United States Department of State

Washington, D.C. 20520

January 16, 2019

INFORMATION MEMO FOR AMBASSADOR LISA A. JOHNSON, NAMIBIA

FROM: S/GAC – Ambassador Deborah L. Birx, MD

SUBJECT: FY 2019 PEPFAR Planned Allocation and Strategic Direction

We are grateful to you, Ambassador Johnson, and your Deputy Chief of Mission, Peter Lord, for your engagement in planning, review and implementation, and with the community and Government to enhance PEPFAR program impact. We are grateful for your attention to core policy adoption and holding partners to account and performance for improved outcomes and greater impact. Finally we are grateful to your incredible PEPFAR staff in country, working together across agencies to ensure the most effective and efficient use of taxpayer dollars.

Since 2004, PEPFAR has partnered with the Government of the Republic of Namibia (GRN) to advance progress toward achieving HIV epidemic control. PEPFAR's bilateral investment of $969,132,295 from Fiscal Year (FY) 2004 – 2018 has supported scale up of treatment and as of September 30, 2018, 179,844 HIV positive Namibians are currently receiving ART through PEPFAR-supported facilities in the public sector. This comprises over 84 percent of the estimated PLHIV in Namibia. Combined with the estimated 18,000 PLHIV receiving treatment in the private sector and continued progress in the current fiscal year, Namibia is on the verge of realizing the global UNAIDS 95-95-95 goals. We will be working with your PEPFAR team, community and the GRN to define how we ensure our collective successes are maintained and identify the USG footprint and resources needed to protect our collective investment and ensure the epidemic in Namibia remains under control. This collective planning is needed over the next 3 months to be prepared for the next phase of PEPFAR support.

In FY 2018, the PEPFAR Namibia team continued to advance progress toward epidemic control by scaling effective HIV prevention interventions, including voluntary medical male circumcision (VMMC), pre-exposure prophylaxis (PrEP) and DREAMS, and identifying a large number of people living with HIV and initiating them on treatment. Collectively, PEPFAR supported HIV testing services for 498,211 people, which resulted in 21,695 people being newly identified as HIV positive, including 6,188 men and 2,807 HIV+ pregnant women. Of those, 17,924 HIV+ individuals were newly initiated on treatment. Viral load suppression among people stably on treatment remained high at 95 percent. PEPFAR also provided care and support for 29,016 orphans, vulnerable children, and their caregivers in FY 2018. Finally, the team continued to expand VMMC services, providing 38,665 procedures, a 40 percent increase in men seeking services from last year.

Throughout these efforts, the team has built strong working relationships with the government, multilateral partners, civil society, and other stakeholders, leading to increased coordination of

the HIV/AIDS response in Namibia. This continued coordination will be instrumental as Namibia moves forward to be among the first countries in Sub-Saharan Africa to reach epidemic control. For the 2019 Country Operational Plan (COP 2019), PEPFAR Namibia must begin to evolve from a scale up program to one focused on sustaining control. This includes expansion of recency and self-testing, establishing case-based surveillance, and ensuring underlying health systems are sufficiently strong to stand on their own. For COP 2019, PEPFAR Namibia should begin to streamline management of the program by consolidating treatment and prevention services by agency in order to ensure efficiency and cost-effectiveness.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) total planning level for Namibia for COP 2019 is **$80,000,000**, inclusive of all new funding accounts and applied pipeline. This budget reflects additional resources to ensure that any Angolans or other non-Namibian citizens seeking services along the northern border are provided with clinical services, including funding to cover HRH and commodity needs on the Namibian side of the border for those who cross the border to receive lifesaving services and PMTCT. This funding is contingent on integration of data from legacy systems in an integrated system. These data must come from commodities and supply chain, patient management and laboratory systems.

If you have questions about the priorities and guidance laid out in this letter, please contact your Chair and Program Manager. My office is continually grateful for your team's work on the PEPFAR program, helping us to move towards an AIDS-free generation by supporting the HIV response in Namibia.

