected core indicators; (4) Ongoing QI coaching and mentoring at participating sites, and; (5) Promotion of patient engagement in HIV care.

Funding for HIVQUAL is split between HTXS, PDTX, HBHC and PDCS because the program focuses on quality improvement of clinical services in all four program areas.

In COP10, the activity will be conducted under the leadership of the MOHSS Directorate of Special Programs (DSP) in close collaboration with CDC Namibia and the US-based HIVQUAL team for technical support. By the end of COP09, the program will have rolled out to all 34 health districts of Namibia, and at least five health centers offering HIV care through the Integrated Management of Adolescent and Adult Illness (IMAI) strategy. Activities in COP10 will focus on quality program implementation in these sites, and expansion to additional health centers.

1) Quality Improvement (QI) training. The USG HIVQUAL team will continue to build capacity for QI among MOHSS staff and healthcare providers in Namibia. Advanced level short term in-service trainings will be provided to staff who have received training in prior years, as well as basic training for new staff. The training activities will be done in collaboration with I-TECH. Specifically activities for COP10 will include Training of Trainers workshops to promote decentralization of QI trainings throughout Namibia, and to support the expanded national quality program.

2) Assessment of quality management programs at the participating clinics. An assessment tool to measure the capacity of the quality management program at each facility will be used. It will measure the growth of quality management activities as well as the quality of staff members' skills. The findings from these assessments will guide coaching interventions. Aggregated facility-specific data will provide population-level performance data to indicate priorities for national quality improvement activities and campaigns. Similarly, local performance data will be used to improve services at local facilities.



3) Performance measurement (at six-month intervals) on selected core indicators. HIVQUAL will continue to develop providers' skills for collecting and using performance data within their own organizations to improve their pediatric HIV treatment and care. Pediatric indicators will track the provision of the basic pediatric treatment and care package. Selected indicators will include ART services ART adherence, growth monitoring, nutrition assessment, immunizations, use of Cotrimoxazole prophylaxis, and TB screening. Facility-level data derived from the national health information system will be used to improving quality.

4) Ongoing QI coaching and mentoring at participating sites. In COP10, the program will focus mainly on transferring knowledge and skills to local technical advisors in the MOHSS with the ultimate goal of building country ownership and strengthening sustainability. The transfer of QI skills will be accomplished through coaching and mentoring for MOHSS staff and health care providers.

5) Promotion of consumer engagement in HIV care. HIVQUAL will provide technical assistance to the MOHSS on strategies to develop local, regional, and national strategies and programs to increase consumer (patient) involvement in HIV/AIDS programs. Increased participation by patients and other "consumers" will improve HIV care and treatment services by enhancing the feed-back loop between patients, providers and the MOHSS. Special focus within the Pediatric Care and Support area will be paid on engaging adolescents living with HIV through formation of site specific Young Adults Consumer Advisory Committees (YACACs). Specifically this activity will include working with the MOHSS to devise a written plan for consumer involvement. The plan will outline structures to ensure active participation of people living with HIV/AIDS in the development and improvement of HIV/AIDS programs. This will also include a needs assessment to determine local, regional, and national priorities. Regional civil society groups will be engaged to identify and solicit diverse community opinions.

Sustainability: HIVQUAL values cost efficiency and to this end has worked within MOHSS structures to provide targeted technical assistance from New York-based consultants and from USG Namibia technical staff. This strategy is consistent with the new PEPFAR vision of enforcing country ownership through responsive technical engagement. The MOHSS coordinates the program with other partners in the public sector through its Case Management Unit, and thus is able to expand coverage of the program with low costs. The use of Case Managers also builds human capacity within the MOHSS system. In 2009, the MOHSS took over management of these positions from a private contract firm. This was a first step toward the full absorption of these into the MOHSS human resource system.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9876	Mechanism Name: Cooperative Agreement
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	1U2GPS002058
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Namibia Institute of Pathology	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,173,000	
Funding Source	Funding Amount
GHCS (State)	1,173,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

SUBSTANTIALLY CHANGED FROM LAST YEAR The purpose of this cooperative agreement is to strengthen the national laboratory systems necessary to conduct quality assured surveillance for HIV infection, sexually transmitted infections (STIs), and tuberculosis (TB), as well as to expand the access to diagnostic and bio-clinical monitoring services.

To achieve these objectives the Namibia Institute of Pathology (NIP) will use funding through this IM to accomplish the following activities:

1. Develop a plan for the continued quality improvement of systems for surveillance of HIV, STD and TB. This will include improving the quality of testing at all levels of the NIP laboratory network. These activities will emphasize the standardization of training and operating procedures, equipment and supplies, laboratory information management systems, and a systematic staff proficiency testing scheme.
2. Improve and expand the use of dried blood spot technology for Early Infant Diagnosis in support of the prevention of mother-to-child transmission (PMTCT) and pediatric ART programs.
3. Expand and improve HIV rapid test evaluation and monitoring systems to include quality assurance schemes for testing, and staff proficiency evaluations.
4. Enhance and expand viral load and CD4 testing capacity, including use of point-of-care equipment.
5. Participate in a regional laboratory network to strengthen the quality of HIV and ART diagnostic and bio-clinical monitoring services.
6. Increase the capacity of the NIP to perform routine laboratory tests to monitor patients on ART for potential drug toxicity.
7. Develop the capacity of NIP to monitor HIV drug resistance, and to implement new serological



technologies to estimate HIV incidence.

8. Organize national workshops, working groups and meetings with laboratory representatives from academia and the private sector to exchange information, develop consensus on mutual goals and objectives, and facilitate quality control measures regarding HIV/AIDS, STDs and TB activities.

How the Implementing Mechanism is linked to the Partnership Framework goals and benchmarks over the life of its agreement/award.

Through support for quality bio-clinical monitoring and training, this implementing mechanism is key to the USG commitments related to the PF goal of "scaling up and enhancing antiretroviral treatment services (including pre-ART) as well as reducing TB/HIV co-infection" The technical assistance delivered through this IM will specifically aid the GRN and the USG to meet the following PF objectives:

- 1) Enhance the quality of ART care through quality assured bio-clinical monitoring.
- 2) Expand coverage of screening for TB/HIV co-infection.

The implementing Mechanism's geographic coverage and target population:

This mechanism is designed to provide national coverage through the NIP network of laboratories. APHL will work with NIP and other partners to provide training to staff working in all of the NIP laboratories. The gap analyses and mentoring assistance will be rolled out in a targeted manner, depending on identified needs.

Key contributions to Health System Strengthening:

Strengthening an integrated laboratory network and providing quality and accessible laboratory services to the country, will contribute to improvements in ART and TB drug adherence and patient monitoring. These clinical improvements will, over time, contribute to a reduction in costs.

Implementing Mechanism's cross-cutting programs and key issues:

Strengthening laboratory capacity for the public healthcare system assures that services are accessible, equitable, effective, affordable, and of high quality for all. Strategic planning has also been identified as a priority for NIP and the Ministry of Health and Social Services (MOHSS) in the new National Strategic Framework for HIV/AIDS (NSF). Direct TA to NIP staff will build local human resource capacity, another key objective in the NSF.

The Implementing Mechanism's strategy to become more cost efficient over time:

The Namibia Institute of Pathology (NIP) is a public limited company established by Act of Parliament in 1999. NIP started operations in December 2000 and has assumed responsibility for 37 MOHSS laboratories since then. This approach has avoided the creation of a parallel laboratory structure within the HIV/AIDS response. NIP's budget is structured to recover a substantial portion of its costs through reimbursements from public and private insurance plans. This innovative cost-recovery system is a model that could be adapted by other GRN programs which could charge fees for services provided to the private sector.

Monitoring and evaluation:

All CDC cooperative agreement grantees must submit a detailed work plan with their annual continuation



application. This work plan must be based on PEPFAR indicators and aligned with targets set for each country. All IDP consortium members must also submit bi-annual status reports to the IDP program manager in Atlanta. These reports are shared with CDC program managers in Namibia and used to inform any year-on-year changes to the work plan.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	527,850
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Key Issues

Child Survival Activities
TB

Budget Code Information

Mechanism ID:	9876		
Mechanism Name:	Cooperative Agreement 1U2GPS002058		
Prime Partner Name:	Namibia Institute of Pathology		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	35,000	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES
 This is a continuing activity from COP09. It includes one component: 1) salary support to the Namibia Institute of Pathology (NIP) for a dedicated laboratory technologist to perform viral load tests.
 1) Salary support for laboratory technician. With a growing number of patients on ART in Namibia, viral load testing has become an increasingly critical part of bio-clinical monitoring. In 2006, the national ART treatment guidelines were updated to include viral load testing for patients in whom treatment failure is suspected. With USG support, NIP has equipped a state-of-the-art molecular biology lab with viral load testing capacity. Anticipating increasing demand for viral load testing, a dedicated laboratory technician will be supported in COP10 to ensure NIP may meet this demand. At least 12,000 viral load tests are expected in COP10.
 Supportive Supervision: The NIP laboratory technician will receive supportive supervision and mentoring



from the CDC laboratory technical advisor, and by technical experts funded through the International Laboratory Branch Consortium (see APHL, ASM, ASCP and/or CLSI narratives).

Sustainability: NIP is a public limited company established by Act of Parliament in 1999. NIP started operations in December 2000 and has assumed responsibility for 37 MOHSS laboratories since then. NIP's budget is structured to recover a substantial portion of its costs through reimbursements from public and private insurance plans. PEPFAR will work with NIP to ensure that this and other USG-subsidized positions are gradually absorbed by the NIP or GRN budgets.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	350,000	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes two components: 1) Ongoing quality assurance (QA) support for rapid testing, and; (2) salary support for six staff.

1) Ongoing QA for Rapid Testing. These activities support the expansion of provider-initiated testing and counseling (PITC), as well as existing HCT. To date, a total of 1,043 health workers and community counselors have been successfully trained in rapid HIV testing. Among these, 887 have been certified and 156 are in the process of certification. From July 2008 to September 2008, 3,234 retests were performed for the certification of testing personnel. An additional 1,566 retests were performed as part of the quality assurance program. The MOHSS has lowered the retesting requirement from 10% of tests to 5%. During the same period, 148 sets of External Quality Assurance proficiency panels and 370 Quality Control sets were sent out to the RT sites. NIP will continue to support these activities in COP10.

2) Salary Support for Staff. In COP10, PEPFAR will support fewer NIP staff due to a transition of the responsibility for HCT QA to the MOHSS. (See MOHSS HVCT narrative for details.) The six NIP staff to be supported in COP10 will include:

- one senior QA manager
- four QA medical technologists
- one administrative assistant

The QA staff will be responsible for the validation of any new RT technologies introduced in Namibia, and for making recommendations to the MOHSS on the RT algorithm and selection of test kits. These QA experts will also support training and post-training certification of all MOHSS personnel who administer rapid tests; preparation, distribution, and analysis of quality controls and proficiency panels; retesting of 5% of all rapid tests done at sites by ELISA; proficiency follow-up with rapid test sites and personnel; and; submission of reports on rapid test QA to the MOHSS HCT unit.

Supportive Supervision: NIP laboratory technicians will receive supportive supervision and mentoring from MOHSS QA officers based in the HCT program. The QA staff will provide follow-up supervision and mentoring to MOHSS personnel who perform rapid tests at the facility-level. Additional mentoring and



supervision will be provided by the CDC laboratory technical advisor, and by technical experts funded through the International Laboratory Branch Consortium (see APHL, ASM, ASCP and/or CLSI narratives).

Sustainability: As noted above, changes in the MOHSS quality assurance policy for rapid testing has reduced the proportion of tests subject to QA re-testing each year. This reduction has reduced costs associated with the NIP QA program. Additional costs savings are anticipated as supportive supervision is expanded and the skills of rapid test users improve. As a public limited company, NIP's budget is structured to recover a substantial portion of its costs through reimbursements from public and private insurance plans. PEPFAR will work with NIP to ensure that these and other USG-subsidized positions are gradually absorbed by the NIP or GRN budgets.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	35,000	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuation activity from COP09. It includes one component: 1) salary support for a dedicated technologist at the Namibia Institute of Pathology (NIP) in support of early infant HIV diagnosis (EID) by PCR.

1. Dedicated technology to support EID. NIP is responsible for provision of all HIV-related testing technologies for the public sector. During COP05, the diagnostic algorithm for using dried blood spots (DBS) and PCR for pediatric diagnosis was developed and field-tested in Namibia. During COP06, the Ministry of Health and Social Services (MOHSS) PMTCT program and NIP began testing symptomatic infants and screening HIV-exposed infants at six weeks of age.

Laboratory staff has been trained in PCR, new equipment has been procured, specimens are being processed, and health workers have been trained in the collection of DBS specimens. Approximately 20,000 EID PCR tests will be performed in COP 10. The technologist funded by PEPFAR will be dedicated to ensuring all of these tests are performed in a quality assured and timely manner.

Supportive supervision: The NIP technician will receive supportive supervision and mentoring from the CDC laboratory technical advisor. Additional mentoring and supervision may be provided throughout the year by technical experts funded through the International Laboratory Branch Consortium (see APHL, ASM, ASCP and/or CLSI narratives).

Sustainability: NIP is a public limited company established by Act of Parliament in 1999. NIP started operations in December 2000 and has assumed responsibility for 37 MOHSS laboratories since then. NIP's budget is structured to recover a substantial portion of its costs through reimbursements from public and private insurance plans. PEPFAR will work with NIP to ensure that this and other USG-subsidized positions are gradually absorbed by the NIP or GRN budgets.



Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	600,000	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes three components: (1) the maintenance of laboratory testing equipment and revisions to the MEDITECH Laboratory Information System (LIS); (2) support to expand access to MEDITECH at ARV clinics, and; (3) salary support for two laboratory trainers, a training administrative assistant and a program officer based at the Namibia Institute of Pathology (NIP).

1. Equipment maintenance. Namibia's antiretroviral treatment program is rapidly expanding in remote areas. By its mandate, NIP is required to support the treatment program wherever it is launched. NIP will continue to strengthen its peripheral laboratories in providing diagnostics and basic bio-clinical monitoring services in these facilities. Increased access to facility-based laboratory services will minimize costs, delays and risk of loss associated with transporting samples to central testing facilities. In COP10, funds will be used to maintain laboratory equipment purchased for these sites in previous years. A portion of the funds in this budget line will be used to support revisions in the MEDITECH health information system.

2. Linking data systems. The MEDITECH revisions described above will be aimed at integrating data captured by the NIP laboratory information system (LIS) and the broader health information system used by the Ministry of Health and Social Services (MEDITECH). Linking the LIS to ARV clinics will allow clinicians to access lab results as soon as they are available. This will reduce waiting time for patients and contribute to a reduction in the number of patients lost to follow-up. In collaboration with MOHSS, this work will include the development of a standardized unique identification system to improve tracking of patient records and laboratory records.

3. Salary support. COP10 funds will support the following NIP salaries:

- Two laboratory trainers
- One administrative assistant assigned to the training unit
- One program officer assigned to the training unit.

Prior year support for training and renovation is not described in COP10. NIP will use carry-over funds from COP09 to support on-going training activities, as well as renovations.

Supportive Supervision: NIP staff will receive supportive supervision and mentoring from the CDC laboratory technical advisor, the CDC SI advisor; information technology consultants hired by the MOHSS, and, where relevant, by technical experts funded through the International Laboratory Branch Consortium (see APHL, ASM, ASCP and/or CLSI narratives).

Sustainability: NIP is a public limited company established by Act of Parliament in 1999. NIP started operations in December 2000 and has assumed responsibility for 37 MOHSS laboratories since then.



NIP's budget is structured to recover a substantial portion of its costs through reimbursements from public and private insurance plans. PEPFAR will work with NIP to ensure that this and other USG-subsidized positions and activities are gradually absorbed by the NIP or GRN budgets. Support for routine maintenance will be emphasized throughout the NIP program. Technical assistance will encourage the inclusion of routine maintenance and the amortization of replacement costs in future NIP budgets.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	153,000	

Narrative:

NEW/REPLACEMENT NARRATIVE

This is a continuing activity from COP09. It includes one component: 1) salary support for TB laboratory staff based in the Namibia Institute of Pathology (NIP).

(Note: USG support for TA and other costs for TB drug resistance surveillance in COP10 is described in the MOHSS Strategic Information narrative.)

- 1) Salary Support for NIP TB staff. The following NIP positions will be subsidized by PEPFAR in COP10.
- One TB Central Lab Supervisor. The TB Lab supervisor is responsible for the day-to-day management of the TB Reference Laboratory, providing leadership to the team, overseeing implementation of all activities including the evaluation of new technology, assessing the competency of technologists, training, updating SOPs and compiling reports.
 - One medical technologist for Quality Assurance. The TB QA technologist is responsible for monitoring the implementation of quality indicators at the facility level, managing proficiency testing results, doing blind slides rechecking, and site supervisions.
 - Six laboratory assistants. The Laboratory assistants are deployed as microscopist and lab aids at district lower level laboratories. These are good examples of task shifting in the context of lack of qualified lab technologists.

Supportive supervision: The Central Laboratory Supervisor will provide direct supportive supervision to the medical technologist and laboratory assistants assigned to TB screening work. The medical technologist will provide step-down supervision to facility-based staff related to quality assurance testing. All NIP laboratory staff will receive supportive supervision and mentoring from the CDC laboratory technical advisor. Additional mentoring and supervision may be provided throughout the year by technical experts funded through the International Laboratory Branch Consortium (see APHL, ASM, ASCP and/or



CLSI narratives).

Sustainability: NIP is a public limited company established by Act of Parliament in 1999. NIP started operations in December 2000 and has assumed responsibility for 37 MOHSS laboratories since then. NIP's budget is structured to recover a substantial portion of its costs through reimbursements from public and private insurance plans. PEPFAR will work with NIP to ensure that this and other USG-subsidized positions are gradually absorbed by the NIP or GRN budgets. The laboratory assistant positions are an example of task-shifting within the laboratory sector. The laboratory assistant position was created through a task-shifting initiative at NIP. As such, these entry-level positions represent a locally-owned response to staffing shortages at the facility level. These positions are also a first rung on the laboratory service career ladder, and may provide young or inexperienced workers an opportunity to advance over time.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9877	Mechanism Name: I-TECH
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Washington	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 5,114,934	
Funding Source	Funding Amount
GHCS (State)	5,114,934

Sub Partner Name(s)

(No data provided.)

Overview Narrative

SUBSTANTIALLY CHANGED FROM LAST YEAR The HHS/HRSA cooperative agreement with I-TECH Namibia is a continuing mechanism from FY09. CDC Namibia provides oversight for these activities. This



mechanism aims to build the capacity of the Ministry of Health and Social Services (MOHSS), and the University of Namibia (UNAM) to train healthcare workers to deliver HIV and other healthcare services. These activities also leverage and complement other PEPFAR investments in health systems strengthening.

Objectives: I-TECH Namibia has 10 objectives under this mechanism: (1) Increase health workers' capacity to provide integrated PMTCT services in MCH/ANC sites, including early infant diagnosis (EID); (2) Increase HCW ability to provide sexual prevention messaging, including information on sexually transmitted infections and prevention with positives; (3) Increase HCW ability to deliver male circumcision services; (4) Increase public and private sector HCW capacity to provide effective ART to adults as part of comprehensive HIV care and treatment services; (5) Increase public and private sector HCW capacity to provide effective care and treatment to children living with HIV/AIDS; (6) Increase public and private sector HCW capacity to diagnose and treat TB/HIV co-infection; (7) Increase MOHSS capacity to provide HCT services, including couples counseling and rapid HIV testing (RT); (8) Disseminate HIV training program results and lessons learned to government, partners, and other stakeholders as part of an integrated M&E strategy; (9) Increase HIV content in pre-service and in-service nurse training curricula; (10) Increase MOHSS capacity to utilize Digital Video Conferencing (DVC) facilities to strengthen and expand the National HIV/AIDS response.

Partnership Framework: This mechanism encompasses a broad range of activities and commitments described in the Partnership Framework currently under development. This mechanism supports key objectives under all four thematic areas, specifically: Prevention (male circumcision and PMTCT), Treatment, Care and Support (TB/HIV, palliative care and ART services), Impact mitigation (food security/nutrition), and Coordination and Management (human resources/human capacity development, and monitoring and evaluation).

Coverage: The activities under this mechanism are national in scope. The target populations include: doctors, registered nurses, enrolled nurses/midwives, pharmacist assistants, and laboratory staff. I-TECH works with the National Health Training Center (NHTC) network and UNAM to train in-service and pre-service healthcare workers. The NHTC network consists of the national center in Windhoek, and four regional training centers. In addition, I-TECH works with the Faculty of Medical Science at UNAM to train student nurses on HIV-related topics. For the past five years, this mechanism has supported a UNAM review of its nursing curricula to integrate HIV topics. In addition, through this mechanism, clinical instructors are recruited and deployed to UNAM and the NHTC network to teach HIV components of the revised curricula. HIV clinical mentors are recruited and deployed to high-volume sites to strengthen the capacity of local physicians to deliver quality HIV care and treatment. These mentors also support HCW to implement strategies to mainstream HIV services with other healthcare services.



Health systems strengthening: The key contributions of this mechanism relate to in-service and pre-service capacity development of HCW. This mechanism contributes to the global PEPFAR goal of training 140,000 new HCW. This mechanism supports long-term national capacity building by providing support exclusively to Namibian institutions (NHTC and UNAM).

Cross-cutting/Key issues: This mechanism will contribute to Human Resources for Health objectives through cross-cutting support for in-service and pre-service education for public health professionals. Cross-cutting technical assistance supported by this mechanism will emphasize nutrition policy development, other healthcare curriculum development and HCW training.

Cost efficiency: Activities supported under this mechanism are integrated with CDC's direct technical assistance to the MOHSS, both at the national level and in the field. By supporting training activities exclusively through MOHSS structures and systems, this mechanism avoids parallel or duplicative training efforts. Hiring of trainers, tutors and other key staff is coordinated with MOHSS and CDC through a cost-efficient local human resources contractor. I-TECH deliberately works with collaborating institutions to integrate recurrent costs, including staff salaries and benefits into the institutions' annual budgets. In COP09 alone, four regional trainers were fully absorbed into the NHTC (MOHSS) staff establishment.

M&E: The monitoring and evaluation of this mechanism includes PEPFAR indicators and a more detailed I-TECH M&E annual plan. I-TECH maintains a robust M&E system to capture progress towards objectives, to compare progress towards achieving goals, and to improve the quality of training and capacity building activities. A detailed M&E plan is developed each year and is reported to CDC and HRSA on a quarterly basis. Other data collection tools have been developed and are used to monitor outputs and outcomes of capacity building. I-TECH is committed to transferring operational control over these systems to its Namibian partners.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	500,000
Human Resources for Health	4,000,000

Key Issues



Addressing male norms and behaviors
 Increasing gender equity in HIV/AIDS activities and services
 Child Survival Activities
 Military Population
 Safe Motherhood
 TB
 Family Planning

Budget Code Information

Mechanism ID: 9877			
Mechanism Name: I-TECH			
Prime Partner Name: University of Washington			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	556,042	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09, and includes four components: (1) Training to enhance health care workers (HCW) capacity to diagnose and manage STIs in PLWHA; (2) Strengthen STI surveillance among PLWHA; (3) Support training of doctors and pharmacists in clinical care of HIV/AIDS, and diagnosis and management of opportunistic infections (OIs), and; (4) training of nurses in HIV/AIDS related nutrition.

1. STI Capacity Building: HCW capacity to correctly diagnose and manage STIs using the syndromic management approach will be enhanced and monitored. Various tools including IEC materials, STI management flow charts, and wall charts will be developed to strengthen training in health facilities. In addition, the STI guidelines will be disseminated. I-TECH will conduct three trainings for HCW, with 25 participants each, for a total of 75 people trained.
2. Strengthen STI Surveillance: Monitoring of STI management is essential for evaluation of patient care and program performance. The I-TECH STI Technical Advisor, in collaboration with the MOHSS and a technical working group, will develop an STI surveillance tool. This will be piloted in four districts located in the four regions of Namibia with the highest STI burden. Three sites will be selected per district. Three participants per site will be trained in a one day course for a total of 36 HCW trained.
3. Support Training in Clinical HIV Care and OIs: I-TECH will enhance doctors' and pharmacists' capacity

to appropriately diagnose and manage OIs through trainings. I-TECH, in collaboration with MOHSS and a technical working group, will revise the curriculum for "Clinical Care of HIV, AIDS and Opportunistic Infections" to correspond to new national guidelines. The curriculum will also build skills for HCWs to assess and manage pain; provide appropriate psychological, social, and spiritual support with the goal of improving the quality of life for PLWHA. I-TECH will conduct two trainings with 20 government doctors and pharmacists each, as well as two trainings for 10 private doctors each, for a total of 60 people trained.

4. Training of Nurses in HIV/AIDS related Nutrition: Nutrition is a critical component of improved treatment outcomes for PLWHA. It is critical that nurses are provided with the skills and knowledge to enable them to address nutrition related issues in the health care setting. I-TECH will continue to support the revision of the curriculum on HIV/Nutrition Management and will conduct three regional trainings, of 25 participants each, for a total of 75 HCW trained. One Trainer of Trainers for HIV/Nutrition will also be conducted.

Supportive Supervision/Quality Assurance/Quality Improvement: I-TECH HIV clinical mentors will provide mentoring support to clinicians following training in clinical management of HIV/AIDS and OIs. The CM will use data from other monitoring tools used by the MOHSS and HIVQUAL to drive the improvement of the quality of care.

The I-TECH STI Technical Advisor in collaboration with other MOHSS staff will undertake two weeks of supportive supervisory visits to health facilities to assess quality of implementation of STI management. Quality Assurance for STI surveillance will be enhanced through the piloting of a new STI surveillance tool. In addition, the STI technical advisor, in collaboration with MOHSS, will conduct supportive supervisory visits to selected sites to assess their implementation of the syndromic management of STIs. Tutors in the regions will use a structured support visit tool to assess nutrition service provision and will provide on-site mentorship and support as needed.

Sustainability: I-TECH's focus on technical assistance rather than service delivery promotes national ownership and reduces MOHSS dependency on external experts. I-TECH does this through support for in-service training as well as pre-service training to nursing students at the National Health Training Centre (NHTC) and University of Namibia (UNAM). Additionally, I-TECH provides training to doctors, pharmacists and nurses in both the public and private sectors, to support compliance to standardized treatment guidelines in HIV, STI, and TB care and treatment. The training of Namibian trainers is a prime example of I-TECH's commitment to local ownership. Training on the Syndromic Management of STI will be sustained by Namibian staff who have received training as trainers. Country ownership will be further enhanced as more of these local trainers are absorbed by the MOHSS as civil service staff of the National Health Training Center. The development of "Guidelines for the Clinical Management of HIV and AIDS" and the revision of the "Clinical Care of HIV, AIDS and Opportunistic Infections" curricula will promote standardization of skills across the public and private healthcare sectors, and support the GRN's push to decentralize healthcare training and decision-making. As noted in other BCN, I-TECH is



committed to strengthening and integrating GRN data systems. These systems play an increasingly important role in GRN decision-making and have allowed the development of evidence-based strategies, including the new National Strategic Framework (NSF).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	1,338,949	

Narrative:

NEW/REPLACEMENT WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09, and includes six components: (1) Training in management of antiretroviral therapy (ART); (2) HIV Clinical mentors; (3) training for cervical cancer screening; (4) training of health care workers (HCW) and expert patient trainers in the Integrated Management of Adult Illnesses (IMAI) strategy; (5) training for Clinical Instructors, and; (6) training of nurses in adherence counseling.

1. ART training: Capacity to manage ART in adults with HIV will be enhanced through training. The current curriculum will be updated based on recent ART guidelines. I-TECH will conduct two basic ART courses for public sector doctors and pharmacists, with 20 participants each, for a total 40 people trained. An advanced curriculum on ART in adults and TB management will be revised and used to conduct two courses, with 20 participants each, for a total of 40 trained. In addition, one course in advanced ART and TB for ten private practitioners will be held.

2. HIV Clinical Mentoring for Doctors: Six HIV expert physician clinical mentors will continue to provide mentoring support primarily to doctors in 10 of the 13 regions. Clinical mentors will also assess training needs and routinely provide didactic and hands-on training. They will assist clinics to establish systems such as efficient patient flow to reduce patient waiting times. They will also promote a multi-disciplinary approach to HIV care, and strengthen mechanisms to address site specific patient retention and referrals including the use of outreach and bi-directional referral systems. Guidelines, medical textbooks, and journals will be procured and placed in resource centers.

3. Cervical Cancer Screening capacity building: HCW capacity to perform cervical cancer screening will be enhanced through training. In collaboration with MOHSS, I-TECH developed a concise, practical, on-site training curriculum for conducting pap smears in women with HIV infection. I-TECH will support eight training courses, with ~8 eight HCW per site, for a total of 64 HCW trained. Equipment required for the on-site training will also be procured. I-TECH will develop a register which will allow facilities to record screened patients and track test results to ensure that patients receive their results and required services.

4. Training of HCW and Expert Patient Trainers in IMAI: I-TECH will continue to support task shifting through IMAI training. I-TECH will update the IMAI curriculum to reflect national task shifting protocols.



Three regional IMAI trainings for nurses and community counselors will be conducted, with 60 participants each, for a total of 180 participants trained.

5. Training in Clinical Mentoring for Nurses: I-TECH will continue supporting clinical mentoring of nurses by recruiting an additional nurse mentor and training 34 newly recruited regional Clinical Instructors who will be placed in the districts. These instructors will provide nurse mentoring support in the regions. In addition, the nurse clinical mentors will work closely with IMAI facilities and will provide technical assistance and support to nurses at these facilities.

6. Training of Nurses in Medicine Adherence Counseling: I-TECH will continue training nurses in adherence counseling, printing of training materials and procurement of supplies and equipment for training. With COP10 funds, I-TECH will conduct one TOT training for 20 people, and 3 regional trainings, of 27 participants each, training a total of 81 HCWs.

7. Supportive Supervision/Quality Assurance/Quality Improvement: Clinical mentors will provide supportive supervision at health facilities providing ART, including the performance of pap smears for HIV positive women. Clinical mentors will also assess quality of care provided by mentees every six months from using tools from MOHSS and HIVQUAL to improve the quality of care.

Sustainability: I-TECH's focus on technical assistance rather than service delivery promotes national ownership and reduces MOHSS dependency on external experts. I-TECH does this through support for in-service training as well as pre-service training to nursing students at the National Health Training Centre (NHTC) and University of Namibia (UNAM). Additionally, I-TECH provides training to HCWs in both the public and private sectors to support compliance to standardized treatment guidelines in HIV, STI, and TB care and treatment. The training of Namibian trainers is a prime example of I-TECH's commitment to local ownership. Training on IMAI and treatment adherence will be sustained by Namibian trainers and mentors who have received training as trainers. I-TECH support for training of lay health care workers will also promote the GRN's task-shifting initiative and reduce workloads on doctors and nurses. Country ownership will be further enhanced as more of these local trainers are absorbed by the MOHSS as civil service staff of NHTC. The development of guidelines and revision of curricula will promote standardization of skills across the public and private healthcare sectors, and support the GRN's push to decentralize healthcare training and decision-making. As noted in other BCNs, I-TECH is committed to strengthening and integrating GRN data systems. These systems play an increasingly important role in GRN decision-making and have allowed the development of evidence-based strategies, including the new National Strategic Framework (NSF).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	380,924	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes three components: (1) Training of nurses and community counselors in HIV counseling; (2) training of HCW in rapid HIV testing, and; (3) development of training videos.

1. Training in HIV Counseling and Testing: HCT is the entry point for PLWHA to access care and treatment. Accordingly, there is a great need to train nurses and community counselors (CC) throughout the country to increase service coverage. Nurses and CC will be trained in HCT. The counseling component involves training in HIV individual counseling, couples HIV counseling and testing (CHCT) and Provider-initiated testing and counseling (PITC). In COP10, a total of 108 health workers will be trained in both VCT and PITC. This is in line with the MoHSS's goal of increasing the number of persons receiving CT, and to identify those in need of care and treatment. Three additional trainings in CHCT will be conducted to train a total of 81 health workers. Overall, a total of 189 HCW will be trained in HCT.

2. Rapid Test Training: Rapid testing is critical in identifying patients with HIV and getting them into care and treatment. Rapid testing allows clients to receive their HIV test results on the same day. This approach has vastly increased the uptake of HIV testing, and increased the percentage of people who know their HIV results. To promote universal access to rapid testing, training of nurses and CC throughout Namibia is essential. In COP10, one training of trainers (TOT) will be held for 20 participants. These trainers will conduct an additional three trainings for 80 HCW. Two groups of CCs with a total of 52 participants will also be trained. Overall, a total of 132 HCW and CCs will be trained in rapid testing with COP10 funding.

3. Development of Training Videos: Interactive training materials, such as videos, are known to be highly effective in transferring knowledge to trainees. In COP10, I-TECH will complement existing HCT print materials by developing videos. One short rapid testing video will be produced which will clearly demonstrate how to correctly perform the parallel rapid HIV testing algorithm. Because of the demonstrated prevention effectiveness of CHCT, a second short video will be produced on counseling discordant couples. This will be used during the CHCT trainings.

Supportive Supervision/Quality Assurance: Using structured clinical support visit assessment tools, tutors from the Regional Health Training Centres will conduct quarterly clinical support visits to facilities providing HCT services. These visits will promote the transfer of learning and provide on-site mentorship. During these visits, two to three tutors will work as a team and will assess the facility, supplies, and HCT service provision. Depending on the size of the facility, these visits, which will be coordinated with the MOHSS, may take from one to five days.

Sustainability: I-TECH's focus on technical assistance rather than service delivery promotes national ownership and reduces MOHSS dependency on external experts. I-TECH does this through support for in-service training as well as pre-service training to nursing students at the National Health Training Centre (NHTC) and University of Namibia (UNAM). Additionally, I-TECH training to doctors, pharmacists



and nurses in traditional healthcare settings as well as in the correctional system will promote the use of standardized counseling, testing and treatment guidelines for HIV, STI, and TB. Funding through the HVCT technical area will further enhance professional and lay healthcare workers' ability to delivery HCT at the facility and community level. The training of Namibian trainers is a prime example of I-TECH's commitment to local ownership. Sustainability of the HVCT training program will be promoted through multiple means. Training on HCT will be sustained by Namibian trainers and mentors who have received training as trainers. I-TECH support for training of lay health care workers will also promote the GRN's task-shifting initiative and reduce workloads on doctors and nurses. Country ownership will be further enhanced as more of these local trainers are absorbed by the MOHSS as civil service staff of the National Health Training Center. The development of national training curricula for HCT will promote standardization of skills across the public and private healthcare sectors, and support the GRN's push to decentralize healthcare training and decision-making. As noted in other BCN, I-TECH is committed to strengthening and integrating GRN data systems. These systems play an increasingly important role in GRN decision-making and have allowed the development of evidence-based strategies, including the new National Strategic Framework (NSF).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	188,347	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09 which includes 3 components: (1) training of doctors, pharmacists and nurses in comprehensive pediatric HIV care; (2) training and supervision by HIV Clinical Mentors (CM) to support healthcare workers (HCW) managing children with HIV and; (3) training on Community Based Child Growth Monitoring (CBCGM).

1. Pediatric HIV care training for doctors, nurses and pharmacists. Doctors, nurses and pharmacists' capacity to manage children with HIV will be enhanced through training in comprehensive pediatric HIV care using a curriculum which includes clinical pre-ART and ART care, management of common clinical conditions and opportunistic infections (OI), nutrition, growth monitoring, psychosocial challenges, and other palliative care. The current curriculum will be updated to align with the Namibian guidelines on the use of ART therapy in children (to be revised in COP10).

An advanced ART curriculum addressing the use of ARV in adults and children, as well as the management of TB/HIV co-infection will be regularly revised and used to conduct training for public and private doctors and pharmacists already trained in the basic courses. I-TECH will continue to support revision of guidelines/policies related to nutrition, growth monitoring, infant and young child feeding; in line with international guidelines and evidence from the literature.

I-TECH will conduct 2 pediatric HIV/AIDS courses for government doctors, nurses and pharmacists, each with 20 people and 1 pediatric HIV/AIDS course for 10 private practitioners. An important module on HIV disclosure and psychosocial support especially for older children and adolescents will be delivered in an interactive manner for 10 and a TOT on this topic will be held for 12 participants for a total of 72 people trained.

2. HIV Clinical Mentoring: I-TECH will continue to support 6 experienced HIV physician CM who provide mentoring support primarily for doctors managing adults and children with HIV in 10 of 13 Namibia Regions (see Adult Treatment). CM will continue to assist facilities to focus on increasing access to early infant diagnosis, ART treatment of all confirmed HIV-positive infants <12 months, close monitoring of children =12 months to allow treatment at the earliest qualifying time and overall management of children with HIV, both before and after starting ART. Pediatric reference materials have been supplied to 16 ART sites, allowing easy access to information needed by HCW and will supply materials to 4 additional sites in COP10.

3. Support of Community Based Child Growth Monitoring and Promotion: I-TECH will support the initiation of CBCGM, which will aid in early identification of children with growth challenges resulting from HIV infection or related illness. This will coincide with support and promotion of exclusive breastfeeding with appropriate complimentary feeding for up to 2 years and beyond. I-TECH will also procure nutrition training materials and equipment and will print and disseminate infant and child nutrition related information, education and communication. Additionally, with COP10 funds, I-TECH will purchase infant/child nutrition related books for 8 resource centers within the National Health Training Network (NHTC) and the University of Namibia (UNAM). Two courses on Management of Severe Acute Malnutrition will be held with 25 participants each, for a total of 50 trained.

Supportive Supervision/Quality Assurance/Quality Improvement: I-TECH HIV CM will provide mentoring support to clinicians following training in clinical management of HIV, AIDS and OI. The CM will work with HCW and use data from other PEPFAR supported quality monitoring tools such as HIVQUAL to drive the improvement of the quality of care provided by health facilities.

Sustainability: I-TECH's focus on technical assistance rather than service delivery promotes national ownership and reduces MOHSS dependency on external experts. I-TECH does this through support for in-service training as well as pre-service training to nursing students at NHTC and UNAM. I-TECH also provides training to private and public doctors, pharmacists and nurses, to support compliance with HIV, STI, and TB care and treatment standardized guidelines. Funding through the PDCS technical area will further enhance clinicians' ability to diagnose and treat pediatric HIV patients. The training of Namibian trainers is a prime example of I-TECH's commitment to local ownership. Sustainability of the HBHC training program will be promoted through multiple means. Training on IMAI and treatment adherence will be sustained by Namibian trainers and mentors who have received training as trainers. I-TECH support for training of lay HCW will also promote the GRN task-shifting initiative and reduce doctors and nurses workloads. Ownership will be further enhanced as more local trainers are absorbed by the MOHSS as

NHTC civil service staff. The development of guidelines and revision of curricula will promote standardization of skills across the public and private healthcare sectors, and support the GRN push to decentralize healthcare training and decision-making. As noted in another BCN, I-TECH is committed to strengthening and integrating GRN data systems which play an increasingly important role in GRN decision-making and have allowed the development of evidence-based strategies, including the new National Strategic Framework.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	280,947	

Narrative:

SUBSTANTIAL CHANGES

This is a continuing activity from COP09, and includes three components: (1) Training of HCWs in comprehensive pediatric HIV care; (2) HIV Clinical Mentor support to HCWs managing children with HIV, and; (3) support for training in Community Based Child Growth Monitoring (CBGM).

1. Pediatric HIV care training: I-TECH will train HCWs in comprehensive pediatric HIV care using a curriculum which includes: clinical pre-ART and ART care; management of common clinical conditions and opportunistic infections; nutrition and growth monitoring; psychosocial challenges, and other palliative care issues. The current curriculum will be updated to include the WHO 2008 treatment recommendations to treat all HIV-infected infants less than 12 months with ART, without waiting for clinical and immunological criteria. I-TECH will assist in the revision of guidelines on the use of ART in children, which are expected to be revised in 2010.

An advanced curriculum addressing the use of ARVs in adults and children as well as the management of TB/HIV co-infection will be used to conduct training for government HCWs who have already been trained in the basic courses. I-TECH will continue to support revision of guidelines and policies related to nutrition, growth monitoring, and infant and young child feeding to reflect international guidelines. I-TECH will conduct two training courses on pediatric HIV/AIDS, each with 20 people, for government doctors and pharmacists, for a total of 40 people. One pediatric HIV/AIDS training course for ten private practitioners will be conducted. In addition, a special course on HIV disclosure in children will be conducted with ten participants. Additionally, a TOT on this topic will be held for 12 participants, for a total of 72 individuals trained.

2. HIV Clinical Mentoring: I-TECH will continue to support six HIV physician Clinical Mentors who provide mentoring primarily for doctors managing adults and children with HIV in 10 of the 13 Regions in Namibia. Clinical Mentors will continue to assist facilities to focus on increasing access to early infant diagnosis and ART treatment of all infants < 12 months old who are confirmed HIV-positive. In addition, close monitoring of children =12 months to allow treatment at the earliest qualifying time, as well as



overall management of children with HIV, both before and after starting ART will be emphasized. As part of the clinical mentoring program, pediatric reference materials will be supplied to sites.

3. Support of Community Based Child Growth Monitoring and Promotion: In view of the shortage of HCWs, I-TECH will support the initiation of Community Based Growth Monitoring and Promotion (CBGMP), which will assist in early identification of children with poor growth as a result of HIV infection and related illness. This will coincide with support and promotion of exclusive breastfeeding with appropriate complimentary feeding for up to two years and beyond. In addition, I-TECH will procure nutrition training materials and equipment and will print and disseminate infant and young child nutrition related IEC materials. Furthermore, I-TECH will purchase Infant/child nutrition related books for eight resource centers within the National Health Training Network and the University of Namibia. Two courses on Management of Severe Acute Malnutrition will be conducted with 25 participants each, for a total of 50 people trained.

Supportive Supervision/Quality Assurance/Quality Improvement: I-TECH HIV clinical mentors will provide mentoring support to clinicians following training in pediatric clinical management of HIV/AIDS. The CM will work with the HCWs and use data from monitoring tools used by the MOHSS and HIVQUAL to drive the improvement of the quality of care.

Sustainability: I-TECH's focus on technical assistance rather than service delivery promotes national ownership and reduces MOHSS dependency on external experts. I-TECH does this through support for in-service training as well as pre-service training to nursing students at the National Health Training Centre (NHTC) and University of Namibia (UNAM). Additionally, I-TECH provides training to doctors, pharmacists and nurses in both the public and private sectors, to support compliance to standardized treatment guidelines in HIV, STI, and TB care and treatment. Funding through the PDCS technical area will further enhance clinicians' ability to diagnose and treat pediatric HIV patients. The training of Namibian trainers is a prime example of I-TECH's commitment to local ownership. Sustainability of the HBHC training program will be promoted through multiple means. I-TECH support for training of lay health care workers will also promote the GRN's task-shifting initiative and reduce workloads on doctors and nurses. Country ownership will be further enhanced as more of these local trainers are absorbed by the MOHSS as civil service staff of the National Health Training Center. The development of guidelines and revision of curricula will promote standardization of skills across the public and private healthcare sectors, and support the GRN's push to decentralize healthcare training and decision-making. As noted in other BCNs, I-TECH is committed to strengthening and integrating GRN data systems. These systems play an increasingly important role in GRN decision-making and have allowed the development of evidence-based strategies, including the new National Strategic Framework (NSF).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	725,000	

Narrative:

NEW/REPLACEMENT WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP 09 which includes 4 components: (1) Training workshops in various health sector tools; (2) System for Program Monitoring (SPM) trainings; (3) support task-shifting demonstration project, and; (4) support for a training needs assessment (TNA).

1. Training workshops in various health sector tools. Health sector data collection, analysis, and use is the responsibility of the Ministry of Health and Social Services (MOHSS), Response Monitoring and Evaluation (RM&E) unit. The RM&E will train its regional staff, including data clerks and HIS officers, so they are proficient in collecting, entering, cleaning, and analyzing data. The training will build skills in data entry, management, and reporting to increase proficiency in using the MOHSS ART, PMTCT, HCT, TB and STI management information systems. Five training workshops will be held with 15 persons per training for a total of 75 trained.

2. System for Program Monitoring (SPM) trainings. The SPM is the system by which all non-health sector HIV/AIDS related activities are reported through the Ministry of Regional and Local Government to the National AIDS Commission. This activity will support 4 SPM refresher trainings for regional implementers, one report writing training for regional M&E officers and community liaison officers (CLO), and one M&E officers and CLO retreat. One workshop will be conducted to review and revise existing SPM data collection and reporting forms. A total of 5 trainings/workshops, with 20 people each will be conducted with a total of 100 trained. New SPM guidelines are being developed which will result in new trainings with a modified curriculum. Training of trainers will be used to implement the new guidelines.

3. Support Task-shifting Demonstration Project

An evaluation of the feasibility, acceptability, and effectiveness of shifting uncomplicated case ART service provision from physicians to nurses will be demonstrated in 3 sites compared to continued physician ART service provision in 3 comparison sites. After 6 months, qualitative and quantitative methods will be used to compare the quality of care and health outcomes for ART patients in demonstration and comparison sites. The demonstration project will assess the feasibility and effectiveness of task-shifting to meet the increasing demands for HIV care and treatment given the on-going human resource (HR) shortages, especially in rural areas.

4. Support Training Needs Assessment (TNA).

A TNA will assess the coverage and quality of HIV/AIDS training for Namibia health care workers (HCW). The TNA will use existing training data to graphically represent HIV/AIDS training coverage with HR data as well as population data by region. A quality assessment (QA) administered through HCW will assess

the transfer of skills from trainings to facilities which will identify training gaps/needs which will be used to tailor future trainings, better plan audiences for trainings, and enhance/modify existing HIV/AIDS curricula.

Supportive supervision/Quality Assurance: Supportive supervision of regional M&E officers is conducted through quarterly visits from the MOHSS RM&E. Data clerks also receive supportive supervision from quarterly visits from regional level staff in addition to annual supervision visits from national level staff. Gaps and areas for improvement identified through these regional and national visits are communicated to staff through reports disseminated after the visits. Teachers observe and follow up with participants after the courses to assess skills transfer.

Sustainability: I-TECH's focus on technical assistance rather than service delivery promotes national ownership and reduces MOHSS dependency on external experts. I-TECH does this through support for in-service training as well as pre-service training to data managers and other support staff at the National Health Training Centre (NHTC), the University of Namibia (UNAM), and within the MOHSS RM&E unit. Additionally, I-TECH training promotes the use of standardized data collection and management tools and indicators. Funding through the HVSI technical area will further enhance the GRN's ability to collect, manage, analyze and use data for evidence-based decision making. Training of Namibian trainers is a prime example of I-TECH's commitment to local ownership. Sustainability of the HVSI training program will be promoted through multiple means. Training on data systems, tools, and QA will be sustained by Namibian trainers and mentors who have received training as trainers. I-TECH support for training of lay HCW will also promote the GRN's task-shifting initiative and reduce workloads on clinicians and senior data managers. Country ownership will be further enhanced as more local trainers are absorbed by the MOHSS as civil service staff of the NHTC. The use of a national training curriculum for M&E will promote standardization of skills across the public healthcare system and allow for greater integration with data systems used by the private healthcare sectors. Integration and coordination will support the GRN's push to decentralize healthcare training and decision-making. As noted in other BCN, I-TECH is committed to strengthening and integrating GRN data systems which play an increasingly important role in GRN decision-making and have allowed the development of evidence-based strategies, including the new National Strategic Framework.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	597,985	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes three components: (1) Strengthen the National

Health Training Center's capacity to deliver in-service and pre-service training; (2) Strengthen University of Namibia's capacity to deliver quality pre-service training for Registered Nurses, and; (3) Assist MOHSS to utilize the Digital Video Conference system.

1. Strengthen National Health Training Center: With funds from COP10, I-TECH will continue supporting NHTC to revise nursing curricula, renovate class rooms and procure training equipment and materials. In addition, I-TECH will continue supporting NHTC to develop training standards, guidelines and a monitoring and evaluation system. Through COP10 funds I-TECH will continue training NHTC tutors who will implement facility-based follow-up and mentoring for former trainees. COP10 funds will also support the procurement of books and electronic materials for the NHTC resource centers.

2. Strengthen UNAM Capacity to deliver quality pre-service training: With COP10 funds, I-TECH will continue working with the Faculty of Medical Science to review nursing curricula and integrate the latest evidence-based information on HIV, TB and other health issues. Previously developed materials by I-TECH will also be reviewed and evaluated including the Lecturer's Resource Guide, which was developed and disseminated with COP08 funds. In addition, faculty development and training will continue with COP10 funds. Training material and equipment will also be procured through COP10 funds.

3. Assist MOHSS to utilize efficiently Digital Video Conference system: I-TECH will continue working with MOHSS and sub-national partners to strengthening the utilization of DVC. With COP10 funds, I-TECH will assist MOHSS to develop a five year plan to take over this activity by 2012. I-TECH will support this plan through training for MOHSS staff to operate and maintain the equipment and it programs.

Supportive Supervision/Quality Assurance: Using structured DVC support visit assessment tools, DVC manager from I-TECH's Windhoek office will conduct quarterly DVC support visits to provide training and mentoring for local DVC operators. I-TECH developed monitoring and evaluation tools to assess all services and support provided to NHTC and UNAM. With COP10 funds, I-TECH will conduct assessments to evaluate the impact of DVC trainings and other training materials on skills uptake.

Sustainability: I-TECH's focus on technical assistance rather than service delivery promotes national ownership and reduces MOHSS dependency on external experts. I-TECH does this through support for in-service training as well as pre-service training to clinicians, lay healthcare workers, data managers and other support staff at the National Health Training Centre (NHTC), the University of Namibia (UNAM), and within the MOHSS Response M&E unit. Additionally, I-TECH training promotes the use of standardized clinical guidelines and data collection and management tools and indicators. Funding through the OHSS technical area will further enhance the GRN's ability to collect, manage, analyze and use data for evidence-based decision making. Training of Namibian trainers is a prime example of I-TECH's commitment to local ownership. Sustainability of the OHSS training program will be promoted through multiple means. Training on data systems, tools, and quality assurance will be sustained by Namibian trainers and mentors who have received training as trainers. I-TECH support for training of lay health care workers will also promote the GRN's task-shifting initiative and reduce workloads on clinicians

and senior data managers. Country ownership will be further enhanced as more of these local trainers are absorbed by the MOHSS as civil service staff of the National Health Training Center. The use of national training curricula for M&E and clinical practice will promote standardization of skills across the public and private healthcare systems, and allow for greater integration of public and private data systems. Integration and coordination will support the GRN's push to decentralize healthcare training and decision-making. As noted in other BCN, I-TECH is committed to strengthening and integrating GRN data systems. These systems play an increasingly important role in GRN decision-making and have allowed the development of evidence-based strategies, including the new National Strategic Framework (NSF).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	200,000	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP 2009. It includes four components: (1) Training of regional managers on the Namibian MC policy and its implementation; (2) training of trainers (TOT) in MC; (3) creation of an MC operational manual to be used in MC trainings, and; (4) training of doctors, nurses, and community counselors as MC service providers, including follow-up support visits to trainees for supportive supervision.