APPENDICES:

1. **COP 2019 PLANNING LEVEL**
2. **COP 2019 BUDGETARY REQUIREMENTS & GUIDANCE**
3. **PAST PERFORMANCE**
4. **COP 2019 DIRECTIVES**

APPENDIX 1: COP 2019 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the FY 2018 Q4 POART and performance information, the total COP 2019 planning level is estimated to be comprised as follows:

Table 1. COP 2019 Budget **

Namibia TOTAL COP 2019 PLANNING LEVEL: $80,000,000			
Total Base Budget for COP 2019 Implementation			**$ 80,000,000**
Total COP 19 New Funding	$	67,836,335	
of which, VMMC	*$*	*8,273,173*	
of which, DREAMS	*$*	*10,000,000*	
Total Applied Pipeline	$	12,163,665	

***Applied pipeline by agency is provided in chart below.*

Table 2. Applied Pipeline**

Namibia COP 2019 Applied Pipeline By Agency		
Total Applied Pipeline	**$**	**12,163,665**
HHS/CDC	$	6,265,294
Peace Corps	$	165,146
USAID	$	5,733,225

***Based on agency reported available pipeline from EOFY.*

All planning levels are subject to further adjustment, **based upon appropriations**, further analysis determining the availability of excessive pipeline, and other developments during the course of COP 2018 implementation and the COP 2019 review process. The total spend in the implementation of COP 2019 (FY 2020) may not exceed the total COP 2019 planning level of $80,000,000.

APPENDIX 2: COP 2019 BUDGETARY REQUIREMENTS

Table 3. COP 2019 Earmarks

Namibia COP 2019 EARMARK REQUIREMENTS		
Care and Treatment (C&T)	$	35,953,258
% of base funds allocated to C&T		*53%*
HKID	$	4,748,543
Gender Based Violence (GBV)	$	110,000
Water	$	50,000

Care and Treatment: If there is no adjustment to the COP 2019 new funding level due to an adjustment in applied pipeline, Namibia's minimum requirement for the care and treatment earmark is reflected in the chart above. Your care and treatment requirement is calculated as the sum of total new FY 2019 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS budget codes, 30% of the total funding programmed to the MTCT budget code, 80% of the total funding programmed to the HLAB budget code, and 30% of the total funding programmed to the HVCT budget code. This minimum care and treatment earmark has been derived based upon a requirement that your country programs a minimum of 53% of all **new FY 2019 Base Funds** to care and treatment of people living with HIV.

HKID Requirement: Namibia's COP 2019 minimum requirement for the HKID budget code is reflected in the chart above. Your COP 2019 HKID requirement is derived based upon the approved COP 2018 HKID level. The COP 2019 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

Gender Based Violence (GBV): Namibia's COP 2019 minimum requirement for the GBV earmark is reflected in the chart above. Your GBV earmark requirement is calculated as the total **new FY 2019** funding programmed to the GBV cross-cutting code. Your COP 2019 earmark is derived by using the final COP 2018 GBV earmark allocation as a baseline. The COP 2019 planned level of new FY 2019 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Namibia's COP 2019 minimum requirement for the water earmark is reflected in the chart above. Your water earmark requirement is calculated as the total **new FY 2019 funding** programmed to the water cross-cutting code. Your COP 2019 earmark is derived by using the final COP 2018 water earmark allocation as a baseline. The COP 2019 planned level of new FY 2019 funds for water can be above this amount; however, it cannot fall below it.

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of

these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal **by agency** by the end of FY20, and must meet 40% by FY19. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each Namibia agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY20 as appropriate through their COP 2019 submission.

COP 2019 Applied Pipeline

All agencies in Namibia should hold a 3 month pipeline at the end of COP 2019 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP 2018 implementation (end of FY 2019) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP 2019, decreasing the new funding amount to stay within the planning level.

The Applied Pipeline amount of $12,163,665 given by S/GAC as a part of the COP 2019 planning level has been calculated to reflect the projected excessive pipeline as of the beginning of the COP 2019 implementation cycle (FY 2020), and is the minimum amount that Namibia must apply as pipeline in the COP 2019 submission. The distribution of new base funds and Applied Pipeline was calculated to ensure 3 months of pipeline remains with mechanisms, based upon the financial data submitted for the FY 2018 Q4 Obligation and Outlay and FY 2018 End of Fiscal Year (EOFY) reports. Expired funds, funds on expired mechanisms and projected FY 2019 outlays as submitted in the EOFY report were all taken into consideration to inform the projected excessive pipeline and the required COP 2019 applied pipeline amount.

Unliquidated obligations on closed mechanisms identified in the FY 2018 EOFY report should be de-obligated in a timely manner. This will continue to be monitored throughout FY 2019 (COP 2018 implementation) and into COP 2019.

APPENDIX 3: PAST PERFORMANCE TRENDS

Table 4. COP 2017/ FY 2018 Outlays versus Approved Budget*

Row Labels	Sum of Approved COP 2017 Planning Level	Sum of Total FY 2018 Outlays	Sum of Over/Under Outlays
Namibia	**$ 68,300,000**	**$ 39,273,937**	**$ (29,026,063)**
HHS	$ 33,760,845	$ 23,987,975	$ (9,772,870)
PC	$ 1,266,000	$ 748,840	$ (517,160)
State	$ 739,711	$ (4,807,467)	$ (5,547,178)
USAID	$ 32,533,444	$ 19,357,239	$ (13,176,205)
Grand Total	**$ 68,300,000**	**$ 39,273,937**	**$ (29,026,063)**

** State obligations and outlays have not yet been reconciled and the numbers in this table may change based on reconciliation.*

Namibia's total FY 2018 outlay level of $39,273,937 is under your approved spend level of $68,300,000 (COP 2017 budget). Within this total, HHS, Peace Corps, State, and USAID spent below their approved level.

Table 5. IP FY18 Outlays*

** This table was based off the FY18 EOFY submissions, but edited to reflect OPUs as of January 15th, 2019. Agencies outlaid to the following Implementing Mechanisms 125% or more in excess of their COP17 approved planning level.*

Mech ID	Prime Partner	Funding Agency	COP17/FY18 Budget (New funding + Pipeline + Central)	Actual FY18 Outlays ($)	Over/Under FY18 Outlays (Actual $ - Total COP17 Budget $)
12752	Ministry of Health and Social Services, Namibia	HHS/CDC	No COP17 Budget	$119,868	$119,868
14390	University of Namibia	HHS/CDC	No COP17 Budget	$122,696	$122,696
17529	JHPIEGO	USAID	$1,866,200	$2,523,697	$657,497
18088	Catholic Relief Services	USAID	No COP17 Budget	$41,689	$41,689

Table 6. COP 2017/ FY 2018 Results versus Targets

** Financial and target performance data not a one-to-one correlation as program classification expenditures encompass more than those towards indicator/target presented.*

Agency	Indicator	FY18 Result	FY18 Target	% Achievement	Program Classification	FY18 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	317,608	279,497	114%	HTS	$ 2,919,741	76%
	HTS_TST_POS	15,345	20,734	74%			
	TX_NEW	12,355	20,813	59%	C&T	$ 11,951,645	47%
	TX_CURR	131,355	145,077	91%			
	VMMC_CIRC	19,384	23,451	83%	PREV: CIRC	$ 3,570,192	93%