1. Orientation for Managers: In this activity, regional managers will be trained on the Namibian policy for Male Circumcision and its implementation. I-TECH, in collaboration with the MOHSS, will develop a curriculum for managers and provide two trainings, with 25 regional managers each, for a total of 50 people trained.

2. Training of Trainers: Roll-out of MC requires provision of services by clinicians highly trained on the theory and practice of the procedure. Skilled trainers of providers will therefore be needed. I-TECH will train ten clinicians who have demonstrated competence in performing MC in a TOT course. The trainees will then act as facilitators in future MC training courses.

3. Training of Service Providers: Training of doctors, nurses, and community counselors will be conducted as part of a national HIV prevention strategy. The MC training curriculum covers technical skills for clinicians. The curriculum for both clinicians and counselors focuses on MC as part of a comprehensive package which includes prevention counseling, provider initiated counseling and testing, active exclusion of STI and their syndromic management where required, and the promotion of consistent and correct use of condoms. It is anticipated that each course will cater to clinicians from four sites. Non-consumable surgical equipment and consumable commodities will be required for use in the training courses. Three trainings will be conducted for doctors, nurses and community counselors, with 25 participants each, for a total of 75 people trained.

Supportive Supervision/Quality Assurance: Following the trainings for MC providers, a team from I-TECH



including a physician trainer and a nurse training manager will conduct supportive supervision visits to the 75 clinicians who received MC training (see above). One to two days will be spent at each site as required. A Quality Assurance assessment tool will be used to evaluate MC service provision and to assist in additional skills transfer where necessary.

An experienced and technically competent MC physician trainer who can devote much of his time to the training is crucial. Therefore a physician trainer will be recruited to serve this purpose.

Sustainability: I-TECH's focus on technical assistance rather than service delivery promotes national ownership and reduces MOHSS dependency on external experts. I-TECH does this through support for in-service training as well as pre-service training to nursing students at the National Health Training Centre (NHTC) and University of Namibia (UNAM). Additionally, I-TECH provides training to doctors, pharmacists and nurses in both the public and private sectors, to support compliance to standardized treatment guidelines in HIV, STI, and TB care and treatment. By building capacity of local teams in the districts to offer high quality male circumcision services, sustainability of the services will be enhanced.

The training of Namibian trainers is a prime example of I-TECH's commitment to local ownership.

Sustainability of the MC program will be promoted through multiple means. The development of MC curricula for managers, clinicians, and counselors will ensure standardization and strengthen the GRN's push to decentralize healthcare training and decision-making. As noted in other BCN, I-TECH is committed to strengthening and integrating GRN data systems. These systems play an increasingly important role in GRN decision-making and have allowed the development of evidence-based strategies, including the new National Strategic Framework (NSF).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	200,000	

Narrative:

SUBSTANTIAL CHANGES

This is a continuing activity from COP09 includes 5 components: (1) training of healthcare workers (HCW) in prevention for persons living with HIV (PLWHA); (2) training alcohol-related HIV prevention; (3) HIV prevention training for case managers and expert patients; (4) quality assurance of the case management program, and; (5) training for HCW based in correctional facilities.

1) Training of HCW in Prevention for PLWHA. I-TECH will support the roll out of the training of Prevention for PLWHA curriculum. The core framework of this course is based on CDC's Prevention with PLWHA evaluation intervention and includes: prevention messaging (e.g., disclosure, partner testing, condom use, alcohol prevention), syndromic screening for STIs as well as the provision of FP counseling. The prevention course will also include a brief overview of TB and nutrition screening. I-TECH will continue to develop, revise, and print training materials, posters, patient-provider flipbooks, provider cards, and patient educational materials associated with the project. Five trainings will be conducted, with ~27

participants each, for a total of 135 health workers trained.

2) Alcohol Training. I-TECH will conduct training on the alcohol brief motivational interview (BMI) intervention as part of the above mentioned Prevention for PLWHA course. In addition, the course will be delivered to HCW outside of the ARV clinic settings, as well to correctional staff. I-TECH will develop a 2-day, stand alone alcohol BMI training course with training materials. I-TECH will conduct four trainings with 24 participants in each training, with at least two of those courses in the correctional setting.

3. Training for Case Managers (CM) and Expert Patients. In COP10, I-TECH will train 34 case managers (CM) that will be based within ART clinics and ANC sites. A client assessment tool will allow for early recognition of client issues that could impact compliance with care, treatment, prevention, and overall positive living. CM will coordinate clinical resources (e.g., FP, STI services, etc) as well as links to the community resources and social support. They will also assist with default tracing.

As part of the development of the overall CM program, an assessment will determine the potential role and responsibilities of expert patients (e.g., default tracing, education, etc). I-TECH will provide training and support to the expert patients as part of the development of a comprehensive CM program. I-TECH will provide a minimum of 2 courses for expert patients (20 participants each).

CM and expert patients will facilitate PLWHA support groups at facility level, as well as referrals to community PLWHA support groups. They will also provide referrals to other health and social services (e.g., counseling for drug/alcohol treatment and domestic violence). Particular emphasis will be placed on encouraging men to seek services and to support their partners and children in doing the same.

4. Quality Assurance of the Case Management Program. Using structured clinical support visit assessment tools, tutors from the National Health Training Centers/Regional Health Trainings Centers will provide quarterly visits to the facilities in their regions to ensure transfer of learning, provide on-site mentorship and support, identify gaps, and make recommendations for improvement.

5. Correctional Staff Training. In 2009, CDC supported an extensive review of HIV and TB activities within Namibia's correctional system. The review identified several areas for future support, including: TB and HIV training to clinical and correctional staff to increase awareness of TB/HIV co-infection and build skills to provide inmates with counseling and testing services for both diseases. Additional training was recommended to support an expansion of HIV/TB treatment services in prisons. In COP10, I-TECH will train ~80 correctional staff.

Sustainability. I-TECH support for in-service and pre-service training to nursing students at the National Health Training Centre (NHTC) and University of Namibia (UNAM) contributes to the GRN's long-term strategy to develop integrated HCW training programs. This focus on integration across the healthcare system is a primary objective in the GRN's Human Resources for Health (HRH) strategy. Support for these national training institutions highlights I-TECH's focus on technical assistance rather than service delivery. I-TECH training for HCW further contributes to the national HRH strategy and supports standardization and coordination in HIV, STI, and TB care and treatment. Support for the CM program also builds the capacity of MOHSS by improving the ability of lay healthcare workers and expert patients

to absorb task-shifting responsibilities. These cadres will increasingly be absorbed into the MOHSS HR system, either as civil servants (e.g., through the Health Extension cadre) or as MOHSS-managed and financed contractors. Supportive supervision will enhance skills uptake following training. The training-of-trainers model (TOT) that I-TECH employs ensures a growing pool of trainers to expand access to training courses. NHTC staff are involved in all I-TECH trainings and each trainer becomes a trainer of trainers. I-TECH has transitioned six of a core of 20 NHTC-based trainers over to the MOHSS payroll, and has plans to transition six trainers each year until they are 100% absorbed into the ministry system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	359,240	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It has one component: (1) Training of nurses in the provision of PMTCT and EID services.

Background

Namibia's PMTCT guidelines were revised in 2008 to include the more efficacious drug regimen recommended by WHO in 2006. The revised guidelines also recognize the importance of PMTCT follow-up and early determination of HIV status. With the National Health Training Center (NHTC), I-TECH helped to revise the PMTCT training curriculum to include Dried Blood Spot (DBS) collection and other aspects of infant follow-up such as cotrimoxizole (CTX) prophylaxis, intensive infant feeding, counseling and Provider Initiated Testing and Counseling (PITC) for children.

1) Training of nurses in PMTCT/EID. In COP09, a PMTCT/EID training-of-trainers (TOT) course was conducted for 20 participants at the NHTC. In COP10, I-TECH will continue to leverage Global Fund support to expand PMTCT/EID training. Specific I-TECH activities will include support for materials and facilitators to conduct four regional trainings for 25 participants. A total of 100 health workers will be trained.

Supportive supervision/Quality Assurance: Using structured clinical support visit assessment tools, tutors from the Regional Health Training Centers will conduct quarterly clinical support visits to facilities providing PMTCT/EID services in the regions to ensure transfer of learning and to provide on-site mentorship. During these visits, two to three tutors will work as a team to assess the facility, supplies, and quality of service provision in PMTCT/EID.

The five tutors (plus one driver) based at the NHTC were recruited by and receive some human resource services (e.g., payroll) from a private staffing agency. However, in line with the Namibian Labour Law, all are all directly supervised by the MOHSS and have contracts identifying the MOHSS as their formal employer (see Potentia BCN). The use of this outsourcing model to support a portion of HR services

associated with these positions has allowed the MOHSS to rapidly scale up tutoring services. A process to strengthen the capacity of the MOHSS human resource department is on-going. In COP09, this transition included the addition of an HR manager under the Directorate of Special Programmes (DSP). The transition of supervisory responsibility for these employees to the MOHSS is a first step toward the eventual full absorption and financing of these positions (either as civil servants or as contractors) by the MOHSS.

Sustainability: I-TECH contributes to the sustainability of the national PMTCT program by developing and revising PMTCT/EID curricula, guidelines, M&E tools, and other related training materials. These materials strengthen the national health education system and promote training opportunities for Namibian healthcare workers in Namibia, a key objective described in the Partnership Framework. Pre-service training of University of Namibia nursing students further strengthens sustainability efforts in Namibia. I-TECH also contributes to the sustainability of the national PMTCT program by developing and revising the various PMTCT/EID curricula, guidelines, M&E tools, and other related training materials. These materials will build the systems and help ensure the delivery of high-quality, standardized PMTCT training in Namibia. Finally, through a robust quality assurance system to ensure that high-quality PMTCT services are delivered at the facility level, with regular support visits to ensure transfer of learning and to provide guidance and mentorship, the national PMTCT program will not only be sustained but will be of high quality.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	287,500	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes three components: (1) Training of public sector doctors and pharmacists on TB/HIV co-infection; (2) training of private nurses in the management of TB/HIV co-infection, and; (3) provision of training materials for TB/HIV training in the public sector.

1. Training of doctors and pharmacists on TB: Training by I-TECH will strengthen the abilities of public sector doctors and pharmacists to prevent, diagnose, and manage TB in the era of HIV and multiple drug resistant (MDR) TB. It is anticipated that the 2006 TB Management guidelines will be revised in 2010. These guidelines will focus on TB screening in HIV patients, testing for HIV in suspected TB cases, and provision of isoniazid preventive therapy (IPT) to all eligible HIV positive persons. It will also focus on TB infection control and the surveillance and management of drug-resistant TB. I-TECH will update the basic TB/HIV course to align with the revised 2010 guidelines, and reflect the WHO 3Is principles. Using these documents, I-TECH will conduct three basic TB courses, with 20 participants each, for a total of 60 doctors and pharmacists trained. One additional training course in TB/HIV will train 15 private doctors and pharmacists. I-TECH will also tailor this basic TB/HIV course to train health staff based in

correctional facilities. I-TECH will conduct two basic TB courses, with 20 participants each, for a total of 40 correctional staff trained.

For public sector doctors and pharmacists already been trained in the management of TB, a course called "Updates in TB management: the 2010 TB guidelines," will be developed. This curriculum will be used to conduct three trainings for public sector doctors and pharmacists, with 20 participants each, for a total of 60 people trained.

An advanced curriculum will be used to conduct training for individuals who have already been trained in the basic courses.

2. Training of Private Nurses: Nurses in the private sector see many patients but often lack the necessary knowledge and skills to recognize and manage TB according to the national guidelines. I-TECH will continue to train private nurses in TB/HIV and will conduct two trainings, with 20 participants each, for a total of 40 persons trained. These trainings will focus on the new TB guidelines. (Note: public sector nursing training is supported via the Global Fund).

3. Provision of TB Training Materials: I-TECH will continue to provide training materials for HIV/TB training courses offered to public sector healthcare workers. This includes trainer manuals, participant manuals, and all the relevant handouts and teaching aides. Training for public sector nurses is funded by the Global Fund, however, I-TECH will provide the training materials for the training of 250 nurses.

Supportive Supervision/Quality Assurance: Quality assurance for TB/HIV will be enhanced through training and capacity building of HCW using high quality, updated TB/HIV curricula. I-TECH has six clinical mentor positions that are based in the regions. Clinical mentors provide daily in-service training for healthcare staff and will provide mentoring support to clinicians following the training in TB/HIV. HIV testing of all TB suspects and patients, and provision of IPT to all eligible HIV positive clients will continue to be promoted through on-site mentorship. Tutors from the National Health Training Centers/Regional Health Trainings Centers will provide quarterly visits to the facilities in their regions to ensure transfer of learning, provide on-site mentorship and support, identify gaps, and make recommendations for improvement.

Sustainability: I-TECH's focus on technical assistance rather than service delivery promotes national ownership and reduces MOHSS dependency on external experts. I-TECH does this through support for in-service training as well as pre-service training to nursing students at the National Health Training Centre (NHTC) and University of Namibia (UNAM). Additionally, I-TECH training to doctors, pharmacists and nurses in traditional healthcare settings as well as in the correctional system will promote the use of standardized treatment guidelines in HIV, STI, and TB care and treatment. Funding through the HVTB technical area will further enhance clinicians' ability to diagnose and treat TB/HIV co-infection. The training of Namibian trainers is a prime example of I-TECH's commitment to local ownership. Training on IMAI and treatment adherence will be sustained by Namibian trainers and mentors who have received training as trainers. I-TECH support for training of lay health care workers will also promote the GRN's



task-shifting initiative and reduce workloads on doctors and nurses. Country ownership will be further enhanced as more of these local trainers are absorbed by the MOHSS as civil service staff of the National Health Training Center. The development of guidelines and revision of curricula will promote standardization of skills across the public and private healthcare sectors, and support the GRN's push to decentralize healthcare training and decision-making. As noted in other BCN, I-TECH is committed to strengthening and integrating GRN data systems. These systems play an increasingly important role in GRN decision-making and have allowed the development of evidence-based strategies, including the new National Strategic Framework (NSF).

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9940	Mechanism Name: Cooperative Agreement 1U2GPS0018665166
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	Funding Amount
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

SUBSTANTIALLY CHANGED FROM LAST YEAR Objectives

This is a "to be determined (TBD)" partner. A request for proposals for a five-year cooperative agreement was issued in early 2009. An award is expected within the COP10 approval timeframe.



This program cuts across the HVAB, HVOP, HBHC, PDCS and HVCT technical areas. The main goal is to deliver prevention interventions to individuals in household and community settings. These interventions will include: home-based HIV counseling and testing (HCT), HIV education to promote behavior change, referrals to clinical services, counseling on ART adherence, and referrals to PMTCT services

To achieve this goal the program has five objectives:

1. Train at least 250 field officers (FO).
2. Enhance cross-referrals between facility-and community-based programs.
3. Provide basic "Prevention for Positives" counseling to HIV-positive clients.
4. Collaborate with other organizations to avoid duplication.
5. Mobilize and empower individuals and communities to change HIV risk behaviors.

Links to the Partnership Framework (PF)

As part of the USG contribution to the PF goal of "enhancing prevention," the USG commits to strengthen the GRN capacity to design, implement and finance comprehensive HIV prevention programs.

The PF is aligned with the priority prevention areas described in Namibia's National Strategic Framework for HIV and AIDS 2010-2015 (NSF), and include:

1. Social and Behavior Change
2. HIV Counseling and Testing
3. Prevention of HIV among the Most-At-Risk and Vulnerable Groups
4. HIV Prevention Involving People Living with HIV and AIDS
5. Medical Male Circumcision
6. PMTCT
7. Post-Exposure Prophylaxis (PEP)
8. Condom Social Marketing and Distribution
9. Prevention of Sexually Transmitted Infections
10. Blood Safety

The partner will address all of the above-mentioned prevention priorities with the exception of PEP and blood safety.

Coverage and Target population

This partner will work in the Omusati, Oshana, Oshikoto, Ohangwena, Kavango, Caprivi, and Khomas regions, which have the highest rates of HIV in Namibia. With the exception of the Khomas Region (Windhoek), the remaining regions are in the north, where the majority of the population resides. Emphasis will be placed on reaching remote populations.



Health Systems Strengthening

This program contributes to PEPFAR's broader effort to build human resource capacity by strengthening career pathways within the healthcare sector. The FO cadre could represent an entry-level access point to the GRN civil service, which will be expanded in COP10 to include a new cadre of "Health Extension Workers." With additional training and experience, FO will have the opportunity to advance to extension workers, community counselors, or work in other public health sector positions. FO ensure stronger linkages between health care facilities and communities.

Cross-Cutting Programs and Key Issues

This activity addresses several; cross-cutting programs and key issues including gender, economic strengthening, and wraparounds to other health programs.

Human Resources for Health: This program will build human resource capacity by providing training and stipends to over 250 community-based FO.

Gender: As part of counseling, FO will refer women to local income and productive resources, as well as gender-specific healthcare and social services (e.g., cervical cancer screening, PMTCT, and gender-based violence programs).

Economic Strengthening: The partner will refer HIV-infected individuals to PLWHA support groups, work with existing groups to strengthen them, and help communities to create new groups. Since many PLWHA support groups are involved in microenterprise (e.g., community gardens), program support from the partner will expand these groups' capacity to provide economic support to members.

Wraparound activities will include: Child survival (referrals to health facilities); family planning (counseling and referrals); malaria (education and bed nets); safe motherhood (referrals to PMTCT and ANC care); and TB (screening, and referral).

Cost Efficiencies Over Time

This activity is designed to be cost efficient. Community-based service delivery and outreach utilizes local volunteers who receive a modest monthly stipend. Expanding this model, which has been implemented in Namibia since 2005, can be done at relatively low cost. The partner will collaborate with other partners and MOHSS to ensure efficient delivery of services and to avoid duplication of efforts. Direct technical assistance is provided by CDC technical advisors. HIV test kits will be procured through the existing MOHSS system. Further cost efficiencies are achieved through utilizing the new community-based networks for other public health activities, e.g., distribution of insecticide-treated bed nets and mobilization for events such as National HIV Testing Day and immunization campaigns.

Monitoring and Evaluation Plans

The partner is required to have an extensive monitoring and evaluation (M&E) plan that is linked to



PEPFAR and GRN indicators. The partner will submit bi-annual reports on the number of individuals reached, individuals tested, and individuals linked to services. The partner will have a system for adjusting program activities based on M&E information. The evaluation plan will include indicators for each program activity. In addition, an impact evaluation will be included in the TBD partner's scope of work

Cross-Cutting Budget Attribution(s)

Economic Strengthening	Redacted
Education	Redacted
Human Resources for Health	Redacted

Key Issues

- Addressing male norms and behaviors
- Increasing gender equity in HIV/AIDS activities and services
- Increasing women's access to income and productive resources
- Malaria (PMI)
- Child Survival Activities
- Mobile Population
- Safe Motherhood
- TB
- Family Planning

Budget Code Information

Mechanism ID: 9940			
Mechanism Name: Cooperative Agreement 1U2GPS0018665166			
Prime Partner Name: TBD			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	Redacted	Redacted
Narrative:			
NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES			

This activity is a continuation from COP09. It includes one primary component: Support for a "to be determined (TBD)" partner to provide community-based HIV prevention, HIV counseling and testing, and referral services through door-to-door, household outreach in six high prevalence regions in Namibia. Specific activities under the HBHC program area will include: 1) The door-to-door delivery of educational materials and counseling about HIV, STI, and TB prevention, care, and treatment to households; 2) referrals to clinical services; 3) technical assistance and other support for PLWHA support groups, and; 4) training.

A request for proposals for a five-year cooperative agreement was issued in early 2009. An award is expected within the COP10 approval timeframe. As such, reference to a "TBD partner" will be made throughout this narrative.

In COP10, the TBD partner will train and deploy at least 250 Field Officers (FO) to conduct door-to-door counseling and outreach sessions, as well as HCT, with individual households. Details on these activities may be found in the HVOP, HVAB and HVCT narratives. These 250 FO will also perform the following HBHC-related activities:

1) HIV, STI, and TB information outreach. FO will identify households with individuals at increased risk of HIV, STI, and TB infection. FO will provide in-home information about HIV, STI, and TB prevention, care and treatment services to household members.

2) Referrals to HIV, STI, and TB care and treatment services. Households and individuals at risk of HIV, STI, and TB will receive referrals to appropriate testing, care and treatment services. FO will make the referrals during home visits. In certain cases, FO may also accompany patients to facilities to ensure the individual obtains appropriate treatment. FO will also make referrals and linkages to care for PMTCT and family planning related services.

3) Technical and other assistance to PLWHA support groups. FO will provide organizational assistance, guidance, leadership and encouragement to community-led PLWHA support groups. The TBD partner and the FO will also help these local groups coordinate with other groups in other regions, and with the national response. The TBD partner will ensure that FO have appropriate information, education and communication (IEC) materials (e.g., on addressing stigma and discrimination) to use in trainings and informational sessions with these groups.

4) Training. The TBD partner will provide extensive training for FO on the most up-to-date, evidence-based, approaches for effective prevention and referral counseling, and for strategies to address HIV and TB prevention, care and treatment. The TBD partner will also produce appropriate job aids and tools for



the FO, as well as supporting IEC materials for clients.

Sustainability: With a shift towards greater emphasis on sustainability and local ownership within PEPFAR, recruiting and deploying field officers in their own communities is a good example of an efficient utilization of resources in a constrained budget environment. On this note, the TBD partner will be expected to have strong local roots in Namibia. Efficiencies will be achieved by a focus on recruiting and deploying staff within their own communities.

The TBD partner will develop an assessment and evaluation system to track financial (e.g., cost per test performed by FO), administrative (e.g., logistics, supervision, coordination with MOHSS, HR), and technical (e.g., testing uptake by first-time clients) indicators. Data collected through this system will be used to revise program activities, as needed, and contribute to national monitoring and evaluation systems. These data will also be used to determine if additional tasks might be shifted to FO in future years. If the FO model is successful in expanding home-based HCT, other task-shifting opportunities may be considered for screening and Directly Observed Treatment for TB; PMTCT follow-up and mobilization; ART adherence support; and/or alcohol counseling and referrals.

PEPFAR will work with all partners to encourage data sharing in line with the commitments and objectives outlined in the National Strategic Framework (NSF) and the Partnership Framework Implementation Plan (PFIP).

This program contributes to PEPFAR's broader effort to build human resource capacity by strengthening career pathways within the healthcare sector. Since all of the FO will be Namibian, these individuals will model and reinforce professional skills, as well as health-promoting behaviors to the general public. The FO cadre could represent an entry-level access point to the GRN civil service, which will be expanded in COP10 to include a new cadre of "Health Extension Workers." With additional training and experience, FO will have the opportunity to advance to become extension workers, community counselors, or work in other public health sector positions. In addition, FO ensure stronger linkages between health care facilities and communities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This activity is a continuation from COP09. It includes one primary component: Support for a "to be



determined (TBD)" partner to provide community-based HIV prevention, HIV counseling and testing, and referral services through door-to-door, household outreach in six high prevalence regions in Namibia. Specific activities under the HVCT program area will include: 1) Mobilizing communities to access mobile HCT services operated by the Ministry of Health and Human Services (MOHSS), and; 2) Delivering HCT services during household outreach visits.

A request for proposals for a five-year cooperative agreement was issued in early 2009. An award is expected within the COP10 approval timeframe. As such, reference to a "TBD partner" will be made throughout this narrative.

In COP10, the TBD partner will train and deploy at least 250 Field Officers (FO) to conduct door-to-door counseling and outreach sessions, as well as referrals, with individual households. Details on these activities may be found in the HVAB, HVOP and HBHC narratives. The 250 FO will perform the following HVCT-related activities:

1) Community mobilization to access MOHSS mobile HCT services. FO will use their unique position in the community to mobilize demand for mobile HCT services offered by the MOHSS. These services are delivered through four MOHSS vans, which will operate across several regions. Each MOHSS mobile team includes a camper van staffed by four community counselors (two to provide counseling and testing and two to coordinate logistics and supplies), a nurse, and a driver. FO will develop a monthly schedule with the MOHSS to ensure consistency (e.g., the first Thursday of each month) and maximize public awareness. FO will also work with the MOHSS team, community leaders, and local radio stations to promote each outreach visit. To support this activity, the TBD partner will provide FO with salaries, transportation (e.g., a bicycle or transportation costs), printed materials (e.g., flyers and IEC materials in local languages), and support for public and MOHSS coordination meetings (e.g., tents, office space).

2) Delivery of HCT services during household outreach visits. In 2008, the MOHSS Permanent Secretary approved the delivery of HCT in non-traditional settings for the first time. FO will receive training in rapid testing before rapid test kits are deployed with FO as part of their standard household outreach toolkit. The TBD partner will work closely with MOHSS to ensure that all guidelines and procedures are followed in the implementation of household-based testing. All rapid test kits used by FO will be procured and provided by the MOHSS Central Medical Stores.

USG technical advisors for HCT will provide technical assistance to the TBD partner, and, where possible, individual mentoring to FOs.

Sustainability: With a shift towards greater emphasis on sustainability and local ownership within PEPFAR, recruiting and deploying field officers in their own communities is a good example of an efficient utilization of resources in a constrained budget environment. On this note, the TBD partner will be expected to have strong local roots in Namibia. Efficiencies will be achieved by a focus on recruiting and deploying staff within their own communities.

The TBD partner will develop an assessment and evaluation system to track financial (e.g., cost per test performed by FO), administrative (e.g., logistics, supervision, coordination with MOHSS, HR), and technical (e.g., testing uptake by first-time clients) indicators. Data collected through this system will be used to revise program activities, as needed, and contribute to national monitoring and evaluation systems. These data will also be used to determine if additional tasks might be shifted to FO in future years. If the FO model is successful in expanding home-based HCT, other task-shifting opportunities may be considered for screening and Directly Observed Treatment for TB; PMTCT follow-up and mobilization; ART adherence support; and/or alcohol counseling and referrals.

PEPFAR will work with all partners to encourage data sharing in line with the commitments and objectives outlined in the National Strategic Framework (NSF) and the Partnership Framework Implementation Plan (PFIP).

This program contributes to PEPFAR's broader effort to build human resource capacity by strengthening career pathways within the healthcare sector. Since all of the FO will be Namibian, these individuals will model and reinforce professional skills, as well as health-promoting behaviors to the general public. The FO cadre could represent an entry-level access point to the GRN civil service, which will be expanded in COP10 to include a new cadre of "Health Extension Workers." With additional training and experience, FO will have the opportunity to advance to become extension workers, community counselors, or work in other public health sector positions. In addition, FO ensure stronger linkages between health care facilities and communities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

This is a continuing activity from COP09. It includes one primary component: Support for a "to be determined" (TBD) partner to provide community-based HIV prevention, counseling, testing and referral services through door-to-door and community outreach. Specific activities under the PDCS program area will include: 1) Referral services (to care and treatment for families, especially children; 2) Technical assistance for community support groups for PLWHA 3. Support for the coordination and integration of activities with the Ministry of Health and Social Services (MOHSS).

A request for proposals for a five-year cooperative agreement was issued in early 2009. An award is expected within the COP10 approval timeframe. As such, reference to a "TBD partner" will be made throughout this narrative.

In COP10, the TBD partner will train and deploy at least 250 Field Officers (FO) to conduct door-to-door counseling and HCT sessions, household-based referrals to HIV and TB care and treatment, and

community outreach. Details on HCT activities may be found under HVCT. Referral services are described under HBHC. Home-based HIV prevention messaging is described in HVOP and HVAB.

Specific PDCS activities will include:

1) Referral services (HIV, STI, and TB care and treatment, as well as preventive care) for families. FO will work with families to promote whole-family health. An emphasis will be placed on ensuring that family members of an HIV positive person (including children) are tested for HIV. In addition, testing or referral for TB will be emphasized when at least one member may have TB disease, as children have a higher risk of developing primary TB. In addition, to an emphasis on referrals for early identification of HIV and TB exposure, cotrimoxazole prophylaxis and early initiation of ART in those who test HIV-positive will also be emphasized. Adolescents will require special attention; and FO will include in their activities, age-appropriate prevention messages for youth, including such messages as delaying sexual debut and abstinence. FO will also be vigilant on child sexual abuse as a cause of pediatric HIV, and make appropriate referrals to government protection units.

2) Technical assistance to community support groups for PLWHA. Assistance will be provided by the FOs, who will emphasize the provision of psycho-social support and advising on small income-generating projects (e.g. community gardens). Special focus will be placed on building PLWHA's capacity and skills to care for HIV-impacted children. Where older children and adolescents are already HIV-infected, additional support will be provided for disclosure of HIV-status, adherence to OI prophylaxis and or ART, caregivers' concerns and referrals to OVC programs.

3) Coordination and integration. The TBD partner and individual FOs will coordinate their activities with other community-based groups. As noted above, a special focus will be placed on coordination with support groups for PLWHA. Such integration will be encouraged where cost savings may be achieved. In each region, the TBD partner will coordinate the FOs activities with the Regional AIDS Coordinating Committees (RACOCs), Constituency AIDS Coordinating Committees (CACOCs), local leaders, and other government and nongovernmental organizations. This coordination will enhance the supervision of FOs and avoid duplication. Links with regional and local coordinating bodies will also allow the FO system to be leveraged to deliver messages about other health events (e.g. National Immunization Days) or to distribute materials such as insecticide-treated bed nets. This leveraging is in line with the "mainstreaming" objectives described in the Partnership Framework Implementation Plan (PFIP) and the National Strategic Framework for HIV/AIDS (NSF).

USG technical advisors in the area of pediatric care and prevention will provide technical assistance to the TBD partner.

Sustainability: With a shift towards greater emphasis on sustainability and local ownership within PEPFAR, recruiting and deploying field officers in their own communities is a good example of an efficient utilization of resources in a constrained budget environment. The partner will be expected to

have strong local roots in Namibia. Efficiencies will be achieved by a focus on recruiting and deploying staff within their own communities.

The TBD partner will develop an assessment and evaluation system to track financial (e.g., cost per test performed by FO), administrative (e.g., logistics, supervision, coordination with MOHSS, HR), and technical (e.g., testing uptake by first-time clients) indicators. Data collected through this system will be used to revise program activities, as needed, and contribute to national monitoring and evaluation systems.

This program contributes to PEPFAR's broader effort to build human resource capacity by strengthening career pathways within the healthcare sector. The FO cadre could represent an entry-level access point to the GRN civil service, which will be expanded in COP10 to include a new cadre of "Health Extension Workers." With additional training and experience, FO will have the opportunity to advance to become extension workers, community counselors, or work in other public health sector positions. In addition, FO ensure stronger linkages between health care facilities and communities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes one primary component: Support for a "to be determined" (TBD) partner to provide community-based HIV prevention, counseling, testing and referral services through door-to-door outreach. Specific activities under the HVAB program area will include: 1) Door-to-door community outreach with HIV prevention messages; 2) HIV outreach to youth, especially girls and young women, and; 3) training.

A request for proposals for a five year cooperative agreement was issued in early 2009. An award is expected within the COP10 approval timeframe.

In COP10, the TBD partner will train and deploy at least 250 Field Officers (FO) to conduct door-to-door counseling and HCT sessions, household-based referrals to HIV and TB care and treatment, and community outreach. Details on HCT activities may be found under HVCT. Referral services are described under HBHC and PDCS. Home-based HIV prevention messaging is also described in HVOP. HVAB-related activities will include:

1) Home-based HIV prevention messaging. The TBD partner will provide door-to-door, age-appropriate, education and prevention counseling to households and community members. Based on assessments conducted during the outreach visits, individually tailored packages of advice and services will be prepared. These packages should include:

- Information on HCT, as well as the ability to perform HCT on site
- Information on strategies to reduce sexual risk taking behaviors (e.g., abstinence, multiple concurrent partnerships, correct and consistent condom use, responsible drinking)
- Information and referrals for male circumcision where appropriate.
- Tailored prevention information for PLWHA
- Referral information and links to appropriate care, and treatment services, including HIV care and treatment services, PMTCT, as well as TB and STI treatment
- Referral information for social and mental health services including alcohol, abuse support, gender-based violence, and nutrition support
- Condoms as appropriate

Given that many of the clients served by this program will be in rural areas with limited access to services, HCT services will also be offered during the outreach visits. This is a new activity for Namibia. Details on this activity are included in the TBD Budget Code Narrative for HVCT.

2) Outreach to youth, especially girls and young women. Because youth are at high risk for HIV infection, particularly young girls, FO will emphasize abstinence messages to youth under the age of 15 and individuals who are not sexually active. During home-based or school-based sessions with youth, the FO will discuss knowledge about HIV transmission; decisions to avoid HIV infection; delaying the first sexual encounter; and pregnancy and STI risks.

3) Training. The TBD partner will provide extensive training for FO on the most up-to-date, evidence-based approaches for effective prevention counseling. The TBD partner will also produce appropriate job aids and tools for the field officers, as well as supporting IEC materials for clients.

Supportive Supervision: In each region, the TBD partner will coordinate the FO activities with the Regional AIDS Coordinating Committees (RACOC), Constituency AIDS Coordinating Committees (CACOC), local leaders, and other government and nongovernmental organizations. This coordination will enhance the supervision of FO and avoid duplication. Links with regional and local coordinating bodies will also allow the FO system to be leveraged to deliver messages about other health events (e.g. National Immunization Days) or to distribute materials such as insecticide-treated bed nets. This leveraging is in line with the "mainstreaming" objectives described in the Partnership Framework

Implementation Plan (PFIP) and the National Strategic Framework for HIV/AIDS (NSF).

USG technical advisors in the area of HIV prevention will provide technical assistance to the TBD partner, and, where possible, individual mentoring to FO.

Sustainability: With a shift towards greater emphasis on sustainability and local ownership within PEPFAR, recruiting and deploying field officers in their own communities is a good example of an efficient utilization of resources in a constrained budget environment. The partner will be expected to have strong local roots in Namibia. Efficiencies will achieved by a focus on recruiting and deploying staff within their own communities.

The TBD partner will develop an assessment and evaluation system to track financial (e.g., cost per test performed by FO), administrative (e.g., logistics, supervision, coordination with MOHSS, HR), and technical (e.g., testing uptake by first-time clients) indicators. Data collected through this system will be used to revise program activities, as needed, and contribute to national monitoring and evaluation systems.

This program contributes to PEPFAR's broader effort to build human resource capacity by strengthening career pathways within the healthcare sector. The FO cadre could represent an entry-level access point to the GRN civil service, which will be expanded in COP10 to include a new cadre of "Health Extension Workers." With additional training and experience, FO will have the opportunity to advance to become extension workers, community counselors, or work in other public health sector positions. In addition, FO ensure stronger linkages between health care facilities and communities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes one primary component: Support for a "to be determined" (TBD) partner to provide community-based HIV prevention, counseling, testing and referral services through door-to-door outreach. Specific activities under the HVOP program area will include: 1) Door-to-door community outreach with HIV prevention messages; 2) training, and; 3) HIV outreach to special groups and public HIV information campaigns.

A request for proposals for a five-year cooperative agreement was issued in early 2009. An award is

expected within the COP10 approval timeframe. As such, reference to a "TBD partner" will be made throughout this narrative.

In COP10, the TBD partner will train and deploy at least 250 Field Officers (FO) to conduct door-to-door counseling and outreach sessions, as well as household-based HCT and referrals to clinical services. Details on these activities may be found in the HVCT and HBHC narratives. HVOP-related activities will include:

1) Community Outreach. The TBD partner will provide door-to-door, age-appropriate, education and prevention counseling to households and community members. Based on assessments conducted during the outreach visits, individually tailored packages of advice and services will be prepared. These packages should include:

- Information on HIV counseling and testing, as well as the ability to perform on site counseling and testing.
- Information on strategies to reduce sexual risk taking behaviors (e.g., abstinence, multiple concurrent partnerships, correct and consistent condom use, responsible drinking).
- Information and referrals for male circumcision where appropriate.
- Tailored prevention information for PLWHA.
- Referral information and links to appropriate care, and treatment services, including HIV care and treatment services, PMTCT, FP services, as well as TB and STI treatment.
- Referral information for social and mental health services including alcohol, abuse support, gender-based violence, and nutrition support
- Condoms as appropriate.

Details of the HCT activity are included in the TBD HVCT BCN.

2) Training. The TBD partner will provide extensive training for FO on the most up-to-date, evidence-based approaches for effective prevention counseling. The TBD partner will also produce appropriate job aids and tools for the field officers, as well as supporting information, education and communication (IEC) materials for clients.

3) Public Outreach to Special Groups and Public Information Campaigns. The TBD partner will also be expected to conduct other community-based prevention efforts including education for traditional leaders, youth and other groups. The TBD partner will also establish tailored referral guides for each region, and will establish community-based resource centers.



In addition, FO will conduct public events to raise public awareness about HIV STI, and TB prevention, care, and treatment.

Supportive Supervision and Collaboration: In each region, the TBD partner will coordinate the FO activities with the Regional AIDS Coordinating Committees (RACOC), Constituency AIDS Coordinating Committees (CACOC), local leaders, and other government and nongovernmental organizations. This coordination will enhance the supervision of FO and avoid duplication. Links with regional and local coordinating bodies will also allow the FO system to be leveraged to deliver messages about other health events (e.g., National Immunization Days) or to distribute materials such as insecticide-treated bed nets. This leveraging is in line with the "mainstreaming" objectives described in the Partnership Framework Implementation Plan (PFIP) and the National Strategic Framework for HIV/AIDS (NSF).

USG technical advisors in the area of HIV prevention will provide technical assistance to the TBD partner

Sustainability: With a shift towards greater emphasis on sustainability and local ownership within PEPFAR, recruiting and deploying field officers in their own communities is a good example of an efficient utilization of resources in a constrained budget environment. The partner will be expected to have strong local roots in Namibia. Efficiencies will be achieved by a focus on recruiting and deploying staff within their own communities.

The TBD partner will develop an assessment and evaluation system to track financial (e.g., cost per test performed by FO), administrative (e.g., logistics, supervision, coordination with MOHSS, HR), and technical (e.g., testing uptake by first-time clients) indicators. Data collected through this system will be used to revise program activities, as needed, and contribute to national monitoring and evaluation systems.

This program contributes to PEPFAR's broader effort to build human resource capacity by strengthening career pathways within the healthcare sector. The FO cadre could represent an entry-level access point to the GRN civil service, which will be expanded in COP10 to include a new cadre of "Health Extension Workers." With additional training and experience, FO will have the opportunity to advance to become extension workers, community counselors, or work in other public health sector positions. In addition, FO ensure stronger linkages between health care facilities and communities.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details



Mechanism ID: 9942	Mechanism Name: Cooperative Agreement U62/CCU024084
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health and Social Services - Haiti	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 18,125,608	
Funding Source	Funding Amount
GHCS (State)	18,125,608

Sub Partner Name(s)

(No data provided.)

Overview Narrative

SUBSTANTIALLY CHANGED FROM LAST YEAR

The USG provides direct support to the Ministry of Health and Social Services (MOHSS) to strengthen public health infrastructure and build human resource capacity to improve access to comprehensive HIV/AIDS care.

To achieve these objectives, CDC supports the MOHSS to perform the following activities:

1. Clinical care to patients with HIV/AIDS.
2. Procurement and distribution of ARV drugs
3. PMTCT and Early Infant Diagnosis services for pregnant women and their babies
4. HIV counseling and testing.
5. Renovations of health facilities and training centers
6. Identify trainees for pre-service training in nursing, medicine, pharmacy, counseling, and laboratory sciences.
7. Combination HIV prevention, including PMTCT, ABC, male circumcision, blood safety and referrals to care and treatment.
8. Community mobilization to expand access to PMTCT, VCT, and other services.
9. Monitoring and evaluation and surveillance
10. Quality improvement in HIV/AIDS care and treatment, and in the diagnosis and treatment of related



infections, including STIs and TB.

Links to the Partnership Framework

This activity closely supports the USG and GRN commitments in the Partnership Framework (PF) currently under development.

In Namibia, unlike many other PEPFAR-supported countries in sub-Saharan Africa, a majority of the annual PEPFAR budget is currently structured to provide direct support to GRN and other local entities. A large portion of that direct support is provided to this partner, the MOHSS. The MOHSS currently has a mandate to manage and coordinate the national HIV/AIDS response in accordance with the current national strategic plan for HIV/AIDS (MTP 3), and the new National Strategic Framework for HIV/AIDS (NSF), which will be finalized in 2010.

PEPFAR is committed to strengthening GRN capacity and ownership, especially in the areas of human resources, and the financing and operation of national healthcare systems. In COP10, PEPFAR will emphasize the GRN's capacity to plan, oversee, manage and, eventually, finance a growing share of the commitments made in the four priority areas identified by the PF: Prevention; Treatment, Care and Support; Impact Mitigation; and Coordination and Management.

Coverage and Target population

This mechanism is designed to support activities with a national scope. The public sector is structured in a three-tier hierarchy comprised of central, regional and district levels. The central level (MOHSS) has responsibility for policy formulation, regulation, planning, management and development. The regional directorates oversee 34 districts which are ultimately responsible for service delivery. With one national referral hospital, three intermediate hospitals, 30 district hospitals, 44 health centers, and more than 265 clinics, the public sector is the largest provider of healthcare. At the same time, a substantial imbalance exists in the healthcare workforce, with the majority of health professionals working in the private sector. Addressing this imbalance is a priority area for the USG.

Health Systems Strengthening

In 2008, MOHSS, with support and involvement from other healthcare stakeholders (including USG), conducted a comprehensive review of the government's health and social service systems. Two areas of structural weakness within the GRN (public sector) healthcare system stood out: Unequal access to health facilities and human resources.

In COP10, USG technical assistance for the MOHSS will focus on the following areas:

- Capacity building of all cadres of health workers (frontline and support)



- Strengthening of partnerships between the public and private sectors (including companies, insurance schemes, and private providers) to jointly achieve national goals and objectives for health
- Strengthening civil society's ability to participate in health sector dialogue.
- Organizational, financial, and management support to MOHSS to strengthen its role as steward and foster equitable resource allocation.
- Expanding the decentralization process
- Situation analyses and the development of engagement strategies.

Cross-Cutting Programs and Key Issues

This activity's main cross cutting area is Human Resources for Health. This program will contribute to PEPFAR's broader effort to build human resource capacity by improving the capacity of MOHSS to recruit, manage and retain staff. USG support for pre and in-service service training will also build a sustainable pool of Namibian healthcare workers in nursing, medicine, pharmacy, counseling, and laboratory sciences.

Cost Efficiencies Over Time

USG technical assistance in this area will support the development of transition plans. These plans should include, but not be limited to, discussions on: 1) Costs; 2) non-financial resources needed to meet program goals (e.g., human resources, equipment); 3) resource mobilization strategies, and; 4) options to institutionalize the activity within a particular sector (e.g., GRN, NGO community, for-profit, etc.).

Over time, the USG is committed to working with MOHSS to identify activities that may be absorbed completely by the GRN, that require continuing technical assistance from the USG, and that could be terminated.

Monitoring and Evaluation Plans

The MOHSS will build on M&E plans and systems developed to date with PEPFAR support. All indicators will be aligned with the NSF and PEPFAR targets. Bi-annual reports will identify progress and describe any necessary changes based on available evidence.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	360,000
Human Resources for Health	10,000,000



Key Issues

Addressing male norms and behaviors
 Increasing gender equity in HIV/AIDS activities and services
 Increasing women's access to income and productive resources
 Child Survival Activities
 Mobile Population
 Safe Motherhood
 TB
 Family Planning

Budget Code Information

Mechanism ID: 9942			
Mechanism Name: Cooperative Agreement U62/CCU024084			
Prime Partner Name: Ministry of Health and Social Services - Haiti			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	56,250	
Narrative:			
NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES			
<p>This is a continuing activity from COP09. It contains one component: 1) Support for equipment and supplies for ART and palliative care facilities.</p> <p>Funding under this activity supports procurement of equipment necessary to provide essential HIV-related clinical care, including tools to improve clinical monitoring. In an effort to address barriers to proper care of HIV-infected women, equipment will also be procured to improve gynecological screening and care of HIV-positive women to more adequately address HIV-related conditions such as cervical dysplasia and reproductive tract infections. Funding will further be used to replace outdated equipment in existing Integrated Management of Adolescent and Adult Illnesses (IMAI) sites as well as to procure new equipment for new sites joining the IMAI network. This includes office supplies and tools essential for IMAI palliative care rollout, including printing of IMAI patient cards and files, as well as scales, examination tables, lamps, and other standard clinical equipment.</p>			



The MOHSS is responsible for national coordination, resource mobilization, monitoring and evaluation, training, and policy development in support of all HIV and TB related services. The MOHSS manages a network of more than 300 health facilities spread out over a vast geographic area in 13 health regions and 34 health districts. The MOHSS strategy for facility-based palliative care for adult persons living with HIV and AIDS (PLWHA) is based on the WHO IMAI framework. IMAI Guidelines for Namibia were approved in COP09. Implementation will be expanded in COP10.

The procurement of new equipment will also support the national task-shifting initiative, which is central to the success of the IMAI strategy. Taking on tasks previously provided by physicians, nurses will increasingly provide palliative care including screening and treatment of patient with minor OI, Nutrition assessment and management. The nurses will also manage pre- ART clients as well as stable ART clients who have completed their first six months of ART without incident. Furthermore they will provide appropriate referrals and linkages with Community-based Health Care (CBHC) organizations.

Supportive supervision: In COP10, CDC will recruit and hire a Namibian locally employed staff (LES) as a palliative care technical advisor (see CDC HBHC budget code narrative). This advisor will work alongside MOHSS counterparts in the Directorate of Special Programmes and the Directorate of Primary Health Care. In COP10 the advisor will provide supportive supervision and other technical assistance to nurses supporting the IMAI rollout in all 13 regions of the country. The advisor will also monitor the delivery, installation and use of equipment procured by PEPFAR.

Sustainability: Support for the IMAI strategy will leverage current and past PEPFAR investments in HIV/AIDS services to benefit the broader healthcare system. Likewise, investments in capital infrastructure and equipment will expand access to HIV and non-HIV clinical services and improve patient uptake of and adherence to ART. Task-shifting and improvements in the working environment at healthcare facilities may also enhance staff morale, create workflow efficiencies that reduce workload burdens, and improve staff retention. As part of a health systems-wide assessment, the USG will work with the MOHSS and other partners to develop transition plans for the GRN to absorb, over time, most of these capital and maintenance costs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	5,070,311	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It contains six primary components: 1) Routine bio-clinical

monitoring; 2) HPV and cervical cancer screening; 3) Partial funding, human resource (HR) management and training for community counselors (CC); 4) Nutrition support to PLWHA; 5) Equipment and supplies for ART sites, and; 6) Mobile clinical services.

1. Routine bio-clinical monitoring tests. Funding will support routine bio-clinical monitoring tests (CD4, viral loads, full blood counts, liver function tests, syphilis and Hepatitis B screening, renal function tests, and other tests depending on the ART regimen) for patients at MOHSS facilities. These tests will be performed by the Namibia Institute of Pathology (NIP). In COP10, bio-clinical monitoring services will be required for approximately 90,700 ART patients. Funding will also support CD4 monitoring of non-ART patients enrolled in palliative care. These funds, which will reimburse NIP, are routed to the MOHSS rather than NIP to increase MOHSS ownership and oversight of bio-clinical monitoring costs.

The MOHSS will also begin linking clinical and laboratory data systems to allow clinicians to access the lab results as soon as they are available. This linkage will reduce turnaround time and improve data quality.

In COP10, PEPFAR will also support revisions to the national ARV treatment guidelines based on WHO recommendations. As noted in the HTXS TAN, the MOHSS may lower the ART enrollment threshold. PEPFAR will continue to work with the MOHSS to ensure a sustainable transition to the lower threshold with minimal disruptions to existing services.

2. HPV and cervical cancer screening. A pilot project will introduce cervical cancer screening in HIV-positive women enrolled in care and treatment services. The MOHSS and I-TECH will develop an on-site training course for nurses and doctors. Clinical Mentors and Nurse Tutors in the regions will pilot the training in three sites, training six nurses/doctors per site. Following the pilot training, training will be done in six additional sites for six participants at each site.

3. Community Counselors Initiative. Namibia introduced the CC program in 2004 as part of the national task-shifting initiative. Facility-based CC provide HCT (see HVCT narratives) and referral services, deliver prevention messages, and play a major role in supporting clinical PMTCT providers in antenatal clinics. In addition, CC distribute condoms, promote couples counseling, and encourage all of their clients, particularly people living with HIV and AIDS (PLWHA), to reduce high-risk sexual behaviors.

In COP10, funding for 650 CC is distributed among six program areas: PMTCT, HVAB, HVOP, HVTB, HVCT, and HTXS. CC will devote approximately 10% of their time to HTXS activities. In calendar year 2009, management and supervisory responsibility for these positions was transferred to the MOHSS from the Namibian Red Cross. This transition was required by revisions to the Namibian Labour Law, which



mandated the establishment of a clear employee-employer relationship between entities supporting contract staff and the individual staff members.

Because of this transition, COP10 funds will also partly support salaries for the following MOHSS HR staff based in the Directorate of Special Programmes (DSP): An HR manager, two HR officers, a CC assistant coordinator, and one HR administrator.

COP10 funding will also support refresher training workshops for 400 CC at the National Health Training Center, with TA from I-TECH. CC will also receive training in patient counseling and referrals for Male Circumcision, Prevention for PLWHA, and alcohol abuse.

4. Nutrition support for PLWHA on ART, including children. PEPFAR will support MOHSS systems to procure, store, monitor, and distribute nutritional supplements in line with the Food by Prescription program for approximately 2,500 PLWHA. The MOHSS will also collaborate with community based organizations to link recipients of the nutrition supplement with sustainable nutrition and income generating strategies such as gardening projects in their communities.

5. Procurement of basic clinical equipment. Funding will include tools to improve clinical monitoring, gynecological screening, and Integrated Management of Adolescent and Adult Illnesses (IMAI) services.

6. Mobile HIV services. This high-priority effort initiated in COP09 will be continued in COP10. Three MOHSS outreach teams will deliver prevention counseling, CT services, and ART services to remote areas of Namibia. Funding for these teams is divided between HVAB, HVCT and HTXS. Each mobile team will consist of a camper van, two CC for testing and mobilization, a nurse, and a driver. The teams will conduct monthly visits to remote communities.

Sustainability: Support for bio-clinical monitoring protects investments in ART drugs and helps control the emergence of drug-resistance. The IMAI strategy, including cervical cancer screening, will leverage current and past PEPFAR investments in HIV/AIDS services to benefit the broader healthcare system. Likewise, investments in capital infrastructure and equipment will expand access to HIV and non-HIV clinical services and improve patient uptake of and adherence to ART. Task-shifting, mobile services, and improvements in the working environment at healthcare facilities may also enhance staff morale, create workflow efficiencies, reduce workload burdens, and improve staff retention.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	1,788,610	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09 which includes four components: (1) Partial funding and human resource (HR) management support for community counselors (CC); (2) Procurement and distribution of HIV test kits and supplies; (3) Promotion of HIV counseling and testing (HCT) through Namibia's National HIV Testing events, and; (4) Provision of outreach-based HCT services.

1. Community Counselors. Namibia introduced the CC program in 2004 as part of the national task-shifting initiative. Facility-based CC provide HCT and referral services, deliver prevention and PMTCT messages, distribute condoms and promote couples counseling, encourage all their clients to reduce high-risk behaviors.

In COP10, funding for 650 CC is distributed across 6 program areas: PMTCT, HVAB, HVOP, HVTB, HVCT, and HTXS. CC will devote approximately 15% of their time to HVCT activities.

In calendar year 2009, management and supervisory responsibility for these positions was transferred to the MOHSS from the Namibian Red Cross. This transition was required by revisions to the Namibian Labour Law, which mandated the establishment of a clear employee-employer relationship between entities supporting contract staff and the individual staff members. Because of this transition, COP10 funds will partly support salaries for the following MOHSS staff based in the Directorate of Special Programmes (DSP): An HR manager, two HR officers, a CC assistant coordinator, and one HR administrator.

COP10 funding will also support refresher training workshops for 400 CC at the National Health Training Center, with TA from I-TECH. Lastly, COP10 funds will support MOHSS staff supervisory visits, planning meetings and an annual CC retreat.

2. Procurement of HIV Test Kits and Supplies. MOHSS will continue to purchase the following: Determine and Unigold HIV test kits (using a parallel testing algorithm) for approximately 175,000 clients at 300 MOHSS facilities; ELISA or a MOHSS-approved rapid test device for tie-breaker re-testing in discordant cases ; HIV rapid test starter packs to launch new testing sites; and rapid HIV test supplies for training CC. These will be procured and distributed by the MOHSS Central Medical Stores. MOHSS will also continue a feasibility assessment for implementing oral fluid rapid HIV testing in specific settings, including outreach and correctional settings.

3. Promotion of HCT through an Annual National HIV Testing Event. In COP09, the MOHSS held its second five day National HIV Testing Event. A total of 82,211 persons were tested and received their results. Seventy four percent (74%) of these clients were tested for the first time. While men are generally underrepresented in routine HCT services, 40% of the clients tested during this event were men. In COP 10, the MOHSS will promote two national HCT events, including a regional event on World AIDS Day.



Funding will support promotional activities in all 13 regions, including drama presentations, radio announcements, other entertainment/educational events, speeches by national and local leaders, and production and distribution of print and electronic media. Outreach-based HIV counseling and testing services will be provided during the World AIDS Day event.

4. Outreach Counseling and Testing Services. The MOHSS launched Guidelines for Outreach/Mobile Counseling and Testing Services towards the end of 2007. Given the vast distances and rural populations of Namibia, outreach/mobile services are critical to providing HIV and other public health services to all corners of the country. In COP09, funding supported procurement of four (4) mobile/outreach vans, related equipment, and personnel for a pilot phase. In COP10 PEPFAR will expand testing services by the staff assigned to these four mobile units.

Quality Assurance and Supportive Supervision: The MOHSS HCT program's commitment to quality activities is clearly demonstrated in its policy documents, as well as in the length (12 weeks) and quality of training for CC. Follow up systems are in place to monitor skills uptake and utilization following training, as are stringent internal and external quality control mechanisms for rapid HIV testing.

Sustainability: The use of CC in public health facilities demonstrates the GRN's commitment to task shifting, a shared objective for the NSF and PFIP. With a critical shortage of locally trained doctors and pharmacists, CC have proven to be an effective, reliable, affordable and sustainable resource to address the human resource challenges in MOHSS facilities. Capacity building through training of locally recruited and deployed CC and health workers will ensure sustainable scale up to additional sites nationwide. The MOHSS has subcontracted a local, Namibian, training agency for the CC program. Support and supervision of CC at regional levels is conducted by nurse supervisors at health facilities. In support of sustainability objectives in the Partnership Framework, the MOHSS will continue to review its capacity to eventually absorb CC as civil servants or as contractors.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	1,125,616	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes two components: 1) Support for basic clinical equipment required to provide pediatric care services, and; 2) Support for DNA PCR tests required by Ministry of Health and Social Services' (MOHSS) Early Infant Diagnosis (EID) Program.

HIV-infected children have been accommodated in HIV care and treatment services since the inception of the ART program in Namibia. The proportion of children in care has grown from 13% in the early days of PEPFAR to a high of 16% in 2006. By COP10 the rate has stabilized at 12%, a phenomenon that could be a reflection of a successful scale-up of the PMTCT program. As PMTCT program effectiveness increases, more pediatric infections will be averted and fewer children will be born HIV infected and

require treatment. The program budget for care and support is shared with HBHC, with approximately 85% supporting adult services and 15% supporting pediatrics through PDCS.

1. Clinical Equipment and Supplies. Funding under this activity supports procurement of equipment necessary to provide essential HIV-related clinical care, including tools to improve clinical monitoring and care for children. Emphasis will be put into monitoring growth and nutritional related symptoms. As such, MUAC tapes, scales and height boards will be needed to ensure all Maternal and Child Health facilities and pre-ART sites are able to monitor growth of children as part of a basic package of care. Additionally, job aides and patient education materials will be produced, printed and disseminated to improve nutritional knowledge of both health workers and clients.

Funding will further be used to replace outdated equipment in existing Integrated Management of Adolescent and Adult Illnesses (IMAI) sites as well as to procure new equipment for new sites joining the IMAI network. This includes office supplies and tools essential for IMAI palliative care rollout, including printing of IMAI patient cards and files, as well as scales, examination tables, lamps, and other standard clinical equipment.

The procurement of new equipment will also support the national task-shifting initiative, which is central to the success of the IMAI strategy. Taking on tasks previously provided by physicians, nurses will increasingly provide palliative care including screening and treatment of patient with minor OI, Nutrition assessment and management. The nurses will also manage pre-ART clients as well as stable ART clients who have completed their first six months of ART without incident. Furthermore they will provide appropriate referrals and linkages with Community-based Health Care (CBHC) organizations.

2. HIV DNA PCR testing for early infant diagnosis. This activity was previously funded under the PMTCT program area. Namibia was one of the first countries to roll out Dried Blood Spots and DNA PCR for EID. In 2006, the PMTCT program introduced DNA PCR for symptomatic infants and HIV-exposed infants from as early as six weeks of age. Since that time, PEPFAR funds have supported training of technicians and technologists from the Namibia Institute of Pathology (NIP) and other laboratories in PCR; purchased new equipment; financed the processing of specimens; and expanded decentralized training for health workers in the collection of DBS. This activity is critical to the survival of HIV-infected children as early diagnosis of HIV-infection facilitates early initiation of ART in the first year of life. Without any intervention, 30% of HIV-infected children will die with the first year. Additionally, exclusion of an HIV diagnosis is reassuring for parents and caregivers who have HIV-exposed children.

Supportive Supervision: The CDC technical advisors for laboratory, PMTCT and quality improvement will provide day-to-day technical support and supervision to MOHSS staff engaged with these activities. As noted in other narratives, revisions to the Namibian Labour Law have driven an expansion of human resource (HR) management capacity at the MOHSS. Four new HR administrators in the Directorate for Special Programmes (DSP) will provide additional supervisory and administrative support to field staff.

Sustainability: In COP10, the MOHSS will continue to receive direct funding to reimburse NIP for DNA



PCR testing. Funding for this activity is provided to the MOHSS, rather than NIP to encourage MOHSS ownership and oversight over the program. The costs of PCR tests will gradually be absorbed by the MOHSS over the next five years. COP10 funds will support the costs of approximately 20,000 diagnostic PCR tests. This activity will also leverage resources from the Clinton Foundation, which has committed to supporting reagents for PCR in 2010.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	958,506	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09 which supports five components: 1) Routine bio-clinical monitoring; 2) Partial funding, human resource (HR) management and training for community counselors (CC); 3) Nutrition support to PLWHA; 4) Procurement of equipment and supplies for IMAI/IMCI and ART sites; 5) Support for mobile ART outreach.

1. Routine bio-clinical monitoring tests. Funding will support routine bio-clinical monitoring tests (CD4, viral loads, full blood counts, liver function tests, syphilis, Hepatitis B screening, renal function tests, and other tests depending on the ART regimen) for pediatric patients at MOHSS facilities. These tests will be performed by the Namibia Institute of Pathology (NIP). In COP10, bio-clinical monitoring services will be required for approximately 10,000 pediatric ART patients. Funding will also support CD4 monitoring of non-ART patients enrolled in palliative care. These funds reimburse NIP, but are routed to the MOHSS rather than NIP to increase MOHSS ownership and oversight of bio-clinical monitoring costs.

The MOHSS will also begin linking clinical and laboratory data systems to allow clinicians to access the lab results as soon as they are available. This linkage will reduce turn around time and improve data quality.

In COP10, PEPFAR will also support revisions to the national ARV treatment guidelines based on WHO recommendations. As noted in the HTXS TAN, the MOHSS may lower the ART enrollment threshold. PEPFAR will continue to work with the MOHSS to ensure a sustainable transition to the lower threshold with minimal disruptions to existing services.

2. Community Counselors Initiative. Namibia introduced the CC program in 2004 as part of the national task-shifting initiative. Facility-based CC provide HCT (see HVCT narratives) and referral services, deliver prevention messages, and play a major role in supporting clinical PMTCT providers in antenatal clinics. In addition, CC distribute condoms, promote couples counseling, and encourage all of their

clients, particularly people living with HIV and AIDS (PLWHA), to reduce high-risk sexual behaviors.

In COP10, funding for 650 CC is distributed among six program areas: PMTCT, HVAB, HVOP, HVTB, HVCT, and HTXS. CC will devote approximately 15% of their time to PDTX activities. In calendar year 2009, management and supervisory responsibility for these positions was transferred to the MOHSS from the Namibian Red Cross. This transition was required by revisions to the Namibian Labour Law, which mandated the establishment of a clear employee-employer relationship between entities supporting contract staff and the individual staff members. Because of this transition, COP10 funds will also partly support salaries for the following MOHSS staff based in the Directorate of Special Programmes (DSP): An HR manager, two HR officers, a CC assistant coordinator, and one HR administrator.

COP10 funding will also support refresher training workshops for 400 CC at the National Health Training Center, with TA from I-TECH. CC will also receive training in patient counseling and referrals for male circumcision, prevention for PLWHA, and alcohol abuse.

3. Nutrition support for PLWHA on ART, including children. PEPFAR will support MOHSS systems to procure, store, monitor, and distribute nutritional supplements in line with the Food by Prescription program for approximately 2,500 PLWHA. The MOHSS will also collaborate with community based organizations to link recipients of the nutrition supplement with sustainable nutrition and income generating strategies such as community gardening projects.

4. Procurement of basic clinical equipment. Funding will include tools to improve clinical monitoring, gynecological screening, and Integrated Management of Adolescent and Adult Illnesses (IMAI) services.

5. Mobile HIV services. This high-priority effort initiated in COP09 will be continued in COP10. Three MOHSS outreach teams will deliver prevention counseling, CT services, and ART services to remote areas of Namibia. Funding for these teams is divided between HVAB, HVCT and HTXS. Each mobile team will consist of a camper van, two CC for testing and mobilization, a nurse, and a driver. The teams will conduct monthly visits to remote communities.

Supportive Supervision: The CDC technical advisors for laboratory, PMTCT and quality improvement will provide day-to-day technical support and supervision to MOHSS staff engaged with these activities. As noted in other narratives, revisions to the Namibian Labour Law have driven an expansion of human resource (HR) management capacity at the MOHSS. Four new HR administrators in the Directorate for Special Programmes (DSP) will provide additional supervisory and administrative support to field staff.

Sustainability: Support for bio-clinical monitoring protects investments in ART drugs and helps control

the emergence of drug-resistance. The IMAI strategy, including cervical cancer screening, will leverage current and past PEPFAR investments in HIV/AIDS services to benefit the broader healthcare system. Likewise, investments in capital infrastructure and equipment will expand access to HIV and non-HIV clinical services and improve patient uptake of and adherence to ART. Task-shifting, mobile services, and improvements in the working environment at healthcare facilities may also enhance staff morale, create workflow efficiencies, reduce workload burdens, and improve staff retention.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	510,000	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It included four components: (1) Support for the Ministry of Health and Social Services (MOHSS) RM&E Program; (2) support for the management of MOHSS Health Information Systems (HIS) and national database server; (3) support for an evaluation of the national ART program, and; (4) support for the 2010 sentinel surveillance survey in antenatal clinics (ANC).

1. RM&E Program Support: The following items will be procured by MOHSS to expand and enhance the capture, processing, and dissemination of routine data produced by programs within the national HIV/AIDS response:

- Computers, monitors, printers, and uninterrupted power supplies will be procured for all new data clerks and HIS officers in all ART, PMTCT, CT, and TB clinic sites. The COP10 budget will also include funds for repairs and replacement parts for computer systems which are identified by MoHSS staff.
- Software (including antivirus) upgrades and 65 memory sticks.
- Connectivity options will be assessed and technical assistance will be provided to implement appropriate internet connectivity tools for secure email access for all facility-based and regional informatics personnel.
- In COP07 patient care books were updated to conform to WHO standards. COP10 will support production of approximately 20,000 patient books.
- Three laptop computers and 3G internet connectivity devices will be purchased to facilitate training and travel by RM&E staff.
- Support routine printing of necessary patient record forms and site registers for collection and dissemination of routine ART/PMTCT/CT/TB data.
- Printing and dissemination of the RM&E Annual Report.
- COP 10 will support the provision of office furniture for continued expansion of RM&E activities at the sub-national level.
- PEPFAR will support travel for RM&E staff to conduct supportive supervision, mentoring, data collection



and other reporting.

2. MOHSS Health Information Systems (HIS) and National Database Server Support: Technical assistance and upgrades for HIS will be provided at the national and sub-national level. Refresher trainings will be provided for all sub-national data clerks. In addition, MOHSS will support a consultant to continue the rollout of a the district health information system, conduct trainings, and assist with the development of a strategy to ensure the efficient and effective use of data collected at all levels of the MOHSS.

In addition, continuing training and support for the implementation of a national database server. This server will be based in the Office of the Prime Minister and house integrated healthcare data from across the MOHSS system.

3. Evaluation of ART program. MOHSS will plan and conduct a national ART program evaluation to assess the quality of care and outcomes of its HIV care and treatment activities.

4. ANC Sentinel Surveillance 2010: Every two years the MOHSS conducts a sentinel HIV survey in ANC sites to estimate HIV prevalence among pregnant women. COP10 funding will support planning, tool development, training, site selection, supportive supervision, data analysis, and printing and dissemination of the final report.

Supportive supervision/Quality Assurance: Supportive supervision for quality assurance by MOHSS and USG staff will be a focus for COP10. As improvements and modifications are implemented with data systems and as more staff are trained, a structured schedule of site visits and other communication will be implemented.

Sustainability: Sustainability is achieved through support for training courses and ongoing hands-on mentoring of RM&E staff. In line with the strategic objectives outlined in the Partnership Framework, MOHSS will also conduct an assessment of its current HIS capacity. This assessment will describe gaps in the data collection system, and areas where HIS systems may be better integrated (within the health sector and across other sectors, e.g., human resources). The assessments will inform the development of an MOHSS transition plan to describe how and when responsibilities may be absorbed, and how and where USG technical assistance should be provided.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	1,100,000	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes one component: 1) Support for scholarships and bursaries for Namibian students in the healthcare sciences.



PEPFAR has provided scholarship and bursary support to the MOHSS since COP05. A total of 943 bursaries have been awarded for Namibians to study medicine, nursing, pharmacy, social work, public health, and other allied health fields. Some of these bursaries have supported students to attend educational programs abroad. However, an increasing number of bursaries have supported training in Namibia.

Inadequate human resource capacity is among the leading obstacles to the development and sustainability of HIV/AIDS-related health services in Namibia. The USG has recognized pre-service training as instrumental in scaling up and sustaining the national HIV/AIDS response, and to strengthening the overall healthcare system.

Critical human resources gaps exist at all facility levels of the healthcare system, from the national administration to local facilities. The lack of pre-service training institutions for doctors and pharmacists in Namibia, coupled with limited local training opportunities for other allied health professionals, has contributed to a chronic shortage of health professionals. In 2007, the vacancy rate in the Ministry of Health and Social Services (MOHSS) was 35% for doctors, 22% for registered nurses, 26% for enrolled nurses, and 41% for pharmacists.

Since COP05, PEPFAR has made substantial investments to build local training capacity in Namibia.

Other non-PEPFAR resources from the USG are leveraged to improve Namibia's weak secondary education system to prepare students for health careers. This includes support from the Millennium Challenge Account for textbooks and the Ambassador's Scholarship Program that support scholarships for young girls to attend grades 8 through 12.

COP10 will support bursaries for a minimum of 400 Namibians to train as doctors, pharmacists, pharmacy assistants, nurses, enrolled nurses, laboratory technologists, social workers, public health administrators, epidemiologists, and nutritionists in Namibia, South Africa, Kenya, and elsewhere. Students are technically bonded to serve the MOHSS upon completion of their studies, however enforcement of these bonds is lax. In COP10, the USG will lead an evaluation of returned scholarship recipients to quantify attrition rates and identify methods to improve retention within the public healthcare sector.

As noted above, PEPFAR support for local educational institutions has permitted more Namibians to remain in Namibia for pre-service training. These pre-service programs include the nursing and pharmacy training programs at the National Health Training Center (NHTC) and University of Namibia (UNAM), the medical technology training program at the Polytechnic of Namibia (PoN), and the public health program at UNAM.

1. Nursing and Pharmacy Training. To fill urgently needed nursing and pharmacy positions, this activity will support MOHSS plans to increase the output of enrolled nurses and pharmacy assistants from the NHTC, who can be trained in two years instead of four years, and for registered nurses at UNAM. These positions are urgently needed as task-shifting and Integrated Management of Adult Illness (IMAI) continues to be rolled out. In COP10, some of the students enrolled in the nursing program are former



community counselors. PEPFAR will promote the "graduation" from lay community counselor to professional healthcare worker in its broader strategy to strengthen the career ladder at all levels of the health system.

2. Medical Technology Training. PEPFAR will support bursaries for students in the laboratory technologist program at the PoN, which began enrolling students in January 2008.

3. Public Health Training. Bursaries will also support students who enroll in the PEPFAR-supported MPH program in public health leadership and certificate programs in monitoring and evaluation and nutrition.

Supportive Supervision: PEPFAR will work with the MOHSS' Division of Public Policies and Human Resources Development (PPHRD) to track students receiving bursaries and assess the impact of returning students on the healthcare system. This assessment process will also examine the bursary program retrospectively to determine the number of students who ultimately took jobs within the public healthcare sector. This retrospective review will quantify attrition rates and determine the extent of the healthcare worker "brain drain" from the public to the private sectors in Namibia.

Sustainability: The assessments described above will contribute to a better understanding of the impact PEPFAR-supported bursaries have had on the healthcare shortage in Namibia. The results of this evaluation will directly support the Partnership Framework emphasis on Human Resources for Health. Country ownership of the bursary program will be promoted through technical assistance to build HR capacity within the MOHSS to manage the program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	200,000	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes one primary component: (1) The provision of supplies, equipment, and commodities for male circumcision. This activity is also linked to staffing and training narratives under CIRC (see Potentia and I-TECH).

As the demand for male circumcision (MC) increases in Namibia, PEPFAR will support the MOHSS to ensure that appropriate supplies, equipment, and commodities are available. These supplies and commodities may include, but will not be limited to, surgical equipment, sterile equipment, local anesthetic, patient education materials and training curricula.

The national MC task force, that includes representatives from Ministry of Health and Social Services (MOHSS), USG, UNAIDS, and other non-governmental organizations, will work closely with the MOHSS Central Medical Stores to order, stock, and distribute the appropriate supplies, commodities, and equipment. A distribution plan will be aligned with the roll-out plan for MC services. In September 2009, Namibia initiated pilot MC activities for adults (18 years or older) in five settings in Namibia. In COP10, MC activities will be expanded to all of Namibia's 13 regions.



In addition, traditional circumcisers perform circumcisions on males of any age, but primarily focus on neonates through children aged three years. The MOHSS invited traditional circumcisers to the MC stakeholders meeting held in 2008 and remains interested in working with this group to train, and possibly certify and register, traditional male circumcisers. The MOHSS has also expressed an interest in distributing a male circumcision "supply pack" to traditional circumcisers in an attempt to improve safety and sanitary conditions. Training for traditional providers would accompany and eventual supply pack distribution.

Supportive Supervision: As noted in the Potentia narratives for CIRC, a national MC coordinator will be supported in COP10 to provide supportive supervision, monitoring and evaluation, and training to the specialist physicians and nurses who will perform MC.

Sustainability: COP10 is the third year of funding for Male Circumcision (MC) activities in Namibia. However, MC activities have not been rolled out beyond five pilot sites as the Namibian government is in the process of approving a MC policy. PEPFAR will continue to provide technical assistance and support for management and medical personnel as well as capacity building of existing personnel in this important area. PEPFAR's initial financial support for this activity will help strengthen the MOHSS Central Medical Stores to procure and distribute MC supplies and commodities. Based on the demand of services, MOHSS may need to supplement the PEPFAR investment in this area to cover any budgetary gaps. In the National Strategic Framework and in the Partnership Framework, the MOHSS has identified MC as a priority and has committed to supporting it to scale. In line with these commitments, and based on trends in public uptake of MC services, the PEPFAR will work with the MOHSS to develop a detailed sustainability plan for MC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	2,207,128	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It contains one component: (1) Partial funding and human resource (HR) management support for community counselors (CC).

1. Community Counselors. Namibia introduced the CC program in 2004 as part of the national task-shifting initiative. Facility-based CC provide HCT and referral services, delivery prevention messages to HIV-negative women and others, and play a major role in supporting clinical PMTCT providers in antenatal clinics. In addition, CC will distribute condoms and promote couples counseling and encourage all their clients, but particularly people living with HIV and AIDS (PLWHA), to reduce high-risk behaviors



through abstinence and being faithful to one partner. All activities will incorporate gender messaging in compliance with Namibia's male norms initiative which seeks to address cultural norms that factor into HIV transmission, including lack of health care seeking behavior by men, multiple sex partners, transactional and trans-generational sex, power inequities between men and women, and alcohol abuse. CC are also the primary personnel at health sites responsible for HCT services (see HVCT TAN and associated BCN).

In COP10, funding for 650 CC is distributed among six program areas: PMTCT, HVAB, HVOP, HVTB, HVCT, and HTXS. CC will devote approximately 50% of their time to HVAB activities. In calendar year 2009, management and supervisory responsibility for these positions was transferred to the MOHSS from the Namibian Red Cross. This transition was required by revisions to the Namibian Labour Law, which mandated the establishment of a clear employee-employer relationship between entities supporting contract staff and the individual staff members.

Because of this transition, COP10 funds will also partly support salaries for the following MOHSS HR staff based in the Directorate of Special Programmes (DSP): An HR manager, two HR officers, a CC assistant coordinator, and one HR administrator.

COP10 funding will also support refresher training workshops for 400 CC at the National Health Training Center, with TA from I-TECH. CC will also receive training in counseling and referrals for Male Circumcision, Prevention for PLWHA, and alcohol abuse.

Lastly, COP10 funds will support supervisory visits by MOHSS staff; planning meetings and an annual retreat for CC.

Supportive supervision: The MOHSS now provides additional management oversight and supervision for contract staff.

Sustainability: As noted above, the MOHSS has expanded the duties of the Deputy Director of the (DSP) to include direct management and administration of six contract staff and the CC cadre. This transition represents an important step toward the eventual full absorption and financing of these staff – either as civil servants or as contractors – by the MOHSS. Long-term cost savings are being achieved through the focus on recruiting and deploying staff within their own communities. CC retention rates are also high, suggesting a high level of morale among this cadre of lay healthcare workers. Also of note, several CC have recently "graduated" to enroll in nursing school. Similar transitions will be encouraged throughout the task-shifting initiative.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
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Prevention	HVOP	1,270,378	
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Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It contains four primary components: (1) Partial funding, human resource (HR) management and training for community counselors (CC); (2) Condom procurement; (3) Support for the Ministry of Health and Social Services' (MOHSS) Coalition on Responsible Drinking (CORD), and; (4) Partial support for outreach teams to deliver prevention and testing services to remote communities.

1) Community Counselors. Namibia introduced the CC program in 2004 as part of the national task-shifting initiative. Facility-based CC provide HCT (see HVCT narratives) and referral services, deliver prevention messages, and play a major role in supporting clinical PMTCT providers in antenatal clinics. In addition, CC will distribute condoms, promote couples counseling, and encourage all of their clients, but particularly people living with HIV and AIDS (PLWHA), to reduce high-risk behaviors through abstinence and faithfulness to one partner. All activities will incorporate gender messaging linked to Namibia's male norms initiative which seeks to address cultural norms that factor into HIV transmission, including lack of health care seeking behavior by men, multiple sex partners, transactional and trans-generational sex, power inequities between men and women, and alcohol abuse.

In COP10, funding for 650 CC is distributed among six program areas: PMTCT, HVAB, HVOP, HVTB, HVCT, and HTXS. CC will devote approximately 10% of their time to HVOP activities. In calendar year 2009, management and supervisory responsibility for these positions was transferred to the MOHSS from the Namibian Red Cross. This transition was required by revisions to the Namibian Labour Law, which mandated the establishment of a clear employee-employer relationship between entities supporting contract staff and the individual staff members.

Because of this transition, COP10 funds will also partly support salaries for the following MOHSS HR staff based in the Directorate of Special Programmes (DSP): An HR manager, two HR officers, a CC assistant coordinator, and one HR administrator.

COP10 funding will also support refresher training workshops for 400 CC at the National Health Training Center, with TA from I-TECH. CC will also receive training in patient counseling and referrals for Male Circumcision, Prevention for PLWHA, and alcohol abuse.

Lastly, COP10 funds will support supervisory visits by MOHSS staff; planning meetings and an annual

retreat for CC.

2) Condom Procurement. The majority of condoms in Namibia are financed by the Global Fund (GF). Condoms are distributed free of charge to health facilities and to the community. In COP10, Namibia plans to procure over 20 million condoms. The GF is expected to fund 13 million condoms, PEPFAR six million, and the Namibian government one million. USG support will emphasize sub-national logistics and distribution strategies to improve access to condoms in remote areas.

3. Expansion of CORD. USG funds will continue to support the expansion of the MOHSS Directorate of Social Welfare's Coalition on Responsible Drinking (CORD). CORD incorporates media messaging and works with community, business, and health partners, as well as shebeens (bars) and breweries to reduce alcohol abuse, a major driver of the HIV epidemic in Namibia. CORD will be rolled out to five additional regions and will use these funds to educate business owners and the general public about the association between alcohol consumption, high-risk sexual behavior, and HIV transmission.

4. Outreach Team. This high-priority effort initiated in COP09 will be continued in COP10. Three MOHSS outreach teams will deliver prevention counseling, CT services, and ART services to remote areas of Namibia. Funding for these teams is divided between HVAB, HVCT and HTXS. Each mobile team will consist of a camper van, two CC for testing and mobilization, a nurse, and a driver. The teams will conduct monthly visits to remote communities (e.g. the first Thursday of each month) and will work with community-based field officers, community leaders, and local radio stations to promote each outreach visit.

CT services will be implemented first (see HVCT narrative), with an emphasis on prevention messaging. Costs per client, success in reaching first-time testers, ability to link positive clients to treatment, and community receptiveness will be evaluated in COP10. If the outreach teams are able to effectively deliver these services, other components may be added, including ART, TB screening and DOT, PMTCT, case management, and alcohol counseling and referrals.

Supportive supervision: The MOHSS now provides additional management oversight and supervision for contract staff.

Sustainability: As noted above, the MOHSS has expanded the duties of the Deputy Director of the (DSP) to include direct management and administration of six contract staff and the CC cadre. This transition represents an important step toward the eventual full absorption and financing of these staff – either as civil servants or as contractors – by the MOHSS. Long-term cost savings are being achieved through the focus on recruiting and deploying staff within their own communities. CC retention rates are also high,



suggesting a high level of morale among this cadre of lay healthcare workers. Also of note, several CCs have recently "graduated" to enroll in nursing school. Similar transitions will be encouraged throughout the task-shifting initiative.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,046,167	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuity activity from COP 2009. It supports seven components: (1) Partial funding and management support for community counselors (CC); (2) procurement of routine supplies and equipment; (3) PMTCT training for traditional birth attendants (TBA); (4) support for a PMTCT information, education, and communication (IEC) campaign; (5) support for case managers to improve follow-up of mother-infant pairs; (6) provision of nutritional supplementation for persons living with HIV/AIDS (PLWHA), and; (7) management and administration of contract staff.

1. Community Counselors. In COP10, funding for 650 CC, who dedicate part of their time to this activity is distributed among six program areas: PMTCT, HVAB, HVOP, HVTB, HVCT, and HTXS. CC will devote approximately 10% of their time to PMTCT. In 2009, management and supervisory responsibility for these positions was transferred to the MOHSS from the Namibian Red Cross. This transition was required by revisions to the Namibian Labour Law, which mandated the establishment of a clear employee-employer relationship between entities supporting contract staff and the individual staff members.

Namibia introduced the CC program in 2004 as part of the national task-shifting initiative. Facility-based CC provide HCT and referral services, provide prevention messages to HIV-negative women, and play a major role in supporting clinical PMTCT providers in antenatal clinics. In addition, CC also provide couples counseling services and support patients to address the difficult and often contentious issue of discordance between couples.

2. Procurement of supplies and equipment. In COP 10, PEPFAR will support the printing and distribution of revised ANC and maternity registers, as well as monthly ANC and Labor and Delivery summary forms. In addition, hemoglobinometers will be procured to support anemia monitoring for women on AZT-containing regimens. Clinic furniture and equipment for new PMTCT sites will also be procured. Support will also assist in printing and dissemination of the new national PMTCT guidelines.

3. Training for Traditional Birth Attendants (TBA). Approximately 25% of deliveries in Namibia occur outside of a health facility and are conducted by traditional birth attendants (TBA). While it is critical to engage with, and motivate these TBA to refer pregnant women for a skilled birth attendant, some women in remote areas find it hard to present to maternity for delivery. Training on PMTCT, HIV prevention, reproductive health, and referrals will be provided to 80 TBA in COP10.
4. Support for an IEC campaign promoting PMTCT. A national educational campaign by the Directorate of Primary Health Care to promote PMTCT services in collaboration with the Ministry of Information, Communication and Technology (MICT) will continue in COP10. Funding will be provided to develop, produce, and disseminate PMTCT educational materials for strategic communications in the clinical setting, including the promotion of male involvement. Materials will be produced in local languages as appropriate.
5. Case Managers (CM). COP10 will continue for support 21 case managers who will provide services in eight program areas (HBHC, HVAB, HTXS, PDTX, HVOP, PDCS, and HVTB), including MTCT. Through an intervention/service plan CM will address and reassess the issues that are putting clients at risk of defaulting on treatment or engaging in risky behaviors. In support of MTCT objectives, CM will:
 - a. Coordinate resources for clients, including facilitation of psycho-social support groups for PLWHA caregivers.
 - b. Assist with treatment defaulter tracing, mother-baby pair follow-up and referral to EID, Cotrimoxizole, and other services.
 - c. Counseling patients on adherence, prevention with positives, Family Planning (FP), STI services and disclosure/partner referral
 - d. Referrals to other health and social services (e.g., FP, STI services, drug/alcohol treatment and domestic violence)
 - e. Encourage men to seek services and to support their partners and children in doing the same.
6. Management and administration of contract staff. In early 2009, the passage of a new Labour Law required the MOHSS and other employers to revise contractual mechanisms to shift legal responsibility for contract staff from Potentia, a private HR services firm, to the MOHSS. This shift was required to establish a clear employee-employer relationship with the MOHSS. Potentia will continue to provide some HR services (e.g., payroll) for CM and six MOHSS training staff, but overall responsibility for supervision and management will be assured by the MOHSS Directorate of Special Programmes (DSP).
7. Nutritional supplementation for PLWHA. Improving maternal nutritional status and supporting the nutritional status of pregnant and lactating women will be provided to meet the needs of a minimum of 10% of all HIV-positive pregnant women.

Sustainability: This activity will leverage new USG centrally funded food supplementation activities to be undertaken in public health facilities. The activity will also leverage support from UNICEF and the Clinton Foundation. As noted above, the MOHSS has expanded the duties of the Deputy Director of the (DSP) to include direct management and administration of six contract staff and the CC cadre. This transition represents an important step toward the eventual full absorption and financing of these staff – either as civil servants or as contractors – by the MOHSS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	1,879,596	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity which includes one component: funding support to procure FDA-approved ARVs through the Ministry of Health and Social Services' (MOHSS) Central Medical Stores (CMS). The MOHSS CMS procures and distributes all public sector ARVs in Namibia. Through a single procurement structure, the CMS uses funds from the MOHSS, the USG, the Global Fund, and other partners, including the Clinton Foundation, to simplify procurement and maximize purchasing power.

In 2007, the Government of Namibia (GRN) commissioned a costing exercise from the European Commission to project future HIV/AIDS costs, including ARVs. Currently the GRN finances about 35% of ARVs and this is projected to increase to 43% in 2010 and 55% in 2015. As described in COP09, the Namibia PEPFAR team opted to temporarily remove \$2.5 million from the MOHSS' ARV funding in COP09. USG will restore these funds once a Partnership Framework (PF) is signed between the US and the GRN, now scheduled for sometime in calendar year 2010.

As of June 2009, 73,674 adult and pediatric patients were receiving treatment in 141 sites, up from 101 sites as of the end of September 2008. Approximately 88% were adults and 12% were children.

ART services remain congested at a number of sites, and the continuing focus of the national ART program is to:

- 1) Decentralize care and treatment for both adults and children.
- 2) Focus on quality of care and treatment, including promoting consumer involvement in quality of care issues.
- 3) Incorporate prevention and family planning messages into treatment
- 4) Improve "user friendliness" of ART services,
- 5) Improve linkages to TB and PMTCT services as well as with community-based organizations,
- 6) Roll-out prevention with positives strategies nationwide (excepting three control sites involved in the PwP pilot study), and
- 7) Increase the involvement of people living with HIV/AIDS (PLWHA) in palliative care and/or adherence

support programs to strengthen the adherence strategy.

Namibia has standardized first and second-line regimens. Currently, 71% of adults on first-line regimens are currently on stavudine/lamivudine/nevirapine (d4T/3TC/NVP) or zidovudine/lamivudine/nevirapine (AZT/3TC/NVP), 21% are on stavudine/lamivudine/efavirenz (d4T/3TC/EFV) or AZT/3TC/EFV, and 8% are on a tenofovir (TDF) containing regimen. Only 2.4% of patients on ART were on second-line regimens as at end of June 2009. New national treatment guidelines were released in April 2007 which recommended AZT-based HAART regimen and instead of the previous use of D4T; due to d4T toxicity. Namibia is poised to revise its treatment guidelines to align with the 2009 WHO revised guidelines expected at the end of 2009. The MOHSS Technical Advisory Committee (TAC) has already recommended a move to TDF-based first line and a lowering of the threshold for initiating ART to 350. Both these recommendations have been subjected to a costing analysis. The TAC now awaits MOHSS senior management and their partners to review financial implications of the proposed two new major changes, before making a final decision on the way forward.

In 2007, a procurement plan for 2007 was developed and implemented by the MOHSS, the USG and the Global Fund to consolidate drug procurement through the CMS. Currently, 83% of the drugs procured are FDA-approved and 17% are not FDA-approved. Funds from MOHSS and other donors will continue to be used to procure non-FDA-approved products. The supply chain for ARVs and related drugs works well and cost-effectively in Namibia, with state-of-the-art pharmacy information system and inventory practices that have virtually eliminated ARV stock-outs.

Sustainability:

With USG support, the MOHSS has enhanced its considerable technical capacity to lead all aspects of its national treatment program, from care and treatment guidelines to pharmaceutical management, forecasting, procurement and supply chain management. The GRN is well positioned to sustain this leadership into the future.

The GRN recognizes that its absorption of ARV costs is an important step toward sustainability of its treatment program, and has been increasing the portion of ARV costs covered by MOHSS funding over time, while USG contributions have declined.

The Clinton Foundation/UNITAID will continue to work with CMS to negotiate substantial price reductions for CMS for pediatric and second-line drugs, and signed a multi-year memorandum of understanding with the MOHSS to continue to assist CMS with bringing down drug costs in 2008. These negotiations have resulted in the addition of low-cost pediatric fixed dose combination (FDCs) to the CMS formulary, which is likely to substantially improve adherence and efficacy and reduce wastage from previous regimens which involved messy and difficult-to-measure syrups.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	913,046	

Narrative:



NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes four components: (1) Partial funding and human resource (HR) management support for community counselors (CC) to ensure HIV testing of tuberculosis (TB) patients; (2) procurement of HIV rapid test kits for testing of TB patients; (3) support for laboratory diagnosis and bi-clinical monitoring for TB, and; (4) support TB drug resistance surveillance..

1. Community Counselors. Namibia introduced the CC program in 2004 as part of the national task-shifting initiative. Facility-based CC provide HCT and referral services, deliver prevention and PMTCT messages to HIV-negative women and others, distribute condoms and promote couples counseling, encourage all their clients, but particularly people living with HIV and AIDS (PLWHA), to reduce high-risk behaviors through abstinence and being faithful to one partner. All activities will incorporate gender messaging in compliance with Namibia's male norms initiative which seeks to address cultural norms that factor into HIV transmission, including lack of health care seeking behavior by men, multiple sex partners, transactional and trans-generational sex, power inequities between men and women, and alcohol abuse. CC are also the primary personnel at health sites responsible for HCT services (see HVCT TAN and associated BCN).

In COP10, funding for 650 CC is distributed across six program areas: PMTCT, HVAB, HVOP, HVTB, HVCT, and HTXS. CC will devote approximately 10% of their time to HVTB activities, which will include HIV testing and counseling to TB patients. In 2007, 54% of TB patients were tested for HIV; 59% of these TB patients were HIV positive. In CO09 approximately 80% of TB patients received an HIV test.

In calendar year 2009, management and supervisory responsibility for these positions was transferred to the MOHSS from the Namibian Red Cross. This transition was required by revisions to the Namibian Labour Law, which mandated the establishment of a clear employee-employer relationship between entities supporting contract staff and the individual staff members.

Because of this transition, COP10 funds will also partly support salaries for the following MOHSS HR staff based in the Directorate of Special Programmes (DSP): An HR manager, two HR officers, a CC assistant coordinator, and one HR administrator.

COP10 funding will also support refresher training workshops for 400 CC at the National Health Training Center, with TA from I-TECH. CC will also receive training in counseling and referrals for Male Circumcision, Prevention for PLWHA, and alcohol abuse.

Lastly, COP10 funds will support supervisory visits by MOHSS staff; planning meetings and an annual

retreat for CC.

2. Procurement of HIV Test Kits and Supplies for TB patients and suspects. MOHSS will continue to purchase the following: Determine and Unigold HIV test kits (using a parallel testing algorithm) for approximately 50,000 TB patients and suspects at 250 MOHSS facilities; ELISA or an MOHSS-approved rapid test device for tie-breaker re-testing in cases of discordance; HIV rapid test starter packs to launch new testing sites; and rapid HIV test supplies for training CC. These kits and supplies will be procured and distributed by the MOHSS Central Medical Stores.

3. Lab diagnosis and bio-clinical monitoring for TB. In 2008, 268 cases of all forms of drug resistant TB were reported. Of those, 23 cases were diagnosed as Extensively Drug Resistant (XDR) TB, 201 cases were diagnosed as Multi Drug Resistant (MDR), and 44 were diagnosed as "poly resistant." In COP10, the Namibia Institute of Pathology (NIP) will continue to provide support aggressive TB case finding through diagnostic and bio-clinical monitoring services to MOHSS.

4. TB Drug Resistance Surveillance. In COP10, MOHSS will expand TB drug resistance surveillance with technical assistance from CDC and laboratory support from NIP.

Supportive supervision: As noted above, the MOHSS now provides additional management oversight and supervision for contract staff.

Sustainability: The MOHSS has expanded the duties of the Deputy Director of the (DSP) to include direct management and administration of six contract staff and the CC cadre. This transition represents an important step toward the eventual full absorption and financing of these staff – either as civil servants or as contractors – by the MOHSS. Long-term cost savings are being achieved through the focus on recruiting and deploying staff within their own communities. CC retention rates are also high, suggesting a high level of morale among this cadre of lay healthcare workers. Also of note, several CCs have recently "graduated" to enroll in nursing school. Similar transitions will be encouraged throughout the task-shifting initiative.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10163	Mechanism Name: Society for Family Health (SFH)
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Funding Agency: U.S. Department of Defense	Procurement Type: Cooperative Agreement
Prime Partner Name: Namibian Social Marketing Association	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 562,150	
Funding Source	Funding Amount
GHCS (State)	562,150

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Continuing from FY09

The United States Department of Defense (USDOD) Cooperative Agreement with Population Services International/Social Marketing Association (PSI/SMA) is a continuing mechanism from COP09 which provides a comprehensive HIV prevention services for the Ministry of Defense/Namibian Defense Force (MOD/NDF) to implements its workplace program, the Military Action and Prevention Program (MAPP). The program aims to reach over 13, 000 military personnel and civilians working at the 23 military bases and camps across Namibia with messages focusing on sexual prevention.

This mechanism has two comprehensive goals and objectives; 1) to decrease new HIV infections in the military through behavior change communication (BCC) using military and culture specific approaches with a focus on, abstinence and faithfulness, correct and consistent use of condoms; 2) key prevention strategies of this mechanisms include development and institutional capacity building of the military through the technical assistance and training of commanders, HIV/AIDS coordinators and peer educators, chaplains and gender focal persons at all the bases and camps through in-service training, mentoring and supervision to strengthen ownership, leadership, management and planning capacities and eventually to sustain the HIV/AIDS response in the Namibian military.

This mechanism is contributing to Namibian's five year National Strategic Framework (NSF) and the Partnership Framework Agreement (PFA) and addresses key policy and strategic issues related to sustainability and ownership of programs by Namibians, HIV/AIDS prevention, stigma and discrimination reduction, prevention of alcohol abuse, addressing gender based violence and negative male norms fueling the epidemic and increasing coordination between MOD/NDF, Ministry of Health and Social



services (MOHSS) and other stakeholders working in this field.

Factors such as separation from families, mobility and age particularly make the military vulnerable to HIV infections. Specifically, SMA continue to assist the MOD/NDF a) to reach all military personnel with prevention education and information that is primarily focused on abstinence and /or being faithful, addressing multiple concurrent partnering and gender based violence, b) to reach military personnel with interventions that are primarily focused on increasing condom use, creating demand for uptake of voluntary counseling and testing (VCT) and provider initiated testing and counseling (PITC), creating demand for male circumcision, providing information on sexually transmitted infections (STI) diagnosis and treatment, promoting the practice of positive gender and cultural norms, and to increase knowledge about HIV prevention amongst people living with HIV/AIDS (PLWHA).

In order to strengthen the capacity of the MOD/NDF to take overall ownership and manage its HIV/AIDS prevention program, SMA will continue to implement the following activities:

1. Advocacy to and training of the Base Commanders and Chaplains.
2. Training and provision of technical support to the Steering Committees at the military bases to enable them to provide oversight for the HIV program at the bases while also creating the needed enabling environment.
3. Training and technical support to the HIV/AIDS Unit Coordinators (HUC) who are the focal points for HIV/AIDS prevention activities at the bases and camps.
4. Refresher training of Peer Educators in coordination with the HUC in areas such as management information systems to be able to monitor and evaluate the effectiveness of their programs at the bases, how to refer HIV positive and others to counseling and testing services.
5. Producing and distributing condoms to all military bases and camps, including the clinics and sick bays, counseling and testing centers, barracks and canteens, and promoting consistent and correct condom use at all trainings with peer educators.

Main cross cutting issues include gender, alcohol, stigma and discrimination and human resources for health (in-services training).

Key contributions to cost efficiencies over time include the training of critical MOD/NDF personnel, such as Commanding Officers, HIV/AIDS Unit Coordinators, Chaplains, Steering Committees, Gender Focal points and peer educators to be able to implement and manage the program on their own with limited technical assistance from SMA. In addition, SMA would continue to implement its transitional plan in close collaboration with MOD/NDF.

The monitoring and evaluation plan includes PEPFAR indicators and is fully integrated into the overall



USDOD M&E plan for assistance to the MOD/NDF. In COP10, as the country moves to a national M&E plan with aligned indicators also with the Partnership Framework Agreement, SMA will modify the M&E plan accordingly.

This mechanism is implemented in close collaboration with MAPP and the International Training Centre on HIV (I-TECH), in order to ensure synergies in implementing a comprehensive HIV/AIDS prevention, care and treatment program for the Namibian military. SMA and I-TECH will work together to provide technical assistance to the military to ensure linkages between the prevention services and the care and treatment services in the military.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	56,000
Human Resources for Health	112,000

Key Issues

- Addressing male norms and behaviors
- Increasing gender equity in HIV/AIDS activities and services
- Military Population
- Workplace Programs

Budget Code Information

Mechanism ID: 10163			
Mechanism Name: Society for Family Health (SFH)			
Prime Partner Name: Namibian Social Marketing Association			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	262,150	
Narrative:			
THIS IS A CONTINUING BUDGET CODE NARRATIVE AND HAS BEEN MODIFIED AS FOLLOWS:			
This is an ongoing activity from COP09. The narrative has been substantially modified to reflect the new			



PEPFAR guidance and linkages to the Partnership Framework Agreement (PFA) and the Namibian National Strategic Framework (NSF). This program will continue to deliver prevention activities for the high risk military community in support of the Namibian Ministry of Defense/Namibian Defense Force (MOD/NDF) Military Action and Prevention Program (MAPP).

The overall objective of this budget code is to 1) decrease HIV infection in the military through behavior change communication. While some soldiers may be practicing abstinence and fidelity, separation from families, mobility and age make them vulnerable to HIV infection, messages will continue to strongly focus on abstinence before marriage/seasonal abstinence and faithfulness while away from one's partner. 2) The budget code will continue to reinforce prevention messages focusing on addressing abstinence and faithfulness or delaying sex amongst over 13,000 MOD/NDF members, in particular the youth. In order to ensure ownership, top leadership of the MOD/NDF will be consulted and involved in the planning, implementation monitoring and evaluation of the program.

Key prevention activities include:

- 1) Strengthen the capacity and advocating for leadership commitment of senior NDF personnel to support HIV/AIDS prevention activities through AB. Senior NDF personnel will be trained on addressing HIV/AIDS as a command function, and managing HIV/AIDS in the workplace.
- 2) Build capacity of HIV Unit Coordinators (HUC) and peer educators within the NDF community to take on more responsibility for direct implementation of prevention activities and to promote messages on seasonal abstinence and faithfulness.
- 3) Develop and disseminate military specific HIV/AIDS prevention and awareness raising education and information materials to all military bases and camps. In particular, material will focus on the negative impacts of multiple and concurrent sexual partnerships (MCP), counseling and testing, the dangers of alcohol abuse and gender based violence and HIV/AIDS.
- 4) Train and sensitize chaplains on how best to address issues of abstinence and faithfulness, suicide prevention, counseling and testing, partner reduction, alcohol and drug abuse, gender based violence, couple counseling and marriage counseling, stigma and discrimination and psycho-social support in the military. Chaplains will be encouraged to continue to sessions to promote the sexual rights of women, church sermons to promote the AB messages.
- 5) Support HUC to provide training to new military recruits, the majority who are youthful on HIV/AIDS prevention messages, in particular, focusing on delaying sex and being faithful.
- 6) Provide technical assistance to the Gender Desk in the MOD/NDF to implement the Namibia Strategic Plan on gender activities with the aim of scaling up interventions to change negative male norms and behaviors fuelling HIV/AIDS.
- 7) Train peer educators and HUC to use the popular military films Remember Eliphaz 1 and 2 produced during COP05 and COP06 and Remember Eliphaz 3 developed under COP09, to motivate soldiers to

change their behaviors, access counseling and testing, partner reduction and access care and treatment services in the military settings.

- 8) Conduct informal and focus group discussions on a quarterly basis with military personnel, in particular, unit commanders, HUCs and peer educators to assess the impact on behavior change, pre-test information, education and communication (IEC) materials and test new HIV prevention concepts.
- 9) Provide technical assistance to the MOD/NDF to hold quarterly meetings with the MAPP partners in order to ensure effective planning, coordination and implementation of the program.
- 10) Train HUC and peer educators to continue using the monitoring and evaluation tools (checklist) developed in FY08 to assess and monitor the impact of activities in the military.
- 11) Develop a tracking system to monitor referrals from prevention to other services.

SMA will continue to provide technical and supportive supervision services to the relevant MOD/NDF personnel in order to insure the provision of quality prevention messages as well as to adequately prepare military personnel to ultimately manage the program by themselves over time.

Key program indicators for COP10 will include:

- a) Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards.
- b) Number of individuals from target audience who participated in community-wide event
- c) Number of enterprises implementing an HIV/AIDS workplace program, providing at least one of the 4 critical components
- d) Estimated number of people reached through work place programs.

Optional indicators such as number of targeted condom service outlets, number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful and individuals trained in HIV-related institutional capacity building will also be tracked under this budget code.

This program will be implemented in close collaboration with the DOD PEPFAR funded care and treatment partner in order to ensure synergies and provide a comprehensive integrated prevention, care and treatment program for the Namibian military.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	300,000	

Narrative:

THIS IS A CONTINUING BUDGET CODE NARRATIVE AND HAS BEEN MODIFIED AS FOLLOWS:



This is an ongoing activity from COP09. The narrative has been substantially modified to reflect the new PEPFAR guidance and linkages to the Partnership Framework Agreement (PFA) and the Namibian National Strategic Framework (NSF). This program will continue to deliver prevention activities for the high risk military community in support of the Namibian Ministry of Defense/Namibian Defense Force (MOD/NDF) Military Action and Prevention Program (MAPP).

The overall goal of this budget code is to decrease new HIV infections in the military through increased coverage and quality of behavior change communication (BCC) messages with HIV prevention messages beyond abstinence and faithfulness to reach over 13,000 MOD/NDF members.

Key prevention strategies are 1) capacity building of Commanding officers, HIV/AIDS Coordinators, peer educators, gender focal points, chaplains and counselors, 2) peer education and interpersonal communication (IPC) sessions, 3) promotion of counseling and testing services as well as male circumcision, 4) production and dissemination of information, education and communication (IEC) materials focusing on HIV/AIDS prevention, consistent and correct condom use.