	OVC_SERV	N/A	N/A	N/A	SE for OVC	$ 0	N/A
					Above Site Programs	$ 4,107,060	
					Program Management	$ 6,004,632	
HHS/HRSA	HTS_TST	N/A	N/A	N/A	HTS	$ 0	N/A
	HTS_TST_POS	N/A	N/A	N/A			
	TX_NEW	N/A	N/A	N/A	C&T	$ 355,274	0%
	TX_CURR	N/A	N/A	N/A			
	VMMC_CIRC	N/A	N/A	N/A	PREV: CIRC	$ 0	N/A
	OVC_SERV	N/A	N/A	N/A	SE for OVC	$ 0	N/A
					Above Site Programs	$ 0	
					Program Management	$ 53,403	
Peace Corps	HTS_TST	N/A	N/A	N/A	HTS	$ 0	N/A
	HTS_TST_POS	N/A	N/A	N/A			
	TX_NEW	N/A	N/A	N/A	C&T	$ 0	N/A
	TX_CURR	N/A	N/A	N/A			
	VMMC_CIRC	N/A	N/A	N/A	PREV: CIRC	$ 0	N/A
	OVC_SERV	70	2,800	3%	SE for OVC	$ 9,024	100%
					Above Site Programs	$ 0	
					Program Management	$ 0	
USAID	HTS_TST	186,006	113,328	164%	HTS	$ 3,032,190	70%
	HTS_TST_POS	6,500	10,454	62%			
	TX_NEW	5,582	10,258	54%	C&T	$ 9,067,000	32%
	TX_CURR	48,489	47,332	102%			
	VMMC_CIRC	19,365	20,152	96%	PREV: CIRC	$ 2,963,336	77%
	OVC_SERV	28,946	30,001	96%	SE for OVC	$ 1,899,581	84%
					Above Site Programs	$ 1,334,103	
					Program Management	$ 6,976,311	

COP 2017/ FY 2018 Performance

Overall

- Case-finding: PEPFAR Namibia overachieved on HTS_TST while failing to meet HTS_POS targets, suggesting the need to refine testing approaches as we approach epidemic control. Several partners met or exceeded their testing target while falling under 70% for HTS_POS, specifically:
    - MOHSS (89% and 47%)
    - Project-Hope (97% and 51%)
    - IntraHealth (172% and 52%),
        - University of Washington and JHPIEGO, reached or exceeded their HTS_POS target but also over tested, 188% TST / 118% POS and 1133% TST / 606% POS, respectively.

        - The majority of partners also failed to effectively scale index testing and ensure all newly identified PLHIV serve as index clients. DAPP was the only partner that took index testing to scale in COP 17 and was responsible for the majority of index tests performed. While DAPP only reached 60% of HTS_POS targets, they showed significant improvement in testing yield over time and overall testing numbers were consistent with positives identified.
- Treatment: All partners underperformed against targets for treatment initiation. This is not unexpected given the number of new cases identified and discrepancies between COP17 PLHIV estimates and PHIA estimates. Time to initiation on treatment has remained relatively stagnant from COP 17 with ~60 percent of patients initiating on the same day and 84 percent in the first month. IntraHealth reported improved times to initiation in a select number of sites with 84 percent same day, and 99 percent by day 30.
    - MOHSS continues to underperform compared to other treatment and testing partners and has failed to demonstrate improvement over the last year of implementation.
- Viral Load Suppression: Overall suppression rate is high at 95%, though outcomes for those under 25 are lower, particularly for men (81 percent for men 20-24). Geographic variability was also observed, with Keetmanshoop, Gobabis and Otjiwarongo all following between 80-90 percent.
- OVC: Namibia met targets for OVC_SERV in COP17 and improved known status among those under 18 to ~90%. 76 percent of OVC_SERV were under the age of 18. Children in OVC programs also had improved VLS compared to national averages. This progress was largely as a result of efforts from Project Hope. Peace Corps only reported reaching 70 OVC at APR, a significant drop from the 3100 reported at SAPR. This is a result of a significant number of volunteers having left country between SAPR and APR and Peace Corps aligning their activities to new definitions of OVC_SERV implemented in FY 2018. Peace Corps has recruited a new monitoring and evaluation staff to ensure this does not happen in the future.
- DREAMS: PEPFAR Namibia failed to reach DREAMS-associated targets, largely due to delays in awards and partner launches. By end of Q4 FY 2018, 58 safe spaces were up and running and 5,650 girls had been reached with DREAMS interventions.
- VMMC: As an OU, Namibia performed over 38,000 circumcisions, up from nearly 28,000 the previous year, resulting in an 89% achievement against target. All CIRC partners achieved greater than 80% of target and increased volume from COP16 by a minimum of 10%.
- TB: TB preventative therapy (TPT) has not been fully scaled. Only 11,571 of 94,711 eligible patients were initiated on TPT, though the majority of these, 10,293 or 89%, reported to have completed TPT at the end of FY 2018. Data capture and reporting continues to be an issue. IntraHealth reported significant improvements in data capture, initiation and completion of TPT in supported sites. Data and reporting issues also making it difficult to interpret treatment in HIV and TB co-infected patients. The number of PLHIV screening positive for TB is low based on WHO estimates; Namibia is finding under a third of TB cases. Coverage of HIV testing and treatment of TB+ patients remained high.