Key prevention activities include:

- 1) Enhance the capacities of the 92 peer educators through in-service training and technical assistance approaches to convey prevention messages to ensure the maximum involvement of all soldiers. New recruits will be trained to increase the pool of peer educators in the military.
- 2) Review the roles and responsibilities of peer educators and coordinators and the peer education curriculum developed in COP09 to improve program implementation.
- 3) Provide technical assistance to the 23 HIV/AIDS Unit Coordinators to take over the role of supervising the peer education program at the bases and camps.
- 4) Procure and disseminate approximately 1,000,000, military packaged condoms to all the 23 military service outlets which include the voluntary counseling and testing centers (VCT), military health facilities, canteens and barracks as well as to Namibian peacekeeping contingents.
- 5) Strengthen linkages with the DOD PEPFAR MAPP treatment partner, to assist MOD/NDF to establish support group of people living with HIV/AIDS at the bases where they are non-existent.
- 6) The popular military film Remember Eliphaz 1 and 2 produced under COP05 and COP06 and Remember Eliphaz 3 developed in COP09 will continue to be used to motivate soldiers to change their behavior and to promote counseling and testing and accessing care and treatment services in the military settings.
- 7) Develop military specific prevention information, education and communication materials on issues such as alcohol abuse, male circumcision, stigma reduction, gender, condoms and STIs. Such information will also be made available during national and international days such as World AIDS Day, TB Day, National Testing Day and Military Days.



- 8) Collaborate with the MOD/NDF HIV/AIDS Coordination Unit to procure DVD machines for the bases/camps where they do not exist, so that they can be used for watching HIV/AIDS prevention films.
- 9) Further training on gender and HIV/AIDS and male norms initiatives will be conducted for MOD/NDF personnel.
- 10) Strengthen linkages with the MC Task Force and partners to ensure that MC messages are integrated in BCC activities.
- 11) Support the MOD/NDF in participating on international events such as annual HIV Implementers meeting, regional military HIV/AIDS conference as well as seminar and workshops on specific HIV prevention topics.
- 12) To ensure sustainability of the MAPP program, assist MOD/NDF in building the capacity of established HIV/AIDS Steering Committees at all bases and MOD headquarters.
- 13) Top leadership of the MOD/NDF will be consulted and involved in planning, implementation and monitoring and evaluation of the program. Periodic partnership meetings will be conducted to review the progress of the program. These activities mentioned will enable MOD to take full ownership of the program.

SMA will continue to provide technical and supportive supervision services to the relevant MOD/NDF personnel in order to insure the provision of quality prevention messages as well as to adequately prepare military personnel to ultimately manage the program by themselves over time.

Key program indicators for COP10 will include:

- a) Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards.
- b) Number of individuals from target audience who participated in community-wide event
- c) Number of enterprises implementing an HIV/AIDS workplace program, providing at least one of the 4 critical components
- d) Estimated number of people reached through work place programs.

Optional indicators such as number of targeted condom service outlets, number of individuals trained to promote HIV/AIDS prevention programs through other behavior change beyond abstinence and/or being faithful and individuals trained in HIV-related institutional capacity building will also be tracked under this budget code.

This program will be implemented in close collaboration with the DOD PEPFAR funded care and treatment partner in order to ensure synergies and provide a comprehensive integrated prevention, care and treatment program for the Namibian military.



Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10164	Mechanism Name: University of Washington/International Training & Education Centre for Health (UW/I-TECH)
Funding Agency: U.S. Department of Defense	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Washington	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,785,000	
Funding Source	Funding Amount
GHCS (State)	1,785,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism is intended to develop and build the institutional capacity of the Ministry of Defense/Namibian Defense Force (MOD/NDF), through pre- and in-service training and mentoring, to strengthen ownership, leadership, management and planning capacities and ultimately to sustain the HIV/AIDS response in the Namibian military.

The overall goal of this mechanism is to support the strategic goals and objectives of the 5 year National Strategic Framework (NSF) and the Partnership Framework Agreement (PFA) by providing comprehensive HIV care and treatment services in MOD/NDF.

1. I-TECH has five comprehensive goals under this mechanism. I-TECH assists the MOD/NDF to build capacity to:

- a) Expand and strengthen military counseling and testing services and promote use of these services;
- b) Pilot and establish male circumcision (MC) services;
- c) Strengthen and expand HIV treatment, care and support (including tuberculosis (TB) services and laboratory support), prevention with positives, and promote use of these services;
- d) Build capacity and fortify infrastructure for strategic information; and



e) Strengthen health systems and enhancing human resources for health, through both in-service and pre-service capacity building and mentorship programs for military health personnel, improving the pharmacy and medicine logistics, ensuring quality laboratory services, addressing stigma and discrimination, fostering leadership and management, and supporting MOD policy initiatives.

2. I-TECH will contribute to the goals and benchmarks of the PFA and Partnership Framework Implementation Plan (PFIP) through a focus on building the MOD/NDF's capacity to create an enabling environment to effectively manage and deliver quality, accessible HIV care and treatment services.

COP10 activities support the USG objectives and commitments in the following focus areas: care support and treatment; prevention, and coordination and management. Specifically, I-TECH contributes by:

- a) Assisting the military to tailor MOHSS service delivery systems and tools to fit the specific needs of the military, with emphasis on the establishment of quality assurance (QA) systems. Maintaining focus on building MOD/NDF capacity, including trainings structured to ensure services remain uninterrupted during the military staff rotation process, the continuation of mentoring activities, and introduction of pre-service bursaries in the most critical health areas to address the shortage of human resources for health in the military. Reflecting Namibia's long term goal to integrate antiretroviral treatment (ART) services into primary health care (PHC) settings, activities include supporting the MOD to scale up a standardized, comprehensive package of HIV services that can be expanded as tasks are shifted to the nursing level.
- b) Providing technical assistance and equipment/supplies to support the military to pilot and scale-up MC services.
- c) Enhancing management and leadership skills at both the facility level and the national level so that the military can ultimately take over overall planning, budgeting, management and monitoring and evaluation of the entire health system.

3. The target population is approximately 15,000 MOD/NDF staff and civilian workers at the 23 military bases and camps spread throughout the country.

4. Key contributions to health systems strengthening include support to: roll out the MOD/NDF's first sectoral HIV policy, address HIV-related stigma and discrimination, and enhance management and leadership. In addition, I-TECH works to tailor MoHSS systems to military settings in order to ensure synergies between the national program and the military program and to ensure coordination between MOD/NDF and MOHSS; strengthen QA systems; enhance physical infrastructure; and procure equipment and provider imitated testing and counseling (PITC), and MC services. To date, assistance has enabled the MOD/NDF to launch its first treatment site and to establish the first military laboratory capable of processing HIV-related tests. Technical assistance will be provided to the military in order to strengthen linkages between community based and clinic based HIV care services.



5. Cross-cutting programs and key issues.

X-cutting: Human resources for health

Key issues: Military population (also a mobile population and workforce program)

Health Wrap around: TB and Prevention with Positives

Gender: Addressing male norms and behaviors, through Positive Health Dignity and Prevention (PHDP), VCT and MC counseling

6. Highlights of activities to become more cost efficient over time include: Integrating military HIV services into services regularly provided at each clinic and sick bay, will lower the cost of providing services.

Making provisions for MOD/NDF staff to participate in the MOHSS's existing training programs eliminate the need to update curricula and creates an economy of scale for the MOD.

7. The monitoring and evaluation plan includes PEPFAR indicators and is fully integrated into the overall USDOD M&E plan for assistance to the MOD/NDF. In COP10, as the country moves to a national M&E plan with aligned indicators, I-TECH will modify the M&E plan accordingly.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	100,000
Food and Nutrition: Policy, Tools, and Service Delivery	10,000
Gender: Reducing Violence and Coercion	5,000
Human Resources for Health	500,000

Key Issues

- Addressing male norms and behaviors
- Increasing gender equity in HIV/AIDS activities and services
- Military Population
- Mobile Population
- Workplace Programs

Budget Code Information



Mechanism ID:	10164		
Mechanism Name:	University of Washington/International Training & Education Centre for Health (UW/I-TECH)		
Prime Partner Name:	University of Washington		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	162,000	

Narrative:

THIS IS A CONTINUING BUDGET CODE NARRATIVE AND HAS BEEN MODIFIED AS FOLLOWS:

This continuing activity assists the Namibian Ministry of Defense/Namibian Defence Force (MOD/NDF) contribute to the National Strategic Framework (NSF) and Partnership Framework Agreement (PFA) to strengthen community home based care and palliative care for military personnel and civilian employees working on military bases.

The budget code activity has the following three main components that will assist the MOD/NDF to: (1) expand and enhance clinic-based palliative care service delivery systems (2) strengthen and expand coverage of military support groups for persons infected with and affected by HIV, and (3) reinforce home-based palliative care.

- a) To support the military to expand and enhance clinic-based palliative care service delivery systems, International training and Education Centre on HIV (I-TECH) will assist the military to develop a comprehensive package of HIV services based on national Ministry of Health and Social Services (MoHSS) and nursing board guidelines. Such HIV services could include: prevention counseling, STI screening/treatment, alcohol screening/referrals, male circumcision education/referrals, TB screening/treatment /referrals, PMTCT referrals, screening and Pre-ART treatment, prophylaxis and management of OIs, medicine adherence counseling, nutrition services, psychosocial support/referrals, screening/alleviation of HIV-related symptoms and pain, and HIV treatment and care follow-up and monitoring. In addition, positive health, dignity, and prevention (PHDP) will be rolled-out in the military in COP10.
- b) To support the MOD/NDF to enable four military health facilities to routinely offer this package of services, I-TECH will provide in-service training and mentoring healthcare workers in HIV comprehensive care and treatment service delivery, recording and reporting, and quality assurance.
- c) I-TECH will supply military sites with necessary equipment and starter stock of supplies while the MOD/NDF is preparing itself to take over the management of this budget code.

d) I-TECH will assist the MOD/NDF to strengthen existing support groups and assist the military to establish new groups. Selected military staff will be trained to assist support groups and link groups with psychosocial support. I-TECH will enable support groups to arrange for guest speakers, create an interchange of ideas among groups, as well as create a small fund for innovative support group projects. Military health care workers will be trained to educate support groups on topics such as improving medicine adherence, PHDP topics, and basic nutrition.

e) I-TECH will support military healthcare workers to provide home-based palliative care, psychosocial and spiritual support, and referrals for chronically and terminally ill military staff who require home support. Military healthcare workers, and chaplains, will continue to receive training and technical support in different aspects of home-based palliative care and PHDP, as well as receive the standardized home-based care kit, which is recommended by the MoHSS to enable healthcare workers to conduct effective and quality visits.

This activity contributes to the sustainability of military HIV care and support services through capacity building of military health care workers (HCWs) and establishment and strengthening of HIV care and support systems, with a focus on quality assurance systems. Support in training and quality assurance measures are included as USG sustainability commitments in the Partnership Framework Agreement.

For all HIV care and support indicator targets, it is anticipated that all military services will be offered to adults older than 18 years of age and an estimated 85% of military clients will be male. An estimated 450 eligible adults will be provided with a minimum of one care service and 450 HIV-positive adults will receive a minimum of one clinical service. Given that national guidelines may change to a higher CD4 threshold for eligibility for both ART and CPT, an estimated 200 HIV-positive persons will receive cotrimoxazole prophylaxis. An estimated 50 HIV-positive clinically malnourished clients will be in need of therapeutic or supplementary food. These 50 clients will also be reported as the number of eligible clients who received food and/or other nutrition services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	450,000	

Narrative:

THIS IS A CONTINUING BUDGET CODE NARRATIVE AND HAS BEEN MODIFIED AS FOLLOWS:

The goal of this continuing budget code is to strengthen the capacity of the Ministry of Defence/Namibian Defence Force (MOD/NDF) to provide high quality military HIV treatment services for military staff members and civilian employees working on military bases. This activity contributes to national objectives to increase ART coverage to 85% of adults by 2010, as well as to increase the percentage of ART clients

that are still alive after one year of treatment from to 90% by 2015.

The overall objective of this budget code is to contribute to the National Strategic Framework (NSF) and Partnership Framework Agreement (PFA) to enhance the quality of care by scaling up the pre-ART program. The four main components of this activity include assisting the MOD/NDF to: (1) expand and enhance HIV service delivery systems, including strengthen quality assurance, (2) build human capacity, and (3) increase use of military HIV treatment services.

(1) To expand and enhance HIV services, I-TECH will assist the MOD/NDF to introduce a standardized package of HIV services at four large military clinics. I-TECH will assist the MOD/NDF to establish a package of HIV services that includes screening and pre-ART treatment, adherence counseling, and treatment follow-up and monitoring. Should the task shifting process continue, and the initiation of ART be devolved to nurses, I-TECH will train military nurses to initiate ART. This potential task shifting will contribute in the long-term sustainability objective of integrating ART services into routine primary health care services.

I-TECH will assist the MOD/NDF to continue to tailor MoHSS systems, such as recording and reporting, to the specific needs and requirements of the military. Through building the capacity to record patient data and generate monthly and cohort reports, the military can more easily monitor quality of services, including rapid identification of clients who miss appointments. Additional support will be provided to military staff to monitor quality of care through case reviews.

(2) I-TECH will assist the MOD/NDF to build capacity of military health care workers (HCW) through in-service training and clinical mentoring, as well as through the participation of national and international meetings and conferences. I-TECH will train military personnel to provide ART services including, provision and management of ART, integrated management of adult and adolescent illnesses (IMAI), adherence counseling, and pharmaceutical management.

(3) To assist MOD/NDF to create demand for military HIV treatment services, I-TECH will assist the MOD/NDF to develop military behavior change initiatives, as well as to strengthen referral systems. Through the launch of the MOD/NDF's film, Remember Eliphaz 3, the military can advertise new HIV services at all bases as well as encourage crucial health seeking behaviors, such as seeking care earlier in the disease process. To complement the film, I-TECH will assist the military to develop a facilitator's guide to assist military staff to conduct small group discussions after film viewings. I-TECH will continue to support the military to enhance the capacity of military Counseling and Testing (CT) sites and health facilities to effectively refer HIV-positive clients to military sites offering HIV treatment services.



This activity strengthens quality assurance (QA) by assisting the MOD/NDF to adapt Ministry of Health and Social Services (MoHSS) quality standards, providing support for monitoring patient information that reflects quality of care, initiating case review meetings, presenting options to MOD/NDF for other methods of monitoring quality and models to improve quality.

The activity contributes to the sustainability of military HIV treatment services through capacity building of military staff, and strengthening service delivery systems, with a focus on quality assurance. Support for training, quality assurance measures, and the expedition of scale-up efforts are included as USG sustainability commitments under the Partnership Framework Agreement.

It is anticipated that only adults will access military services and approximately 85% of all clients will be male. 200 adults with advanced HIV infection are expected to newly enroll in ART in COP10. This number is higher than the previous year due to a possible change in national eligibility criteria for the initiation of ART that will shift additional clients from Pre-ART to ART in COP10. Anticipated task shifting of ART initiation to registered nurses would also allow additional military bases to offer services. An estimated 270 adults with advanced HIV infection are expected to be receiving ART at the end of the FY10. 80% of adults are expected to be alive and on treatment 12 months after initiation of antiretroviral therapy. No previous data is available as military ART services were recently launched. This estimate is based on the assumption that many clients still access services late in the disease process. At military facilities, a total of 300 adults with advanced HIV-infection are expected to have ever started ART.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	450,000	

Narrative:

THIS IS A CONTINUING BUDGET CODE NARRATIVE AND HAS BEEN MODIFIED AS FOLLOWS:

This continuing budget code supports the Ministry of Defense and the Namibia Defense Force (MOD/NDF) to strengthen and expand HIV counseling and testing services under the Military Action and Prevention Program (MAPP). Military counseling and testing (CT) services contribute to national objectives by making CT service more accessible to military personnel. In addition, military personnel are primarily male, a population which is currently underutilizing CT services in the country. Prioritizing CT activities and promoting sustainability of CT services is a fundamental strategy of the MOD, PEPFAR, and the Government of Namibia as reflected in the Partnership Framework Agreement (PFA) and the National Strategic Framework (NSF).

This continuing budget code has four primary components that will assist the MOD/NDF to: (1)



strengthen existing military CT services and the health systems that support them, (2) expand services to additional military bases, (3) build the capacity of military health care workers (HCWs), and (4) increase the uptake of CT services.

1) I-TECH will assist the MOD/NDF to enhance existing CT services through strengthening quality assurance (QA) and supportive supervision, referrals, management systems, and integration with additional services and quality assurance for both CT sites and outreach services. I-TECH will continue to assist the MOD/NDF to reinforce internal and external QA systems with a focus on counseling, rapid testing, and data functions. To ensure continuous quality improvement of HCT activities across the military network and to strengthen the institutional capacity of the MOD to manage their CT services.

Quarterly CT program review meetings will augment QA activities. QA for rapid testing will be supported by the MOD laboratory staff and their partnership with the Namibia Institute of Pathology (NIP). NIP will continue to certify MOD/NDF staff trained in HIV rapid testing, as well as to certify new sites.

2) I-TECH will also assist the MOD/NDF to establish quarterly CT program review meetings to analyze data and identify areas for improvement. Additional services will continue to be integrated into CT sites, such as TB screening and referrals, referrals for male circumcision, discussion of gender-based violence and male norms, positive health dignity and prevention (PHDP) for PLWHA, and alcohol use screening. Referral systems will be strengthened to ensure that clients testing positive are linked to other clinical, preventive, psychosocial and spiritual care, including PHDP clinical services.

3) Access to CT services will be extended to additional military bases, through the expansion of existing self-initiated counseling and testing, expansion of CT outreach services, and the launch of provider-initiated testing and counseling (PITC) services. Two additional CT sites will be established, military outreach CT services will be expanded to two additional bases and provider-initiated counseling and testing will be established at a minimum of six sites.

4) To build the capacity of military personnel to conduct counseling and testing services, additional military medics, counselors, and nurses will be trained to offer and promote services. CT site managers and their deputies will receive a specialized training to fortify the management of services. To encourage the further exchange of ideas, site managers will participate in supportive supervision visits to other military facilities.

5) To increase the uptake of CT services, I-TECH will assist the MOD/NDF to develop strategies to increase self-initiated visits through annual National Testing Day(s), special campaigns, and collaborate with the MAPP prevention partner to link CT with the military's peer education network.

An uninterrupted supply of rapid tests and medical consumables for military CT services is built upon the MOD/NDF's existing arrangements with the MOHSS's Central Medical Stores.

An estimated 4,000 individuals will receive CT services and receive their test results in FY10. The uptake

of CT services is expected to increase significantly in COP10 due to the anticipated introduction of PITC, roll-out of services to additional bases, and additional demand generation activities. In the past, approximately 80% of clients tested were male, thus it is expected that 3,200 males and 800 females will receive testing in FY10. All individuals tested are expected to be 15 years of age and older.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	128,000	

Narrative:

THIS IS A CONTINUING BUDGET CODE NARRATIVE AND HAS BEEN MODIFIED AS FOLLOWS:

The goal of this continuing budget code narrative is to build the capacity of the Ministry of Defense/Namibian Defense Force (MOD/NDF) in strategic information, including the ability to gather and analyze service delivery and survey data, utilize data to improve the quality of care, and to strategically plan in response to evolving needs, programmatic innovations, and new technologies. This activity supports the National Strategic Framework (NSF) and the Partnership Framework Implementation Plan (PFIP) for national scale-up and sustainability of services in Namibia.

This budget code has two main components that support the MOD/NDF to:

(1) Strengthen military capacity to monitor and evaluate HIV-related services and activities and use data for continuous quality improvement, and (2) conduct an HIV sero-prevalence and behavior survey.

i.a) To strengthen the MOD/NDF's capacity to monitor and evaluate HIV-related services and activities, I-TECH will continue to:

- Collaborate with the management and information (MIS) working group to guide the development of the MIS and identify military routine reporting requirements.
- Develop an MIS that links HIV clinic database to pharmacy and lab databases. Create monthly and cohort report formats.
- Update and customize the counseling and testing (CT) database to the specific needs of the military.
- Build military staff capacity to maintain equipment and networks in a sustainable way,
- Train military healthcare workers in basic computer skills and use the two databases,
- Procure equipment and internet services necessary to expand computer and internet connectivity.

i.b) To promote the use of data to continually improve the quality of HIV services, the MOD/NDF will be assisted to:

- Generate reports on quality of care indicators that assist military health facilities to identify areas to target for improvement, such as the success of referrals, the rate of client missed appointments for care and treatment, etc.



- Conduct quarterly referral and CT program reviews. During the first few reviews, participants will review data from other sites and make recommendations to improve data collection. These reviews will evolve into the use of data to improve the quality of care and planning.
- Assist the MOD to conduct Quarterly Care and Treatment Program Reviews with a proposed structure similar to the Referral and CT Reviews.
- Assist MOD/NDF to evaluate access to services among military staff and civilian employees working on military bases.

ii. a) Assist the MOD/NDF to conduct an HIV sero-prevalence and behavior survey by training MOD/NDF staff and providing rapid testing kits and other supplies. I-TECH will collaborate with the military to develop the survey methodology and protocol. Twenty-five MOD/NDF staff will be trained to coordinate and implement the survey. The MOD/NDF will be supported to collect and analyze data, and generate a survey report.

ii. b). Provide support to MOD/NDF to build the capacity in conducting HIV research and how to analyze and interpret data.

To foster sustainability, military healthcare workers will be enrolled in computer classes to build a foundation for further training in health management information systems and in monitoring and evaluation approaches. The activity will also build capacity of MOD/NDF information technology (IT) Specialists in systems management and hardware maintenance. In addition, the MIS working group will identify staff to work side-by-side with I-TECH staff to begin the transfer of IT support to the MOD/NDF's MAPP.

Optional indicator targets include: A minimum of thirty individuals trained in strategic information. This includes 25 military staff trained to implement the sero-prevalence survey and five military staff trained in the MIS. Additional staff to be trained in computer and network maintenance and monitoring and evaluation and research approaches will be identified by the MOD/NDF during COP10.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	140,000	

Narrative:

THIS IS A CONTINUING BUDGET CODE NARRATIVE AND HAS BEEN MODIFIED AS FOLLOWS:

This continuing budget code narrative will focus on assisting the Ministry of Defense/Namibian Defense Force (MOD/NDF) to strengthen systems and the enabling environment for implementation of the MOD/NDF's HIV Military Action and Prevention Program's (MAPP) prevention, care, and treatment

services. This budget code contributes to the National Strategic Framework (NSF) and the partnership Framework Implementation Agreement (PFA) by creating and sustaining an enabling policy and legal environment to scale-up prevention and treatment services, building on existing services and ensuring quality and equitable access to care and treatment. The activity also contributes to long term ownership and sustainability of the program by providing support in human capacity development via pre and in-service training, and enabling MOD/NDF to effectively implement the program.

This budget code is comprised of four main components, including supporting the MOD/NDF to: (1) launch the first military sectoral HIV policy, (2) reduce HIV-related stigma and discrimination, (3) build capacity of senior level military personnel through participation in study tours and/or regional and international meetings and trainings, and (4) build institutional capacity and strengthen staff management skills. Efforts will be made to improve the integration and linkages between facility-based and community-based services.

a) I-TECH will assist the MOD/NDF to launch their first sectoral HIV policy. Currently under parliamentary review, the draft policy is expected to be approved in COP10. Upon approval, I-TECH will support the MOD/NDF by translating the policy into three languages and printing 2,000 copies for dissemination to military commanders and HIV coordinators. Two workshops will be conducted for 46 commanders and their deputies to educate them on the content of the new policy and develop action plans to guide its implementation.

b) HIV-related stigma and discrimination remains a key barrier that limits access to military HIV services and hampers the well-being of people living with HIV/AIDS (PLWHA). To address this barrier, as well as to prepare commanders for the launch of the military sectoral HIV policy, I-TECH will continue to collaborate with local non-governmental organizations (NGO) to conduct HIV-related stigma and discrimination reduction trainings for 40 military commanders, unit HIV coordinators, gender focal points, chaplains, and staff involved in HIV care and support.

c) To build the capacity of senior military personnel and expose personnel to recent lessons learned in implementing HIV programs, I-TECH will facilitate the participation of military staff in study tours and/or regional and international meetings and trainings. ITECH will provide support to MOD/NDF to undertake study tours to southern Africa to strategically plan expansion of services, facilitate training in advanced M&E, or participation in the annual HIV Implementers meeting, etc.

d) To build institutional capacity and strengthen staff management skills, I-TECH will facilitate management training for MOD/NDF at the national and health care facility levels.

Indicators for this budget code include: Pre-service training in laboratory technology that will begin in COP10. Ten community health workers are expected to successfully complete a pre-service training program for lay counselors in COP10. One hundred health care workers are expected to successfully complete an in-service training program, in topics such as: palliative care, treatment, positive health, dignity and prevention/prevention with positives (PHDP/PWP), counseling and testing, prevention, male circumcision (MC), laboratory, strategic information, and systems strengthening. In-service training targets have also been established by program area.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	150,000	

Narrative:

THIS IS A NEW BUDGET CODE NARRATIVE ACTIVITY

The goal of this new budget code is to decrease new HIV infections in the Ministry of Defence/Namibian Defence Force (MOD/NDF) through the establishment and expansion of male circumcision (MC) services. The military is considered a high risk group and is predominately male, typically young, and highly mobile. Therefore, building the capacity of and providing technical assistance to the MOD/NDF to offer MC services is critical.

This budget code is in line with the new PEPFAR guidance and is responding to the strategies and principles of the Partnership Framework Agreement (PFA) and the Namibian National Strategic Framework (NSF) to offer medical male circumcision (MC) services, emphasizing that MC be offered as part of an expanded approach to reduce HIV infections in conjunction with other prevention programs, including HIV testing and counseling (TC), treatment for other sexually transmitted infections (STIs), promotion of safer-sex practices and condom distribution.

This budget code has two main components: (1) assist the MOD/NDF to participate in the national MC pilot by building human capacity and procuring equipment and supplies, and (2) support the MOD/NDF to consolidate lessons learned from the pilot and scale-up MC services. In COP09, PEPFAR worked closely with the Ministry of Health and Social services (MoHSS) and other donors in a national task force to develop an MC draft Policy that recognizes MC as an effective HIV prevention method alongside the ABC strategy. In the same year, I-TECH worked very closely with the MoHSS and the MOD/NDF to train and circumcise 50 MOD/NDF volunteers in an MC pilot.

a) IN COP10, the US DOD, through I-TECH, will support the MOD/NDF by assisting the MOD/NDF to: i) determine the feasibility of a second pilot site, ii) procure equipment and supplies for the military pilot

- site(s), iii) train a minimum of four additional nurses and counselors, iv) establish a system for supportive supervision and quality assurance, and v) incorporate MC education into all risk reduction counseling.
- b) Under the pilot, free and confidential MC services will be offered to MOD/NDF staff by military health care workers (HCWs) as part of a comprehensive HIV prevention program which also includes HIV testing and counseling with referrals, treatment for other STIs, counseling on risk-reduction and safer-sex practices, and condom distribution. Following the fundamentals of MC care for facility-based services, military MC services will include informed and voluntary decision making, medically safe clinical procedures and quality assurance.
- c) Support the MOD/NDF to consolidate lessons learned from the pilot and scale-up.
- d) MC services, specifically to assist the MOD/NDF to: i) develop a military strategy and operational plan for scaling up services, (including a multi-year plan for meeting potential pent-up demand and quality assurance measures), ii) evaluate MC services and demand creation activities, including the establishment of an health management information system (HMIS), and iii) prepare the health system for scale up (including equipment/supplies procurement and staff training for any new sites or mobile services outlined in the military scale-up strategy).

Support to MOD/NDF in quality assurance (QA) includes assisting the MOD/NDF to adopt or adapt MoHSS quality standards, presenting options to MOD/NDF for methods for monitoring quality and models to improve quality. I-TECH will assist MOD/NDF to tailor national pilot supportive supervision and QA tools to the military setting.

Activities contribute to the sustainability of military MC services through capacity building of military HCWs, procurement of equipment, and strengthening quality assurance systems. Support in training and quality assurance measures, as well as transitional funding to expedite scale up efforts are included as USG commitments in the Partnership Framework Agreement.

Personnel constraints limit targets for the number of males circumcised as part of the minimum package of MC for HIV prevention. It is estimated that six person days of physician time can be devoted to MC procedures each month for eight months. Assuming that five to six procedures could be completed each day, in COP10, the military could complete approximately 275 procedures among men above 15 years of age. Currently one military facility is committed to participate in the national MC pilot. A second facility will be assessed for suitability.

MC will be conducted on a voluntary basis on HIV-negative soldiers and services will be attentive to socio-cultural context, human rights and ethical principles, health services strengthening, training, gender implications, service delivery, and program evaluation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
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Treatment	HLAB	225,000	
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Narrative:

THIS IS A CONTINUING BUDGET CODE NARRATIVE AND HAS BEEN MODIFIED AS FOLLOWS:

The goal of this continuing budget code narrative is to assist the military to provide effective and quality laboratory testing services to support military HIV service delivery. The US Department of Defence, through the International Training and Education Centre on HIV (I-TECH), will continue to support the Ministry of Defense/Namibian Defense Force's (MOD/NDF) laboratory program.

The narrative has been modified to reflect the new PEPFAR guidance and linkages to the Partnership Framework Agreement (PFA) and the Namibian National Strategic Framework (NSF).

The military's recently launched laboratory facility is the military's first facility that caters for HIV screening, CD4 and other basic laboratory bio-clinical monitoring tests necessary for the diagnosis of HIV infection, evaluation of patients before initiation of ART, and for the monitoring of patients on ART. This budget code activity will continue to strengthen the laboratory services in the MOD/NDF.

The activity has five components, namely to assist the MOD/NDF to:

(1) Ensure appropriate use and maintenance of equipment, (2) finalize draft Standards Operation Procedures, (3) build human resource capacity of military laboratory staff through mentoring and in-service and pre-service training, (4) facilitate accreditation of the laboratory, and (5) establish and strengthen a laboratory network.

(1) I-TECH will assist the MOD/NDF to ensure appropriate use and maintenance of the equipment, establish an effective and sustainable equipment maintenance process in order to ensure uninterrupted services, including arranging for continuing maintenance contracts for the new CD4, hematology, and chemistry analyzers and additional laboratory equipment will be procured as necessary.

(2) In COP10, I-TECH will assist the MOD/NDF to review and finalize draft laboratory Standard Operating Procedures (SOP).

(3) To build the human resource capacity of military staff necessary to ensure provision of quality and sustainable laboratory support services, I-TECH will provide mentoring, and pre-service and in-service training. I-TECH will continue to provide routine mentoring for military laboratory technologists and laboratory assistants. In anticipation of expanding and sustaining laboratory services, I-TECH will collaborate with the MOD/NDF to facilitate the enrollment of military staff in the Polytechnic of Namibia's pre-service degree program for laboratory technologists. To further enhance skills, local and international in-service training will be provided through linkages with the Namibia Institute of Pathology (NIP) and



Centre for Disease Control (CDC's) International Laboratory Branch Consortium partners.

(4) I-TECH will continue to assist the MOD/NDF to take steps toward achieving laboratory accreditation through the South African National Accreditation System, SANAS. A key step toward accreditation is assisting the military to ensure high quality laboratory services through strengthening internal quality assurance and continued enrollment in an External Quality Assurance (EQA) program that meets the requirements of the SANAS and the International Medical Laboratory Accreditation Community.

(5) I-TECH will provide technical assistance to the MOD/NDF to establish and strengthen a laboratory network. The laboratory currently provides services to the adjacent military hospital and has the potential to provide testing to HIV service delivery sites at nearby military bases should the military decide to pursue this option. Quality assurance and technical support for the laboratory network will focus on pre-analytical (client preparation, specimen collection, storage, specimen referral system) and post-analytical (results reporting, archiving, specimen storage and disposal) processes.

As mentioned above, quality assurance support for the laboratory network will focus on pre-analytical and post-analytical, as well as external quality assurance.

In keeping with the MOD/NDF's focus on sustainability, the military has assumed responsibility for the majority of recurrent costs, such as personnel costs, facility maintenance, and procurement of supplies, test kits, and reagents. To further contribute to the sustainability of military laboratory services, I-TECH is assisting the military to establish and strengthen internal and external quality assurance systems, build the capacity of military laboratory staff through in-service and pre-service training, and enhance the close collaboration between the MOD/NDF and the Namibia Institute of Pathology (NIP).

Close collaboration with NIP is also a key component of the MOD/NDF's sustainability strategy for continued laboratory training, procurement of supplies, and other technical assistance. The NIP will provide continued in-service training and technical support to the MOD/NDF laboratory staff and management. Additionally, the NIP will act as a referral laboratory for tests and services not available at the MOD/NDF laboratory. Pre-service training to prepare additional military staff to become laboratory technologists is crucial to the sustainability of the MOD/NDF's program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	80,000	

Narrative:

THIS IS A NEW BUDGET CODE NARRATIVE

The goal of this new budget code narrative is to decrease HIV/TB co-infections in the Ministry of

Defence/Namibian Defence Force (MOD/NDF). It is expanding on previous capacity building for the Namibian military in opportunistic infections, palliative care, and integrated management of adult illness (IMAI). This activity is a priority because military staff are at high risk for HIV and many military staff reside in congregate living settings that facilitate TB transmission.

The budget code has three main components that will assist the MOD/NDF to: (1) build capacity in service delivery, monitoring, and evaluation; (2) establish referral systems; and (3) strengthen infection prevention.

The key activities of this budget code narrative include:

- 1) Assisting the military to scale-up the current TB services for HIV-infected clients, I-TECH will provide technical assistance to the MOD/NDF to conduct a situational analysis of TB prophylaxis and TB/HIV treatment in the military. To build capacity in service delivery, I-TECH will continue to train military nurses and doctors to offer TB treatment and prophylaxis to HIV-infected clients. Nurses and medics will be trained in adherence counseling to promote completion of drug regimens. In addition, the MOD/NDF will be assisted to establish a recording and reporting system for Isoniazid Preventive Treatment (IPT). I-TECH will continue to support the MOD/NDF to reinforce linkages with the National TB Control Programme for the reporting of TB cases.
- 2) I-TECH will assist the military to build a strong referral network for cases with drug resistance beyond the military's capacity to treat, or sputum negative TB suspects at facilities not staffed by a physician. Military sick bays on each base can also assist MoHSS to promote adherence and trace defaulters.
- 3) To strengthen infection control, I-TECH will assist the MOD/NDF to conduct a situational analysis and to enhance prevention policies, policy implementation, and infrastructure in line with Namibian MOHSS TB infection control policies.

Supportive supervision and quality assurance (QA) activities will ensure linkages with the National TB Control Programme and strengthen MOD/NDF systems. Through linkages to the national programme, the MOD/NDF will participate in quarterly regional monitoring and evaluation reviews of TB services. In addition, I-TECH will assist the MOD/NDF to establish systems for internal and external quality assurance, including quarterly palliative care meetings and annual supportive supervision visits. To complement these systems, I-TECH clinical and/or nursing mentors will assist military staff through regularly scheduled on-site mentoring and support that includes support for TB prophylaxis services, screening for and treatment of TB disease in HIV-infected clients, and referral follow-up. Through this capacity building effort, I-TECH will also ensure that MOD/NDF take full ownership of managing the TB/HIV program.



The budget code contributes to sustainable MOD/NDF services through enhancing the capacity of military health systems and strengthening QA. From the outset, MOD/NDF assumed responsibility for the majority of recurrent costs, such as all personnel costs, the operation of military health facilities, anti-TB medicines and key supplies. COP10 activities will assist the MOD/NDF to further build capacity, strengthen infrastructure for infection prevention, and enhance QA. Additionally, linkages to the National TB Control Programme and local hospitals provide a continuous link to up-to-date TB information and guidelines, QA for TB cases, and referral points for TB cases that cannot be treated within military facilities.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10181	Mechanism Name:
Funding Agency: U.S. Peace Corps	Procurement Type: Cooperative Agreement
Prime Partner Name: U.S. Peace Corps	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 50,000	
Funding Source	Funding Amount
GHCS (State)	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a continuing activity. The Government of Namibia (GRN), in collaboration with its development partners, has mounted an aggressive campaign to reduce further spread of HIV and ensure that those who are infected have access to treatment and care services. In FY10, Peace Corps/Namibia (PC/N) will continue PEPFAR-funded prevention and care activities begun in previous years and strive to improve the quality of its programs.

PC/N has 103 Volunteers in country of which 43 are dedicated to the health sector and 60 to the education sector. All health sector Volunteers contribute directly to HIV/AIDS related activities, while



education Volunteers incorporate HIV/AIDS activities into classroom teaching and after-school activities.

The goal of PC/N's Community Health and HIV/AIDS Project (CHHAP) is "to promote healthy living among Namibians, especially those living in underserved communities and affected and infected by HIV & AIDS and related public health diseases." The goals of the education project are to keep Peace Corps' goals and objectives in line with the epidemic and host country concerns, and support USG efforts to address key drivers of the epidemic in Namibia. They align with Namibia's Draft National Strategic Framework (NSF) for HIV/AIDS (2010-2015) as well as the PEPFAR Partnership Framework. According to the Draft document (4 September 2009), the NSF, once approved, will provide policy guidance and leadership on the planning and implementation of the national multi-sectoral HIV/AIDS programs in Namibia. As an active member of the USG country team, PC/N works to complement efforts of the Namibian Government in implementing comprehensive HIV/AIDS prevention and care programs through both health and education sectors.

Volunteers in the CHHAP and Education projects address some of the key drivers of the epidemic in Namibia such as multiple concurrent partnerships, transactional sex and trans generational sex, alcohol abuse, low and inconsistent condom use, as well as gender issues (inequalities and violence) and poverty. PC/N addresses the need for capacity building of local counterparts through training and skills transfer.

In collaboration with national, regional and local government agencies to strengthen the capacity of HAMU, RACE committees, RACOCs and CACOCs, Volunteers and their counterparts in all 13 regions will work to:

- establish or strengthen in-and out of school youth clubs, focusing on AB, particularly delaying sexual debut;
- delivering AB prevention messages through classroom instruction, computer literacy, drama and video shows;
- increase knowledge of communities in developing HIV/AIDS prevention strategies that will lead to behavioral change and referral;
- train community members using EngenderHealth's curriculum on male engagement;
- reach community members and youth through interactive video facilitation such as "Three and a Half Lives of Philip Wetu";
- reach community members with awareness messages on the interface of substance abuse and HIV;
- expand the use of the Health Education Response (HER) services to refer people to services including HIV Counseling and Testing (HCT);
- increase livelihood skills of those infected and affected to mitigate the impact of HIV/AIDS by training



- community members in microgardening in collaboration with relevant government ministries;
- train in developing IGA projects to improve income at the household level;
 - provide basic information on proper nutrition and hygiene to enhance their general health;
 - support OVC programs of government ministries and local CBOs/FBOs with life skills training through the Girls Conference and Camp GLOW; and
 - assist OVCs to access basic psycho-social support services.

PC/N trains and deploys Volunteer Leaders around the country to decentralize training, enabling a rapid scale-up and broader reach than could otherwise have been achieved. Whenever possible, PC/N seeks to collaborate with other organizations and agencies to scale up, share PCV skills and assets, and extend our reach through partnerships.

PC/N uses a standardized Volunteer Reporting Form to monitor all major activities. Volunteers review post's M&E plan during pre-service training to clarify their roles and responsibilities in project monitoring. They receive training techniques to gather and update baseline information, and practice designing, administering, and analyzing results from surveys and pre- and post-tests.

In addition to random and scheduled telephonic contact, Peace Corps staff conduct site visits to Volunteers' sites to make first-hand observations, review documents and conduct informal interviews with Volunteers, their counterparts and others in the school and community. Post will also organize a mid-year review meeting to assess progress and make adjustments where necessary.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Addressing male norms and behaviors

Budget Code Information

Mechanism ID:	10181
Mechanism Name:	
Prime Partner Name:	U.S. Peace Corps



Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	10,000	

Narrative:

This is a continuing activity from FY 09. This activity focuses on promoting food security and income generating activities (IGA) among people living with HIV/AIDS and vulnerable households in all 13 regions of the country and support the draft PEPFAR Partnership Framework, which highlights food and nutrition as a key focus area under impact mitigation.

To address this issue, PC/N will collaborate with Ministry of Agriculture, Water and Forestry (MAWF), other stakeholders and community groups (including PLWHA) to promote and initiate sustainable community gardening projects. HIV affected individuals and families and home based care givers will be trained on how to set up and sustain microgardens to meet basic nutritional and income generating needs.

The current unemployment rate in Namibia is estimated to be greater than 37%. Volunteers will work with local partners and HIV-affected communities to promote and initiate IGAs and develop the capacity of PLWA and their families to implement them. Specifically, Volunteers:

- Help individuals and groups within their communities to assess the viability of new IGAs.
- Support individuals or groups in their communities to start IGAs and identify markets for their products.
- Train members in business management for sustainability.

In addition to providing PEPFAR-funded training to Health and Education Volunteers and their counterparts, PC/N requests funds for three (3) 2-year Volunteers to be placed specifically with relevant host country agencies providing care and support to PLWA. PC/N also makes PEPFAR funds available for small grants to support community-initiated care and support activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	10,000	

Narrative:

This is a continuing activity from FY 09. Volunteers and their counterparts work to improve OVC referral systems and data management at the community level, strengthen family/household ability to improve their general health, and address the psycho-social needs of OVCs and their caregivers. In addition, Volunteers working with service oriented organizations implement measures to ensure quality service delivery. Volunteers target male and female OVCs age 0-18 years old in all 13 regions.



Health and education Volunteers work closely with local Ministry of Health and Social Services, Primary Health Care, (MoHSS PHC) teams to improve the health of OVCs and their caregivers through safer hygiene practices. In partnership with local counterparts, Volunteers help OVCs and their families initiate income generating activities (IGAs) and microgardening to improve food security and basic nutrition for OVCs. Gardens are community school-based. For school gardening projects, the produce is used to provide a nutritious meal through existing soup kitchens to target groups. It is also expected that OVCs will learn gardening skills and replicate them at the household level.

Volunteers, especially those assigned to FBO/NGOs working directly with OVCs, promote the development of life skills during after school programs or youth clubs. In addition, Volunteers refer OVCs to local organizations that provide food supplement/soup kitchens, counseling, educational support and health related services. Volunteers working with organizations that provide soup kitchens such as Catholic AIDS Action (CAA) will be expected to address long term sustainability by initiating microgardening and IGAs.

In addition to providing PEPFAR-funded training to Health and Education Volunteers and their counterparts, PC/N requests PEPFAR funds for three (3) 2-year Volunteers to be placed specifically with relevant host country agencies providing care and support to OVC. PC/N also makes PEPFAR funds available for small grants to support community-initiated activities that benefit OVC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	10,000	

Narrative:

This is a continuing activity from FY 09. This activity targets in-and out of school youth in three main areas: (1) AB prevention messages including delaying sexual debut; (2) life skills development; and (3) substance abuse prevention. Peace Corps Volunteers working in the Health and Education sectors and their counterparts receive pre- and in-service training in these areas with an emphasis using behavior change communication strategies. Education Volunteers target primarily 10-14 year olds through school-based activities in line with the HIV/AIDS policy of the Ministry of Education. Health Volunteers target secondary school youth (age 15+) and out of school youth in the communities in which they are assigned.

Volunteers partner with government ministries and civil society to reach in-and out of school youth in class room settings, community outreach, and by establishing youth clubs. Life skills development activities focus on training in-school youth on positive decision making through camps, girls conferences, youth clubs, drama groups, community cinema, and sports. For out-of-school youth, additional training in



income generating activities and gardening is provided as alternatives to engaging in risky behaviors. In collaboration with the MOHSS and MYNSSC, Volunteers and their counterparts address alcohol and drug use among young people using existing programs and providing alternative activities in their communities.,

Health and Education Volunteers in all 13 regions carry out these activities. In addition, Peace Corps/Namibia (PC/N) requests PEPFAR funds to support the costs of placing five (5) 2-year Volunteers with relevant host country agencies implementing AB prevention activities.

Volunteers and their counterparts can apply for small PEPFAR-funded grants through Peace Corps to support community-based AB initiatives.

PC/N collaborates with existing programs such as UNICEF's "My Future My Choice", "Window of Hope", "Stepping Stone" (by Catholic AIDS Action) and "Journey of Life" by the Church Alliance for Orphans (CAFO), among others.

Volunteers submit periodic reports on their activities. In addition, PC/N staff conduct site visits to monitor the work of Volunteers and their counterparts.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	20,000	

Narrative:

This is a continuing activity from FY 09. There are four main components: (1) behavior change communication (2) gender mainstreaming (3) alcohol awareness raising and (4) referrals, which address key drivers of the epidemic and use specific interventions developed locally to address Namibia's epidemic. The purpose for selecting the above activities is to ensure that Peace Corps Namibia continue to contribute greatly towards the preventions of new HIV infections amongst young people (age 15-24) and adults (age 25+) through appropriate behavior change interventions. HVOP activities will be conducted mainly in the communities as well in the secondary schools.

Volunteers and their counterparts target older youth and adults with activities that address behavior change related to multiple concurrent partnerships, alcohol abuse, low and inconsistent condom use, and transactional and trans-generational sex. Volunteers raise awareness on these drivers using various tools including the recently launched interactive film "Three and a Half Lives of Philip Wetu". Both health and education Volunteers will work with host country counterparts to promote safer sex practices and positive decision making. In addressing the underlying impact of poverty, Volunteers will support local



communities and counterparts to initiate sustainable IGAs and microgardening.

At a Namibian conference held in February 2008 entitled "Namibian Men and HIV/AIDS, Our Time to Act", a call was made to actively engage men in HIV prevention, care and treatment. In contributing to this call, PC/N train Volunteers and counterparts in the use of the EngenderHealth Men as Partners curriculum, which they use with men's groups in their communities.

The misuse of alcohol has a widespread negative impact on public health in Namibia. In 2004, the MOHSS launched the Coalition on Responsible Drinking (CORD) with the mandate to ensure increased awareness on the effects of alcohol. In contributing to the CORD initiative, PC/N will emphasize the interface between Alcohol and HIV infections in communities in collaboration with other local organizations. Specific activities include: working through peer educators and other community forums to raise awareness on risk reduction information related to alcohol and sexual risk behaviors, teach proper and consistent condom use, provide condoms to bar patrons, and refer target groups to a range of services within the prevention, care and treatment continuum, including STI services.

Volunteers will work with host country counterparts to expand the use of the Health Education Response (HER) system developed by a PC/N Volunteer. This text message-based application allows users to ask HIV and health related questions via their cell phone.

All health and education Volunteers will receive training to conduct the activities described above. In addition, PC/N requests funds for six (6) 2-year Volunteers to be placed with relevant host country agencies. PC/N supports small community initiated OP-related activities through PEPFAR-funded VAST (Volunteer Activity Support and Training) grants.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10379	Mechanism Name: FANTA Follow On TBD
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Academy for Educational Development	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No



Total Funding: 476,696	
Funding Source	Funding Amount
GHCS (State)	476,696

Sub Partner Name(s)

(No data provided.)

Overview Narrative

FANTA-2 is a continuing implementing mechanism from FY09.

1. Goals and objectives: FANTA-2 works to improve nutrition and food security policies, strategies and programs through technical assistance (TA) to the USG and its partners including host countries, international organizations, and non-governmental (NGO) partners. The objectives of the program in Namibia are: 1) to provide TA to consolidate and scale up of integrated food and nutrition programs for eligible PLHIV and OVC; and 2) to improve nutrition and food security programs as well as livelihood support through TA to host country government entities and NGO partners.

Since COP07, FANTA-2 has designed PEPFAR-funded nutrition support for malnourished PLHIV and provided TA to strengthen the capacity of health care workers (HCW) in nutrition assessment, education, and counseling (NAEC) and support in HIV care and treatment sites. Activities link with USAID/Namibia's aims to strengthen the effectiveness of services and improve malnourished ART client outcomes through targeted, time-limited nutrition support; these activities also support UNICEF's work with the national integrated management of acute malnutrition program and the World Food Program's efforts to improve food security of PLHIV.

2. Link to Partnership Framework (PF) goals and benchmarks: FANTA-2 will continue to work with the Ministry of Health and Social Services (MOHSS) and PEPFAR implementing partners to improve client outcomes by strengthening NAEC, therapeutic and supplementary feeding of eligible adult and pediatric ART clients, PMTCT clients, and OVC. The food by prescription (FBP) approach initiated with FANTA-2 TA in COP09 and provision of TA to host government agencies and local NGOs to improve nutrition and food security policies and programs is in line with the National Strategic Framework (NSF), PF and Namibian National guidelines.

FANTA-2 TA aims to contribute to the following PF goals and objectives:

- Pediatric and adult treatment care and support: FANTA-2 will improve ART adherence and treatment outcomes by supporting training and TA for the MOHSS to provide quality NAEC.



- Prevention: FANTA-2 will strengthen NAEC in PMTCT sites and improve clinic-community linkages.
- Impact mitigation: FANTA-2 will enhance nutrition for vulnerable households by working with the MOHSS and possibly Ministry of Agriculture, Water and Forestry to integrate food and nutrition into HIV programs and services.

3. Coverage and target populations: FANTA-2 activities will cover the national level (capacity building of the MOHSS to guide and monitor nutrition support and food security interventions for eligible clients) and regional clinic- and community-based care services supported by PEPFAR. Target populations include clinically malnourished adult PLWHA, HIV-positive pregnant and lactating women regardless of nutritional status, and OVC, including pediatric ART clients.

4. Contributions to health systems strengthening: Training of HCW in NAEC.

5. Cross-cutting programs: FANTA-2's activities in COP10 will support two cross-cutting PEPFAR programs under Food and Nutrition: Policy, Tools, and Service Delivery; and Human Resources for Health.

FANTA-2 will support consolidation of services in pilot FBP sites with a possible expansion to other sites if Global Fund resources become available. FANTA-2 will continue to work with the MOHSS to promote NAEC as a standard of care in HIV and OVC services; support training and reprinting of job aids and counseling cards; and visit sites to assure the quality of NAEC and follow-up. FANTA-2 will assist the MOHSS in strengthening systems for follow-up, mentoring, and supervision of trained service providers and document lessons from the FBP sites and/or specific components to inform further programming. FANTA-2 will work with relevant entities to address food security and livelihoods.

6. Cost-efficiency strategy: FANTA-2 will contribute to the sustainability of nutrition interventions in HIV services by continuing to build the capacity of HCW in NAEC and provision of specialized food products to treat malnutrition. Trained trainers and instructors will be available to train others on an ongoing basis. National nutrition and HIV guidelines and counseling materials will be available for reproduction or reprinting by other partners as needed. Supporting expansion of nutrition and HIV services will make these services more cost-efficient because of economies of scale. Integrating nutrition interventions into existing care and treatment services will be cost efficient because new services are not needed and existing services will improve outcomes. Support for local production of specialized food products may lead to greater cost efficiency.