- Key Populations: SFH achievement was strong across all indicators, including HTS, TX and Prevention. Linkage of HIV+ KP to treatment also improved, from ~50% in FY 2017 to ~70% in FY 2018.
- PrEP: All partners administering PrEP exceeded targets, ranging from 172-360%. In addition, University of Washington also launched PrEP activities in supported facilities even though they did not have targets. PEPFAR Namibia also exceeded PrEP targets for KP, initiating 860 in FY 2018 (target of 500). The majority of KP initiating PrEP were sex workers.

APPENDIX 4: COP 2019 DIRECTIVES

Table 7. COP 2019 (FY 2020) Targets

Based on current progress towards epidemic control and funding level, the following FY 2020 treatment targets are recommended for Namibia:

Indicator	Pediatric (<15) Treatment Target	Adult Men (15+) Treatment Target	Adult Women (15+) Treatment Target	Treatment Target Total[a]
COP 18 (FY 19 Targets)				
TX_NEW (New on Treatment)	511	15,398	10,916	26,825
TX_CURR (Current on Treatment)	10,031	85,647	123,262	218,940
TB_PREV	N/A	N/A	N/A	79,694
VMMC_CIRC	N/A	54,306	N/A	54,306
COP 19 (FY 20 Targets)				
TX_NEW (New on Treatment)	1,003	8,565	12,326	21,894
TX_CURR (Current on Treatment)	10,533	89,929	129,425	229,887
TB_PREV	N/A	N/A	N/A	82,042
VMMC_CIRC	N/A	50,000	N/A	50,000
National Treatment Coverage				
Treatment Coverage	97%	96%	114%	102%

[a]Targets should be further allocated by age and sex based on disaggregated PLHIV estimates and unmet need for ART.

These targets were developed based on the following assumptions:

- TX_NEW: Targets for TX_NEW assume that 95% of TX_CURR patients are retained from year to year, and that 90% of the TX_NEW target will be retained and thus contribute to the required TX_NET_NEW to achieve the TX_CURR target. Namibia should consider as they move to Epidemic Control how they can exceed these minimum requirements to maintain control of the epidemic.
- TX_CURR: TX_CURR targets were generated to move Namibia to 95-95-95 at the country-level based on preliminary PLHIV estimates and ART coverage estimates. In order to achieve this target, the team needs accurate reporting and minimization of loss and mortality. This TX_CURR target is inclusive of all public sector patients in all geographies, and patients receiving treatment in the private sector.
- TB_PREV: Targets for TB_PREV were calculated using estimated number of patients expected to be on ART at the start of COP 2019 who would screen negative for TB symptoms, the proportion likely to be ineligible for clinical reasons, the estimated number who would have already received TPT by the start of COP 2019 and projected enrollment and completion rates.
- VMMC_CIRC: Targets for VMMC were developed based on current coverage, past performance, and available funding for prevention activities.

Given the results from NAMPHIA and achievements in COP17 implementation, Namibia will likely achieve epidemic control during the COP 2018 implementation period. PEPFAR's priorities for COP 2019 will need to evolve to supporting the host country government to sustain

control of the epidemic, including refinement of testing strategies, deployment of case-based surveillance and unique identifiers, and ensuring resilience in essential health systems. This may require PEPFAR Namibia to optimize portfolios to best support the shift of services to the GRN.

COP 2019 Minimum Requirements

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements no later than the beginning of COP19 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs. Failure to meet any of these requirements by FY 2020 will result in reductions to the Namibia budget.

Table 8. Minimum Requirements

Minimum Requirement	OU Specific Guidance (if applicable in COP18 or COP19)
1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups.	Already complete.
2. Adoption and implementation of differentiated service delivery models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents.	The majority of stable patients in Namibia are already accessing some form of DSD, including MMS and community-ART delivery. Team should come to the COP 2019 meeting with further information on percent of patients that are able to access 6-month refills and plan to scale during COP18 and COP19. This will be particularly important for facilities near the Angolan boarder.
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine based regimens.	Roll out scheduled to start in October 2019 pending ongoing NTD research. Team should continue to advocate for more rapid transition and ensure broad access for women of reproductive potential.
4. Scale up of Index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established.	Ensure index testing is at scale for all partners by end of FY 2019. If this is not possible, must consider expansion of DAPP or other partners to fill this role. Index testing must be implemented for all new positives and those not virally suppressed. Work with partners to implement standard definition for index testing and methodology for implementation of index testing.

	Self-testing kits are available, but there is no comprehensive policy. Team should continue to work with MOHSS to develop SOPs/Guidelines, and expand self-testing availability for hard to reach populations such as young men and women, and KPs, as well as in private organizations such as mines, employers of men, and faith-based organizations. This should include unassisted models for self-test kits. Self-test kits should also be distributed to non-citizens seeking services at border clinics.
5. TB preventive treatment (TPT) for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package.	There is relatively low uptake of TPT. Shift funds for above site-to-site level interventions, both service delivery and above service delivery. Scale up TPT including improved QI collaborative initiatives and consider new short-course regimens. Refine and expand UTAP's TB screening and care model across other partners.
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Apply best practices found in ART initiation in UTAP-supported sites to all partners.
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC and TB services, affecting access to HIV testing and treatment and prevention.	
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.	VL coverage and suppression has remained high for Namibia. Further strengthen adolescent treatment support programs and teen clubs, and optimize pediatric formulations. Recent challenges with the National Institute of Pathology are impacting ongoing monitoring for all patients, including EID.
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	As described in updated MER and COP 2019 guidance.
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old	In COP 19 continue to link HIV positive pediatric clients to OVC programs to improve patient outcomes, and expand primary prevention of sexual violence programs.

girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management.	
11. Evidence of resource commitments by host governments with year after year increases.	GRN is not poised to sustainably fund epidemic control in the short term. Maintain investments in HRH support for COP19 but begin development of a multi-year transition plan to begin moving PEPFAR-supported staff to GRN in COP20 or 21 (depending on changes in financial situations)
12. Clear evidence of agency progress toward local, indigenous partner prime funding.	PEPFAR Namibia implements through several local entities and awarded a new contract to an additional local partner this year.
13. Scale up of unique identifier for patients across all sites.	Normalize data systems and work with the MOHSS to move to case-based surveillance and deploy a national unique identifier. PEPFAR Namibia must work with existing S/GAC partners to accelerate progress towards systems integration.

Table 9. Other Requirements

In addition to meeting the minimum requirements outlined above, it is expected that Namibia will ensure appropriate progress towards viral load management and improved use of efficient testing strategies.