7. M&E plans: FANTA-2 will work with HIVQUAL, a quality improvement program, and the USG to adapt the HIVQUAL facility self-assessment tools, which focus on food security, to assess NAEC quality in FBP



sites. A full M&E plan will be developed along with plans to ensure data quality of program results. FANTA-2 will also support MOHSS staff to conduct regular site visits for supportive supervision, a crucial element in data quality assurance.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	95,500
Human Resources for Health	190,500

Key Issues

Increasing women's access to income and productive resources
 Child Survival Activities

Budget Code Information

Mechanism ID: 10379			
Mechanism Name: FANTA Follow On TBD			
Prime Partner Name: Academy for Educational Development			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	434,079	

Narrative:

This is a continuing activity from FY 2009 with an expanded focus to improve food and nutrition security for PLHIV and vulnerable households. This activity has five main components: 1) scaling up the integration of nutrition assessment, education and counseling (NAEC) to additional ART sites; 2) establishing a mentoring and supervisory system for health care workers (HCW) who have been trained in nutrition and HIV at ART and PMTCT sites; 3) expanding linkages between clinic and community nutrition, food security, and livelihood interventions; 4) reviewing lessons from FBP implementation sites to improve understanding of the effectiveness of the approach in Namibia; and 5) supporting food security and livelihood interventions.

Since FY 08, FANTA has worked with the MOHSS Food and Nutrition Sub-Division to assess the food

and nutrition needs of PLHIV in Namibia; produce nutrition and HIV assessment and counseling job aids and IEC materials; develop two-day skills-based NAEC training module; and develop operational guidelines for food supplementation for PLHIV. FANTA-2 also supported the MOHSS in initiating the implementation of a FBP program integrated into HIV service provision. In FY09, FANTA-2 assisted the MOHSS and International Training and Education Center on HIV/AIDS (I-TECH) to enhance the NAEC and FBP content of the national training manual on nutrition and HIV, and train regional health managers and HCW in pilot FBP sites as well as community home-based care providers using this training material.

1. In COP10, FANTA-2 will support the MOHSS in scaling up the integration of NAEC into standard patient care to cover all 34 district ART sites, at least ten satellite ART clinics and 41 PMTCT sites. Provision of specialized food products for eligible clients will be scaled-up based on lessons from the pilot. Support will include assisting the MOHSS in updating and reprinting nutrition and HIV job aids and counseling materials.

2. FANTA-2 will continue to assist the MOHSS in building the capacity of clinic- and community-based HCW to provide NAEC and therapeutic and supplementary foods for malnourished ART, PMTCT and HBC clients. To support these efforts, FANTA-2 will support the MOHSS in training 12 regional health managers (two in each of six regions) and 100 ART site HCW in the national nutrition and HIV course (in regions not covered during the initial roll-out of the FBP program). The trained regional health managers will then train service providers at the FBP sites.

FANTA-2 will work with the MOHSS and I-TECH/Namibia to establish and implement an effective mentoring and supervisory system for HCW in ART and PMTCT sites who have been trained in nutrition and HIV. This support will help assure the quality of nutrition counseling and assessment and improve client coverage and follow-up as well as reporting.

3. The challenge in COP10 will be to consolidate and scale up these gains and ensure the quality and sustainability of NAEC, provision of specialized food products to treat acute malnutrition, and links to nutrition and livelihood support services for PLHIV who graduate from the FBP program.

4. As the FBP program expands in COP10, FANTA-2 will work with the MOHSS and partners to review initial results and lessons from implementation sites to improve understanding of its effectiveness. The review will cover processes, efficiencies, participant perceptions, acceptability of food products, challenges and initial outcomes. Findings of the review will be disseminated to stakeholders through a one-day workshop and used to inform further integration of nutrition into HIV services in Namibia.

5. Building on efforts in COP09 to support linkages between clinic and community nutrition services and



other food security and livelihood efforts in collaboration with Pact, FANTA-2 will provide TA to 20 additional health facilities to link PLHIV with opportunities to mitigate food insecurity. Such opportunities may include World Food Program (WFP) food assistance to improve food security of PLWHA families and caregivers. FANTA will support national strategies to increase food security and nutrition for vulnerable households and work in collaboration with Pact to build the capacity of NGOs, communities and PLHIV support groups' caregivers for improved practices for nutrition, food security and livelihoods.

The activities described above will contribute to the sustainability of FBP services in Namibia by strengthening the capacity of the MOHSS to coordinate and monitor FBP services, building and maintaining the capacity of nutrition and HIV trainers to train and supervise health care providers in ART sites, and strengthening quality assurance of FBP services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	42,617	

Narrative:

None

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10381	Mechanism Name: Health Systems 20/20
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Abt Associates	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 971,839

Funding Source	Funding Amount
GHCS (State)	971,839

Sub Partner Name(s)

(No data provided.)



Overview Narrative

Health Systems 20/20 is a continuing Implementing Mechanism.

The Health Systems 20/20 project (HS 20/20) is a Leader with Associates Cooperative Agreement awarded by USAID's Global Health Bureau to Abt Associates and its partners. The goal of HS 20/20 is to increase the use of priority population, health, and nutrition (PHN) services, especially by the disadvantaged. Towards this goal, it implements activities to improve health system performance in four key areas (1) health financing, (2) governance, (3) operations, and (4) local capacity. The project team brings together an exceptional pool of professionals with depth and experience in capacity building, governance, finance and operations.

Health system strengthening related to HIV/AIDS is a key element of the Partnership Framework. HS20/20 is committed to country ownership and the development of local capacity to ensure sustainability of activities initiated under the agreement. Furthermore, HS20/20 will continue its ongoing efforts in Namibia to strengthen human resources for health (HRH) planning, governance, and financial management of HIV/AIDS related activities, three important components of the Partnership Framework.

HS 20/20 will work at the national level with government officials and civil society stakeholders. The key ministry partners will include the Ministry of Health and Social Services, the Ministry of Finance and the proposed new National HIV/AIDS Council. By supporting the GRN in its development of a national costed HRH plan, HS20/20 will also target the cross-cutting issue of HRH strengthening.

The HS 20/20 vision for both strengthening health systems and making them more efficient over time relies on the project's success in its core intervention areas, which include strengthening of financial systems, operations, and governance and building capacity. The project's results framework calls for improvements in these areas.

HS 20/20's work aligns with PEPFAR's cost-efficiency principles by strengthening GRN leadership. Through this approach, HS 20/20 is able to save resources needed to lead, implement, and champion each activity. Instead, the GRN will lead each activity and this allows for HS 20/20 funds to be maximized across a number of activities through the provision of strategic technical assistance provided at key phases—initiation and design, data analysis and interpretation, and in some cases report writing.

At its onset, HS 20/20 drafted a set of program indicators to benchmark its performance. HS 20/20 will apply them to each of the activities proposed for Namibia in order to both monitor and evaluate performance and create opportunities for learning. In addition, HS 20/20 will partner with the MOHSS to collect information on the COP10 core indicator activities and report on targets that have been met. The



data quality for program monitoring will be ensured through data validation exercises undertaken in conjunction with implementing partners in the MOHSS and the Monitoring and Evaluation Officer at USAID. HS20/20 will also strengthen data feedback loops and dissemination mechanisms by working with our implementing partners in the MOHSS to widely share health finance information, final resource allocation criteria, and results from HRH situation assessments, planning workshops, and gap estimations. These dissemination efforts will involve district, regional and national level health system administrators and managers.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000
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Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: 10381			
Mechanism Name: Health Systems 20/20			
Prime Partner Name: Abt Associates			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	971,839	

Narrative:

This continued activity has two components: 1) Health Financing and 2) Human Resources for Health (HRH).

1) Health Financing: Technical assistance to the GRN to strengthen its tracking and policy use of health expenditure data, develop equitable resource allocation processes, and develop a national HIV resource mobilization and sustainability plan.

Namibia completed three rounds of National Health Assessments (NHA), most recently in FY09 for 2007. It is ideally placed to institutionalize NHA, the goals of which are to strengthen and streamline routine NHA production and increase stakeholders' use of NHA data. This includes actions such as integrating

NHA data sources into routine health information systems; building routine in-country capacity for data collection, analysis, and reporting; and designing and implementing tools that simplify the NHA production process. On the demand-side, needed actions are in disseminating NHA results to a wider array of stakeholders and building their capacity to use NHA to guide policy and planning.

In addition, there is a critical need to identify and develop local (including public and private) resource mobilization strategies to sustain an effective response.

HS 20/20 is providing assistance for Namibia's 2009 NHA estimation, which for the first time, includes subaccounts for HIV/AIDS. This is the second NHA to be produced with technical assistance from HS 20/20. Specific tasks include the following:

- Implement the NHA institutionalization assessment tool to assess the level of NHA institutionalization in Namibia and identify strengths and weaknesses.
- Implement specific institutionalization related activities with respect to data collection, including implementation of a donor-NGO database for routine expenditure reporting, incorporation of finance indicators into the MOHSS's health information system, and establishing a protocol for the incorporation of expenditure questions in upcoming household questionnaires.
- Partner with UNAIDS and other donors to strengthen civil society use of finance and HIV expenditure data through training and outreach workshops for civil society organizations.
- Support MOHSS to undertake additional analysis of the NHA data for the purposes of drafting policy briefs, informing resource allocation and mobilization, and developing linkages with other policy planning tools.
- Provide technical support to the MOHSS, Policy, Planning and Human Resources Directorate to develop criteria for an equitable and efficient resource allocation process.
- Support GRN development of a national resource mobilization and sustainability plan for the HIV/AIDS response.

2) HRH: Provision of technical assistance to the MOHSS to develop a comprehensive costed national HRH plan

Namibia's critical shortage of health care workforce is a serious concern for the GRN and to the sustainability of the national HIV/AIDS response. Existing policy, National HR Development Policy (2008-2012), is not focused on health and the HR strategic framework was developed prior to the HIV/AIDS epidemic in 1997. Thus, there is a need to develop a new HR plan for health care to encompass all cadres of workers. In addition, private sector partnerships need to be cultivated to reach national HR goals. A new HRH plan would analyze existing gaps, forecast HR needs, and address issues of recruitment, retention, and capacity building.



HS 20/20 worked with the GRN on HR issues before, serving in the HRH working group of the National Health Systems Review team. In this capacity, HS 20/20 helped collect, analyze, and interpret HRH data and coordinated the drafting of the HRH chapter. Assisting the development of a HRH plan is an extension of HS 20/20's previous work.

HS 20/20 will support the MOHSS:

- Design and conduct HRH situation assessment based on interviews with HR staff regarding job satisfaction, workload, motivation, willingness to stay in public sector, etc.
- Estimate current HRH gaps and needs
- Convene stakeholder HRH planning workshops (inclusive of both the public, private, and donor sectors)
- Draft a national HRH plan
- Cost the HRH plan's activities

HS 20/20 will collaborate with HRH stakeholders in Namibia, including HRH partners such as the Namibia HIV Prevention, Care and Support project.

The outcomes and impact of each activity will be defined jointly at the onset by GRN and HS 20/20. Progress towards these targets will be monitored closely and jointly. Also, HS 20/20 will provide extensive technical review to ensure that the designed national plans and approaches respond to the minimum basic package of services, comparable to other country plans (e.g. HRH) and in accordance with international standards and norms (e.g. for resource tracking institutionalization).

HS20/20 will also strengthen data feedback loops and dissemination mechanisms by working with our implementing partners in the MOHSS to widely share health finance information, resource allocation criteria, and results from HRH situation assessments, planning workshops, and gap estimations.

All the above activities promote sustainability, as they entail direct technical support to the MOHSS to develop better informed and more comprehensive health policies, plans, and processes. The outcomes will contribute to equitable resource allocation practices, stronger accountability of resource use, and a concerted way forward to address the HRH workforce crises.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details



Mechanism ID: 10382	Mechanism Name: Partnership for Health and Development Communication (PHDC) GP0-A-00-07-00004
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Academy for Educational Development	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,130,000	
Funding Source	Funding Amount
GHCS (State)	1,130,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Communication for Change (C-Change) is a continuing Implementing Mechanism from FY09. In 2007, Namibia requested assistance from C-Change to strengthen social and behavior change communication (SBCC) for HIV/AIDS, particularly related to the prevention of sexual transmission of HIV. Country level implementation began in mid-July 2008.

1. C-Change provides SBCC strengthening from national to local levels, focusing on the prevention of HIV sexual transmission through three objectives, reflecting its breadth across technical areas: 1) strengthening the SBCC capacity of PEPFAR-funded partners, 2) strengthening the SBCC capacity of national HIV/AIDS programs, and 3) increasing the number of individuals trained in SBCC for HIV and AIDS.

C-Change assists PEPFAR partners to develop programs based on evidence, focus on changing behaviors related to the drivers of the epidemic, and strengthen approaches to ensure quality program design, implementation and M&E. On the national level, C-Change is helping to define essential packages of services, develop mass media and interpersonal communication materials for partner use, and implement behavioral M&E to monitor results. C-Change is also increasing the number of PEPFAR partners and public, private and civil society partners who are trained in SBCC.

First-year achievements included: rapid assessment of partner programs against SBCC against



standards of quality; in-depth baseline assessments of prevention programs; development of SBCC strategies focusing on the drivers of the epidemic; improved service delivery structures and behavioral M&E; TOT of partner staff in SBCC and behavioral M&E; assistance during baseline data collection and analysis; identification/development of interpersonal communication (IPC) materials related to the drivers; TOT of partner staff in the use of the new materials; and assistance during training of field staff and volunteers. By the end of the period, 20 PEPFAR partners and their prevention programs had received strengthening support in SBCC.

2. The mechanism is in line with USG commitments of the Partnership Framework (PF) in terms of the PF prevention objectives. C-Change will continue to provide support to achieving these objectives through social and behavior change communication strengthening from national to local levels focusing on the key drivers including MC and MCP, youth, adults, MARPS and other vulnerable groups; through civil society, private sector and ministry programs in workplaces, communities, and in clinical settings.

3. Geographic coverage is nationwide. C-Change works directly with partners in every region to improve programs and provide SBCC TA and training.

4. C-Change works with GRN Ministries at the national level to assist in the development of national plans and strategies. For example, under the second objective C-Change has provided assistance to the National Prevention Technical Advisory Committee to develop the National Strategic Plan for HIV and AIDS and the National Strategy for the Prevention of Sexual Transmission of HIV. C-Change has also assisted in the development of national SBCC strategies for MCP, male circumcision, testing and counseling, alcohol and HIV; and development of mass media and IPC materials related to the drivers for partner use in national campaigns. C-Change also worked to strengthen the Ministry of Education's (MOE) regional workplace program through training in SBCC theory, SBCC strategy development, and use of new interpersonal communications (IPC) materials.

5. The cross-cutting nature of SBCC is the reason C-Change works with so many PEPFAR partners and government agencies. C-Change has also worked on gender in collaboration with USG and GRN partners.

6. C-Change will continue to work closely with PEPFAR partners and others to leverage funding and maximize cost-efficiency. Strengthening of PEPFAR partner programs is provided in coordination with other PEPFAR partners funded directly or indirectly. Strengthening of national HIV and AIDS structures and programs is provided in coordination with USAID, CDC and cooperating partners such as UNICEF, UNAIDS and GTZ.



7. C-Change is monitoring SBCC strengthening of PEPFAR partners and ensuring data quality by maintaining detailed lists of individuals trained and organizations strengthened. Outcomes of program strengthening are measured against a set of quality SBCC standards. SBCC strengthening of national level programs is tracked in periodic reports. National surveys tracking key indicators related to the drivers of the epidemic will continue to be the most important measures of national behavior change

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Addressing male norms and behaviors

Budget Code Information

Mechanism ID:	10382		
Mechanism Name:	Partnership for Health and Development Communication (PHDC) GP0-A-		
Prime Partner Name:	00-07-00004 Academy for Educational Development		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	802,975	
Narrative:			
<p>This is a continuing activity from FY09.</p> <p>Communication for Change (C-Change) will provide cross-cutting strengthening in social and behavior change communication (SBCC) in sexual prevention –abstinence/be faithful (AB) through the following three objectives: 1) strengthening the SBCC capacity of PEPFAR partners, 2) strengthening the SBCC capacity of national HIV and AIDS programs, and 3) increasing the number of individuals trained in SBCC for HIV and AIDS. C-Change capacity building activities will be jointly funded from HVAB and HVOP budget codes to ensure a comprehensive approach and results monitored to prevent double counting.</p>			



1. Under the first objective, C-Change will provide support to PACT and IntraHealth partners working in community/workplace/clinical settings. PACT partners include: Change of Life Styles, the Rhenish AIDS Program, Sam Nujoma Multipurpose Center, Catholic AIDS Action, Namibian Association of Community Based Natural Resource Management Support Organizations HIV and AIDS Program, the Chamber of Mines, and Caprivi Hope for Life. IntraHealth partners include 6 hospitals, 7 VCT programs and LifeLine/ChildLine. C-Change Namibia will also support partners who are directly funded by PEPFAR including the Social Marketing Association (SMA), Hope Humana Development AID People to People (DAPP), NawaLife Trust and the Peace Corps.

C-Change will strengthen up to 20 partners through a blended approach involving participatory assessments of SBCC capacities against standards in planning and design, program implementation and M&E, development of SBCC strategies, updating/developing curricula and interpersonal communication (IPC) materials, training of trainer of staff in SBCC theory and methods, technical assistance to partners during training of field staff and volunteers, supportive supervision of field staff and volunteers during field implementation, and training in behavioral M&E and collection of baseline/follow-on data to measure results. This approach to strengthening SBCC prevention among youth, for example, has resulted in programs that are focused on behavioral outcomes, with multi-level/multi-channel interventions, updated materials and behavioral baseline data.

C-Change will strengthen SBCC for HIV prevention, moving partner efforts towards a combined approach addressing key drivers among youth and adults such as multiple or concurrent partners, transactional/cross-generational sex, social norms that underlie these behaviors, and provision of and/or referral to biomedical and structural interventions. IPC will be coordinated with mass media as part of national campaigns. Programs will include those in high prevalence geographical areas such as the northern region, land and water borders and transit corridors.

C-Change will encourage testing of innovative community-based models for behavior change that include all standards of quality SBCC programming and the delivery of integrated packages of prevention services in highest risk areas. Targeted provision of integrated services by civil society has been shown to be less costly and have greater results than more vertical approaches, particularly when coordinated with the public sector from the outset.

2. Under the second objective, C-Change will work closely with USG and cooperating partners to strengthen health systems at the national level. Support may include assistance to the Prevention TAC to determine an integrated package of prevention services for youth and adults and develop supporting materials for partner use, in planning and budgeting of prevention support among cooperating partners, monitoring the response, determining national-level behavioral M&E, and support to mainstreaming

among line ministries.

3. Under the third objective, C-Change will train up to 100 partner staff in SBCC. Those directly trained will include staff from PEPFAR partners and GRN ministries. All capacity building inputs will be in the form of training-of-trainers. Each organization's trained technical staff will train their field staff and volunteers with assistance from C-Change.

The program will continue to coordinate closely with special initiatives such as gender, alcohol, prevention with positives, and male circumcision (Activities 12342.08, 17057.08, 4737.08, 16762.08). Emphasis will be on changing male norms and increasing male involvement in prevention, reducing violence, sexual coercion, and transactional and cross-generational sex. It will also, in conjunction with the PEPFAR/SI team, ensure adaptation and integration of results and recommendations from program evaluations, PHE, the BSS+ and KAP studies into SBCC programs.

Supportive Supervision/QA Activities: C-Change will ensure the quality of partner programs through assessments to ensure that programs meet all standards of SBCC programming and through supportive supervision of field staff and volunteers during field implementation.

Contribution to Sustainability: The sustainability of program efforts will be enhanced through strengthening of partner capacities, training of trainers, and cascade training of field staff and volunteers, and through strengthening of SBCC in national level plans, strategies and programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	327,025	

Narrative:

This is a continuing activity from FY09.

Communication for Change (C-Change) will provide cross-cutting strengthening in social and behavior change communication (SBCC) in sexual prevention – other prevention -- through the following three objectives: 1) strengthening the SBCC capacity of PEPFAR partners, 2) strengthening the SBCC capacity of national HIV and AIDS programs, and 3) increasing the number of individuals trained in SBCC for HIV and AIDS. C-Change capacity building activities will be jointly funded from HVAB and HVOP budget codes to ensure a comprehensive approach and results monitored to prevent double counting.

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community/workplace/clinical settings. PACT partners include: Change of Life Styles, the Rhenish AIDS Program, Sam Nujoma Multipurpose Center, Catholic AIDS Action, Namibian Association of Community Based Natural Resource Management Support Organizations HIV and AIDS Program, the Chamber of Mines, and Caprivi Hope for Life. IntraHealth partners include 6 hospitals, 7 VCT programs and LifeLine/ChildLine. C-Change Namibia will also support partners who are directly funded by PEPFAR including the Social Marketing Association (SMA), Hope Humana Development AID People to People (DAPP), NawaLife Trust and the Peace Corps.

C-Change will strengthen up to 20 partners through a blended approach involving participatory assessments of SBCC capacities against standards in planning and design, program implementation and M&E, development of SBCC strategies, updating/developing curricula and interpersonal communication (IPC) materials, training of trainer of staff in SBCC theory and methods, technical assistance to partners during training of field staff and volunteers, supportive supervision of field staff and volunteers during field implementation, and training in behavioral M&E and collection of baseline/follow-on data to measure results. This approach to strengthening SBCC prevention among youth, for example, has resulted in programs that are focused on behavioral outcomes, with multi-level/multi-channel interventions, updated materials and behavioral baseline data.

C-Change will strengthen SBCC for HIV prevention, moving partner efforts towards a combined approach addressing key drivers among youth and adults such as multiple or concurrent partners, transactional/cross-generational sex, social norms that underlie these behaviors, and provision of and/or referral to biomedical and structural interventions. IPC will be coordinated with mass media as part of national campaigns. Programs will include those in high prevalence geographical areas such as the northern region, land and water borders and transit corridors.

C-Change will encourage testing of innovative community-based models for behavior change that include all standards of quality SBCC programming and the delivery of integrated packages of prevention services in highest risk areas. Targeted provision of integrated services by civil society has been shown to be less costly and have greater results than more vertical approaches, particularly when coordinated with the public sector from the outset.

2. Under the second objective, C-Change will work closely with USG and cooperating partners to strengthen health systems at the national level. Support may include assistance to the Prevention TAC to determine an integrated package of prevention services for youth and adults and develop supporting materials for partner use, in planning and budgeting of prevention support among cooperating partners, monitoring the response, determining national-level behavioral M&E, and support to mainstreaming among line ministries.



3. Under the third objective, C-Change will train up to 100 partner staff in SBCC. Those directly trained will include staff from PEPFAR partners and GRN ministries. All capacity building inputs will be in the form of training-of-trainers. Each organization's trained technical staff will train their field staff and volunteers with assistance from C-Change.

The program will continue to coordinate closely with special initiatives such as gender, alcohol, prevention with positives, and male circumcision (Activities 12342.08, 17057.08, 4737.08, 16762.08). Emphasis will be on changing male norms and increasing male involvement in prevention, reducing violence, sexual coercion, and transactional and cross-generational sex. It will also, in conjunction with the PEPFAR/SI team, ensure adaptation and integration of results and recommendations from program evaluations, PHE, the BSS+ and KAP studies into SBCC programs.

Supportive Supervision/QA Activities: C-Change will ensure the quality of partner programs through assessments to ensure that programs meet all standards of SBCC programming and through supportive supervision of field staff and volunteers during field implementation.

Contribution to Sustainability: The sustainability of program efforts will be enhanced through strengthening of partner capacities, training of trainers and cascade training of field staff and volunteers, and through strengthening of SBCC in national level plans, strategies and programs.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10386	Mechanism Name: The Capacity Project
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: IntraHealth International, Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 8,229,420	
Funding Source	Funding Amount
GHCS (State)	8,229,420



Sub Partner Name(s)

Anglican Medical Services	Catholic AIDS Action, Namibia	Catholic Health Services of Namibia
Democratic Resettlement Community Project	Development Aid from People to People, Namibia	Evangelical Lutheran Church AIDS Program, Namibia
Lifeline/Childline Namibia	Lutheran Medical Services, Namibia	Namibia Red Cross
Walvis Bay Multi Purpose Center, Namibia		

Overview Narrative

The Capacity Project is continuing from FY09. In COP09, this IM funded activities under MTCT, HVAB, HVOP, CIRC, HBHC, HTXS, PDCS, PDTX, HVTB, HVCT, HVSI, and OHSS. In COP10, HVSI is no longer being funded.

The overall objectives under the award are to: 1) build the capacity of indigenous organizations to respond to and implement HIV programs, leading to an increased number of Namibians who know their HIV status, and 2) improve access to high quality HIV prevention, care and support, and treatment services for people affected and infected with HIV.

Since 2006, IntraHealth has been supporting the Government of the Republic of Namibia (GRN) and its partners to reduce the spread and impact of HIV/AIDS through building the capacity of indigenous organizations. Currently, the project has sub-awards with nine local organizations with plans to transition Anglican Medical Services to a tenth sub-award recipient. In addition, IntraHealth supports the activities of two professional organizations, the HIV Clinician's Society and The Pharmaceutical Society of Namibia.

Intermediate award objectives will be met by providing technical support in HIV clinical services, and prevention and capacity building to the indigenous organizations in partnership with the GRN, stakeholders, private providers and other implementing partners in Namibia. The key intermediate results (IRs) are as follows:

1. Increased capacity of indigenous organizations to respond to the epidemic and to implement HIV/AIDS-related programs,
2. Strengthened capacity of local organizations to provide high quality, age-appropriate HIV/AIDS prevention programs and referrals at the health facility and community levels,
3. Improved opportunities for Namibians to know their HIV status by improving local organizations' ability



to provide quality HIV/AIDS counseling and testing services at medical facilities and in communities,

4. Strengthened capacity of local organizations to provide HIV/AIDS care and treatment services for both adults and children, and
5. Increased capacity of the Ministry of Health and Social Services (MOHSS) to manage human resources for health (HRH) through support to the development and implementation of a human resources information system (HRIS).

IntraHealth and its partners are working to achieve the objectives while contributing substantially to the goals of the GRN and PEPFAR program, specifically the Partnership Framework (PF). In an effort to ensure sustainability, IntraHealth supports the GRN in building the capacity of the HR department in the MOHSS through the development of an HRIS, as well as strengthening the capacity of indigenous NGOs and faith-based organizations (FBOs) working in remote areas. Specifically, IntraHealth is helping organizations strengthen financial, human resources, compliance and other management systems so that these institutions will be ready for transition to direct support. IntraHealth is concurrently strengthening partners technical expertise to help them provide quality HIV prevention, care and treatment services. The five IRs are closely linked to the National Strategic Framework and the PF, targeting prevention, treatment, care and support.

The program targets Namibians of all ages and gender, with specific emphasis on at-risk populations. IntraHealth works with indigenous organizations covering rural, semi-rural and urban areas in 11 of Namibia's 13 regions.

Human Resources for Health (HRH) are fundamental to the sustainability of HIV programming. IntraHealth is making significant progress with the MOHSS to strengthen its capacity to manage HRH with health workforce data nearly completed. MOHSS staff has also participated in key capacity building activities on the use of data for decision making. The program will continue to build the capacity of MOHSS and will extend the pilot of the HRIS to all regions in Namibia.

The focus of IR1 is to increase the cost effectiveness of the program by helping build the capacity, beginning with the larger, more developed organizations, and gradually assisting the smaller organizations, to implement HIV programs. Over time, this will enable IntraHealth to have a reduced presence, shifting to a more supportive role to provide targeted technical assistance. IntraHealth will also work with the local organizations to continue seeking economies of scale as their HIV care and treatment programs expand. One example is the development of an electronic patient management system. As a cornerstone of long term care to PLHIVs, this system not only supports quality care and treatment, it also enables clinics to schedule patients more easily and assist with defaulter tracing.



Monitoring and evaluation is fundamental to the success of the program and is a critically important mechanism for strengthening partner capacity. Through a system of data collection, analysis, reporting and feedback, IntraHealth will work closely with its partners, USAID, and MOHSS to ensure the program is on track, while helping to build partners' capacity to monitor and evaluate HIV programs. IntraHealth is committed to ensuring that information produced is timely, valid, precise, accurate and reliable, and will routinely monitor the quality of the information generated, conducting data quality audits with staff from partner organizations to improve this information.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	40,000
Food and Nutrition: Policy, Tools, and Service Delivery	6,000
Human Resources for Health	1,199,076

Key Issues

- Addressing male norms and behaviors
- Increasing gender equity in HIV/AIDS activities and services
- Child Survival Activities
- Safe Motherhood
- TB
- Family Planning

Budget Code Information

Mechanism ID: 10386			
Mechanism Name: The Capacity Project			
Prime Partner Name: IntraHealth International, Inc			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	574,952	
Narrative:			
None			



Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	1,599,262	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	2,161,246	

Narrative:

This is a substantially changed continuing activity from FY2009.

This continued activity has six main components: 1) Access to counseling and testing (CT), 2) referral system, 3) enhancing the quality and consistency of CT services, 4) offering comprehensive support in CT sites, 5) increasing capacity of local organization to run CT services, and 6) collaborating with the MoHSS.

During COP10, IntraHealth will continue to support NewStart (NS) network. This consists of six integrated (facility-based) and 12 standalone (community-based) sites in ten out of thirteen regions. However, based on the CT portfolio review recommendations, given the high cost per client in the New Start franchise, there will be a reduction in the number of sites supported by USG, especially in areas where mobile and facility based services are readily accessible. This will be done after careful consultation with all stakeholders. Integrated sites will support Provider-Initiated Testing and Counseling (PITC) in the clinical setting in accordance with national guidelines and improve access for HIV positive individuals to care and treatment services, while community-based sites will focus on self referral clients. Provision of CT for sexual partners and other family members will continue to be provided. Support for the HIV status disclosure will be strengthened during counseling sessions. IntraHealth will continue to support counseling and HIV negative individuals to keep their HIV status negative. Link with NawaLife Trust in an advisory capacity will ensure aggressive demand creation campaign for HIV testing. This partnership will increase testing numbers at both NS and MoHSS testing sites. The recruitment of community mobilizers in most sites will also enhance this demand creation activity. Also, extending business hours to open on Saturdays and during week days will accommodate individuals who would not have access to HIV CT, and increase demand.

IntraHealth will continue the support for an effective bidirectional referral system between standalone sites, health facilities and CBO/FBO at the community level. The system is comprised of a focal person, HIV/AIDS service directory, a register, forms and referral committee in every site to manage referral in



and out. Continuous evaluation will be conducted.

IntraHealth and its partners are using HIV rapid testing according to the national algorithm. The effective and uninterrupted supply of rapid tests and medical consumables will be accomplished through a continued partnership with SCMS for the standalone and through the Central Medical Stores for the facility-based sites. IntraHealth will continue partnership with the Namibian Institute of Pathology who will provide quality assurance oversight at all regional training sites. IntraHealth will enforce quality of CT provision and services through consolidating and updating the training and supervision of counselors. The two regional VCT Coordinators in the North will continue to support the sites in these remote areas and ensure consistent quality assurance for counseling and site supervision. IntraHealth will conduct supportive supervision visits and performance improvement sessions with all staff at the NS sites using an assessment checklist and scoring system along with analysis of client exit interviews, suggestion boxes and focus group discussions.

Comprehensive support in CT sites will continue through integration of other activities such as screening for TB, alcohol abuse and male circumcision (MC). In COP10, IntraHealth will pilot screening for gender-based violence. The success of these services depends on the reliable and efficient referral system from CT to other relevant service providers. IntraHealth will use its specially designed software to monitor these new activities and the referral.

As a member of the CT Technical Working Group, IntraHealth will continue working closely with the MOHSS, providing expertise on both clinical and counseling issues, and joint supervisory visits. This collaboration also covers training, national testing day events and M&E activities. Since COP 2008, IntraHealth brought the CT training program in line with the minimum standards for training required by the MOHSS. IntraHealth will continue to work with the MOHSS and the training agency to complete training for counselors in the NS network with special emphasis on window period streamline information, TB referral, referral for brief motivational intervention, MC, couple counseling, child counseling, family-based counseling, gender-based violence screening and referral, and male-friendly services.

To improve quality of health services, Intrahealth, the host government and faith-based counterparts, will conduct regular joint supportive supervision visits. Efforts to address the highest-priority problems, including: logistics, commodities, staff turnover, and other pertinent issues will be followed.

As part of the transition and sustainability plan, IntraHealth will work with its partners to assess financial capacity in the provision of community services for CT beyond PEPFAR funding. Building the capacity of local partners will be a primary function, in addition, resource mobilization and exploration of other more cost effective models for community CT services will be undertaken. IntraHealth will ensure that



communities where sites might be reduced will continue to have access to CT services through existing mobile or facility based outlets.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	101,462	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	310,421	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	100,000	

Narrative:

This is a substantially changed continuing activity. In COP10, IntraHealth will support the MOHSS (which is where the HRIS is housed) to create linkages and harmonization of HRH information, embark on HRH data use, working with the Stakeholder Leadership Group (SLG) to link the HRIS with existing systems, such as the private sector NAMA system, TB registry, I-Tech's in-service training database, Health Professionals Council system, and public sector systems such as Ministry of Finance and the OPM. IntraHealth will ensure the SLG continues to function well with strong participation and support from all key members and stakeholders.

In COP10, IntraHealth will also continue to strengthen and build on the foundation phase by focusing on: (i) ensuring the SLG retains its vitality and continues as a functional group; (ii) finalizing the essential HRH indicators for the MOHSS as a first step, and then identifying additional indicators for all the key owners, producers and consumers of HRH information as a second step; (iii) establishing automated interfaces enabling the sharing of common information between the MOHSS and key stakeholders; (iv) providing advanced information technology (IT) training to MOHSS IT staff to manage their enhanced IT infrastructure and HRIS environment; (v) providing advanced computer literacy and system training to MOHSS HR personnel to ensure data completeness and accuracy; and, (vi) ensuring sustainability by training on the effective use of data in developing policy and informing management decisions. PEPFAR technical experts will be available to provide supervision and provide technical input as required by the GRN.



Training on data use not only supports the utility, data quality, and continued strength of HRIS systems but also provides support for many key cross-cutting areas, including identification of gender issues, looking for incentive and retention trends and examination of distribution of staff with specific areas of specialty. The training will also contribute towards the sustainability of the HRIS and enhance the capacity of the health system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	667,366	

Narrative:

This is a substantially changed continuing activity from FY2009.

This continuing activity has 3 main components: (1) communication, education and advocacy on male circumcision; (2) training; and (3) scale up of male circumcision service delivery.

1. Communication, Education and Advocacy on Male Circumcision:

IntraHealth will continue to engage opinion leaders, political leaders and traditional authorities, as well as the community at large, in order to communicate the benefits of including male circumcision (MC) as part of a multi-faceted, robust prevention approach. Critical to the success of MC is an appropriate, affordable and culturally sensitive communication strategy and demand creation tailored to the service availability. IntraHealth will work with the USG lead communication partner (TBD) and other stakeholders to expand education and communications (IEC) materials to ensure MC information is provided to the community. The communication programming will align within Namibian National Strategic framework and the forthcoming National Namibian HIV prevention strategy. As part of the integration of MC into counseling and testing services (CT), CT sites will continue to provide information, education and referral, as appropriate, and help clients consider MC as part of their overall risk reduction strategy. In addition, policy makers and community leaders will become familiar with the international and local evidence on MC and the cost saving related to infections averted. IntraHealth will continue to engage the national leadership at all levels, disseminate findings of the situational analysis and provide opportunities to build a strong political commitment and obtain buy-in from decision makers.

2. Training:

After successfully organizing the first MC skills building training in Namibia in collaboration with JHPIEGO, the MoHSS, the MC task force and other USG partners, IntraHealth will continue to provide support and technical assistance in skill building for safe MC under local anesthesia during COP10. The success of the first training will be translated in pilot sites delivering MC services, to be followed by a national roll out. Trainings will ensure that providers acquire clinical and counseling skills that conform to

the international standards of quality, including follow up care and management of complications.

3. Scale up of male Circumcision Service Delivery:

Currently, all IntraHealth supported district hospitals are providing male circumcision. In many hospitals there is a waiting-list for MC services due to the lack of trained personnel. IntraHealth will bring to scale safe MC in the 6 supported FBO health facilities by allocating staff time and salaries, supplies (consumables), equipment, and sharing facilities. Beyond COP 2010, MC related costs will rely heavily on public sector financing. Additionally, in COP 2010, Intrahealth will deploy a catch-up strategy that will partner with WHO and USG/HQ to deploy JHPIEGO to enhance the current host-country expertise. JHPIEGO will provide critical international technical assistance to run MC clinics. The supply of commodities will be acquired through the government's CMS with support from SCMS, taking into account cost minimization. The service delivery model will adopt the WHO recommended minimum package of prevention services that combine MC with: (1) provider-initiated testing and counseling (PITC) and comprehensive post-test counseling; (2) STI screening and treatment; (3) counseling on risk reduction behaviors with a focus on partner reduction and abstinence; and, (4) condom promotion and provision and appropriate referrals to other sexual and reproductive health services. This package will include strict post operative care with regards to wound care instructions and six week abstinence from sexual activities. It is also imperative to engage traditional MC providers as key community gatekeepers; more than 52% of men currently circumcised in Namibia have been through traditional providers. IntraHealth will provide opportunity for open dialogue. This support will include areas such as registration and regulation, training on hygiene and infection control, competency building on HIV issues and documentation of adverse events and referral linkages to medical providers.

Supportive Supervision & Quality Assurance:

IntraHealth will use the WHO quality assessment tool as adopted by the MC task force. This tool assesses quality of services through monitoring supply chain management, adherence to the prevention minimum package, counseling services, competence of staff performing the procedure, follow-up care and management of complications, and record keeping. In addition, client satisfaction will be sought through interviews with clients using the services. A quality improvement team will be formed and will conduct regular support supervision visits at each site.

Sustainability:

To ensure long term sustainability and cultivate MC awareness in Namibia, IntraHealth will continue to work through the task force to advocate for the inclusion of neonatal circumcision in all districts. This will entail contribution to policy finalization, training of providers (mid-wives) and education and social mobilization campaigns.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
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Prevention	HVAB	299,591	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	521,665	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,828,455	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	65,000	
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10387	Mechanism Name: HCD Coalition for Southern Africa
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: IntraHealth International, Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 200,000	
Funding Source	Funding Amount



GHCS (State)	200,000
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Sub Partner Name(s)

(No data provided.)

Overview Narrative

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000
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Key Issues

Increasing gender equity in HIV/AIDS activities and services
 Increasing women's legal rights and protection

Budget Code Information

Mechanism ID: 10387			
Mechanism Name: HCD Coalition for Southern Africa			
Prime Partner Name: IntraHealth International, Inc			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	200,000	
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10389	Mechanism Name: Strengthening
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	Pharmaceutical Systems GHN-A-00-07-00002-00
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,869,294	
Funding Source	Funding Amount
GHCS (State)	2,869,294

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Management Sciences for Health/ Strengthening Pharmaceutical Systems (MSH/SPS) program in Namibia is a continuing implementing mechanism from FY09. In COP09, this IM funded activities under HTXS, PDTX, HVTB, HVSI and OHSS. In COP10, HVTB is no longer being funded.

MSH/ SPS has four objectives: 1) improve governance in the pharmaceutical sector, 2) strengthen pharmaceutical management systems to support priority public health services and interventions, 3) contain the emergence and spread of antimicrobial resistance (AMR), and 4) expand access to essential medicines. These objectives will be achieved through partnership, capacity building, and coordination with partners to ensure efficiency and sustainability of interventions.

To improve governance in the pharmaceutical sector, SPS implementing mechanism will enhance the registration, inspection, quality assurance and post marketing surveillance units of the Namibia Medicines Regulatory Council (NMRC), resulting in more efficient and effective regulatory system for timely registration of antiretroviral and essential medicines. SPS will also continue to support review of the National Medicines Policy (NMP), and the development and implementation of the National Pharmaceutical Master Plan.

To strengthen pharmaceutical management systems to support priority public health services and interventions, SPS will develop and implement strategies that strengthen systems, human resources and institutional capacity at various levels for the delivery of pharmaceutical services. This involves supporting the Pharmacy Management Information System (PMIS); the facility level patient Electronic Dispensing



Tool (EDT); supporting pharmacy human resources; and strengthening of pre and in-service training of pharmaceutical personnel. These activities will gradually be transitioned to the MoHSS as PEPFAR resources declines.

To contain the emergence and spread of AMR, SPS will support MoHSS in enhancing rational use of medicines by strengthening therapeutic committees and training at facility level. The Program also ensures institutional systems strengthening and the development of cost-effective and sustainable interventions for the containment of spread of antimicrobial resistance. Interventions include monitoring HIV drug resistance early warning indicators (EWIs), adherence interventions, and implementing infection control activities.

ARVs are essential medicines in Namibia that should be continuously available in all health facilities. SPS provides technical assistance to MoHSS and other partners to improve access to essential medicines by strengthening systems for managing pharmaceuticals in the public sector and supports decentralization and interventions aimed at reducing the cost of ART in the private sector.

In line with the partnership framework agreement, MSH/SPS program will focus on key priority areas of treatment, care and support by contributing to expanding ART services, and on key area of coordination and management as it relates to pharmaceutical services.

SPS focuses on leadership and governance in the pharmaceutical sector, community systems strengthening, human resources for health capacity development, and strengthening monitoring and evaluation systems.

SPS has a national coverage and the target population is the entire population of people living with HIV/AIDS in Namibia.

SPS contributes to Health Systems Strengthening by using the adapted capacity building pyramid model as a conceptual framework for building capacity of pharmaceutical services. Key components are:

- Operationalization of structure, systems, and roles through development and implementation of policies, regulations, procedures guidelines and other governance structures
- Strengthen Human Resources for Health capacity and provision of equipment and requisite infrastructure including in-service and pre-service training at the National Health training centre (NHTC) and the University of Namibia to increase supply, skills and competence of personnel
- Deployment of essential tools and information systems for strengthening health systems at facility and national level

Cross-cutting Issues: Increasing gender equity in HIV/AIDS activities and services.



SPS has developed and supports systems that ensure that patient data on ART is disaggregated by gender and age, appropriately analyzed and shared with decision makers.

In order to build efficiency and sustainability, SPS will support scale-up and increased access to ART through decentralization and public-private partnerships. Increasing focus will be on transitioning activities to MoHSS, particularly with regard to the newly recruited pharmacy personnel.

SPS will partner with the National Medicines Policy Coordination, Response Monitoring and Evaluation and Quality Assurance units of MoHSS in implementing national pharmaceutical related M&E systems for pharmaceutical care. Support will also be provided to MoHSS staff to conduct annual data quality audits in 20 sites and facilitate supportive supervision visits, a crucial element in data quality assurance (DQA). SPS will also strengthen data feedback and dissemination mechanisms with quarterly feedback to sites and annual feedback during the pharmacy forum. SPS will conduct two Public Health Evaluations in COP10.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: 10389			
Mechanism Name: Strengthening Pharmaceutical Systems GHN-A-00-07-00002-00			
Prime Partner Name: Management Sciences for Health			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	1,575,230	
Narrative:			
This is a continuing activity from FY09.			
Strengthening Pharmaceuticals Systems (SPS) will work to consolidate previous achievements and			

transition efforts to the MoHSS, who is increasingly assuming ownership per the partnership framework agreement (PFA). This activity has six components: 1) increase access to ART, 2) support treatment guidelines, 3) support the development and implementation of adherence interventions, 4) support monitoring of Anti-microbial Resistance (AMR), 5) strengthen sustainable human resource capacity for delivery of pharmaceutical services, and 6) improve infection control (IC) and environmentally safe disposal of pharmaceutical waste.

1. Increase access to ART through decentralization and public-private partnership activities as follows:

- Support 15 additional ART clinics and provide dispensing equipment (pill cutters, counting trays, measuring cylinders and computers);
- Strengthen inventory and dispensing practices in all ART sites;
- Roll out Electronic Dispensing Tool (EDT) mobile to 35 additional sites; and
- Develop interventions in collaboration with Medscheme (Namibia Health Plan), to train 30 practitioners to improve guidelines compliance and other cost drivers, and enhance data reporting mechanisms from the private to the public sector.

2. Support standard treatment guidelines (STG) development and technical committees.

- Support MoHSS implement STG, monitor its use and set up systems for regular STG updates.
- Support MoHSS in updating Namibia's next edition of the essential medicines list.
- Support the Essential Medicines Committee secretariat to ensure transparency and good governance; and enhance evidence-based selection of essential medicines.

3. Support the development and implementation of adherence interventions. This will be achieved through scale up of adherence interventions implemented in COP08/09 to the national level, including treatment literacy activities, enhanced patient follow-up, and adherence monitoring and reporting activities in all ART facilities.

4. Support monitoring of Antimicrobial Resistance (AMR).

- Train 30 prescribers and 30 dispensers in AMR risk minimization strategies.
- Support interventions to reduce AMR risk and ensure ART cost effectiveness.
- Support Therapeutic Committees (TC) to improve rational use of medicines and mitigation of AMR, and enhance TC functioning and prepare for long term sustainability in COP11.

5. Strengthen sustainable human resource capacity for delivery of pharmaceutical services through:

- Support to MoHSS strategy development for sustaining increased enrollment, training and retention of pharmacist's assistants at NHTC;
- Technical assistance and support to finalize and implement UNAM Pharmacy competency framework

and curriculum initiated in COP09;

- Support the local chapter of the International Network for improving Rational Use of Drugs (INRUD); and
- Continue funding 21 MoHSS pharmacy positions while continuing discussion on strategies to transition the salaries and related costs to the MoHSS by 2011.

6. Improve IC and environmentally safe disposal of pharmaceutical waste through improving awareness and enhancing good IC practices, including ensuring availability of IC commodities in all 34 hospitals in Namibia and implementing strategies for prevention of nosocomial infections.

Quarterly Systems Strengthening (SS) and monitoring visits will ensure program implementation conforms to standards and that pharmaceutical performances are enhanced. During these visits, data quality assessments will be done and validated with other pharmaceutical and ART data sources in the districts.

The current capacity building program and system strengthening with regards to training and retention of pharmaceutical staff, database development and transfer of skills will enable the MoHSS to sustain the services beyond SPS support.

Sustainability/ SS: This activity builds sustainability through rational ARV prescription practices, AMR and transitioning SS roles to the MOHSS. The private sector will be instrumental in increasing access to affordable ARV services. Quality assurance will be provided through standardized tools and EDT integration.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	385,405	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	164,500	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	744,159	



Narrative:
None

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10393	Mechanism Name: PACT TBD Leader with Associates Cooperative Agreement
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Pact, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 9,256,413	
Funding Source	Funding Amount
GHCS (State)	9,256,413

Sub Partner Name(s)

Catholic AIDS Action	Kayec Trust	Legal Assistance Centre, Namibia
LifeLine/ChildLine	Ministry of Gender Equality and Child Welfare, Namibia	Namibia Chamber of Mines
PEACE Centre	TBD	

Overview Narrative

The goal of the Community REACH Namibia Program is to scale up and sustain a comprehensive response to HIV/AIDS services through civil society organizations (CSO) and Government of the Republic of Namibia (GRN) ministries. The award has six objectives: 1. provide a grant-making system for indigenous partners to respond to the HIV/AIDS epidemic; 2. provide CSO with funding and technical assistance to ensure they achieve results and comply with USG requirements; 3. build CSO organizations' and networks' capacities to provide and sustain HIV/AIDS services; 4. strengthen linkages between CSO, the GRN and private sector to promote sustainable capacity building in-country; 5. support the Ministry of Gender Equality and Child Welfare (MGECW) through targeted technical assistance and



capacity building, including implementation of an OVC database; 6. implement a gender sensitive approach to HIV/AIDS programming. Through sub-partners REACH supports services in impact mitigation for orphans and vulnerable children, community and home based health care (CBHC) and prevention of sexual transmission. In COP09, this IM funded activities under HVAB, HVOP, HBHC, PDCS, HKID, HVSI, OHSS and HVTB. In COP10, HVTB AND OHSS are no longer being funded.

In support of the Partnership Framework Agreement, REACH supports the USG commitments to increase social and behavior change to prevent the sexual transmission, programs prevention targeting most at risk populations, and supports workplace programs. REACH supports commitments in strengthening CHBC systems and referrals and prevention with PLWHA. In impact mitigation, REACH supports sustainable livelihoods for vulnerable households; strengthens the MGECW's implementation of the National Plan of Action for OVC; and develops and implements OVC quality and care standards. Under coordination and management, REACH plays a key role in community systems development by strengthening CBOs to deliver quality HIV/AIDS services; and sustainably enhances human resource and capacity development at the MGECW. Aligned with the National Strategic Framework and PEPFAR indicators, REACH supports improved M&E through capacity building at all CBO and ministry partners.

REACH has a national coverage targeting a) CSO that support PEPFAR objectives, 2) the MGECW, and 3) other ministries responsible for coordination of service delivery related to the award's budget code funding. In turn, sub-grantees serve those target populations appropriate to the objectives of their funding.

Many of REACH's activities are focused interventions in support of health systems strengthening. In service delivery, REACH improves partners' capacity to plan service delivery programs focused on outcomes; develops and assists GRN to implement national policy and standards; and supports MGECW planning and quality performance management. REACH provides significant support to leadership and governance by: strengthening the MGECW's and MOHSS's engagement of CSOs; developing management skills at MGECW and CSO partners for strategic planning, monitoring and supervision; promoting a culture of evidence-based decision making and program accountability; supporting CSOs to engage in advocacy and public planning; and promoting problem solving and local ownership of key decisions. REACH supports information by developing and implementing the national OVC data warehouse and ensuring that information is analyzed, widely disseminated, and used by diverse GRN and CSO stakeholders. REACH supports human resources in the MGECW by building capacity to provide targeted in-service training, along with skills building for facilitation, supportive supervision, and mentoring to MGECW staff; and by providing bursaries and stipends in collaboration with MGECW to social work students with financial need who are required to work for the MGECW up on graduation. In finance, REACH promotes accountability in resource allocation within the MGECW; and assists CSO with policies and improved financial management.



REACH supports cross-cutting programs including: pre and in-service training and leadership to build human resources for health at the MGECW and CSOs offering community-based care; gender mainstreaming and programming to address the five cross-cutting gender strategic areas, including a women's empowerment activity; public private partnerships that leverage resources to complement activities and provide technical assistance to partners; support to workplace programs; and food and nutrition.

REACH assists partners with resource allocation, budgeting and financial monitoring that optimizes the use of project funds to achieve objectives. Assistance imparts sustainable resource management that extends beyond project funding. To ensure continuing improvements in efficiency, REACH coordinates partners and uses partner performance and efficiency as key measures when determining continued funding levels.