Requirement	**OU Specific Guidance (if applicable in COP18 or COP19)**
1. Viral load management: Country policy updated.	
2. Screen better and test smarter: Stop over-testing.	Greatly reduce VCT volume, except for KP programs. Introduce risk screening for VCT. Evolve PITC to target only those most at risk. Ensure high yield entry points (TB, STI) maintain high testing coverage. Greatly reduce and/or eliminate support for low yield entry points and deploy risk screening. Come prepared to discuss PITC yields by entry point, age and sex at COP 2019 meetings

	Refine approaches for all remaining testing modalities to include risk screening broadly. Ensure all newly diagnosed PLHIV, recent infections and clients not virally suppressed are engaged as a potential index client.

COP 2019 Technical Priorities

Tuberculosis

PEPFAR OUs are expected to offer Tuberculosis Preventive Treatment (TPT) as a routine part of HIV care, which means that all care and treatment partners are expected to offer TPT and report on it. Programs are expected to fully scale TPT over the next two years, such that all PLHIV who are on treatment and are eligible for TPT have received a course by the end of COP 2020. Therefore, the TB_PREV targets included in this letter were set as described above under the target table. For COP 2019, the number of patients that are expected to complete a course of TPT in Namibia is 82,042, approximately half the total number of eligible PLHIV, per the mandate from S/GAC to fully scale TPT over the next two years. COP 2020 TB_PREV targets will cover the remaining 50% of the eligible PLHIV on ART, adjusted upward for those that will be newly enrolled in ART during the COP 2019 implementation period. In order to ensure successful programming, it is expected that, at a minimum, $459,435 will be budgeted for TPT commodities.

DREAMS

Namibia is allocated $10,000,000 funding for DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) programming in COP 2019, of which, $2,838,343 of your COP 19 HVAB budget code needs to be part of your DREAMS programming. This funding is allocated within your COP 2019 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in accordance with all DREAMS and COP 2019 Guidance. All new funding allocated to AGYW prevention programming, including DREAMS, must be allocated to the AGYW Prevention cross-cutting budget code.

Namibia should:

- Ensure that all curricula reaching DREAMS beneficiaries aligns to DREAMS and COP 2019 Guidance and is implemented with fidelity to the original programming.
- Team should continue to expand violence and HIV prevention through individual interventions such as IMpower and community-mobilization interventions. The team should provide timely refresher training and monitor for implementation quality and fidelity. The team should also monitor AGYW retention in programming, determine completion criteria, and respond to issues linked to drop out.

- Strengthen HIV and violence prevention programming for 9-14 year olds through DREAMS and OVC, including through coordination and co-planning between the platforms.
- Support clinical sites in DREAMS districts to provide the full minimum package of post-GBV care in accordance to WHO guidance.
- The team should confirm a plan, including timeline, for standing up a tracking system and when the team will be able to report on AGYW_PREV should be included in the COP submission.

VMMC

Namibia is allocated $8,273,173 funding for VMMC. As with COP 2018, your total COP 2019 allocation to the CIRC budget code is included in your COP funding determined in this letter. VMMC funding must be used exclusively to support the implementation of VMMC programs in males 10 years and older as pursuant with the CIRC budget code guidance, including the minimum package of clinical and prevention services which must be included at every VMMC delivery point, circumcisions supplies and commodities, communication and demand creation, training, and case finding and linkages for high-risk men.

Namibia's total VMMC target for COP 2019 is 50,000 and a minimum of 32,000 circumcisions should be done in men over age 14.