REACH uses a results chain and performance monitoring plan to measure project performance, which captures REACH assistance in improving organizational and technical effectiveness. Each organization undergoes an assessment to identify areas for monitoring and evaluation (M&E) capacity building. Each partner operates with an approved M&E plan that measures results against PEPFAR indicators and outcome objectives. REACH provides onsite support and training to strengthen M&E capacities and verifies results and provides feedback on how to improve M&E systems and data quality. REACH provides peer to peer exchanges among M&E staff of the sub-recipients to enhance opportunities for capacity building.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	466,594
Education	538,512
Food and Nutrition: Policy, Tools, and Service Delivery	35,506
Human Resources for Health	6,187,396
Water	4,000

Key Issues

Increasing gender equity in HIV/AIDS activities and services



Budget Code Information

Mechanism ID: 10393			
Mechanism Name: PACT TBD Leader with Associates Cooperative Agreement			
Prime Partner Name: Pact, Inc.			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	2,122,226	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	5,407,402	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	374,510	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	292,570	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	822,741	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount



Prevention	HVOP	236,964	
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10397	Mechanism Name: Tuberculosis Control Assistance Program
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: KNCV Tuberculosis Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 950,000	
Funding Source	Funding Amount
GHCS (State)	950,000

Sub Partner Name(s)

NABCOA	Project HOPE	
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Overview Narrative

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

TB



Budget Code Information

Mechanism ID: 10397			
Mechanism Name: Tuberculosis Control Assistance Program			
Prime Partner Name: KNCV Tuberculosis Foundation			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	950,000	
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10780	Mechanism Name: Cooperative Agreement 1U58PS001452
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Washington	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 658,000	
Funding Source	Funding Amount
GHCS (State)	658,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

SUBSTANTIALLY CHANGED FROM LAST YEAR The CDC cooperative agreement with University of



Washington/I-TECH is a continuing mechanism from FY09. It aims to strengthen graduate-level public health education in the Republic of Namibia.

Objectives: UW/I-TECH has five objectives under the award: (1) To enhance the UNAM MPH program through specializations in Nutrition, Strategic Information, Health Policy and Management, and integration of HIV and AIDS content into MPH courses; (2) To institutionalize support to MPH students to complete their thesis requirements within 2-4 years; (3) To strengthen institutional capacity of UNAM by increasing faculty development opportunities; (4) To strengthen the UNAM Health Resource Center library systems and services; and (5) To establish and maintain on-going collaborative relationships with UNAM to ensure sustainability of project results.

Partnership Framework: By promoting Namibian institutional capacity to strengthen public health leadership competencies, this mechanism directly contributes to several of the goals and benchmarks of the Namibian Partnership Framework currently under development. This mechanism addresses USG commitments in Goal 4, Coordination and Management, objectives 3 and 4, Human Resource Capacity Building, and Monitoring and Evaluation, among others.

Coverage: The activities of this mechanism are national in scope. The target population is MPH students, lecturers, and librarians at the UNAM Faculty of Medical and Health Science at the UNAM campuses in Windhoek and other satellite campus in the north of the country, including Oshakati. These targeted beneficiaries include the incoming cohort of students of the UNAM MPH degree program in years 2010-2014 and at least fifteen UNAM MPH lecturers, administrators, and librarians.

Health systems strengthening: Key contributions to health systems strengthening through this mechanism include providing better trained and higher numbers of public health professionals for the health sector of Namibia, through a competencies-based public health curriculum at UNAM. This support will help Namibia to exceed the targets outlined in the Human Resources Development Strategy 2008-2014.

Cross-cutting/Key issues: This mechanism will contribute to Human Resources for Health objectives through cross-cutting support for management and leadership development and pre-service education for public health professionals.

Cost efficiency: This mechanism has been designed from the start with cost efficiency in mind. Supporting a Namibian institution for graduate-level public health education will obviate the need to send Namibians abroad for similar training. Investments in the public education sector will also support the public sector career ladder for faculty and staff, and contribute to a retention of talented Namibian



instructors. This mechanism will promote innovative cost-effective approaches including distance communication and e-learning technologies, such as digital video conferencing for distance-based co-teaching, guest-lecturing, mentorship, and professional development workshops to students and MPH lecturers. The use of electronic journals and texts such as the World Health Organization's HINARI e-journal database will replace the costs of purchasing and shipping expensive hardcopy textbooks and teaching resources while contributing to UNAM's collection of educational resources. Over the course of the life of this mechanism, UNAM and UW/ITECH plan to enhance sustainable regional collaboration through a partnership with the University of Western Cape in South Africa.

M&E: A detailed monitoring and evaluation plan for the five years of the cooperative agreement has been developed to monitor progress towards achieving the stated goals and objectives. Benchmarks and indicators have been developed to ensure the implementation of each component. Progress will be reported semi-annually to CDC. The indicators tracked through this mechanism are drawn from the Next Generation PEPFAR indicators and are aligned with the GRN indicators in the NSF. This mechanism will also contribute to the targets outlined in the Human Resources Development Strategy 2008-2014. The monitoring and evaluation plan for the five year project will be modified and adjusted as the years progress to ensure that arising needs are accommodated.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	460,600
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Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: 10780			
Mechanism Name: Cooperative Agreement 1U58PS001452			
Prime Partner Name: University of Washington			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	658,000	
Narrative:			

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It aims to strengthen graduate-level public health education in the government of the Republic of Namibia under PEPFAR. This activity has 6 main components: (1) Enhance the UNAM MPH program through increasing specializations in Nutrition, Strategic Information, Health Policy and Management, and greater integration of HIV and AIDS content into MPH courses; (2) Institutionalize support to MPH students to complete thesis requirement within 2-4 years; (3) Strengthen institutional capacity of UNAM by increasing faculty development opportunities; (4) Strengthen Health Resource Center library systems and services at UNAM; (5) Establish and maintain on-going collaborative relationships with UNAM to ensure sustainability of project results (6) Enhance the Distance learning systems in UNAM

1. Enhance the UNAM MPH program: With FY10 funds I-TECH will continue with the development of specialized MPH program and will continue strengthening the nutrition, strategic information, and health policy and management components of the MPH program while ensuring integration of HIV/AIDS content into all areas of the curriculum.

2. Support to MPH students to complete thesis requirement within 2-4 years: With FY10 funds, I-TECH will continue supporting the development and strengthening of strategies for thesis advisors and students to ensure the overall thesis completion and graduation of MPH students. By strengthening strategies for the finalization of thesis within the MPH program, students within MPH program will graduate within the course timeframe and thereby deliver needed public health services for the nation.

3. Increasing faculty development opportunities: With FY10, I-TECH will continue capacity building of MPH lecturers by implementing the recommendations of the faculty needs assessment that was carried out in FY09. In addition, with FY10 funds, I-TECH will facilitate MPH lectures to twin with Global Health Faculties within the MPH course at the University of Washington so the lecturers from both universities can share and exchange experience of teaching public health.

4. Strengthen Health Resource Center library systems and services at UNAM: In order to provide the latest information and resources in public health including teaching, learning, and research material for the MPH student and lectures, I-TECH with FY10 funds will continue procuring the necessary books and equipment for the MPH resource centers at UNAM.

5. Establish and maintain on-going collaborative relationships with UNAM: In an effort to promote long-term cost effectiveness and sustainability, I-TECH will facilitate the establishment of regional collaboration between the University of Western Cape in South Africa and UNAM. This collaboration will include exchange visits between the universities and bringing topical specialists from UWC to coach and work with MPH lectures in UNAM. In addition, University of Washington topic specialists in the areas of nutrition, strategic information, and policy and leadership will continue working with both UWC and UNAM lecturers to ensure that the overall MPH course meets UW standards.

6. Enhance Distance Learning Systems in UNAM: In FY10 I-TECH will work with UNAM to strengthen its



distance learning system in order to reach students in remote sites with lectures in real time. I-TECH will install and utilize basic technologies and educational methodologies developed and used by the Computer Science Department at University of Washington. Through the FY10 funds this technology will be piloted in three sites in order to validate feasibility and efficiency of this method of teaching. Furthermore, with FY10 funds, the distance learning infrastructure will be built and UNAM distance learning staff will be trained.

Supportive supervision/Quality Assurance: UW/I-TECH and UNAM have jointly developed a robust M&E plan for this project in collaboration with the designated CDC GAP project officer. This M&E or Performance Plan includes benchmarks and indicators to monitor outputs and outcomes. Indicators, data sources, and persons responsible have been clearly defined. These indicators and benchmarks will be reported on semi-annually and an annual program review will be undertaken to take stock of achievements, identify areas for improvement, and make modifications for subsequent years' activities.

Sustainability The human resources crisis in Namibia is a severe constraint in achieving national and PEPFAR targets for HIV prevention, care, and treatment. This program will contribute to sustainable Public Health human resources in Namibia will contribute to PEPFAR goals to train 140,000 new HCW. Strengthening the MPH degree program at UNAM will also ensure that more public health professionals graduate each year with skills in policy development, capacity building, strategic information, and nutrition related to HIV and AIDS and these graduates will work within the Namibian public health system.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11572	Mechanism Name: US Centers for Disease Control and Prevention
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: USG Core
Prime Partner Name: HHS/Centers for Disease Control & Prevention	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 3,866,918	
Funding Source	Funding Amount
GHCS (State)	3,866,918



Sub Partner Name(s)

(No data provided.)

Overview Narrative

SUBSTANTIALLY CHANGED FROM LAST YEAR

The CDC Global AIDS Program (GAP) provides technical assistance and direct funding to partners working in the national HIV/AIDS response in Namibia. CDC's main partner is the Ministry of Health and Social Services (MOHSS), which hosts CDC's offices through a co-location agreement. CDC technical advisors and administrators provide direct support to MOHSS to strengthen public health infrastructure and build human resource capacity.

CDC support for MOHSS includes technical input through evaluations, assessments and surveys, supportive supervision and mentoring, human resource capacity building, and collaboration on joint initiatives such as the Partnership Framework (PF).

In COP10, continuing technical emphasis will be placed on:

- Training for providers on revised ART, PMTCT and STI guidelines.
- Expanding and evaluating prevention efforts
- Supporting the decentralization of ART services.
- Integrating TB and HIV services.
- Surveillance systems
- Evaluating the impact of task-shifting.
- Expanding access to palliative care and pediatric treatment.
- Assisting with the response to drug-resistance (TB and HIV)
- Supporting rapid HIV testing by community counselors and through mobile services.
- Building the evidence base to support expanded HCT and care and treatment services in Namibian prisons.
- Coordinating resources with the Global Fund, the government of Namibia (GRN) and other donors.

CDC also provides technical and financial assistance to local partners, including, Development Aid People to People (DAPP), the Namibia Institute of Pathology (NIP), and the Blood Transfusion Service of Namibia (NAMBTS). In COP09, 86% of CDC-managed funds were allocated to partners, of whom 79% were local Namibian entities. The balance of CDC's budget supported CDC technical advisors and office operations.

Links to the Partnership Framework



In Namibia, unlike many other PEPFAR-supported countries in sub-Saharan Africa, a majority of the PEPFAR budget provides direct support to the GRN and other local entities. Given these considerable local investments, CDC is already deeply engaged in strengthening GRN capacity and ownership, especially in the areas of human resources, and the financing and operation of national healthcare systems. In COP10, PEPFAR will emphasize the GRN's capacity to plan, oversee, manage and, eventually, finance a growing share of the commitments made in the four priority areas identified by the PF: Prevention; Treatment, Care and Support; Impact Mitigation; and Coordination and Management.

Coverage and Target population

CDC supports activities with a national scope. In COP10 and beyond, CDC will increasingly promote multi-sectoral coordination and integration to mainstream the impact of PEPFAR's HIV/AIDS investments.

Health Systems Strengthening

In 2008, an MOHSS review identified two areas of structural weakness within the GRN healthcare system: Unequal access to health facilities and human resources.

In COP10, CDC technical assistance will emphasize training and other capacity building for all cadres of health workers. CDC will also support expanded access to services. Special emphasis will be placed on supporting administrative systems to manage Human Resources for Health.

Cross-Cutting Programs and Key Issues

This activity's main cross cutting area is Human Resources for Health. This program will contribute to PEPFAR's broader effort to build human resource capacity by improving the capacity of MOHSS to recruit, manage and retain staff. CDC's support for pre- and in-service service training will also build a sustainable pool of Namibian healthcare workers in nursing, medicine, pharmacy, counseling, and laboratory sciences.

Cost Efficiencies Over Time

CDC's technical assistance to the MOHSS and other partners supports the development of sustainable engagement and, where relevant, transition plans. These plans are evidence-based. Special emphasis will be given to cost-efficient strategies, including task-shifting and the recruitment and deployment of locally-trained community lay healthcare workers. In COP10, CDC will continue support for on-going GRN costing activities, and conduct programmatic assessments to determine the costs and impact of



community-based strategies. These assessments will be linked to the bi-annual PEPFAR reporting calendar, and respond to reporting requirements embedded in the cooperative agreement mechanisms used to manage PEPFAR funds. CDC will also continue support for long-term strategic planning, including the National Strategic Framework and associated costing exercises. Key areas for CDC support in this area include: 1) Actual and projected costs; 2) non-financial resources needed to meet program goals (e.g., human resources, equipment); 3) resource mobilization strategies, and; 4) options to institutionalize the activity within a particular sector (e.g., GRN, NGO community, for-profit).

Over time, CDC is committed to working with MOHSS to identify activities that may be absorbed completely by the GRN, that require continuing technical assistance from the USG, and that could be terminated.

Monitoring and Evaluation Plans

The CDC works with MOHSS and other development partners to strengthen, integrate, and align M&E plans, indicators and systems. All of CDC's program indicators have been aligned with NSF and PEPFAR targets. Bi-annual reports identify progress and describe any necessary changes based on available evidence.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	3,866,918
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Key Issues

- Addressing male norms and behaviors
- Impact/End-of-Program Evaluation
- Increasing gender equity in HIV/AIDS activities and services
- Increasing women's access to income and productive resources
- Malaria (PMI)
- Child Survival Activities
- Military Population
- Mobile Population
- Safe Motherhood
- TB
- Workplace Programs



Family Planning

Budget Code Information

Mechanism ID: 11572			
Mechanism Name: US Centers for Disease Control and Prevention			
Prime Partner Name: HHS/Centers for Disease Control & Prevention			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	75,000	

Narrative:

NEW/CONTINUING ACTIVITY WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes one component: 1) partial salary support for a CDC technical advisor for palliative care. This position will work with a team of other CDC technical advisors embedded with the Ministry of Health and Social Services (MOHSS) Directorate for Special Programmes (DSP).

Palliative care is a multidisciplinary approach that improves the quality of life for children and their families through prevention of, and relief from pain, as well as through treatment of other symptoms of disease and provision of psychosocial and spiritual support. The funds from this activity cover 75% of salary and personnel-related costs for a Palliative Care Technical Advisor. The remaining funds are reflected in the PDCS program area. In COP10, this position will be a Locally Employed Staff (LES). The technical advisor will provide specific technical assistance to the MOSS in the following areas:

1. Quality assurance for adult and pediatric HIV care services. This support will also cover QA activities related to the national Integrated Management of Adult Illness (IMAI) and Integrated Management of Childhood Illness (IMCI) programs.
2. Mentoring and program support for the MOHSS Coordinator for Palliative Care and Opportunistic Services in the DSP. This assistance will emphasize leadership capacity building.
3. Serve as a liaison to the MOHSS Case Management Unit, CDC's HIVQUAL Coordinator, I-TECH's training and mentorship programs, the IMAI site nurses and district ART doctors.
4. Collaborate with the MOHSS Family Health Division, to promote integration of nutrition, family planning and other community and home-based health programs with HIV services and HIV palliative care. These priorities include, cotrimoxizole prophylaxis for HIV-exposed children; support for the 3 I's of TB prevention (infection control, isoniazid preventive therapy, and intensified case finding); integrated HIV counseling and testing; safe motherhood and child survival cross-cutting activities (e.g., infant feeding counseling for HIV-positive mothers); referrals to other health programs (e.g., immunizations);



combination prevention messaging, and; condom promotion.

5. Coordinate procurement and supply chain management issues with MOHSS ART sites, Central Medical Stores, and SCMS.

6. Support for opportunistic infection management, routine clinical monitoring, and systematic pain and symptom management.

Supportive Supervision: The palliative care technical advisor will complement other direct technical assistance offered by other members of the CDC technical advisory team (prevention, PMTCT, HIVQUAL, laboratory, health communications). Supportive supervision will be provided through site visits and in conjunction with training courses offered by other partners. The palliative care TA will also collaborate with the African Palliative Care Association (APCA) and a USAID Regional Technical Advisor for HIV/AIDS Palliative Care.

Sustainability: Support for the CDC palliative care advisor is in line with PEPFAR's vision of constructive, government-to-government engagement through technical assistance. Through other technical areas (Health Systems Strengthening), CDC will continue to support the MOHSS to build additional human resource capacity within the MOHSS civil service. This support will emphasize the creation of HR structures to absorb a wide range of healthcare personnel, including community-based prevention counselors and nurses with integrated training in HIV/AIDS, IMAI and IMIC. Direct technical assistance in this area will also contribute to the development of a national palliative care policy as well as palliative care ask-shifting activities within the MOHSS.

Lastly, through supportive supervision visits, closer partnerships with districts and communities will allow increased opportunities to leverage HIV/AIDS investments to benefit other community health objectives, e.g., safe water and malaria prevention.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	444,073	

Narrative:

NEW/CONTINUING ACTIVITY WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes two components: (1) personnel-related costs for CDC's HIVQUAL Technical Advisor, (2) a portion of the costs of HIVQUAL program administration. Funding for this activity is reflected 85% in Adult Treatment (HTXS) and 15% in Pediatric treatment (PDTX)

1. Personnel-related costs for CDC's HIVQUAL Technical Advisor: Since FY 2007 COP, PEPFAR has funded a technical advisor to assist the Ministry of Health and Social Services (MOHSS) with rollout of the HIVQUAL program The HIVQUAL Technical Advisor provides high-quality technical assistance to PEPFAR country team, MOHSS, technical workgroups, and implementing partners to ensure that the



portfolio of program activities contributes to the national HIV/AIDS strategic goals and targets. The HIVQUAL TA assists MOHSS with continuous quality improvement of HIV care and treatment services through leadership of the HIVQUAL initiative as well as through training and monitoring of personnel at participating clinical sites.

2. HIVQUAL program administration. COP10 funds will be used to support general administration of the HIVQUAL program, as well as in-country travel for quality improvement (QI) coaching and training costs related to rolling out the HIVQUAL program in treatment and care settings. The sharing of best practices is necessary to learn from the experiences of others and promote quality improvement. The national coordinators of HIVQUAL participate in QI conferences to learn from others and share experiences.

Supportive supervision

The HIVQUAL coordinator along with MOHSS staff make frequent support supervision visits to participating clinics throughout Namibia. During these visits the HIVQUAL team assesses the following: 1) quality management programs at the participating clinics; 2) performance measurement of selected core indicators. The HIVQUAL coordinator also provides ongoing QI coaching at participating sites and promotes consumer engagement in HIV care. The HIVQUAL team has regular conference calls with the US-based team and develops and disseminates QI related IEC materials including the HIVQUAL International Newsletter.

An assessment tool is used to measure the capacity of the quality management program at each facility. Aggregate facility-specific data provides population-level performance data that indicate priorities for national quality improvement activities and campaigns. Publication and dissemination of these data will be done under the auspices of the MOHSS. An important emphasis of this approach is to develop the skills of providers for collecting and using performance data within their own organizations to improve their systems of care. The HIVQUAL technical advisor will complement other direct technical assistance offered by other members of the CDC technical advisory team (prevention, PMTCT, HIVQUAL, laboratory, health communications).

Sustainability

COP10 HIVQUAL activities will be conducted under the leadership of the MOHSS Directorate of Special Programs (DSP) in close collaboration with the CDC HIVQUAL Technical Advisor. The HIVQUAL program will support capacity building for QI for all public health facilities providing HIV care and treatment. This approach is in sync with the new PEPFAR vision for sustainability and will ensure integration of the quality improvement program at all levels of management and HIV service delivery. In addition, by building capacity at the national and local levels for quality improvement and use of strategic information by providers for program improvement, the activity will strongly contribute to overall health systems strengthening. Support for the CDC HIVQUAL technical advisor is in line with PEPFAR's vision of constructive, government-to-government engagement through technical assistance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
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Care	HVCT	297,500	
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Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes one component: 1) salary and related personnel costs for CDC's Counseling and Testing Technical Advisor. Since 2005, PEPFAR has funded a technical advisor to assist the Ministry of Health and Social Services' (MOHSS) National Counseling and Testing Coordinator via a non personal services contract. In COP 2009, this position was converted to a personal services contract (PSC).

The CT Advisor will continue to play a key role in the deployment of community counselors to public health facilities, outreach teams, and correctional facilities. In COP10, the Advisor will continue to support CT related policy development and changes that facilitate the implementation of HCT activities in Namibia. As part of maintaining quality while expanding coverage, the Advisor will support the HCT program's quality assurance activities for both rapid HIV testing and counseling. With shifting of HCT tasks from the laboratory personnel to community counselors (CC), the Advisor will work with the MOHSS to ensure that CC provide high quality, and cost effective, services.

The Advisor will provide technical assistance to the head of the Counseling and Testing Unit within MOHSS' Directorate of Special Programmes (DSP) to promote provider-initiated testing and counseling (PITC) in clinical settings. The Advisor will also guide the national program in the continued implementation of national CT guidelines and will support the regions and districts in the implementation and monitoring of programs. This work will be done in line with the implementation of a new national Decentralization plan. The Advisor will also continue to support the unit with the continued scale up and supervision of rapid HIV testing as well as counseling and testing sites in health facilities, correctional facilities, and new outreach activities.

Supportive Supervision: The advisor will continue to play a key role in the training and mentoring of CCs for CT services and to support strategies described in the Partnership Framework Implementation Plan to link HCT with other programmatic areas, including PMTCT, AB, condoms/other prevention, TB/HIV, and care and treatment services. Within ART sites, CCs provide adherence and couples counseling, among other responsibilities. The advisor will be intimately involved with other CDC technical advisors in the MOHSS' continuing implementation of the prevention with positives initiative at the national level. The Advisor will continue to serve as a co-chair and member of the HCT national technical working group and a co-chair of the National HIV Testing Day (NTD) steering committee. The advisor will continue to play a key role in NTD planning and implementation, as well as similar testing events coordinated with World AIDS Day.

Sustainability: In COP10, the Advisor will continue to build the capacity of the CT program through mentorships and technical assistance aimed at transferring skills to MOHSS counterparts. In addition to technical guidance on HCT, the Advisor will also support the development of administrative capacity,



leadership, and country-ownership within the MOHSS. Specific emphasis will be placed on strengthening the MOHSS's ability to plan, manage and finance national mobilization and advocacy events, such as the National Testing Day.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	25,000	

Narrative:

NEW/CONTINUING ACTIVITY WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes one component: 1) partial salary support for a CDC technical advisor for palliative care. This position will work with a team of other CDC technical advisors embedded with the Ministry of Health and Social Services (MOHSS) Directorate for Special Programmes (DSP).

Palliative care is a multidisciplinary approach that improves the quality of life for children and their families through prevention of, and relief from pain, as well as through treatment of other symptoms of disease and provision of psychosocial and spiritual support. The funds from this activity cover 25% of salary and personnel-related costs for a Palliative Care Technical Advisor. The remaining funds are reflected in the Adult Care and Support (HBHC) program area. In COP10, this position will be converted from a contractor to a Locally Employed Staff (LES).

The technical advisor will provide specific technical assistance to the MOSS in the following areas:

1. Quality assurance for adult and pediatric HIV care services. This support will also cover QA activities related to the national Integrated Management of Adult Illness (IMAI) and Integrated Management of Childhood Illness (IMCI) programs.
2. Mentoring and program support for the MOHSS Coordinator for Palliative Care and Opportunistic Services in the DSP. This assistance will emphasize leadership capacity building.
3. Serve as a liaison to the MOHSS Case Management Unit, CDC's HIVQUAL Coordinator, I-TECH's training and mentorship programs, the IMAI site nurses and district ART doctors.
4. Collaborate with the MOHSS Family Health Division, to promote integration of nutrition, family planning and other community and home-based health programs with HIV services and HIV palliative care. These priorities include, cotrimoxizole prophylaxis for HIV-exposed children; support for the 3 I's of TB prevention (infection control, isoniazid preventive therapy, and intensified case finding); integrated HIV counseling and testing; safe motherhood and child survival cross-cutting activities (e.g., infant feeding counseling for HIV-positive mothers); referrals to other health programs (e.g., immunizations); combination prevention messaging, and; condom promotion.
5. Coordinate procurement and supply chain management issues with MOHSS ART sites, Central Medical Stores, and SCMS.
6. Support for opportunistic infection management, routine clinical monitoring, and systematic pain and



symptom management.

Supportive Supervision: The palliative care technical advisor will complement other direct technical assistance offered by other members of the CDC technical advisory team (prevention, PMTCT, HIVQUAL, laboratory, health communications). Supportive supervision will be provided through site visits and in conjunction with training courses offered by other partners. The palliative care TA will also collaborate with the African Palliative Care Association (APCA) and a USAID Regional Technical Advisor for HIV/AIDS Palliative Care.

Sustainability: Support for the CDC palliative care advisor is in line with PEPFAR's vision of constructive, government-to-government engagement through technical assistance. Through other technical areas (Health Systems Strengthening), CDC will continue to support the MOHSS to build additional human resource capacity within the MOHSS civil service. This support will emphasize the creation of HR structures to absorb a wide range of healthcare personnel, including community-based prevention counselors and nurses with integrated training in HIV/AIDS, IMAI and IMIC. Direct technical assistance in this area will also contribute to the development of a national palliative care policy as well as palliative care ask-shifting activities within the MOHSS.

Lastly, through supportive supervision visits, closer partnerships with districts and communities will allow increased opportunities to leverage HIV/AIDS investments to benefit other community health objectives, e.g., safe water and malaria prevention.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	25,795	

Narrative:

NEW/CONTINUING ACTIVITY WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes two components: (1) personnel-related costs for CDC's HIVQUAL Technical Advisor, (2) a portion of the costs of HIVQUAL program administration. Funding for this activity is reflected 15% in Pediatric treatment (PDTX) and 85% Adult Treatment (HTXS).

1. Personnel-related costs for CDC's HIVQUAL Technical Advisor: Since FY 2007 COP, PEPFAR has funded a technical advisor to assist the Ministry of Health and Social Services (MOHSS) with rollout of the HIVQUAL program. The HIVQUAL Technical Advisor provides high-quality technical assistance to PEPFAR country team, MOHSS, technical workgroups, and implementing partners to ensure that the portfolio of program activities contributes to the national HIV/AIDS strategic goals and targets. The HIVQUAL TA assists MOHSS with continuous quality improvement of HIV care and treatment services through leadership of the HIVQUAL initiative as well as through training and monitoring of personnel at participating clinical sites.



2. HIVQUAL program administration. COP10 funds will be used to support general administration of the HIVQUAL program, as well as in-country travel for quality improvement (QI) coaching and training costs related to rolling out the HIVQUAL program in treatment and care settings. The sharing of best practices is necessary to learn from the experiences of others and promote quality improvement. The national coordinators of HIVQUAL participate in QI conferences to learn from others and share experiences.

Supportive supervision

The HIVQUAL coordinator along with MOHSS staff make frequent support supervision visits to participating clinics throughout Namibia. During these visits the HIVQUAL team assesses the following: 1) quality management programs at the participating clinics; 2) performance measurement of selected core indicators. The HIVQUAL coordinator also provides ongoing QI coaching at participating sites and promotes consumer engagement in HIV care. The HIVQUAL team has regular conference calls with the US-based team and develops and disseminates QI related IEC materials including the HIVQUAL International Newsletter.

An assessment tool is used to measure the capacity of the quality management program at each facility. Aggregate facility-specific data provides population-level performance data that indicate priorities for national quality improvement activities and campaigns. Publication and dissemination of these data will be done under the auspices of the MOHSS. An important emphasis of this approach is to develop the skills of providers for collecting and using performance data within their own organizations to improve their systems of care. The HIVQUAL technical advisor will complement other direct technical assistance offered by other members of the CDC technical advisory team (prevention, PMTCT, HIVQUAL, laboratory, health communications).

Sustainability

COP10 HIVQUAL activities will be conducted under the leadership of the MOHSS Directorate of Special Programs (DSP) in close collaboration with the CDC HIVQUAL Technical Advisor. The HIVQUAL program will support capacity building for QI for all public health facilities providing HIV care and treatment. This approach is in sync with the new PEPFAR vision for sustainability and will ensure integration of the quality improvement program at all levels of management and HIV service delivery. In addition, by building capacity at the national and local levels for quality improvement and use of strategic information by providers for program improvement, the activity will strongly contribute to overall health systems strengthening. Support for the CDC HIVQUAL technical advisor is in line with PEPFAR's vision of constructive, government-to-government engagement through technical assistance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	1,518,700	

Narrative:

NEW/CONTINUING ACTIVITY WITH SUBSTANTIAL CHANGES



This is a continuation of COP 09 activities. It includes four components: (1) support for Strategic Information (SI)-related database systems (ePMS/HIS) and programs; (2) salary support for three CDC technical advisors; (3) support for an HIV prevalence survey in correctional facilities, and; (4) technical assistance for rapid assessments, population size estimations and behavioral surveillance of most at risk populations (MARPS).

1) Database and SI program support: Namibia has adopted or developed information systems for the ART and TB programs that are separate from the routine Health Information System (HIS). These clinical systems are patient-based (with one record per patient per encounter), unlike the routine HIS systems, which collect aggregated data. CDC will support technical assistance to maintain, update and integrate these systems. This support will include training, supportive supervision to clinical sites, database management, updating the software based on user feedback, and revising protocols (e.g., due to changes in ART guidelines). Additional support will promote software standardization across MOHSS M&E units, and ensure software licenses are up to date.

2.) Support for three technical advisors (M& E, Health Management Information Systems, SI): The Monitoring and Evaluation technical advisor provides direct support to the MOHSS Response M&E department (RM&E). The technical advisor will provide support on epidemiological methods for program evaluation, surveillance activities, research, and operational research. The Health Management Information Systems (HMIS) technical advisor will support the development, expansion and integration of MOHSS health information systems across multiple technical areas (ART, PMTCT, VCT, pharmacy, and lab). The Strategic Information (SI) advisor supports routine program monitoring, program evaluation, data capture and tool development, data triangulation, costing, PEPFAR-related SI, and other special SI projects. In COP10 these three positions will be funded as Personal Service Contractors (PSC).

3. Prison HIV prevalence survey: The HIV/AIDS Program in the Government of Namibia's Department of Prison Services, Ministry of Safety and Security has requested technical assistance from CDC for an HIV prevalence survey among inmates in the national prison system. Although voluntary HIV counseling and testing is currently offered in correctional facilities, there is varied delivery and uptake of these services, and the rate of HIV infection among prisoners and prison staff is unknown. An assessment of potential routes of HIV transmission in prisons will inform the development of prison HIV/AIDS prevention programs, and serve as an advocacy tool for HIV/AIDS-related prison policies. The survey will be conducted in six Namibian prisons. It will include HIV testing as well as an assessment of behavioral risk behaviors.

4. Rapid assessment, population size estimation, and bio- behavioral survey of MARPS: This is a new activity in COP10. To enhance understanding of HIV epidemiology among most at risk populations in Namibia (e.g., sex workers and men who have sex with men), CDC will support formative work and surveys among these vulnerable populations.

Supportive supervision: The SI, M&E and HMIS advisors will complement other direct technical



assistance offered by other members of the CDC technical advisory team (prevention, PMTCT, HIVQUAL, laboratory, health communications). Supportive supervision will be provided through site visits, day-to-day on-site collaboration, and in conjunction with training.

Sustainability: Support for CDC technical advisors is in line with PEPFAR's vision of constructive, government-to-government engagement through technical assistance. Through other technical areas (Health Systems Strengthening), CDC will continue to support the MOHSS to build additional human resource capacity within the MOHSS civil service. This support will emphasize the creation of HR structures to absorb a wide range of healthcare personnel, including community-based prevention counselors and nurses with integrated training in HIV/AIDS, IMAI and IMIC. Direct technical assistance in this area will also contribute to the development of a national palliative care policy as well as palliative care ask-shifting activities within the MOHSS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	388,087	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This activity includes two primary components: (1) continuing support for a CDC Prevention Technical Advisor to the Ministry of Health and Social Services (MOHSS) (2) start-up funding to assess implementation and piloting of CDC's Families Matter! Intervention.

1. CDC Prevention Technical Advisor: The CDC Prevention technical advisor supports a national counterpart in the Directorate of Special Programmes. The MOHSS prevention coordinator provides leadership on national prevention activities. The USG prevention advisor works closely with his MOHSS counterpart and provides ongoing technical assistance to plan, implement, and enhance prevention programming. Additional technical assistance by the TA will include capacity development to provide national leadership on the most evidence-based prevention strategies available, including behavioral change interventions and medical interventions (e.g. male circumcision,).

In addition, the prevention TA supports a process to adapt best practices from other countries and to promote dissemination of best practices from within Namibia at the national and international level. This includes support for the development of a National Prevention Strategy and the National Prevention Technical Advisory Committee.

The prevention TA also supports a local partner's program to provide community-based, door-to-door

prevention. In 2009, this partner's activities were assessed and enhanced by placing an additional emphasis on behavior change (e.g., abstinence, HIV testing, links to services, and reduction in sexual risk behaviors). The TA works with the local partner to adopt curricula incorporating AB messaging proven to be effective.

2. Needs Assessment and Pilot Activities for CDC Families Matter!

PEPFAR will add a new intervention to promote positive parenting practices and effective parent-child communication about sexuality and sexual risk reduction for parents and guardians of 9-12 year olds. .

The Families Matter! Program (FMP) intervention is an adaptation of the US-based "Parents Matter!" curriculum which CDC has evaluated in the US. The ultimate goal of FMP is to reduce sexual risk behaviors among adolescents, including delayed onset of sexual debut, by giving parents tools to deliver primary prevention to their children. Families Matter! is a community-based, group-level intervention that is delivered over five consecutive 3-hour sessions.

Funding for the first year of FMP in Namibia would include resources to assess how the FMP can be incorporated into the work of existing partners. A needs assessment will take place, as well as pilot implementation based on needs assessment results. Resources would also be used for travel expenses for technical assistance from CDC Atlanta. Additional resources will be used for translation of materials, trainings, and workshops.

Supportive supervision: The CDC prevention technical advisor is embedded in the MOHSS Directorate of Special Programmes. As such, the advisor is available to provide day-to-day assistance to the MOHSS prevention coordinator and other colleagues and other partners. The prevention advisor will complement other direct technical assistance offered by other members of the CDC technical advisory team (VCT, PMTCT, HIVQUAL, health communications). Supportive supervision will be provided through site visits and in conjunction with training courses offered by other partners (e.g., I-TECH). The CDC prevention technical advisor also serves as a conduit for additional expert technical assistance from CDC headquarters and from international and regional counterparts. This role as a "twinning" advisor promotes regional and south-to-south cooperation.

Sustainability: Support for the CDC Prevention TA is in line with PEPFAR's vision of constructive, government-to-government engagement through technical assistance. Through other technical areas



(Health Systems Strengthening), CDC will continue to support the MOHSS to build additional human resource capacity within the MOHSS civil service. This support will emphasize the creation of HR structures to absorb a wide range of healthcare personnel, including community-based prevention counselors and nurses with integrated training in HIV/AIDS, IMAI and IMIC. Direct technical assistance in this area will also contribute to the development and implementation of a national prevention strategy and the national prevention technical advisory committee.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	559,448	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09, and includes two main components: (1) salary support for a CDC PMTCT technical advisor (TA), and; (2) support for two CDC PMTCT field support nurses based at Oshakati State Hospital.

USG will continue to work closely with MOHSS at the national, regional and service levels in the 34 health districts to monitor the implementation and expansion of PMTCT services to all 256 antenatal care (ANC) sites.

Specific activities include:

1) Support for a CDC PMTCT Technical Advisor to the MOHSS. The CDC PMTCT technical advisor (TA) supports a national counterpart in the Directorate for Primary Health Care (PHC). In COP10, the TA will continue to support revisions to the MOHSS PMTCT guidelines based on revised guidance from WHO. The TA will be involved in making sure costing implications are taken into consideration. The TA will also work to increase collaboration with other key related program areas; including care and treatment, ART (Pediatrics and Adult), OVCs, lab, prevention, strategic information (SI) and others. Additionally, the TA will assist with curriculum development activities for PMTCT, early infant diagnosis of HIV, ART, Pediatric ART, Integrated Management of Adult Illness (IMAI), Integrated Management of Childhood Illnesses (IMCI), and infant feeding. Lastly, supervisory support visits will be undertaken to provide mentoring and technical backstopping to the regions.

2) CDC PMTCT field support nurses. These nurse mentors are stationed in Oshakati State Hospital, the largest hospital in the north. Working with MOHSS staff, these nurses conduct supervisory support visits to PMTCT sites. They provide on-site monitoring, training, and assessment of the quality of services,



patient flow, and record keeping. These visits also help to identify challenges and future training needs. In COP10, the nurses will emphasize monitoring of rapid testing services in PMTCT settings, the integration of PMTCT with other HIV prevention, care and treatment services, and conduct trainings for traditional birth attendants. The field nurses will cover facilities in six regions: Oshana, Oshikoto, Ohangwena, Omusati, Kunene (new) and Kavango (new). CDC/Oshakati field nurses partner with other programs to identify needs, facilitate and implement supportive programs.

The field nurses will also continue to support the collection of PMTCT data at ANC and delivery sites, and support health care workers with monitoring and evaluation activities, including the use of local data for program improvement. As part of this effort, the nurses will emphasize community outreach workers' work to follow-up mother-baby pairs and refer at risk mothers and babies back to PMTCT services. The field support nurses will work on strengthening community outreach utilizing existing community based organizations to encourage women to present early for ANC, and will work towards establishing mother-to-mother support groups that will provide psychosocial support and support for safe infant feeding, as well as help to ensure retention in ANC and care and treatment for HIV-positive women and their families as appropriate.

Supportive Supervision: The CDC TA for PMTCT will provide supportive supervision for the CDC field nurses, and for MOHSS staff at the national and sub-national levels. This assistance will be complemented by supportive supervision from a PMTCT coordinator employed by the MOHSS with Global Fund support. The CDC field nurses will provide follow-up supervision and mentoring the local and facility-based community outreach workers, as well as to other nurses.

Sustainability: This activity leverages Human Resource for Health (HRH) funding from the Global Fund, which supports a PMTCT Coordinator within the MOHSS system. Support for the CDC TA and the CDC field nurses is in line with PEPFAR's vision of constructive, government-to-government engagement through technical assistance. Through other technical areas (Health Systems Strengthening), CDC will continue to support the MOHSS to build additional human resource capacity within the MOHSS civil service. This support will emphasize the creation of HR structures to absorb a wide range of healthcare personnel, including community-based lay counselors and nurses with integrated training in HIV/AIDS, IMAI and IMIC. CDC support for early infant diagnosis and mother-baby tracing will leverage PEPFAR funds for PMTCT to improve maternal and child health outcomes, two priority objectives for the USG and the GRN.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	272,320	

Narrative:

NEW/CONTINUING ACTIVITY WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes one component: 1) partial salary support for a laboratory technical advisor on the CDC Namibia staff. This advisor will provide expert support and assistance to the Namibia Institute of Pathology (NIP), the MOHSS, and other partners involved in laboratory services. Since this laboratory scientist will also support TB activities, 30% of the funding is described in the HVTB program area. HLAB supports the remaining 70%.

Since 2005, CDC has supported a laboratory scientist to provide technical assistance to NIP and the MOHSS. This advisor has helped to develop and implement standard operating procedures for quality services related to diagnostic DNA PCR, CD4, HIV incidence testing, and TB and HIV drug resistance testing.

The advisor will continue to work with the International Laboratory Branch Consortium (ILBC) to coordinate ongoing information sharing between NIP and other laboratories, as well as the technical activities describe in the ILBC narrative In addition, the advisor will provide oversight and technical assistance to support the activities described in the NIP HLAB narrative. Specifically, the advisor will work with NIP and MOHSS to improve linkages between clinical patient records and laboratory records. The advisor will work with NIP and MOHSS to capture and link the new e-PMS patient data with information captured by the NIP Laboratory Information System. This linkage will improve tracking and program reporting systems.

The advisor will also contribute to sustainability at NIP and MOHSS through mentorship and skills transfer to laboratory staff nationally. This support will also improve utilization and data sharing between NIP and MOHSS. The advisor will also support a new cooperative agreement with the Polytechnic of Namibia. This new implementing mechanism will support laboratory training and "twinning" activities between the Polytechnic and international technical assistance partners (e.g., University of Arkansas).

Supportive Supervision: The laboratory advisor will complement other direct technical assistance offered by other members of the CDC technical advisory team (prevention, PMTCT, HIVQUAL, health communications). Supportive supervision will be provided through site visits, day-to-day on-site collaboration, and in conjunction with training courses offered by other partners (e.g., ILBC).

Sustainability: Support for the CDC laboratory advisor is in line with PEPFAR's vision of constructive, government-to-government engagement through technical assistance. Through other technical areas (Health Systems Strengthening), CDC will continue to support the MOHSS to build additional human resource capacity within the MOHSS civil service. This support will emphasize the creation of HR structures to absorb a wide range of healthcare personnel, including community-based prevention counselors and nurses with integrated training in HIV/AIDS, IMAI and IMIC. Direct technical assistance in this area will also contribute to the development of a national palliative care policy as well as palliative care ask-shifting activities

Strategic Area	Budget Code	Planned Amount	On Hold Amount
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Treatment	HVTB	260,995	
Narrative:			
<p>NEW/CONTINUING ACTIVITY WITH SUBSTANTIAL CHANGES</p> <p>This is a continuing activity from COP09, includes three primary components: (1) continued technical support for the Electronic TB Register (ETR), (2) partial support for salary and related personnel costs for a continuing CDC Technical Advisor for Laboratory Services, and (3) support for salary and related personnel costs for a TB Laboratory Advisor. Both advisors will be assigned to the Namibia Institute of Pathology (NIP).</p> <p>1. Electronic TB Register. Namibia is one of several southern Africa countries that adopted the ETR developed by the BOTUSA Project (Botswana-CDC collaboration) in Botswana. The ETR records information on HIV status and use of ART in TB/HIV patients and is used to measure key indicators and monitor expansion of HIV care and treatment among TB patients. The ETR is expected to further contribute to enhancements in TB surveillance, and inform improvements in TB prevention, early detection, and treatment. , CDC will continue to support the Ministry of Health and Human Services' (MOHSS) ongoing implementation of the ETR through a local contract with WAMTech of South Africa. WAMTech is the sole provider of ETR software and support.</p> <p>In 2008, Namibia has reported over 300 cases of multidrug resistant TB (MDR TB), and approximately 20 cases of Extensively Drug Resistant TB (XDR TB) have been confirmed. The MOHSS is interested in adding an X/MDR component to the ETR to enhance monitoring and surveillance of X/MDR TB cases.</p> <p>2. CDC Technical Advisor for Laboratory Services. The CDC/Namibia office has seconded a laboratory technical advisor to the Namibia Institute of Pathology (NIP) since 2005. The original scope of work for this position was to serve as a liaison between CDC, NIP, and the MOHSS to build capacity and to ensure quality for HIV bioclinical monitoring. Since then, the technical advisor has become more involved in strengthening NIP capacity for TB diagnosis, including culture and DST. He has worked closely with the International Laboratory Branch Consortium (ILBCP) to facilitate short- and long-term technical advisors to work alongside NIP staff. This collaboration aims to build staff expertise and to upgrade the TB laboratory, with an ultimate goal of obtaining accreditation. The laboratory technical advisor salary is reflected in HVTB (0.20 FTE) and the HLAB Program Areas (0.80 FTE). The lab technical advisor has also provided technical assistance related to the diagnosis and ongoing monitoring of X/MDR TB cases in Namibia.</p> <p>3. TB Laboratory Advisor. COP10 funds will support an advisor to provide mentoring and on-the-job</p>			



training to NIP technologists and technicians performing TB culture and drug sensitivity testing, both at the national and peripheral level. As possible, this advisor will provide similar support to private laboratories in the country.

Supportive Supervision: The laboratory advisor will complement other direct technical assistance offered by other members of the CDC technical advisory team (prevention, PMTCT, HIVQUAL, health communications). Supportive supervision will be provided through site visits and in conjunction with training courses offered by other partners (e.g., the International Laboratory Branch Consortium partners).

Sustainability: A number of independent assessments of the TB program in Namibia have indicated that TB laboratory services need to be improved and expanded. While short-term assistance from the ILBCP has been beneficial, long-term assistance in this area is essential given staff turnover, the lack of attention that can currently be given to peripheral labs, and the need to implement a comprehensive response to increasing numbers of drug-resistant cases of TB in Namibia. This will be a locally employed staff (LES) position. Sufficient capacity now exists within the country to hire a Namibian

The addition of an LES TB Laboratory Advisor will enhance communication, coordination, and institutional memory between CDC and NIP over the long-term. This addition will also allow the senior CDC Laboratory technical advisor to focus more thoroughly on laboratory system strengthening activities and moving key programmatic activities forward.

Support for the CDC laboratory advisor is in line with PEPFAR's vision of constructive, government-to-government engagement through technical assistance. Through other technical areas (Health Systems Strengthening), CDC will continue to support the MOHSS to build additional human resource capacity within the MOHSS civil service. This support will emphasize the creation of HR structures to absorb a wide range of healthcare personnel, including community-based prevention counselors and nurses with integrated training in HIV/AIDS, IMAI and IMIC.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12431	Mechanism Name: ASCP
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement



Prevention	
Prime Partner Name: ASCP	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 100,000	
Funding Source	Funding Amount
GHCS (State)	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES The International Laboratory Branch (ILB) consortium partners' main goal is to strengthen laboratory systems through technical assistance to the Namibia Institute of Pathology (NIP). NIP, in turn, provides quality laboratory services to MOHSS HIV, TB and OIs programs.

To achieve this goal each of the four ILB consortium members provides technical assistance in specific areas. For the American Society of Clinical Pathology (ASCP), those objectives include:

- 1) Theoretical and hands on training on bio-clinical monitoring assays methods and instrumentations.
- 2) Support for the development of a national laboratory training resource center.

How the Implementing Mechanism is linked to the Partnership Framework goals and benchmarks over the life of its agreement/award:

Through support for quality bio-clinical monitoring and training, this implementing mechanism is key to the USG commitments related to the PF goal of "scaling up and enhancing the antiretroviral treatment services as well as reducing TB/HIV co-infection" The technical assistance delivered through this IM will specifically aid the GRN and the USG to meet the following PF objectives:

- 1) Enhance the quality of ART care through quality assured bio-clinical monitoring.
- 2) Expand coverage of screening for TB/HIV co-infection.

The implementing Mechanism's geographic coverage and target population:

This mechanism is designed to provide national coverage through the NIP network of laboratories. ASCP will work with NIP and other partners to provide training to staff working in all of the NIP laboratories. Quality Management Systems training will target all laboratories. The gap analyses and mentoring assistance will be rolled out in a targeted manner, depending on identified needs.

Key contributions to Health System Strengthening:

The ASCP technical approach is built on the results of continuous situation assessments. These are



followed by training on quality management and the development of implementation plans. Emphasis is placed on Train-the-Trainer (TOT) courses, which produce local trainers. These individuals represent a growing core of local expertise to provide on-going supervision, mentoring and additional training. Through this system, ASCP helps build capacity at the systems level and at each facility. This local capacity will sustain the national laboratory system over the long-term and gradually reduce NIP's dependence on external TA.

Implementing Mechanism's cross-cutting programs and key issues:

As noted above, technical assistance from ASCP contributes to a strengthening of local expertise. NIP laboratory staff trained to conduct trainings and supportive supervision represent a strong foundation on which future human resources for health may be built within the public healthcare sector.

The Implementing Mechanism's strategy to become more cost efficient over time:

All ILB consortium partners provide short-term technical trainings or consultancy services. NIP manages the logistics of the trainings and consultancies, and, increasingly, provides trainers from its own staff to conduct follow-up mentoring and monitoring. NIP is also responsible for procuring equipment and reagents for the trainings. These procurements, including stock management and delivery, are done through NIP's local ordering system. As indicated above, the training of trainers as instructors and mentors will, over time, reduce ASCP's role in Namibia. On that note, ASCP's role is already 100% technical assistance. NIP is solely responsible for laboratory service delivery. A USG objective for the next five years is to develop NIP's administrative capacity to allow NIP to contract and fund its own technical relationships, as needed, with IDP consortium members.

Monitoring and evaluation plans for included activities:

All CDC cooperative agreement grantees must submit a detailed work plan with their annual continuation application. This work plan must be based on PEPFAR indicators and aligned with targets set for each country. All IDP consortium members must also submit bi-annual status reports to the IDP program manager in Atlanta. These reports are shared with CDC program managers in Namibia and used to inform any year-on-year changes to the work plan. All trainees are required to develop an individual work plan. These are followed up by NIP and ASCP mentors during supportive visits. Other key indicators include the monitoring of results for quality and progress made toward accreditation by SANAS.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	50,000
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Key Issues

(No data provided.)



Budget Code Information

Mechanism ID: 12431 Mechanism Name: ASCP Prime Partner Name: ASCP			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	100,000	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP 2009. It includes one component: 1) Technical assistance from the American Society for Clinical Pathology (ASCP) to the Namibia Institute of Pathology (NIP). PEPFAR Namibia will support ASCP through a cooperative agreement managed by the CDC Global AIDS Program International Laboratory Branch (ILB) in Atlanta. Other partners supported through this mechanism include the American Society for Microbiology (ASM), the Association of Public Health Laboratories (APHL) and the Clinical Laboratory Standards Institute (CLSI). ASM's work is described in the HVTB technical area. CLSI and APHL are described in separate narratives under HLAB.

In COP10, ASCP support for NIP will include:

- ? Training on bio-clinical monitoring assays such as CD4 methods, chemistry and hematology, as well as basic laboratory operations training for district level laboratories.

Supportive Supervision: ASCP experts will provide direct technical assistance and supportive supervision to NIP staff. Additional supervision and mentoring will be provided by laboratory advisors from CDC Namibia. NIP managers and supervisors will provide day-to-day management oversight and supervision.

Sustainability: All ILB consortium partners provide short-term technical trainings. NIP manages the logistics of the trainings to be conducted, and, increasingly, provides trainers from its own staff to conduct follow-up mentoring and monitoring. NIP is also responsible for procuring equipment and reagents for the trainings. These procurements, including stock management and delivery, are done through NIP's local ordering system. The use of training of trainers (TOT) methods will, over time, reduce ASCP's role in Namibia. On that note, ASCP's role is already 100% technical assistance. NIP is solely responsible for laboratory service delivery. A USG objective for the next five years is to develop NIP's administrative capacity to allow NIP to contract and fund its own technical relationships, as needed, with IDP consortium members.

Implementing Mechanism Indicator Information



(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12432	Mechanism Name: ASM
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: ASM	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 50,000	
Funding Source	Funding Amount
GHCS (State)	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES The International Laboratory Branch (ILB) consortium partners' main goal is to strengthen laboratory systems through technical assistance to the Namibia Institute of Pathology (NIP). NIP, in turn, provides quality laboratory services to MOHSS HIV, TB and OIs programs.

To achieve this goal each of the four ILB consortium members provides technical assistance in specific areas. For the American Society for Microbiology (ASM), those objectives include:

- 1) Training on TB microscopy, culture and drug susceptibility testing
- 2) Technical assistance to establish a TB diagnostics quality assurance system
- 3) Assist in the decentralization of TB culture services to Oshakati and Walvis Bay Laboratories.

Links to the Partnership Framework goals and benchmarks over the life of its agreement/award.

Through support for quality TB diagnostic and monitoring services, this implementing mechanism is key to the USG commitments related to the PF goal of "reducing TB/HIV co-infection." The technical assistance delivered through this IM will specifically aid the GRN and the USG to meet the following PF objectives:

- 1) Enhance the quality of ART care through quality assured bio-clinical monitoring.
- 2) Expand coverage of screening for TB/HIV co-infection.

Geographic coverage and target population:

This mechanism is designed to provide national coverage through the NIP network of laboratories. ASM



will work with NIP and other partners to cover all TB diagnostic laboratories in Namibia. Trainings and microscopy quality assurance will target all laboratories performing TB diagnosis. This assistance will also strengthening TB culture and drug susceptibility testing at the Windhoek central reference laboratory, as well as at the Oshakati and Walvis Bay laboratories.

Key contributions to Health System Strengthening:

The ASM technical approach is built on the results of continuous situation assessments. These are followed by training on quality management and the development of implementation plans. Emphasis is placed on Train-the-Trainer (TOT) courses, which produce local trainers. These individuals represent a growing core of local expertise to provide on-going supervision, mentoring and additional training. Through this system, ASM helps build capacity at the systems level and at each facility. This local capacity will sustain the national laboratory system over the long-term and gradually reduce NIP's dependence on external TA.

Cross-cutting programs and key issues:

As noted above, technical assistance from ASM contributes to a strengthening of local expertise. NIP laboratory staff trained to conduct trainings and supportive supervision represent a strong foundation on which future human resources for health may be built.

Strategy to become more cost efficient over time:

All ILB consortium partners provide short-term technical trainings. NIP manages the logistics of the trainings to be conducted, and, increasingly, provides trainers from its own staff to conduct follow-up mentoring and monitoring. NIP is also responsible for procuring equipment and reagents for the trainings. These procurements, including stock management and delivery, are done through NIP's local ordering system. As indicated above, the training of trainers as instructors and mentors will, over time, reduce ASM's role in Namibia. On that note, ASM's role is already 100% technical assistance. NIP is solely responsible for laboratory service delivery. A USG objective for the next five years is to develop NIP's administrative capacity to allow NIP to contract and fund its own technical relationships, as needed, with IDP consortium members.

Monitoring and evaluation plans for included activities:

All CDC cooperative agreement grantees must submit a detailed work plan with their annual continuation application. This work plan must be based on PEPFAR indicators and aligned with targets set for each country. All IDP consortium members must also submit bi-annual status reports to the IDP program manager in Atlanta. These reports are shared with CDC program managers in Namibia and used to inform any year-on-year changes to the work plan. All trainees are required to develop an individual work plan. These are followed up by NIP and ASM mentors during supportive visits. Other key indicators include the monitoring of TB diagnostic results for quality and progress made toward accreditation by SANAS.



Cross-Cutting Budget Attribution(s)

Human Resources for Health	25,000
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Key Issues

TB

Budget Code Information

Mechanism ID: 12432 Mechanism Name: ASM Prime Partner Name: ASM			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	50,000	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP09. It includes one component: 1) technical assistance from the American Society of Microbiologists (ASM) to enhance TB laboratory services at the Namibia Institute of Pathology (NIP). ASM support is provided through a cooperative agreement managed by the CDC Global AIDS Program International Laboratory Branch.

1) Technical assistance from ASM. ASM has provided short- and long-term technical advisors to work with the CDC laboratory technical advisor, alongside NIP staff at the main laboratory in Windhoek, to improve their proficiency with TB diagnostic testing. This assistance has included on-the-job training on TB-related laboratory equipment and infection control practices. In COP 10, ASM will focus support on peripheral NIP laboratories. Areas of technical focus for this training and TA will include establishing a blinded quality assurance process for rechecking slides; strengthening the management of existing external quality assurance systems, and; training for NIP laboratory technicians on fluorescence microscopy.

Supportive Supervision: ASM experts will provide direct technical assistance and supportive supervision to NIP staff. Additional supervision and mentoring will be provided by laboratory advisors from CDC



Namibia. NIP managers and supervisors will provide day-to-day management oversight and supervision.

Sustainability: NIP is a public limited company established by Act of Parliament in 1999. NIP started operations in December 2000 and has assumed responsibility for 37 MOHSS laboratories since then. NIP's budget is structured to recover a substantial portion of its costs through reimbursements from public and private insurance plans. PEPFAR will work with NIP to ensure that appropriate administrative systems exist to allow NIP to sustain an independent relationship with partners like ASM. Support for improve TB diagnostic services will contribute to case identification and promote efficiencies in linking new cases to treatment.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12433	Mechanism Name: CLSI
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Clinical and Laboratory Standards Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 339,655	
Funding Source	Funding Amount
GHCS (State)	339,655

Sub Partner Name(s)

(No data provided.)

Overview Narrative

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES The International Laboratory Branch (ILB) consortium partners' main goal is to strengthen laboratory systems through technical assistance to the Namibia Institute of Pathology (NIP). NIP, in turn, provides quality laboratory services to MOHSS HIV, TB and OIs programs.

To achieve this goal each of the four ILB consortium members provides technical assistance in specific



areas. For the Clinical and Laboratory Standards Institute (CLSI), those objectives include:

- 1) Conduct gap analyses to evaluate existing laboratory operations against South African National Accreditation System (SANAS) accreditation requirements.
- 2) Train NIP staff on Quality Management Systems.
- 3) Assist NIP in developing a quality improvement implementation plan.
- 4) Provide onsite technical assistance for monitoring the progress of the plan.

How the Implementing Mechanism is linked to the Partnership Framework (PF) goals and benchmarks over the life of its agreement/award:

Through support for quality laboratory services, this implementing mechanism is key to the USG commitments related to the PF goal of "scaling up and enhancing antiretroviral treatment services ... [and] reducing TB/HIV co-infection." The technical assistance delivered through this IM will specifically aid the GRN and the USG to meet the following PF objectives:

- 1) Enhance the quality of ART care through quality assured bio-clinical monitoring.
- 2) Expand coverage of screening for TB/HIV co-infection.
- 3) Improve surveillance for drug resistance.

The implementing Mechanism's geographic coverage and target population:

This mechanism is designed to provide national coverage through the NIP network of laboratories. CLSI will work with NIP and other partners to cover all laboratories in Namibia. Quality Management Systems training will target all laboratories. The gap analyses and mentoring assistance will be rolled out in a targeted manner, depending on identified needs.

Key contributions to Health System Strengthening:

The CLSI technical approach is built on the results of continuous situation assessments. These are followed by training on quality management and the development of implementation plans. Emphasis is placed on Train-the-Trainer (TOT) courses, which produce local trainers. These individuals represent a growing core of local expertise to provide on-going supervision, mentoring and additional training. Through this system, CLSI helps build capacity at the systems level and at each facility. This local capacity will sustain the national laboratory system over the long-term and gradually reduce NIP's dependence on external TA.

Implementing Mechanism's cross-cutting programs and key issues:

As noted above, technical assistance from CLSI contributes to a strengthening of local expertise. NIP laboratory staff trained to conduct trainings and supportive supervision represent a strong foundation on which future human resources for health may be built within the public healthcare sector.

The Implementing Mechanism's strategy to become more cost efficient over time:

All ILB consortium partners provide short-term technical trainings. NIP manages the logistics of the trainings to be conducted, and, increasingly, provides trainers from its own staff to conduct follow-up mentoring and monitoring. NIP is also responsible for procuring equipment and reagents for the trainings. These procurements, including stock management and delivery, are done through NIP's local ordering



system. As indicated above, the training of trainers as instructors and mentors will, over time, reduce CLSI's role in Namibia. On that note, CLSI's role is already 100% technical assistance. NIP is solely responsible for laboratory service delivery. A USG objective for the next five years is to develop NIP's administrative capacity to allow NIP to contract and fund its own technical relationships, as needed, with IDP consortium members.

Monitoring and evaluation plans for included activities:

All CDC cooperative agreement grantees must submit a detailed work plan with their annual continuation application. This work plan must be based on PEPFAR indicators and aligned with targets set for each country. All IDP consortium members must also submit bi-annual status reports to the IDP program manager in Atlanta. These reports are shared with CDC program managers in Namibia and used to inform any year-on-year changes to the work plan. All trainees are required to develop an individual work plan. These are followed up by NIP and CLSI mentors during supportive visits. Other keys indicators including the monitoring of results for quality and progress made toward accreditation by SANAS.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	170,000
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Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: 12433			
Mechanism Name: CLSI			
Prime Partner Name: Clinical and Laboratory Standards Institute			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	339,655	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a continuing activity from COP 2009. It includes one component: 1) Technical assistance from the Clinical Laboratory Standards Institute (CLSI) to the Namibia Institute of Pathology (NIP).

PEPFAR Namibia will support CLSI through a cooperative agreement managed by the CDC Global AIDS



Program International Laboratory Branch (ILB) in Atlanta. Other partners supported through this mechanism include: the American Society of Clinical Pathology (ASCP), the American Society for Microbiology (ASM), and the Association of Public Health Laboratories (APHL). ASM's work is described in the HVTB technical area. APHL and ASCP are described in separate narratives under HLAB.

In COP10, CLSI technical assistance to NIP will include:

-Support for quality management systems as NIP prepares for laboratory accreditation through the South African National Accreditation System (SANAS). CLSI will support a thorough assessment of NIP's quality management system and practices, conduct an active gap analysis, and an assessment of overall program effectiveness. Based on these assessments and reviews, CLSI will help NIP to produce standardized laboratory methodologies..

Supportive Supervision: CLSI experts will provide direct technical assistance and supportive supervision to NIP staff. Additional supervision and mentoring will be provided by laboratory advisors from CDC Namibia. NIP managers and supervisors will provide day-to-day management oversight and supervision.

Sustainability: All ILB consortium partners provide short-term technical trainings. NIP manages the logistics of the trainings to be conducted, and, increasingly, provides trainers from its own staff to conduct follow-up mentoring and monitoring. NIP is also responsible for procuring equipment and reagents for the trainings. These procurements, including stock management and delivery, are done through NIP's local ordering system. The use of training of trainers (TOT) methods will, over time, reduce CLSI's role in Namibia. On that note, CLSI's role is already 100% technical assistance. NIP is solely responsible for laboratory service delivery. A USG objective for the next five years is to develop NIP's administrative capacity to allow NIP to contract and fund its own technical relationships, as needed, with IDP consortium members.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12434	Mechanism Name: TBD (Potentia followup)
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No



Total Funding: Redacted	
Funding Source	Funding Amount
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

NEW NARRATIVE

In COP10, a new, competitive, CDC cooperative agreement will be awarded to support a limited number of human resource-related services on behalf of the Ministry of Health and Social Services (MOHSS). A TBD partner will be identified to provide these services, including, administering payroll with a local bank to ensure that electronic funds transfers are completed to MOHSS contract staff on time, and, when requested by the MOHSS, support for recruitment.

This mechanism will be awarded during the first half of COP10. Preference will be given to local, Namibian, applicants. Activities funded through this new mechanism are currently funded through a cooperative agreement that will expire in the first half of COP10.

Objectives. This mechanism has one primary objective: (1) to provide limited human resource services to the MOHSS and other PEPFAR-supported partners. These services, which have been provided since COP05, fill a substantial human resource capacity gap within the MOHSS and the broader GRN civil service. The TBD partner will provide a scope of HR services that respond to requirements described in the Namibian Labour Law. In COP09, revisions to the Law forced a significant shift in the management of contract positions. Under the revised law, clients of contract firms are required to establish formal "employee-employer" relationships with contract staff. For the MOHSS, this requirement led to an expansion of human resource (HR) capacity within the Directorate for Special Programmes (DSP). Four HR positions were established under the direction of the Deputy Director of the DSP. These HR specialists now manage the day-to-day relationship between the MOHSS and several dozen contract staff. As noted above, in COP10, the TBD partner's duties will be restricted to overseeing the electronic payroll transfers from a local bank to the employees' personal bank accounts. The TBD partner may also provide limited recruiting services to the MOHSS, but this activity, too, has been substantially absorbed by the MOHSS.

Partnership Framework: This mechanism encompasses a broad range of activities and commitments



described in the Partnership Framework (PF). Specifically, key objectives are supported under the Coordination and Management thematic area (human resources/human capacity development, and monitoring and evaluation). By linking professionals to MOHSS positions, private HR contract agencies also indirectly support other technical areas (e.g., prevention, care and treatment). However, as the management responsibilities of private contracting firms are increasingly transferred to clients, including the MOHSS, this indirect impact will be minimized.

Coverage: The activities under this mechanism are national in scope. The target clientele includes the MOHSS and other PEPFAR-supported partners (e.g., I-TECH). In COP10, the USG will work with GRN ministries to strengthen the capacity of the civil service to, either, absorb contract staff within the civil service, or manage an outsourcing program for short-term contractors. In COP10, the following personnel categories will receive limited HR support from the TBD partner: Physicians, nurses, pharmacists and pharmacy assistants, case managers, training staff, data management staff and supervisors.

Health systems strengthening: As noted above, this mechanism played an essential role in the successful scale-up of ART services in Namibia. Short-term HR services provided through this mechanism were highlighted as a best-practice for rapidly scaling up ART service delivery (Capacity Project report, 2006). Without a private outsourcing mechanism, weaknesses in the MOHSS HR system would have delayed scale-up and negatively impacted patient care. In the last year, the success of the outsourcing model in supporting the rapid scale-up of HIV/AIDS programs has been complemented by the transition to MOHSS ownership driven by the new Labour Law. As the role of private HR service companies evolves, the USG will support the development of HR systems within the GRN civil service. While the USG will continue to support the GRN civil service as the primary public sector employment mechanism, technical assistance will encourage the development of flexible and diverse HR mechanisms within the civil service, including outsourcing.

Cross-cutting/Key issues: This mechanism will contribute to Human Resources for Health objectives through support the development of transparent and flexible HR systems within the MOHSS and GRN civil service.

Cost efficiency: Activities supported under this mechanism are integrated with CDC's technical assistance to the MOHSS, both at the national level and in the field. As the TBD partner's responsibilities for contract staff are reduced so, too, will the management fees.

M&E: All CDC cooperative agreement grantees must submit a detailed work plan with their annual continuation application. This work plan must be based on PEPFAR indicators and aligned with targets set for each country. Grantees must also submit bi-annual status reports to program managers in



Namibia. Data in these reports may be used inform any year-on-year changes to the work plan.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	Redacted
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Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: 12434			
Mechanism Name: TBD (Potentia followup)			
Prime Partner Name: TBD			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	Redacted	Redacted
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	Redacted	Redacted
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted



Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	Redacted	Redacted
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	Redacted	Redacted
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	Redacted	Redacted
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	Redacted	Redacted
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount



Prevention	MTCT	Redacted	Redacted
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12435	Mechanism Name: Scaling-up Palliative Care for People Living with HIV/AIDS
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: African Palliative Care Association	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 451,799	
Funding Source	Funding Amount
GHCS (State)	451,799

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a new implementing mechanism but continues Pact Regional Award's previous work.

1. APCA has one comprehensive goal which is to provide technical assistance and build capacity within selected countries across the Southern African region in order to promote the development of palliative care in the region. Specifically in Namibia, APCA contributes to the HIV and AIDS response by scaling-up



palliative care provision through a public health approach that strives to balance quality and coverage. The primary emphasis areas are human capacity development and local organization capacity building.

2. The goals that APCA has set in Namibia are directly linked to those within the Partnership Framework in the Focus Area of Care, Treatment and Support. Under this Focus Area, the overarching goal is "To reduce mortality, morbidity and improve the quality of life of those affected by HIV." Palliative care is defined as an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illnesses, including HIV. Therefore, by increasing the number of healthcare providers trained to implement palliative care, more patients will be able to receive it. Palliative care is applicable to patients with HIV and AIDS in their homes, in the community and within public health facilities regardless of whether they are on treatment or not. Therefore this directly contributes to the objectives of the Partnership Framework within the Care Focus Area.

3. Specific target populations include HIV/AIDS care providers at all levels in government, NGOs, CBOs, FBOs and policy makers throughout the entire country.

4. APCA is committed to moving forward palliative care policy, standards and guidelines within Namibia. It is important that palliative care is integrated into standards of care at various levels (basic, primary and tertiary levels) and settings (i.e. home based, antiretroviral therapy, prevention of mother-to-child transmission) so that patients receive comprehensive and holistic services. By improving the quality of care that terminally ill patients receive in their homes, public health facilities are not as burdened by long term patients. This is advantageous to the healthcare system as a whole, and is usually more comfortable for patients and their families.

5. The focus area of APCA's program is palliative care.

6. Part one of the Public Health Evaluation (PHE) planned to begin in COP09 looks at the availability of care services and relative to the palliative care sites as compared to the burden of the disease in catchment areas. It is hoped that this exercise will help to identify gaps in referral procedures that can be amended, and improve cost effectiveness by encouraging organizations to utilize the services of other community organizations and health facilities as appropriate.

7. APCA Namibia is supported by the Southern Africa Regional Office based in Johannesburg, including an M&E officer who is responsible for overseeing the effectiveness and performance of APCA programs in the region.



Cross-Cutting Budget Attribution(s)

Human Resources for Health	316,260
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Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	12435		
Mechanism Name:	Scaling-up Palliative Care for People Living with HIV/AIDS		
Prime Partner Name:	African Palliative Care Association		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	360,685	

Narrative:

This is a continuing activity from FY 09 but under a new implementing mechanism.

This continued activity has five main components: (1) to expand and develop the palliative care program with Catholic AIDS Action (CAA), (2) to support the MOHSS in developing national guidelines and standards for palliative care, (3) to build capacity for palliative care at all levels, (4) to support the development of a functional National Palliative Care Task Force, and (5) to implement Phase 2 of the Palliative Care Public Health Evaluation. HCD is a key cross-cutting area.

1. The CAA palliative care program will expand to the final four offices. This will require additional staff, training, and mentorship at the new sites. The existing sites will continue to need strengthening through ongoing mentorship and training. As the nurses at the original sites become more experienced, they will also take part in trainings and mentoring of others. It is hoped that CAA will become a centre of excellence for palliative care in Namibia that can be used as a site for clinical placements. APCA will assist to facilitate the collaboration between the MOHSS and CAA. Standard Operating Procedures for the nurses will be developed in collaboration with the MOHSS. Social workers will be hired for some of the palliative care sites. They will need to attend palliative care training and be mentored.

2. APCA will support the MOHSS in developing the National Palliative Care Standards and Guidelines to

ensure quality care and open access. These will provide a mandate for the MOHSS to roll out palliative care more widely, increasing the number of patients with improved quality of life.

3. APCA plans to increase the capacity of key stakeholders in the implementation of palliative care services through education and training. Building on the work of COP 09, APCA will provide assistance to the MOHSS and national training institutions to disseminate the National Palliative Care Training Curricula and guide tertiary training institutions in adapting it into pre-service curricula.

4. APCA will continue to support the National Palliative Care Task Force in their aim of becoming a National Association of Palliative Care. Once established, APCA will provide mentorship and organizational development so that they can become a sustainable source of palliative care expertise and advocacy.

5. The Public Health Evaluation beginning in COP 09 will be ongoing and mid-term results will be used to improve programming as appropriate.

APCA works closely with its partners to ensure sustainability. Through a large investment in human capacity development and utilizing models of integration into existing structures, APCA plans to devolve work to local institutions and eventually take a supervisory and mentorship role. APCA will support training efforts of the MOHSS with technical assistance and funding as required, working to improve local ownership of programs.

APCA will develop and implement a minimum data set for palliative care in Namibia in conjunction with the MOHSS. Following its adaptation, there will be piloting of the training for its use along with implementation and scale up. Data quality is ensured through ongoing data checks, supervision and mentorship of the PC sites and by completing Trainet forms that are part of a larger training database. APCA is working with CAA to assist them in implementing a quality assurance tool that will involve interviewing patients and families.

Palliative care awareness and capacity is growing and developing in Namibia as a result of ongoing training, technical assistance and mentorship. However, limited in-country expertise necessitates ongoing support to key stakeholders, namely the MOHSS. APCA will act as a source of technical expertise to the MOHSS and other stakeholders so that national efforts to integrate and implement palliative care utilize best practice models.

Ongoing mentorship and supportive supervision are critical to the successful integration and development of palliative care. Recognizing that palliative care is relatively new to Namibia, APCA sees

mentorship as the cornerstone of capacity building. Within the CAA program, the nurses and volunteers receive ongoing mentorship visits from palliative care experts to observe their practice, provide them with feedback and coach them on quality improvement. Phase Two of the Palliative Care PHE will identify the value of mentorship by comparing the CAA nurses who receive ongoing input through mentorship and nurses from a variety of public health facilities who do not. The evaluation aims to identify a model of mentorship for facility based staff that can be used with the National Palliative Care Curriculum as it is disseminated throughout the country.

APCA plans to build local capacity in palliative care whilst creating an enabling policy environment for implementation. By integrating palliative care into existing institutions and building the capacity of national stakeholders, including the MOHSS, palliative care becomes part of the continuum of care of HIV/AIDS patients and others living with life limiting illnesses.

The work of APCA in Namibia will be coordinated by an in-country project coordinator with the support of an administrator and technical support officer. Overall oversight of the program will remain with APCA head office and other APCA staff will provide technical assistance as required.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	91,114	

Narrative:

This is a continuing activity from FY 09 but under a new implementing mechanism.

This continued activity has four main components: (1) to expand and develop the palliative care program with Catholic AIDS Action (CAA) with special attention to the needs of children, (2) to support the MOHSS in developing national guidelines and standards for palliative care that specifically addresses the needs of children (3) to build capacity for pediatric palliative care at all levels, and (4) to work with the MOHSS and other stakeholders to develop a framework for palliative care monitoring and evaluation for Namibia. HCD is a key cross-cutting area included in the program.

1. APCA will provide technical assistance to CAA to further develop and expand the palliative care program with specific attention to the needs of children. The palliative care program with Catholic AIDS Action (CAA) will expand to the final four offices, so that all CAA offices are implementing palliative care. This will require additional staff, training and mentorship at the new sites. The existing sites will continue to need strengthening through ongoing mentorship and training. As the nurses at the original sites become more experienced, they will also take part in trainings and mentoring of others. It is hoped that CAA will become a centre of excellence for palliative care in Namibia that can be used as a site for

clinical placements. Social workers will be hired for some of the palliative care sites. They will need to attend palliative care training and be mentored. The role of the social workers will be multi-faceted, but a large emphasis will be on children. It is hoped that they will be able to address some of the emotional and social issues facing children, families and other OVC. The social workers will be trained in bereavement and will be assisted in developing programs that support children specifically in their grief. OVCs in need of palliative care will be identified through the existing OVC program at CAA by strengthening internal referrals. The palliative care needs of a growing number of HIV positive adolescents including disclosure issues, self esteem, and psychosocial support will be addressed.

2. APCA will support the MOHSS in developing National Palliative Care Standards and Guidelines incorporating the specific palliative care needs of children.

3. APCA will build capacity in pediatric palliative care at all levels by ensuring that all palliative care training curricula include a component on children, particularly adolescents and their distinctive needs.

4. APCA will work with the MOHSS and other stakeholders to develop a framework for palliative care monitoring and evaluation for Namibia. The Public Health Evaluation beginning in COP 09 will be ongoing and mid-term results will be used to improve programming as appropriate. It is anticipated that the PHE will highlight some of the needs of children requiring palliative care, which will be used to inform program planning and technical support provided to the MOHSS. The results will also help APCA support the MOHSS to develop a framework for palliative care monitoring and evaluation for Namibia, and APCA will provide technical assistance in developing the tools for ongoing monitoring and evaluation of palliative care such as the APCA African Pediatric Palliative Outcome Scale.

APCA plans to build local capacity in palliative care with special attention to the needs of children, whilst creating an enabling policy environment for implementation. By integrating pediatric palliative care into existing institutions and building the capacity of national stakeholders, including the MOHSS, palliative care becomes part of the continuum of care of pediatric patients and others living with life limiting illnesses like HIV/AIDS.

Within the CAA program, the nurses and volunteers receive ongoing mentorship visits from palliative care experts to observe their practice, provide them with feedback and coach them on quality improvement.

The work of APCA in Namibia will be coordinated by an in-country project coordinator with the support of an administrator and technical support officer. Overall oversight of the program will remain with APCA head office and other APCA staff will provide technical assistance as required.

Implementing Mechanism Indicator Information



(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12436	Mechanism Name: Central Bureau of Statistics, National Planning Commission, Office of the President
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Office of the President	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 328,700	
Funding Source	Funding Amount
GHCS (State)	328,700

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Central Bureau of Statistics (CBS) /National Planning Commission (NPC)/Office of the President is a new implementing mechanism.

CBS/NPC/Office of the President has two main goals under the award: (1) to provide direct technical support to CBS so that they can manage and administer USG-funded surveys; and (2) build local research capacity so that CBS can be the coordinating body for major research in Namibia.

Under the draft Statistics Bill of 2009, CBS is the agency within the National Statistics System that is responsible for the collection, compilation, custody, analysis, publication, and dissemination of official statistics for Namibia. The functions of CBS include conducting statistical studies, either alone or in collaboration with government bodies or private sector entities; publishing and disseminating official and other statistics; ensuring compliance with statistical standards; keeping an inventory of official statistics of Namibia; providing statistical services and assistance to government bodies or the private sector; formulate a national plan for official statistics; and liaising with national and international organizations on statistical matters.



This award builds local research capacity and increases country ownership of research activities and surveys in Namibia, and, as such, is in line with the goals for the Partnership Framework. The long-term goal of this agreement is that the CBS will be able to coordinate, plan, and implement, on its own, major studies such as the Census, the Demographic and Health Survey (DHS), the Service Provision Assessment, and the AIDS Indicator Survey.

Although targeted at the main CBS office in Windhoek, this award will have national-level impact, since all regions will benefit from increased research capacity at CBS. The target population of the award is the staff of the CBS and research collaborators from other ministries, such as the Ministry of Health and Social Services.

This award strengthens Namibia's health system by strengthening local research capacity among the main governmental research body in Namibia, the Central Bureau of Statistics. Since health programs and policies depend upon accurate data on the health of the population, increasing Namibian research capacity will improve the quality of the health data produced by surveys and over time it will reduce the costs of collecting such data. In COP 2010, CBS will be expected to play a key role in the roll-out of Namibia's first AIDS Indicator Survey and the dissemination of the results.

The cross-cutting issue addressed by this award is human resources for health. This award will strengthen health information systems (broadly defined to include surveys and other studies) in Namibia and thus improve Namibia's ability to plan and monitor its HIV/AIDS response and to coordinate, plan and prioritize future surveys. Long-term benefits will enable the public sector to budget and target its resources more efficiently.

Effective implementation of this award will decrease the costs of conducting surveys and other studies in that the CBS will be less reliant on external technical assistance, which can be the most expensive component of large-scale studies like the DHS.

This award will include a monitoring and evaluation plan, complete with indicators and targets. Indicators will likely focus on numbers of people trained, organizations provided technical assistance, and other measures of research capacity development. Reports will be submitted quarterly and regular data quality assurance checks will be in place.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	328,700
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Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12436		
Mechanism Name:	Central Bureau of Statistics, National Planning Commission, Office of the President		
Prime Partner Name:	Office of the President		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	328,700	

Narrative:

This is a new activity.

This new activity has three main components:

- (1) To provide training to build research capacity at the Central Bureau of Statistics (CBS). Staff at CBS will be encouraged to attend trainings in study design, sampling, statistical software and analysis, questionnaire design, interviewing techniques, project management, etc.
- (2) To purchase statistical and other research software – e.g., for qualitative analysis software, GIS, data-entry, and the training needed to operate the software.
- (3) To bring technical experts, as needed, to build research capacity among local staff.

Supportive supervision for this activity will be provided directly by the USAID Strategic Information Advisor and Program Assistant, who will liaise with CBS in determining their needs and assessing the quality of activities undertaken.

This award contributes to sustainability by increasing local research capacity to such an extent that minimal external assistance will be required in future studies (DHS, AIS, SPA, census, etc.), making such studies considerably less expensive to conduct. The award directly strengthens health information systems in Namibia (broadly defined) by strengthening the ability of CBS to design, manage, and conduct



major studies that will inform HIV/AIDS and health programming in Namibia.

Indicators for monitoring the progress of this award will be a mix of standard PEPFAR indicators (e.g., number of individuals training in strategic information) and more customized indicators that address the specific activities undertaken.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12437	Mechanism Name: TBD CAFO Follow-on
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Church Alliance for Orphans, Namibia	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 760,000	
Funding Source	Funding Amount
GHCS (State)	760,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a new implementing mechanism that will follow-on to Church Alliance for Orphans (CAFO), whose funding under the New Partners Initiative (NPI) and from field support ends in September 2010. CAFO provides small incentive-grants to sub grantees undertaking OVC projects and services to over 10,000 orphans and vulnerable children as well as caregivers. Sub grantees are church congregations and other community-based organizations.

1. The new mechanism will be a cooperative agreement with a focus on community mobilization and advocacy for holistic and sustainable services to orphans and vulnerable children. It will have the following two strategic objectives: 1) to increase community capacity to address OVC needs, and 2) to advocate for comprehensive services to OVC.



2. The mechanism is in line with USG commitments of the Partnership Framework in terms of mitigating the impact of HIV/AIDS through increased access to comprehensive care and support for OVC and PLWA, especially by way of supporting community initiatives to provide services to OVC. It is also fully in line with the forthcoming National Strategic Framework on HIV/AIDS and the National Plan of Action for OVC (NPA).

3. The geographic coverage will be limited to selected regions yet to be identified. Target populations will be orphans and vulnerable children and their caregivers.

4. The mechanism will empower communities to hold government accountable for implementation of OVC related policies and regulations, including access to welfare grants and fee waivers for services in education and health. Activities under this mechanism will also forge better networks and referrals between the social welfare, community development, and health and education sectors.

5. The following cross-cutting programs will be covered by the mechanism: Food and Nutrition, Education, and Economic Strengthening.

6. Sustainability of OVC community services will be addressed through low-technology income-generating activities which will contribute towards continuing OVC support with the need for external support decreasing over time.

7. A monitoring system with clear guidelines, procedures, and tools will be developed, which will be in line with the M&E plan of the NPA, and which will be compatible with the Ministry of Gender Equality and Child Welfare's (MGEWCW) data system ('data warehouse').

Cross-Cutting Budget Attribution(s)

Economic Strengthening	100,000
Education	200,000
Food and Nutrition: Policy, Tools, and Service Delivery	100,000

Key Issues



Increasing women's access to income and productive resources
 Safe Motherhood

Budget Code Information

Mechanism ID: 12437			
Mechanism Name: TBD CAFO Follow-on			
Prime Partner Name: Church Alliance for Orphans, Namibia			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	760,000	

Narrative:

This is a new activity.

Building on the results of the New Partners Initiative, this new activity has three main components: 1) sub-grants to community OVC projects, 2) training of community institutions and project committees on income-generation and quality OVC services, 3) data collection of violation of child rights for OVC.

1. Sub-grants to community OVC projects. Through community structures such as churches and traditional leaders, communities will mobilize to take responsibility for OVC in need of psycho-social, educational, nutritional or other support. Communities will build capacity to plan and to cost-out realistic community-level intervention. Sub-grants will then be issued to community projects for the implementation of the intervention, which should cover at least two of the seven PEPFAR service areas for OVC.

2. Training of community-based institutions project committees on income-generation and quality OVC services. Community institutions, project committees and leadership will receive training on project management, introducing income-generating activities that can support the OVC services, and quality OVC services (e.g. how to run an after-school activity, HIV life skills for OVC, early childhood activities, etc.). Project leaders will also receive training in the national standards for OVC services and medical referrals.

3. Data collection of violation of child rights for OVC. Cases of denial of rights or failure of service providers to grant access to vulnerable children will be recorded and used in targeted advocacy actions. These could include issues such as costs involved with education.



Regular supportive supervision and monitoring visits to all sites will be undertaken to ensure quality service provision, data capturing and proper financial management of sub-grants.

Sustainability components will include income-generating activities and building of private sector partnerships, as well as facilitation of access of social welfare grants for OVC and their caregivers.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12438	Mechanism Name: TBD COM
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No
Total Funding: Redacted	
Funding Source	Funding Amount
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a new implementing mechanism.

PEPFAR Namibia will competitively award a single partner or consortium to promote normative change and adoption of safer sexual behaviors, with the aim of reducing new HIV infections among general population adults and youth. The new program will incorporate distinct activities in two sectors that will be closely coordinated by local partners during implementation: 1) media, and 2) comprehensive, community-based prevention. Activities under this award will provide coordinated social and behavior change communication and interventions to support sexual prevention, male circumcision (MC), HIV counseling and testing (CT), and prevention with HIV-infected persons.



This follow-on program responds to a headquarters review in March 2009 which found that many PEPFAR prevention interventions lack adequate structure and "dosage," and are limited in coverage to scattered sites across the country. Several existing prevention agreements that support media and community outreach are ending, including the NawaLife Trust agreement. This provides an opportunity to restructure the prevention portfolio to substantially enhance quality, geographic focus, and potential for impact.

The program will align with Government of Namibia (GRN) priorities and directly support the Prevention Thematic Area of the Partnership Framework, especially Objective 1 "Increase Social and Behavior Change focusing on the Key Drivers of the Epidemic." The recipient will participate in the Prevention TAC and implement activities falling within the national HIV prevention strategy.

The media component will be national in scope. This component will build capacity of the GRN to plan and manage an effective media program, while also providing implementation support for specific media campaigns and activities. The comprehensive community-based prevention component will focus on the northern zone of Namibia, which has the highest HIV prevalence and where two-thirds of the population resides. This component will build the capacity of regional and local-level GRN structures for program coordination and monitoring, while providing implementation support for a comprehensive, robust program of social and behavior change. Since USG resources are insufficient to provide national coverage of more intensive (and high cost) outreach and interpersonal approaches, implementation will focus selectively on priority regions and districts where the aim will be to provide "saturation" community-level coverage in conjunction with other PEPFAR and non-PEPFAR partners.

At the core of the strategy is support for effective implementation of an appropriate combination package that includes behavioral/social, bio-medical, and structural interventions with populations at high risk of infection in high incidence areas. These interventions will focus on: breaking the sexual networks that drive transmission; increasing consistent and correct condom use, especially in high risk sexual encounters and by HIV-positive persons; increasing the number of males who are circumcised; and increasing the age of sexual debut. The package of interventions will be based on evidence and use proven technologies and approaches. It will be grounded in local culture to address epidemic drivers through clear, specific, consistent messages and behavior and social norm change approaches.

A gender lens will be integrated into all activities, recognizing that cultural and gender norms reinforce key drivers of the epidemic such as multiple and concurrent partners and cross-generational and transactional sex. A high priority will be prevention for young adult women, who in Southern Africa have among the highest rates of HIV infection, together with efforts to influence norms, attitudes and behaviors of the adult



men who put them at risk.

The program will build capacity and leadership of the Namibian government and civil society institutions to plan and implement effective prevention interventions. The program will promote sustainability by engaging individuals, communities, and leadership in ways that enable them to feel ownership of activities and results. Key principles will include using resources effectively and strategically; achieving quality, scale and scope; strengthening systems; and using existing structures to ensure sustainability beyond PEPFAR. It will create synergies through effective linkages with other partners, programs, and activities.

Evaluation will focus on changes in individual behavior and social norms relating to rates of multiple concurrent partnerships, age mixing in sexual partnerships, transactional sex, condom use in different types of relationships, alcohol use related to high risk sex, sexual violence, as well as onset of sexual activity and secondary abstinence among youth. Evaluation efforts will seek to measure trends in estimated HIV incidence in program districts. The program will also assess the capacity of GRN leadership at various levels to use data and evidence for improved programming and to coordinate partners and institutions in a sustained effective prevention effort. USG Namibia will seek HQ support to design, fund and conduct a rigorous evaluation of this ambitious program.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Addressing male norms and behaviors

Budget Code Information

Mechanism ID: 12438 Mechanism Name: TBD COM Prime Partner Name: TBD			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted
Narrative:			



This is a new follow-on activity.

This activity will build on COP09 demand creation activities with local partners in: 1) media, including related media campaigns, and 2) community outreach activities to support community mobilization.

In media and community outreach activities, the activity will initiate a comprehensive program to promote normative change and adoption of safer sexual behaviors, with the aim of reducing new HIV infections among general population adults and youth. Efforts will focus on refining existing materials, supporting events and promotions and additional language adaptations, and focusing on intensifying depth, breadth and dosage of HIV prevention activities and strengthening linkages to biomedical interventions.

In COP09 activities supported by Nawa Life Trust developed and implemented an umbrella communications and community outreach campaign to increase the overall uptake of HIV testing services in voluntary counseling and testing, the acceptance of provider-initiated counseling and testing, promoting acceptance of couples counseling and other models of HCT including outreach and mobile services. The key behavioral objectives were to mobilize persons that don't know their HIV status. Based on current findings from the implementation, this required increasing a sense of risk perception and decreasing fear of positive results among the target population as well as helping create convenient opportunities for testing. Activities were also structured to reinforce HIV prevention behaviours for those who complete HCT and are HIV negative.

In collaboration with various GRN and USG stakeholders, the recipient will target activities under this award to geographical focus areas where HIV counseling and testing coverage and access is below the national average.

1. Media activities will be coordinated with GRN and conducted on a national scale with the intent of supporting demand creation for HCT services.

2. Community outreach activities will build on past demand creation activities including related media campaigns and support to community mobilization. Efforts will be focused on refining existing materials, supporting events and promotions and additional language adaptations focusing on intensifying depth, breadth and dosage of HIV prevention activities and strengthening linkages to biomedical interventions.

Regular supportive supervision, distribution of standardized materials and monitoring visits will be undertaken by the USG and prime recipients to ensure that media and community outreach activities are being conducted to standards established by the GRN and USG, that linkages are strengthened to biomedical interventions available and that data reporting is accurately reflecting progress against

PEPFAR indicators.

Sustainability components will include capacity building of local civil society and regional administrations to better coordinate and implement evidence-based HIV prevention strategies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	Redacted	Redacted

Narrative:

This is a new follow-on activity. This activity complements clinic-based investments in CIRC through other USG partners.

This activity consists of two main components: 1) promote normative change and adoption of safer sexual behaviors through media and community outreach activities associated with known epidemic drivers, and 2) build upon an existing MC communication strategy.

Background

According to the NDHS (2006/07), approximately 21% of men aged 15-49 were circumcised by 2007. A total of 11% of the circumcisions were performed by a health worker at a health facility, while 4% were conducted by traditional health practitioners. 84% of the men were circumcised before the age 13. The available evidence does not show significant variations in the MC prevalence by age. Some variations were noted in the regions with estimates ranging from 6% in Caprivi to 57% in Omaheke.

1. This activity will promote normative change and adoption of safer sexual behaviors through media and community outreach activities associated with known epidemic drivers. Building on results of the Nawa Life Trust activities in COP09, local partners will conduct distinct media and community outreach activities that will support and reinforce normative changes associated with known epidemic drivers, including: multiple concurrent partnerships; inconsistent condom use; excessive alcohol use; intergenerational and transactional sex; and a lack of HIV testing and public awareness of HIV serostatus.

2. This activity will build upon an existing MC communication strategy, which includes demand creation strategies, informational campaigns for males and females to better understand the procedure, as well as positioning MC within the larger context of HIV prevention strategies to discourage inhibition. Expanding on basic materials developed or adapted to Namibia, the recipient will partners with other stakeholder to implement campaigns utilizing mass media. Local partners conducting media and community outreach activities supported under CIRC will participate in the National Male Circumcision Task Force. The task



force ensures a coordinated effort to develop and adapt non-clinical training, message development, and outreach models related to the promotion and demand creation of adult male circumcision.

The activity is closely aligned with the GRN's NSF priority of supporting advocacy strategy development and male circumcision campaigns to generate community acceptability and demand for MC.

Regular supportive supervision, distribution of standardized materials, and monitoring visits will be undertaken by the USG and its partners to ensure that media and community outreach activities are being conducted according to standards established by the GRN and USG, that linkages are strengthened to biomedical interventions, and that data reporting accurately reflects progress against PEPFAR indicators.

Sustainability components will include capacity building of local civil society and regional administrations to better coordinate and implement evidence-based HIV prevention strategies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

This is a new follow-on activity.

The USG and GRN collaborated to detail known epidemic drivers in 2008/9.

PEPFAR Namibia will initiate a comprehensive program to promote normative change and adoption of safer sexual behaviors, with the aim of reducing new HIV infections among general population adults and youth. The award will provide coordinated social and behavior change communication and interventions to support sexual prevention, male circumcision (MC), HIV counseling and testing (CT), and prevention with HIV-infected persons. The new activity will incorporate distinct activities in two sectors that will be closely coordinated during implementation: 1) media; and 2) comprehensive, community-based prevention.

Media and community outreach activities will be closely coordinated.

1. Media activities will be on a national scale and will build capacity of the GRN to plan and manage an effective media program, while also providing implementation support for specific media campaigns and activities. Local partners conducting media activities will assess and adapt past campaign materials to address national audiences in selected areas of Namibia. Activities will continue to support the Ministry

of Information, Communication and Technology's (MICT) Take Control MCP program.

2. Community outreach will focus on the northern zone of Namibia which has the highest HIV prevalence and where two-thirds of the population resides. This component will build the capacity of regional and local-level GRN structures for program coordination and monitoring, while providing implementation support for a comprehensive, robust program of social and behavior change. Local partners conducting community outreach activities will adapt outreach materials and training guidelines previously developed under PEPFAR, strengthen community groups' implementation of structured prevention activities and implement a strengthened M&E system to support program management.

The behavioral change objectives include building skills for safe behaviors such as abstinence and delay of sexual debut, increasing perceptions of risk regarding multiple concurrent partnerships, increasing correct and consistent condom use, increasing risk perceptions of alcohol consumption, cross generational and transactional sex, and increasing positive attitudes for gender empowerment and male engagement.

Regular supportive supervision, distribution of standardized materials and monitoring visits will be undertaken by USG and prime recipients to ensure that media and community outreach activities are being conducted to standards established by the GRN and USG, that linkages are strengthened to biomedical interventions available and that data reporting is accurately reflecting progress against PEPFAR indicators.

Sustainability components will include capacity building of local civil society and regional administrations to better coordinate and implement evidence-based HIV prevention strategies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

This is a new follow-on activity.

The new activity will incorporate distinct activities in two sectors that will be closely coordinated during implementation: 1) media; and 2) comprehensive, community-based prevention. PEPFAR Namibia will initiate a comprehensive program to promote normative change and adoption of safer sexual behaviors, with the aim of reducing new HIV infections among general population adults and youth. The award will provide coordinated social and behavior change communication and interventions to support sexual prevention, male circumcision (MC), HIV counseling and testing (CT), and prevention with HIV-infected



persons.

Building on results of the Nawa Life Trust activities in COP09 local partners will conduct distinct media and community outreach activities that will support and reinforce normative changes associated with known epidemic drivers including: multiple concurrent partnerships; inconsistent condom use; excessive alcohol use; intergenerational and transactional sex; and a lack of HIV testing and public awareness of HIV serostatus.

The USG and GRN collaborated to detail known epidemic drivers in 2008/9. Media and community outreach activities will be closely coordinated. Media activities will be on a national scale and will build capacity of the GRN to plan and manage an effective media program, while also providing implementation support for specific media campaigns and activities. Community outreach will focus on the northern zone of Namibia which has the highest HIV prevalence and where two-thirds of the population resides. This component will build the capacity of regional and local-level GRN structures for program coordination and monitoring, while providing implementation support for a comprehensive, robust program of social and behavior change.

The behavioral change objectives include building skills for safe behaviors such as abstinence and delay of sexual debut, increasing perceptions of risk regarding multiple concurrent partnerships, increasing correct and consistent condom use, increasing risk perceptions of alcohol consumption, cross generational and transactional sex, and increasing positive attitudes for gender empowerment and male engagement.

Local partners conducting media activities will assess and adapt past campaign materials to address national audiences in selected areas of Namibia and continue to support the Ministry of Information, Communication and Technology's (MICT) Take Control MCP program. Local partners conducting community outreach activities will adapt outreach materials and training guidelines previously developed under PEPFAR, strengthen community groups' implementation of structured prevention activities and implement a strengthened M&E system to support program management.

Regular supportive supervision, distribution of standardized materials and monitoring visits will be undertaken by USG and its partners to ensure that media and community outreach activities are being conducted to standards established by the GRN and USG, that linkages are strengthened to biomedical interventions available and that data reporting is accurately reflecting progress against PEPFAR indicators.

Sustainability components will include capacity building of local civil society and regional administrations



to better coordinate and implement evidence-based HIV prevention strategies.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12439	Mechanism Name: TBD Kayec Trust
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Kayec Trust	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,163,750	
Funding Source	Funding Amount
GHCS (State)	1,163,750

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a new implementing mechanism which will be a follow on to the work of KAYEC Trust, currently a sub-grantee under PACT, delivering vocation training services to OVC and caregivers as well as psycho-social support to school learners.

KAYEC Trust is an innovative vocational skills training provider in Namibia. KAYEC uses a demand driven approach to economic empowerment that has been proven effective in targeting vulnerable OVC and youth caregivers of OVC with short courses in vocational trades. KAYEC trains up to 950 adolescents annually through short courses (six to 12 weeks) at its two training centers in Windhoek and Ondangwa. The most recent tracer study has demonstrated that up to 73% of KAYEC graduates are earning an income derived from their newly acquired skills, often through small enterprises. Their average income is N\$ 1032 (US\$ 138) per month, with which children in their families were supported.

1. The mechanism will focus on vocational training and HIV prevention for adolescents with the following goals: 1) to improve livelihoods of adolescent OVC and junior heads of households by providing



appropriate market-driven vocational education and training; and 2) to provide adolescents with appropriate skills and self-esteem to protect their selves from HIV infection.

2. The interventions under this mechanism links to the Partnership Framework and the National Strategic Framework by employing evidence-based approaches to improve livelihoods for vulnerable populations and by providing capacity development for HIV prevention activity with vulnerable populations.

3. The interventions will target vulnerable adolescents, in and out of school, aged 12 to 18, as well as older youth caring for OVC in four to six regions, still to be determined.

4. Key contributions to health systems strengthening are the inclusion of HIV prevention education into vocational training for OVC. Namibia's vocational training sector is currently undergoing major reform and restructuring in order to respond to market demands for skilled labor and to address sustainability. This implementing mechanism will support institutionalization of HIV prevention education into vocational training.

5. Service provision to vulnerable adolescents and adolescent caregivers in vocational training cover the cross-cutting budget attributions of education, as well as economic strengthening.

6. The provision of vocational training by government and by the private service providers is set to become more cost-efficient due to current government efforts to establish a National Training Fund, to which businesses will contribute in the form of a national training levy. A number of development partners are providing technical support in this area, including the USG through the Millennium Challenge Account (MCA).

7. A comprehensive monitoring and evaluation plan will be developed.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	300,000
Education	800,000

Key Issues

Increasing women's access to income and productive resources



Budget Code Information

Mechanism ID: 12439			
Mechanism Name: TBD Kayec Trust			
Prime Partner Name: Kayec Trust			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	712,500	

Narrative:

This is a new activity, focusing on direct service delivery in the area of vocational education.

The activity will have the following key components: 1) deliver vocational training for out-of-school adolescents who are orphaned or vulnerable or who care for siblings or other OVC, and 2) provide business and mentoring support to vocational graduates. The existing government vocational training institutions are not meeting current demand and suffer from low quality outcomes. This problem is recognized by government, and sector reform is underway.

1. Deliver vocational training for out-of-school adolescents.
 Short courses in vocational trades that are in demand in the local construction and other industries will be offered. These courses are based on existing and proven curricula, which are currently being reviewed for accreditation by a newly established government body for regulating the vocational training sector (Namibia Training Authority). Courses will include carpentry, bricklaying, electrical installation, plumbing, and engine maintenance, etc. Training intakes will be advertised through national media, and all applications will be screened against defined vulnerability criteria. Training will focus primarily on mastering practical skills, with a sound foundation on relevant theoretical skills.

2. Provide business and mentoring support to vocational graduates.
 Under this component, stronger networks with the private industry sector will be developed to help place new training graduates with contractors. Graduates will receive mentoring support on how to start up small enterprises and on basic business skills, such as costing, pricing, administration and finance.

The monitoring and evaluation system will cover the quality of training, as well as tracing of graduates to establish their marketability and benefit to their households, including younger OVC.



Longer-term sustainability of vocational training through government and private providers will be supported through a national training levy.			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	451,250	
Narrative:			
<p>This is a new activity.</p> <p>The activity will have the following components: 1) provide HIV/AIDS life skills training to adolescents in vocational training, and 2) conduct a youth development program for vulnerable in-school-adolescents.</p> <p>1) Provide HIV/AIDS life skills training to adolescents in vocational training Technical assistance will be provided to vocational training institutions to develop or adapt an evidence-based interpersonal HIV prevention skills curriculum, which addresses the key drivers of the epidemic. The curriculum would target young people, particular multiple and concurrent partnerships, intergenerational and transactional sex, HIV risk perception and low prevalence of male circumcision. Training will be provided to instructors at vocational training institutions to deliver HIV/AIDS life skills education.</p> <p>The target group will be adolescents aged 16-18 attending vocational training institutions, as well as junior heads of households caring for OVC.</p> <p>This activity will be carried out in close collaboration with the Namibian Training Authority (NTA), a new regulatory body charged with developing unit standards for all vocational trades. The NTA is committed to the inclusion of HIV in its training units.</p> <p>2) Conduct a youth development program for vulnerable in-school-adolescents A youth development program based on the International Youth Award (IYA) will be delivered to vulnerable children aged 12 – 18, as after-school program in selected towns. The program combines interpersonal HIV prevention education with self-esteem building and leadership development. Integral to the program is also learning support to enable children to perform academically, to stay and do well in school, and to develop a vision for their future in which they can become responsible adults free of HIV.</p> <p>The IYA consists of different levels, each of which last two years and contains different experiential learning components such as health and HIV life skills, learning support, sports, community service and youth camps. After successful completion of each level, participants receive certificates and medals.</p>			



Youth participants in their final year of secondary education will also receive career counseling, and links will be built to vocational training supported with USG funds as well as with tertiary education facilities.

The program will be implemented in close collaboration with the Ministry of Education, using schools as primary catchment areas. Teachers identify vulnerable children and are also the contact and resource persons tracing the progress of participants. In addition, peer mentors who have participated in the youth development program implemented by KAYEC and who have reached or completed the last level of IYA will be used.