	COP19					
	Target	**Total $**	**VMMC coverage 15-24**	**VMMC coverage 15-49**	**Minimum % 15+**	**Minimum VMMC in 15+**
Namibia	50,000	$ 8,273,173	22	36	64	32,000

Cervical Cancer Screening and Treatment

Alongside COP 2018, Namibia was allocated a total of $2,000,000 in two-year Central Funds for Cervical Cancer Screening and Treatment programming. These Central Funds were provided in order to reduce morbidity and mortality of women on ART in Namibia by increasing the screening of HIV positive women for cervical cancer and the treatment for pre-invasive cervical lesions. The COP 2019 target for screening HIV positive women for cervical cancer is 41,781, calculated as 50% of women 25-49 on treatment per the number of women on ART for the 25-49 year old age band in Namibia at the end of COP 2017 / FY 2018 implementation period. A detailed description of implementation status and scale-up plans is requested within the Strategic Direction Summary for COP 2019.

Other Technical and Programmatic Priorities for Namibia

Testing and Case Finding:

- Ensure DAPP continues to optimize and share best practices from increasing yields in Zambezi and other districts with other partners.
- Ensure all newly identified positives are engaged as a potential index client

- Evolve PITC and VTC programs to target only those most at risk. Ensure high yield entry points (e.g. TB and STI) maintain high testing coverage. Greatly reduce and/or eliminate support for low yield entry points. Deploy risk screening for all entry points, especially to identify men entering the health sector.
- Scale up index testing and counseling for high-risk clients, including KPs.
- Complete scale up of recency testing to include all new positives.
- Extend TA to centrally-supported districts to ensure uniform testing package throughout Namibia

Care and Treatment:

- Expand GRN data systems to capture PLHIV seeking services in the private sector.
- Evaluate progress towards ART coverage in centrally-supported districts and deploy above-service delivery support to ensure quality package of service across the clinical cascade.
- Team should consider whether additional TA may be needed to ensure the MOH-supported sites reach similar quality of services.

Prevention Activities:

- Leverage faith-based networks via Department of State small grants and sub-recipients to help advance primary prevention of sexual violence and objectives for finding men.
- Continue to scale PrEP for high risk populations, including key populations and adolescent girls and young women.
- Intensify AGYW prevention services such as PrEP and access to condoms in hotspots identified by recent testing.
- Scale up PrEP and GBV screening at antenatal clinics and family planning facilities.

Border Epidemic:

- PEPFAR should support GRN to provide services to non-Namibians seeking treatment within Namibia. This should include six month dispensing of ARVs and other key commodities, distribution of self-test kits, and provision of viral load tests. PEPFAR should not actively program across the border at this time.

Program Management:

- As Namibia moves to sustain control of the epidemic, PEPFAR must evolve how the program is managed. Transition to local partners will require additional oversight from PEPFAR staff to ensure program quality is maintained. As such, the Namibia team should analyze the existing staffing footprint and align to meet this goal.
- This evolution also provides opportunity to realign agency portfolios around technical areas, as opposed to geographic. PEPFAR Namibia should plan to transition over the next two years clinical service activities (for example, treatment, TB, cervical cancer) to CDC and prevention activities (for example, DREAMS, VMMC and KP) to USAID and PC, using contract end dates as appropriate.
- As a few USAID and CDC mechanisms over-outlaid in FY2018 due to closeout costs hitting at the beginning of fiscal year 2018, PEPFAR Namibia must ensure any close out costs that will be incurred in FY2020 are included in the total budget envelope.

COP 2019 Stakeholder Engagement

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP 2019 remains a requirement for all PEPFAR programs, and as such the COP 2019 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2018 Q4 and FY 2018 APR results and analyses and the convening of an in-country planning retreat with local stakeholders no later than the week of January 28, 2019 in order to introduce and discuss all COP 2019 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 2019. In February, initial COP tools will be submitted to S/GAC for review and feedback. S/GAC will provide feedback prior to the in-person meetings in March and April, and teams should reflect the feedback with their revised submissions. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team.

In March 2019, PEPFAR will convene in-person meetings in Johannesburg, South Africa, where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Engagement with all stakeholders is required beyond the meetings and throughout the COP 2019 development and finalization process. As in COP 2018, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP 2019 Guidance for a full list of requirements and engagement timelines (Section 2.5.3).