Both components link closely with a Public Health Evaluation (PHE), which will begin shortly. A longitudinal study to be conducted by Boston University will develop qualitative and quantitative tools to measure determinants of adolescent OVC vulnerability to HIV, including exposure to interventions for HIV risk reduction, as well as interventions aimed at reducing the impact of HIV on orphans and vulnerable children.

Longer-term sustainability for HIV/AIDS life skills training at vocational training institutions will be guaranteed through the delivery modes by the training centers' own staff. For the youth development program, the involvement of schools and teachers ensures a transition to improved cost-effectiveness.

A monitoring and evaluation plan will be developed, based on existing tools in use by KAYEC.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12440	Mechanism Name: TBD Lifeline
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Lifeline Childline Proposed Voluntary Counseling and Testing	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 300,000	
Funding Source	Funding Amount
GHCS (State)	300,000



Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a new implementing mechanism.

Addressing gender norms is a key guiding principle of the Partnership Framework and the GRN's National Strategic Framework. Prevention programs have not been sufficiently gender specific; and haven't adequately targeted the key drivers of the epidemic among men and women.

This implementing mechanism builds on several years of technical assistance through the male norms initiative to a Namibian organization, and transition technical leadership from an international NGO to a Namibian partner sustaining progress to date and establishing cost efficiencies for the USG. This new implementing mechanism (Lifeline) was the sub-recipient under the EngenderHealth award and now in COP2010 has graduated to a prime. The program has three goals and objectives: (1) to work with partners to address gender norms that contribute to multiple concurrent partnerships, transactional sex and, intergenerational sex, (2) to work with partners to address harmful gender norms among most at risk populations, and (3) to work with partners to address harmful gender norms in the regions that have the highest HIV prevalence.

The recipient, through USG and non-USG supported programs reaching subpopulations, will target young adults aged 15 to 29, men in workplace settings, especially those related to the mining and fishing industries, and migrant populations. This is primarily a technical assistance activity to local organizations.

In support of broader transition and systems strengthening the Namibian organization will strengthen relationships with the MOHSS and Ministry of Gender to better address gender norms within the context of HIV and AIDS. A core component of activities will be to support local organizations strengthen their approaches to the integration of male norms in their work that contribute to the HIV epidemic.

Monitoring and evaluation plans will be developed based on previous technical assistance work.

Sustainability will be achieved through ensuring that capacity to implement gender programming is integrated into the programmatic activities of each selected organization and by strengthening GRN and civil society capacity in program design, implementation, training and monitoring and evaluation through supportive supervision and mentoring.



Graduating a Namibian partner to receive direct PEPFAR funding will sustain in-country capacity and achieve cost efficiencies for the USG.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	300,000
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Key Issues

Addressing male norms and behaviors
 Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID: 12440			
Mechanism Name: TBD Lifeline			
Prime Partner Name: Lifeline Childline Proposed Voluntary Counseling and Testing			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	300,000	

Narrative:

This is a new activity but a follow-on from COP09.

Addressing gender norms is a key guiding principle of the Partnership Framework and the GRN's National Strategic Framework. Prevention programs have not been sufficiently gender specific; and haven't adequately targeted the key drivers of the epidemic among men and women.

PEPFAR will graduate a Namibian organization, previously a sub grantee engaged with the USG male norms initiative for several years, to provide technical leadership and implementation to build on previous work under the male norms initiative. This activity has three main components: (1) to work with partners to address gender norms that contribute to multiple concurrent partnerships, transactional sex and, intergenerational sex; (2) to work with partners to address harmful gender norms among most at risk populations, and (3) to work with partners to address harmful gender norms in the regions that have the highest HIV prevalence.

1. Work with partners to address gender norms that contribute to multiple concurrent partnerships, and transactional and intergenerational sex. Utilizing the capacity gained from several years as a sub partner under the male norms initiative, the recipient will incorporate gender messages and activities into their programmatic strategies to reduce the key drivers of the HIV epidemic in Namibia. The recipient will develop specific technical assistance plans for local partners and the GRN to help them integrate gender activities into their programmatic activities. A key activity under this objective will be to raise awareness at the national level around how gender issues are contributing to the key drivers of the epidemic in Namibia. A critical partner at this level will be the MoHSS who has expressed interest in building on the national conference on Men and HIV and AIDS that was held in 2008. The MoHSS would take the advocacy effort to the regional level and work with key stakeholders on male engagement in HIV prevention, care and support. National level efforts will also be supported by the Ambassadors project, which was initiated in 2009, that identified leaders in Namibia and supported them to be champions in their communities and in their peer groups around gender issues and HIV.

2. Work with partners to address harmful gender norms among at risk populations. In a recent report, specific populations were considered most at risk in Namibia of the HIV and AIDS epidemic. This included men in workplaces, and young men and women aged 15-24. The recipient will specifically implement activities within workplaces and with partners who are able to reach young men and women such as within universities to implement HIV prevention activities with a gender perspective. These activities will help partners reach individuals to understand how harmful gender norms put them at risk of HIV and AIDS and help them assess their risk for HIV and AIDS.

3. Work with partners to address harmful gender norms in regions/areas that have the highest HIV prevalence. According to the latest report on the HIV and AIDS epidemic, the regions and areas that have the highest HIV prevalence are those in the north and in Walvis Bay. The recipient will work with organizations that have a strong presence in the North and in Walvis Bay on integrating gender programming into their current HIV and AIDS programming, and to specifically reach populations that are most at risk in this region. The recipient will continue to build on the successful work that was done in 2009 with voluntary, counseling and testing centers in the North, and on implementing demand creation strategies to increase HIV testing among men. Based on the work done in 2009 with religious and traditional leaders previously by EngenderHealth and Lifeline/Childline, the recipient will partner with religious and traditional leaders in the North who are especially influential in their communities.

Ongoing supervision and monitoring will be provided in a variety of ways: through joint program design, implementation, and training; in-country field visits and discussions on ways to address challenges, and; feedback through email and phone discussions.



Sustainability will be achieved through ensuring that capacity to implement gender programming is integrated into the programmatic activities of each selected organization and by strengthening GRN and civil society capacity in program design, implementation, training and monitoring and evaluation through supportive supervision and mentoring.

Graduating a Namibian partner to receive direct PEPFAR funding will sustain in-country capacity and achieve cost efficiencies for the USG.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12441	Mechanism Name: TBD MARP
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	Funding Amount
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a new implementing mechanism which is a follow-on to the Population Services International (PSI)/Social Marketing Association (SMA) Corridor of HOPE program which comes to an end in March 2010. During the end of COP09, PEPFAR Namibia will competitively award a new program to strengthen HIV prevention services for the following most-at-risk populations (MARPs): men who have sex with men (MSM), sex workers (SW) and clients of sex workers including truckers, seafarers and miners.

This new mechanism has three main components: 1) increased access to a comprehensive package of



prevention services leading to reduced risk of HIV transmission among MSM, SW and clients of sex workers; 2) creation of an enabling environment for the provision of HIV services for these populations; and 3) increased organizational capacity of local stakeholders to develop, manage, and evaluate effective HIV prevention interventions for the target population.

This mechanism will fill an important gap in MARP programming in Namibia. Although commercial and male-to-male sex are not the source of most new HIV infections in Namibia, available data suggest that SW and MSM have some of the highest rates of HIV prevalence of any population sub-groups and remain important target audiences for prevention efforts. However, to date most prevention efforts have focused on awareness creation among youth and adults in the general population. The primary activity related to addressing higher-risk populations to date has been the SMA activity, but SMA also lacked a sharper focus on these most-at-risk groups.

The activity supports the prevention priorities of the Government of Namibia (GRN) as articulated in the draft National Strategic Framework for HIV/AIDS. The partner will participate in the Prevention Technical Advisory Committee (TAC) and work under the National Prevention Strategy currently under development. This program contributes to the draft USG Partnership Framework through the objective "Increased prevention programming for most at risk and vulnerable populations (MARPs), including youth, sex workers, men who have sex with men, prisoners, truck drivers and other mobile populations."

Geographically, the new activity will, in collaboration with the GRN, establish selected high-risk areas in which to operate, specifically, those with a high density of MARP, high HIV prevalence and a thriving commercial sex industry.

A key focus of the program will be to identify and capacitate local organizations representing and serving MARP to operate in a cost-effective and accountable way and to develop the capacity of these groups and civil society to advocate for increased commitment by government and other stakeholders for improved HIV prevention, care and treatment services for MARP. By transferring technical knowledge and skills required to establish, operate and sustain these interventions to qualified indigenous organizations, and working with the GRN and stakeholders to create an enabling environment, USG will increase the likelihood of sustaining HIV prevention interventions with MARP in the future.

The program will address gender issues, recognizing that food insecurity, poverty and unemployment are among the reasons why women join the sex trade, and that power imbalances make it difficult for SW to insist on condom use with clients during paid sex.

During COP10, the USG will conduct research and surveillance regarding MARP including geographical



mapping, size estimations, biomarker and behavioral surveys. The current Global Fund (GFATM) proposal includes support to NGOs working with MARP to collect qualitative and quantitative information to assess the size and behaviors of these groups. The USG will coordinate with these efforts and incorporate data in program design, planning and implementation. The mechanism will undertake additional formative and quantitative assessment to fill information gaps as needed.

The USG will work closely with the recipient to build M&E capacity of local partners and the GRN for program management of prevention for MARP, disaggregating beneficiary-level indicators by sex and category of MARP, and tracking data on planned coverage of interventions. Limited indicators exist to effectively monitor key accomplishments in the areas of policy development, organizational capacity building and creation of an enabling environment. The program will utilize indicators additional to the required PEPFAR indicators to monitor key accomplishments in these areas, based on global standards.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	Redacted
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Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID: 12441			
Mechanism Name: TBD MARP			
Prime Partner Name: TBD			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

This is a new activity.
 This new activity has three major areas of activity that parallel the overarching objectives outlined in the Implementing Mechanism narrative: 1) Delivery of a comprehensive package of services to MARP, 2) Policy and advocacy to create an enabling environment for the provision of HIV services to MARP, and 3)

Building the organizational capacity of local stakeholders to develop, manage and evaluate effective HIV prevention interventions for the target populations.

Despite increases in service delivery to Namibians, current GRN policies criminalize specific MARP and impede HIV programs that work with MARP. There is a risk that MARP remain marginalized and do not universally access available HCT and other HIV and AIDS services available.

1) Delivery of a comprehensive package of services to MARP: There is substantial evidence for the effectiveness of a comprehensive package of interventions for populations most-at-risk of HIV, including MSM, SW and SW clients. The program will roll-out a comprehensive package for MARP including the following core components:

- Targeted condom and lubricant promotion
- Peer education and outreach
- HIV counseling and testing
- Risk reduction activities and counseling
- Use of data for evidence-based programming

The program will establish and strengthen innovative and tailored models for delivering HCT testing in "MARF-friendly" settings to sex workers, clients and MSM, which may include mobile services, etc. in addition to different testing models including VCT, PITC and couples testing. Referral approaches for MARP populations to HIV counseling and testing in addition to care and treatment, given the high prevalence in these populations, should be further considered and strengthened. These linkages may also include referrals for circumcision, substance abuse treatment, PMTCT (including family planning), and post-exposure prophylaxis, tailored to the needs of each vulnerable group as appropriate. Sensitization of health care providers to provide MARF-friendly services will also be part of the package. The program will explore opportunities to bring mobile HIV testing services to locations that are convenient to MARP.

The new program will scale-up delivery of this package to MARP in priority program areas through collaboration with local organizations, including MARP-led organizations. The program will use information derived from program monitoring to strengthen service delivery and to propose additional innovative approaches to reaching MARP with prevention services.

HIV counseling and testing service delivery points will be sensitized to work with MARP populations appearing for HCT services. The partner will establish M&E systems to track referrals to HCT from IPC activities. Qualitative and quantitative reviews of where MARP access HCT services will be conducted to better focus technical assistance.

2) Policy and Advocacy: Namibia maintains policies and legislation that criminalize MARP and impede HIV prevention activities with MARP. Mobilization of key stakeholders is critical to create a legal, political and social environment where MARP can be reached with effective prevention programming. In the Namibian context, where sex between men and commercial sex remain illegal, HIV/AIDS programs must enlist the explicit cooperation of law enforcement, health authorities, and the political and religious communities, to reduce the fear of arrest and stigmatization that cause MARP to avoid health seeking behaviors.

The program will partner with MSM, SW and human rights organizations and networks, in spearheading advocacy for policies to reduce barriers to delivery of services. A range of local, national and regional stakeholders will be capacitated to assume leadership of advocacy efforts, so that this policy work is sustainable beyond the life of the project. The program will support stakeholders by ensuring timely and accurate use of data for policy work and advocacy, and for evidence-based decision making.

3) Organizational Capacity Building: The transfer of knowledge and skills required to operate efficient, cost-effective, accountable and transparent organizations is essential to managing integrated interventions for MSM, SW and their clients. Solid organizational performance is core to the short and long-term success of scaling up interventions. The program will focus on meeting the particular organizational development needs of specific target organizations. Capacity-building will cover a broad range of substantive areas, ranging from advocacy to administration and finance, governance, leadership, management, networking, and strategic planning. Particular attention will be given to monitoring and evaluation, supportive supervision and quality assurance, given the importance of the quality of interventions to achieving successful behavior change.

Regular supportive supervision, distribution of standardized materials and monitoring visits will be undertaken by USG and prime recipients to ensure that outreach activities are being conducted to standards established by the GRN and USG, that linkages are strengthened to biomedical interventions available and that data reporting is accurately reflecting progress against PEPFAR indicators. Sustainability components will include capacity building of local civil society and regional administrations to better coordinate and implement evidence-based HIV prevention strategies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

This is a new activity.

This new activity will support a comprehensive package of prevention services for most-at-risk populations (MARPs), including supportive policy development, capacity building of local organizations and the GRN in addition to ensuring risk avoidance as a component among clients. This narrative links to other narratives in HVAB, HVOP and HVCT. MSM and clients of sex workers are among the key populations targeted by this program. As one component of a comprehensive package for MARPs, AB prevention funds will support outreach and education efforts to reduce multiple and concurrent partners among sex work clients and MSM.

1) Outreach and education to reduce multiple partners

Because many clients of sex workers have regular partners in addition to commercial partners, they act as a 'bridging' population to continually spur new HIV infections in the general population. Clients of sex workers in Namibia are frequently individuals who have migrated for work or are in occupations requiring that they spend long periods of time away from home. Seafarers, truckers, and miners especially are thought to be occupational groups that frequently purchase sex from SW; rough estimates suggest there may be 2,600 truckers and 2,000 seafarers in Namibia at any point in time. The risk factors for HIV among these migrant populations include unprotected sex with paid and casual partners, multiple concurrent partnerships, and low risk perception. While men in some occupations are easily identified as likely to engage in paid sex, other clients of sex workers are less readily identifiable as a risk group. MSM in Africa often have frequent concurrent partnerships with both male and female partners, as well as high turnover of partners. The regular or noncommercial partners of sex workers are another important core group. Both MSM and other populations practice lower rates of condom use within stable relationships.

Little formative research on male clients of sex workers exists in Namibia, but studies elsewhere indicate that the decision to pay for sex often begins at entertainment establishments such as bars and beer gardens that are frequented by sex workers. This decision is often influenced by peer pressure from friends and business partners, and by the loss of control owing to the influence of alcohol. Apart from their contact with sex workers, clients routinely report intercourse with wives, girlfriends, and casual acquaintances. In some countries, HIV interventions have reduced the proportion of men who visit sex workers, as well as the frequency of visits by those who continue to engage in commercial sex.

The new program will conduct formative research to develop a profile of sex work clients in targeted areas and to identify entry points for program intervention, since vulnerabilities relating to HIV are often specific to each industry and sector. For men belonging to easily identified occupational risk groups, the program will identify relevant organizations such as truck and mining companies and port authorities and help them to develop and implement targeted prevention interventions for their workers. Innovative



interpersonal communications (IPC) tools and materials will be used to increase risk perception and understanding of the potential impact of risky sexual behavior on their families, and to build skills needed to adopt responsible decisions and behaviors. The program will also emphasize the role of alcohol as a facilitating factor for risk behavior.

Strategies for reaching clients of sex workers who do not form a visible, coherent social group will include support to local community organizations for outreach in bars and entertainment establishments and other venues where men who frequent sex workers are to be found. The project will develop IPC interventions to engage target audiences in these settings, supported by educational materials about HIV. The program will develop mechanisms for supportive supervision of outreach staff, and will periodically undertake assessments to monitor trends in behavior among target populations.

Messages about reducing partners and patronage of sex workers for these high-risk men will be integrated within a comprehensive approach to risk reduction, and will at all times be accompanied by condom promotion, demonstration and distribution.

Regular supportive supervision, distribution of standardized materials and monitoring visits will be undertaken by USG and prime recipients to ensure that outreach activities are being conducted to standards established by the GRN and USG, that linkages are strengthened to biomedical interventions available and that data reporting is accurately reflecting progress against PEPFAR indicators.

Sustainability components will include capacity building of local civil society and regional administrations to better coordinate and implement evidence-based HIV prevention strategies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

This is a new activity. This activity will have three major areas that parallel the overarching objectives outlined in the implementing mechanism narrative: 1) delivery of a comprehensive package of services to MARP, 2) policy and advocacy to create an enabling environment for the provision of HIV services to MARP, and 3) building the organizational capacity of local stakeholders to develop, manage and evaluate effective HIV prevention interventions for the target populations.

1) Delivery of a comprehensive package of services to MARP: There is substantial evidence for the effectiveness of a comprehensive package of interventions for populations most-at-risk of HIV, including MSM, SW and SW clients. The program will roll-out a comprehensive package for MARP including the following core components:

- Targeted condom and lubricant promotion
- Peer education and outreach
- HIV counseling and testing

- Risk reduction activities and counseling
- Use of data for evidence-based programming

The program will incorporate linkages to "MARP-friendly" health services, especially referrals to HIV care and treatment, given high prevalence in these populations. These linkages may also include referrals for circumcision, substance abuse treatment, PMTCT (including family planning), and post-exposure prophylaxis tailored to the needs of each vulnerable group as appropriate. Sensitization of health care providers to provide MARP-friendly services will also be part of the package. The program will explore opportunities to bring mobile HIV testing services to locations that are convenient to MARP.

The new program will scale-up delivery of this package to MARP in priority program areas through collaboration with local organizations, including MARP-led organizations. The program will use information derived from program monitoring to strengthen service delivery and to propose additional innovative approaches to reaching MARP with prevention services.

2) Policy and Advocacy: Namibia maintains policies and legislation that criminalize MARP and impede HIV prevention activities with MARP. Mobilization of key stakeholders, including government, civil society, and members of targeted populations is critical to creating a legal, political, and social environment where MARP can be reached with effective prevention programming. In the Namibian context, where sex between men and commercial sex remain illegal, HIV/AIDS programs must enlist the explicit cooperation of law enforcement, health authorities, and the political and religious communities, to reduce the fear of arrest and stigmatization that cause MARP to avoid health seeking behaviors.

The program will partner with MSM, SW and human rights organizations and networks in spearheading advocacy for policies to reduce barriers to delivery of services. A range of local, national and regional stakeholders will be capacitated to assume leadership of advocacy efforts, so that this policy work is sustainable beyond the life of the project. The program will support stakeholders by ensuring timely and accurate use of data for policy work and advocacy, and for evidence-based decision making.

3) Organizational Capacity Building: The transfer of knowledge and skills required to operate efficient, cost-effective, accountable and transparent organizations is essential to managing integrated interventions for MSM, SW and their clients. Moreover, solid organizational performance is core to the short and long-term success of scaling up interventions. Given the variable capacity among MSM and SW groups, the program will focus on meeting the particular organizational development needs of specific target organizations. Capacity-building will cover a broad range of substantive areas, ranging from advocacy to administration and finance, governance, leadership, management, networking and strategic planning. Particular attention will be given to monitoring and evaluation, supportive supervision



and quality assurance, given the importance of the quality of interventions to achieving successful behavior change.

Regular supportive supervision, distribution of standardized materials and monitoring visits will be undertaken by the USG and prime recipients to ensure that outreach activities are being conducted to standards established by the GRN and the USG, that linkages are strengthened to biomedical interventions available and that data reporting is accurately reflecting progress against PEPFAR indicators.

Sustainability components will include capacity building of local civil society and regional administrations to better coordinate and implement evidence-based HIV prevention strategies.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12442	Mechanism Name: TBD Project Hope Follow-On
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Project HOPE	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,221,980	
Funding Source	Funding Amount
GHCS (State)	1,221,980

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a new implementing mechanism which is a follow-on to Project Hope, whose Track 1 award ends in June, 2010. Project Hope has been working directly with guardians and parents of orphans and vulnerable children (OVC), providing them with small loans and business training through its Village Health Fund Microcredit Methodology. Under this approach, solidarity groups are formed, and micro-financing is accompanied by a health and parenting course. Since the beginning of the project in 2005,



2,251 caregivers have been trained, and 8,164 OVC have been served.

The new mechanism will target OVC through their caregivers, combining economic strengthening with health education and targeted interventions for TB prevention and management. The program design will utilize the structures of village health funds established by Project Hope, including field workers, and build linkages to local partners and the health system.

1. The new mechanism will focus on mitigating the impact of HIV/AIDS on OVC and OVC caregivers, addressing both economic needs and health aspects of HIV and TB. It has three comprehensive goals and objectives: 1) sustainable economic strengthening of families of OVC through microfinance and business skills training, and 2) building capacity of caregivers to address the emotional, physical and health needs of children in their care and 3) increasing TB awareness and case management.
2. The mechanism is in line with USG commitments of the Partnership Framework in its response to the draft National Strategic Plan on HIV AIDS, both in regard to impact mitigation (improving sustainable livelihoods for households with vulnerable person) as well as care (management of TB/HIV co-infection).
3. The geographic coverage will be six political regions (Oshana, Omusati, Ohangwena, Oshikoto, Kavango, and Caprivi). Target populations will be: a) caregivers of OVC, including elderly and junior heads of households, b) OVC in their care, and c) TB patients and patients co-infected by TB and HIV.
4. The mechanism will be linked to USG support for systems' strengthening of the Ministry of Gender Equality and Child Welfare (MGECW) human resource system and the administration of welfare grants. OVC caregivers will be educated on eligibility and processes for access to OVC grants, and strengthening the MGECW Community Development Directorate will broaden its capacity to support community projects for OVC caregivers. The TB activities will strengthen health systems delivery for DOTS through strengthening linkages and communication between clinics and communities.
5. The mechanism will increase women's access to income and productive resources, and thereby address unequal gender relations and gender-based violence. The proposed mechanism will reach predominantly women since, due to culture and social norms, the majority of OVC caregivers are female. Providing women and the children under their care with the opportunity to generate income through small businesses will contribute towards addressing the prevailing imbalances in power relations between male and female household members.
6. The mechanism will aspire towards long term cost-effectiveness and sustainability by linking operations to an emerging local micro-finance bank, Koshi-Yomuti. The TB activities will utilize and feed into the



national TB control program and existing community structures.

7. An M&E plan will be developed, and outcomes will be measured at the household (household assets) and child (care, health, education) levels. For TB case management, the activities will utilize the government's recording and reporting system and report to the health system.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	800,000
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Key Issues

Increasing gender equity in HIV/AIDS activities and services
 Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID: 12442			
Mechanism Name: TBD Project Hope Follow-On			
Prime Partner Name: Project HOPE			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	1,007,000	

Narrative:

This new activity is follow-on to Project Hope, whose Track 1 award ends in June 2010. This activity compliments the church-based income generating activity by focusing on households instead of institutions. It will have the following three components: 1) economic strengthening of caregivers of OVC, 2) training of OVC caregivers on parenting skills, and 3) collecting socioeconomic data on caregivers and OVC through member profile and parenting maps.

1. Economic strengthening of caregivers of OVC. OVC caregivers will be supported with business skills training and with micro-credit enabling them to engage in small businesses. The best performing micro-credit clients from Village Health Funds established under Project Hope's Track 1.0 program will be selected for continued access to graduated levels of credit and continued business skills training. These

caregivers will be groomed for graduation into the clientele of commercial micro finance bank Koshi Yomuti.

2. Training of OVC caregivers on parenting skills. Linked to the economic strengthening activities, participating caregivers will undergo a health and parenting course, and caregivers will be provided with continued support to improve the well-being of the OVC in their household through a care plan. This care plan will be actionable through referrals to partner organizations, direct service provision via payment for procuring birth certificates and hospital fees, and targeted refresher trainings on topics from the Parenting Training curriculum.

3. Collecting socioeconomic data on caregivers and OVC through member profile and parenting maps. When enrolling caregivers into the program, baseline member profiles will be collected and an assessment of parenting practices conducted. The same data will then be re-collected at periodic intervals.

As with Project Hope, the micro-credit activity will be monitored through accounting systems administered by field officers to help credit recipients manage their payments. Extensive controls will be put in place to ensure the cash payments involved in the process are subject to transparency and the possibility of fraud is minimized. The health education activities delivered by field workers will be monitored by a health coordinator.

Supportive supervision will be included in project activities for field officers. Quality assurance will include a participatory monitoring and feedback system in which outcomes for children are assessed according to the national OVC service standards.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	214,980	

Narrative:

This new activity has 2 main components: 1) to improve TB case management, and 2) to reduce TB defaulter rates in Oshikoto, Oshana and Kavango regions.

1. To improve TB case management

This activity will focus on strengthening existing health delivery systems in the above three regions, identifying gaps in service delivery and targeting the TB clinics with high caseloads and treatment default rates. The program will implement a strategy that educates TB patients and their supporters at the hospital, health centers, clinics, and households through information and education sessions to equip

them with the needed knowledge on treatment regimen, importance of adherence, and follow-up schedule. The activity will also strengthen the linkages between the households, TB patients, hospitals, and their assigned clinics by placing project staff at each level to ensure continuous communication and coverage.

2) Reduce TB defaulter rate in Oshikoto, Oshana and Kavango regions

This activity will continue to support the engagement of existing community health workers (Field Promoters) and "recharge" them to provide strong and consistent support to TB patients and their supporters in their catchment areas; mobilize them with weekly household visits; and provide community education outreach sessions. Where feasible, it will conduct mapping exercises using the GIS system to produce maps of caseloads and defaulters per catchment area. The mapping exercise will serve as a replicable model for controlling TB in rural and hard-to-reach areas.

The implementing partner will conduct supervisory support visits to the health facilities as a way of strengthening inter-workings of project staff with the government/Ministry officers. Most of the MOHSS staff consulted expressed their appreciation toward the field promoters presence that are assisting the overburdened nursing staff with TB and TB/HIV care in the community and health facilities.

Quality assurance will be addressed through regular meetings with MOHSS to review field promoters' performance and training needs. Regularly updated caseload mapping will serve as a monitoring and quality assurance tool.

Data verification will be done during the project supervisory support visits to the health facilities. Other non clinical TB care community activities are collected as additional information. Field staff will be trained on the MOHSS TB program tools for M&E.

Sustainability and Transition

1) The National TB Control Program initiated a coordination and collaboration partners' meeting for all partners in the two North-western regions represented by the Red Cross, Project Hope and Total Control of the Epidemic (TCE 2) to ensure: a clear understanding of all NGO's program activities, reporting systems, sharing of field experiences, and reduction in overlaps.

2) The project will subscribe to the Ministerial national TB control program recording and reporting system, avoiding duplicative or misaligned monitoring and evaluation systems, and enable transition to the to the Ministry upon project completion.

3) The project will conduct focus group discussions between the key district teams to assist the project team in understanding the deeply in-grained community beliefs regarding the spread of TB (how TB is 'inherited' and TB/HIV related misconceptions) which in turn assists in creating better guided and tailored



TB and TB/HIV messages for the household and clinic levels. This coordination with local government promotes ownership and sustainability of the interventions and reduces the use of contracted, and often expensive, external consultants.

4) The project will build the TB component on existing community based interventions, resulting in leveraging of existing activities and resources to reduce overall costs.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12443	Mechanism Name: Polytechnic of Namibia
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Polytechnic of Namibia	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 302,000	
Funding Source	Funding Amount
GHCS (State)	302,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

NEW NARRATIVE This is a new CDC cooperative agreement with the Polytechnic of Namibia (PON). It aims to strengthen graduate-level public health education in the Republic of Namibia, with an emphasis on training for the laboratory sciences. CDC has submitted a single eligibility justification memo for this partner on the grounds that PON is the only institution of higher education in Namibia with existing capacity to conduct bench-level training for laboratory scientists. If the justification is not accepted, a limited competition solicitation will be issued for Namibian universities.

Objectives: Three primary objectives will be supported through this new mechanism: (1) Curricula and instruction in the laboratory technician training program at PON will be strengthened through additional



technical support from the University of Arkansas (already providing assistance through a "twinning" arrangement in COP09) and other international partners. The CDC Laboratory Advisor will support new "twinning" introductions, especially with regional or south-to-south partners. (2) Polytechnic laboratory training facilities, including bench space and the resource library, may be enhanced through renovations and expansion. These improvements will be linked to the technical assistance described above. (3) Practical fellowships and/or internships will be developed with laboratory implementing partners including the Namibia Institute of Pathology (NIP) and the Blood Transfusion Service of Namibia (NAMBTS).

Partnership Framework: By promoting Namibian institutional capacity to train and educate laboratory scientists and technicians, this mechanism directly contributes to several of the goals and benchmarks of the Namibian Partnership Framework currently under development. Specifically, this mechanism addresses USG commitments in Goal 4, Coordination and Management, objectives 3 and 4, Human Resource Capacity Building, and Monitoring and Evaluation, among others.

Coverage: The activities of this mechanism are national in scope. The target population includes students, lecturers, and librarians in the PON laboratory sciences training program in Windhoek. These individuals represent a national cross-section of Namibian society and regions. Upon graduation, students will take on work assignments nationwide. Faculty advisors and specialist trainers will provide supportive supervision to students during practical rotations which could occur in partner laboratories outside of the capital.

Health systems strengthening: Key contributions to health systems strengthening through this mechanism include providing better trained and higher numbers of laboratory scientists and technicians for Namibia. These specialized healthcare workers will graduate from a competencies-based curriculum which will be accredited nationally and internationally. This support will help Namibia to exceed the targets outlined in the Human Resources Development Strategy 2008-2014.

Cross-cutting/Key issues: This mechanism will contribute to Human Resources for Health objectives through cross-cutting support for management and leadership development and pre-service education for public health professionals.

Cost efficiency: This mechanism has been designed from the start with cost efficiency in mind. Supporting a Namibian institution for graduate-level laboratory science education will obviate the need to send Namibians abroad for similar training. Investments in the public education sector will also support the public sector career ladder for faculty and staff, and contribute to a retention of talented Namibian instructors. This mechanism will promote innovative cost-effective approaches including distance communication and e-learning technologies, such as digital video conferencing for distance-based co-



teaching, guest-lecturing, mentorship, and professional development workshops. The use of electronic journals and texts such as the World Health Organization's HINARI e-journal database will replace the costs of purchasing and shipping expensive hardcopy textbooks and teaching resources while contributing to PON's collection of educational resources. This new mechanism also replaces a US-based partner which was funded in COP09 to establish the "twinning" relationship with the University of Arkansas. The Polytechnic has now developed adequate capacity to manage this relationship without an external third party.

M&E: A detailed monitoring and evaluation plan will be developed by the partner for the five years of the cooperative agreement has been developed to monitor progress towards achieving the stated goals and objectives. Be. Progress will be reported semi-annually to CDC. The indicators tracked through this mechanism are drawn from the Next Generation PEPFAR indicators and are aligned with the GRN indicators in the NSF. This mechanism will also contribute to the targets outlined in the Human Resources Development Strategy 2008-2014. The monitoring and evaluation plan for the five year project will be modified and adjusted as the years progress to ensure that arising needs are accommodated.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	241,600
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Key Issues

- Malaria (PMI)
- Child Survival Activities
- TB

Budget Code Information

Mechanism ID:	12443		
Mechanism Name:	Polytechnic of Namibia		
Prime Partner Name:	Polytechnic of Namibia		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	302,000	

Narrative:

NEW/REPLACEMENT NARRATIVE WITH SUBSTANTIAL CHANGES

This is a new activity in COP10. It aims to strengthen graduate-level education for laboratory scientists and technicians at a national university (the Polytechnic of Namibia) in the Republic of Namibia. This activity has three main components: (1) Support technical assistance to the Polytechnic's laboratory training program; (2) Expansion and renovation of Polytechnic laboratory training facilities. (3) Practical fellowships and/or internships will be developed with laboratory implementing partners including the Namibia Institute of Pathology (NIP) and the Blood Transfusion Service of Namibia (NAMBTS).

1) Enhance the Polytechnic laboratory training program: Curricula and instruction in the laboratory technician training program at PON will be strengthened through additional technical support from the University of Arkansas (already providing assistance through a "twinning" arrangement in COP09) and other international partners. The CDC Laboratory Advisor will support new "twinning" introductions, especially with regional or south-to-south partners. With FY10 funds I-TECH will continue with the development of specialized MPH program and will continue strengthening the nutrition, strategic information, and health policy and management components of the MPH program while ensuring integration of HIV/AIDS content into all areas of the curriculum.

2) Expand or renovate Polytechnic training infrastructure. Polytechnic laboratory training facilities, including bench space and the resource library, may be enhanced through renovations and expansion. These improvements will be linked to the technical assistance described above.

3) Practical fellowships. Systems and agreements will be developed with laboratory implementing partners, including the Namibia Institute of Pathology (NIP) and the Blood Transfusion Service of Namibia (NAMBTS), to ensure practical training opportunities for students and recent graduates of the Polytechnic's laboratory program.

Supportive supervision/Quality Assurance: Faculty advisors and lecturers from the Polytechnic of Namibia will provide supportive supervision to students and academic support personnel. This supervision will be aligned with the educational curriculum. Additional supervision and support will be provided by the CDC Laboratory Advisor and technical experts from the University of Arkansas and other technical assistance partners. A CDC GAP project officer based in the CDC Namibia office will support the development of performance plans and other reporting tools. CDC will also ensure that the Polytechnic, as a new partner, will receive appropriate training and guidance in the management of a USG grant.

Sustainability: The human resources crisis in Namibia is a severe constraint in achieving national and PEPFAR targets for HIV prevention, care, and treatment. This program will contribute to the development



of a sustainable laboratory training program embedded within a national university. Building human resources for health in Namibia will also contribute to PEPFAR's goal to train 140,000 new healthcare workers worldwide. Strengthening the practical training elements of the Polytechnic laboratory training program will also give students the opportunity to polish their skills before entering the workplace. Practical fellowships and internships will also be a recruiting tool for the MOHSS, NIP and NAMBTS. This new mechanism also replaces a US-based partner which was funded in COP09 to establish the "twinning" relationship with the University of Arkansas. The Polytechnic has now developed adequate capacity to manage this relationship without an external third party.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12444	Mechanism Name: TBD (Ministry of Health and Social Services (MOHSS))
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	Funding Amount
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

NEW NARRATIVE

This mechanism will provide direct USG support for a broad portfolio of country-driven approaches to build health care systems and strengthen country capacity to deliver quality health care.



Objectives: This mechanism will support a general expansion of the MOHSS's ability to implement cross-cutting programs that leverage investments in HIV/AIDS and other areas across the entire healthcare system. Specific areas of emphasis will include, but not be limited to:

- Development of a national quality management program
- Strengthen laboratory systems planning and management
- Interventions that reduce maternal and infant mortality rates (e.g., the MOHSS Roadmap for the Acceleration of the Reduction of Maternal and Newborn Mortality.)
- Integration of health management information systems

Support for these objectives will focus on strengthening existing healthcare systems, leveraging investments for expanded or new systems, and improving coordination between the public and private healthcare sectors. Support for human capacity development will focus on training and retention of Namibian staff. Special emphasis will be placed on expanding the ability of the GRN civil service to absorb new categories of healthcare workers, and manage short-term contracts to Namibian outsourcing firms. Building transparent and flexible systems will be a priority for this mechanism.

Partnership Framework: In COP10, PEPFAR will emphasize the GRN's capacity to plan, oversee, manage and, eventually, finance a growing share of the commitments made in the four priority areas identified by the PF: Prevention; Treatment, Care and Support; Impact Mitigation; and Coordination and Management.

This mechanism will encompass a broad range of activities and commitments described in the PF. Specifically, key objectives supported under the Coordination and Management thematic area will include leadership and governance, human resources/human capacity development, and monitoring and evaluation. This mechanism builds on more than five years of government-to-government engagement through a CDC cooperative agreement with the MOHSS for specific support to the national HIV/AIDS response. In line with PEPFAR's strategic emphasis on mainstreaming HIV/AIDS investments and supporting multi-sectoral interventions, this cooperative agreement will expand CDC's ability to deliver USG-funded technical assistance for health systems strengthening, primary health care, maternal and child health, and other services offered by the MOHSS.

The direct support model have already proven successful in Namibia, where matching MOHSS contributions to primary care services have grown with the PEPFAR-supported scale-up of ART and other HIV/AIDS services.

Coverage: The activities under this mechanism are national in scope.



Health systems strengthening: This mechanism will leverage on-going MOHSS investments in strategic planning, costing, decentralization and multi-sectoral coordination. Expanding PEPFAR's ability to support cross-cutting programs in primary healthcare, maternal and child health, sanitation and nutrition will open opportunities to leverage PEPFAR's HIV/AIDS investments and integrate them into the broader healthcare system. This new mechanism will also improve PEPFAR's visibility in other areas of the healthcare sector, and allow for new collaborations with other development partners.

The mechanism's specific focus on Human Resources for Health will build on recent MOHSS HR policy changes driven by revisions to the Namibian Labour Law in 2009. While the USG will continue to support the GRN civil service as the primary public sector employment mechanism, technical assistance will encourage the development of flexible and diverse HR mechanisms within the civil service, including outsourcing.

Cross-cutting/Key issues: As noted above, this mechanism will promote the development of strong, transparent and flexible human resource systems within the MOHSS. These systems will allow the GRN to recruit and retain a broader spectrum of healthcare workers, including community-based outreach workers. Through the GRN task-shifting initiative, these workers increasingly contribute to non-HIV health promotion activities, including immunization campaigns, clean water and nutrition awareness, and referrals to testing for TB. The efficient management of these community based human resources will reduce Namibia's dependence on external implementing partners and allow for a realignment of resources to improve access to basic healthcare for all Namibians.

Cost efficiency: This mechanism will specifically strengthen MOHSS ability to plan, implement, monitor and evaluate cross-cutting strategies within and beyond the national HIV/AIDS response. In line with the PF requirement that the USG assess the appropriate role for external partners, this mechanism will expand the MOHSS's capacity to identify, choose and finance its own technical assistance. Support for training and HSS will also promote the availability and use of national experts rather than external partners.

M&E: All CDC cooperative agreement grantees must submit a detailed work plan with their annual continuation application. This work plan must be based on PEPFAR indicators and aligned with targets set for each country. Grantees must also submit bi-annual status reports to program managers in Namibia. Data in these reports may be used inform any year-on-year changes to the work plan.



Cross-Cutting Budget Attribution(s)

Human Resources for Health	Redacted
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Key Issues

Child Survival Activities

Safe Motherhood

Family Planning

Budget Code Information

Mechanism ID:	12444		
Mechanism Name:	TBD (Ministry of Health and Social Services (MOHSS))		
Prime Partner Name:	TBD		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	Redacted	Redacted

Narrative:

NEW NARRATIVE

This is a new activity in COP10. It includes one component: 1) Cross-cutting technical and other assistance to the Ministry of Health and Social Services to expand the impact of HIV/AIDS investments across the national healthcare system.

The MOHSS will develop a work plan based on existing program needs and evidence. Focus activities should include, but not be limited to:

Policy and guideline development. Support for human capacity development in the field of healthcare policy and program management. This support will focus on policies and guidelines related to quality improvement, the national laboratory strategic plan, integration data systems across the healthcare sector, and maternal and child health.

Strengthen management capacity at all levels. Training will strengthen the managerial capacity of health managers at all levels. This will promote the MOHSS strategic objective of devolving decision making to sub-national and facility levels, and strengthening the quality improvement feedback loop.

Training. Training for Namibian healthcare workers in Namibia will promote the availability and use of national experts rather than external partners, and address personnel gaps in MOHSS facilities. Training will cut across multiple technical areas and seek to integrate non-HIV/AIDS elements where possible (e.g., IMAI).

Health Management Information Systems. The MOHSS collects and manages data across several non-integrated systems. In COP10 the USG will support the MOHSS' efforts to integrate these health information systems and promote the timely use of data at the facility level. Additionally, USG will provide TA to support operational research, disease surveillance and provide short term training of staff in epidemiology and research methods.

Maternal and Newborn Health. In support of the Roadmap for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality, MOHSS will expand cross cutting training for health care workers, e.g., in delivering Basic and Emergency Obstetric (and Neonatal) Care. Activities will link with those under HMBL in the provision of safe blood products for women who may need blood transfusion.

Quality Management. Quality assurance is a health system element that has grown in importance as costs of health care have escalated and consumer awareness and demand for quality services have increased. Ensuring the safety of patients and personnel and improving quality have therefore become important objectives for National health systems. The MOHSS will strengthen the national quality management program through training and task-shifting to enhance patient and personnel safety, and improve overall healthcare quality.

Laboratory Services. In conjunction with activities in the HLAB areas, the MOHSS will promote cross-cutting training and capacity building within the national laboratory system. Specific activities may include:

- 1- Strengthening the Laboratory Liaison Committee
- 2- Developing a comprehensive national laboratory strategic plan
- 3- Coordinating and integrating fragmented testing services
- 4- Coordinating and integrating surveillance and response capacities and capabilities
- 5- Training to ensure adequate numbers of laboratory professionals are available.

Supportive Supervision: CDC technical advisors and nurse coordinators will provide supportive supervision to MOHSS counterparts. Other short term TA support will be leveraged from other technical areas e.g. HVSI support for HMIS, or HLAB support for laboratory training.



Sustainability: This activity will specifically strengthen MOHSS ability to plan, implement, monitor and evaluate cross-cutting strategies within and beyond the national HIV/AIDS response. In line with the PF requirement that the USG assess the appropriate role for external partners, this mechanism will expand the MOHSS' capacity to identify, choose and finance its own technical assistance. Support for training and HSS will also promote the availability and use of national experts rather than external partners.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12445	Mechanism Name: Ministry of Health and Social Services
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health and Social Services, Namibia	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 250,000	
Funding Source	Funding Amount
GHCS (State)	250,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a new implementing mechanism, and supports the roadmap to accelerate the reduction of maternal and neonatal mortality and morbidity.

The overall goal of this activity is to provide technical assistance to the Ministry of Health and Social Services (MoHSS), Directorate of Primary Health Care (PHC) in addressing the challenges posed by the Maternal and neonatal Health (MNH). The expected results are increased quality of MNH, and reduced maternal and neonatal morbidity and mortality by the end of the five-year award.



This implementing mechanism links up with the Partnership Framework's prevention program area, and more specifically Objective 1.6: Enhance Prevention of Mother-To-Child Transmission. It is also in line with the GON Roadmap to Accelerate the Reduction of Maternal and Neonatal Morbidity and Mortality. It is a key priority of the government and will also enhance the MoHSS' capacity to meet its Millennium Development Goals (MDG).

Namibia's maternal death rates have almost doubled in the past decade. It has steadily increased since 1992 from 225 to 449 in 2006 (NDHS 2006-7) per 100,000 live births. Consequently, the country is unlikely to achieve its MDG five (improve maternal health) by 2015. Serious shortcoming in treating causes of death has been identified, including insufficient coverage of basic emergency obstetric care services. Nationally, only 4 (11.8%) out of 34 district hospitals provide comprehensive emergency obstetric care services and all are located in the central regions (two in Windhoek, one in Otjiwarongo and one in Oshakati). This finding and other related factors place Namibia with unmet need for emergency obstetrical care of over 80%.

The high prevalence of both obstetric-related maternal mortality and HIV among pregnant women further demonstrates the need for programs that simultaneously address both problems. HIV/AIDS is the third leading cause of infant mortality (8%) and second leading cause of child mortality.

In COP 2010, USAID will transition support from an implementing partner (Intrahealth) to the MOHSS PHC's roll-out of the "Road Map for the Acceleration of the Reduction of Maternity and Neo-Natal Morbidity and Mortality". Under the leadership of PHC, USAID, in collaboration with the WHO, will strengthen PHC's capacity to oversee the integration of PMTCT into overall maternal health services with a focus in the mostly affected northern regions. USAID will contribute to the funding activities identified by PHC's in the roadmap funding gap analysis. This support will contribute to the health system strengthening since it was identified in the MoHSS health systems review as one the major weaknesses that has contributed to drive poor MNH.

This implementing mechanism will leverage the Government of Namibia (GRN) and WHO funds, and has great potential to build the capacity of existing MoHSS staff at minimal cost and without incurring additional costs of doing business through a prime partner. Additionally, the mechanism transitions the GRN from donor dependency for direct service delivery to more of a partnership based on technical assistance needs. While the focus would be on northern regions, USAID will participate in resource mobilization that will ensure that activities under the roadmap can be scaled up in other regions as per the NSF recommendations.

Monitoring and evaluation is fundamental to the success of this program. Routine data from District



Health Information System (DHIS) will be tracked with regards to MNH indicators and data quality assurance will be conducted through joint support supervision with PHC staff. The demographic health survey of 2011 will provide a good opportunity to evaluate concerted efforts of reversing the current trend of maternal mortality.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	62,500
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Key Issues

- Child Survival Activities
- Safe Motherhood
- Family Planning

Budget Code Information

Mechanism ID: 12445			
Mechanism Name: Ministry of Health and Social Services			
Prime Partner Name: Ministry of Health and Social Services, Namibia			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	250,000	

Narrative:

This is a new activity for FY10.

In line with the National Strategic Plan (NSF) and the Partnership Framework, the roadmap for the acceleration of the reduction of maternal and neonatal morbidity and mortality is a key priority. This new activity will be undertaken under the leadership of Directorate of Primary Health Care (PHC) in the Ministry of Health and Social Services (MOHSS) in collaboration with WHO. It has three main components: 1) improved governance, 2) financing and resource mobilization, and 3) Human Resources for Health (HRH) capacity development.

1. Improved governance. This will be achieved by working with regional structures and local

constituencies to improve inefficiencies among service providers, including changing policies to increase maternal and neonatal service delivery coverage.

2. Finance and resource mobilization.

a. Translate the National Health Account Sub Account on Maternal and Child Health into evidence-based actions.

b. Assist the PHC to conduct its own assessments and discussions with stakeholders to rapidly respond to the barriers women face in accessing safe delivery services.

c. Assist the PHC in defining, costing and rolling-out a high-impact minimum package of interventions for mothers, children, and their partners at all levels of the health care delivery system, based on a self-sustaining model.

3. HRH capacity development. In line with the Partnership Framework Agreement (PFA), transitioning to Government of Namibia (GRN) ownership will require innovative capacity building. USAID-supported capacity building in the areas of governance, finance, and resource mobilization directly to the GRN will support an improved enabling environment for maternal, neonatal and child health, and PMTCT by addressing health care workers and improving linkages and referral networks for HIV positive women.

The partnership between USAID and the MOHSS has been consolidated through participation in technical working groups and joint support supervisions. Supporting the GRN directly will allow for integration and PMTCT transitional plans from USG implementing partners to occur more rapidly in line with the PF.

To ensure quality maternal and child health, the WHO tools will be used to track progress towards meeting the standard in the various components of a comprehensive emergency obstetrical care.

This activity is focused on filling the current gaps identified in the Roadmap for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality. The result is an integration of PMTCT into PHC care services, reduced maternal and neonatal morbidity and mortality, enhanced capacity of service providers, and improved governance. This direct technical assistance to PHC management over the next four years will build capacity and transition technical skills to sustain improved governance, HRH capacity, and resource mobilization.

Implementing Mechanism Indicator Information

(No data provided.)



USG Management and Operations

1.

Redacted

2.

Redacted

3.

Redacted

4.

Redacted

5.

Redacted

Agency Information - Costs of Doing Business U.S. Agency for International Development

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services				262,154		262,154
ICASS				372,900		372,900
Institutional Contractors				929,279		929,279
Management Meetings/Professional Development				319,766		319,766
Non-ICASS Administrative Costs				1,056,452		1,056,452
Staff Program Travel				848,263		848,263
USG Renovation				156,090		156,090
USG Staff				3,737,208		3,737,208



Salaries and Benefits						
Total	0	0	0	7,682,112	0	7,682,112

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHCS (State)		262,154
ICASS		GHCS (State)		372,900
Management Meetings/Professional Development		GHCS (State)		319,766
Non-ICASS Administrative Costs		GHCS (State)		1,056,452
USG Renovation		GHCS (State)		156,090

U.S. Department of Defense

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Capital Security Cost Sharing				2,000		2,000
Computers/IT Services				1,000		1,000
ICASS				25,000		25,000
Management Meetings/Professional Development				35,000		35,000
Non-ICASS Administrative Costs				61,000		61,000



Staff Program Travel				40,000		40,000
USG Renovation				5,000		5,000
USG Staff Salaries and Benefits				136,000		136,000
Total	0	0	0	305,000	0	305,000

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GHCS (State)		2,000
Computers/IT Services		GHCS (State)		1,000
ICASS		GHCS (State)		25,000
Management Meetings/Professional Development		GHCS (State)		35,000
Non-ICASS Administrative Costs		GHCS (State)		61,000
USG Renovation		GHCS (State)		5,000

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services				305,000		305,000
ICASS			387,266	10,182		397,448
Management				256,384		256,384



Meetings/Professional Development						
Non-ICASS Administrative Costs				613,627		613,627
Staff Program Travel				190,500		190,500
USG Staff Salaries and Benefits			1,112,734	818,233		1,930,967
Total	0	0	1,500,000	2,193,926	0	3,693,926

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHCS (State)		305,000
ICASS		GAP		387,266
ICASS		GHCS (State)		10,182
Management Meetings/Professional Development		GHCS (State)		256,384
Non-ICASS Administrative Costs		GHCS (State)		613,627

U.S. Department of State

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
ICASS				90,000		90,000
Institutional				219,672		219,672



Contractors						
Management Meetings/Professional Development				35,000		35,000
Non-ICASS Administrative Costs				45,000		45,000
Staff Program Travel				38,000		38,000
USG Staff Salaries and Benefits				113,100		113,100
Total	0	0	0	540,772	0	540,772

U.S. Department of State Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS		GHCS (State)		90,000
Management Meetings/Professional Development		GHCS (State)		35,000
Non-ICASS Administrative Costs		GHCS (State)		45,000

U.S. Peace Corps

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Management Meetings/Professional Development				75,000		75,000



Non-ICASS Administrative Costs				101,500		101,500
Peace Corps Volunteer Costs				1,328,900		1,328,900
Staff Program Travel				45,200		45,200
USG Staff Salaries and Benefits				391,800		391,800
Total	0	0	0	1,942,400	0	1,942,400

U.S. Peace Corps Other Costs Details

Category	Item	Funding Source	Description	Amount
Management Meetings/Profession al Development		GHCS (State)		75,000
Non-ICASS Administrative Costs		GHCS (State)		101,500