

Approved



Namibia

Country Operational Plan

FY 2014

Note: *Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.*



Operating Unit Overview

OU Executive Summary

Namibia's selection as one of the first three PEPFAR countries to develop a Country Health Partnership (CHP) is reflective of the high level of host country ownership of the GRN HIV/AIDS response. The Government of the Republic of Namibia's (GRN) strong political, administrative, and financial leadership has resulted in Namibia having impressively high coverage levels for treatment and prevention of mother-to-child transmission (PMTCT), rapidly adopting new international guidelines and best practices, and increasing domestic financing for HIV programming. As a result, new HIV infections and HIV/AIDS-related mortality in Namibia have declined substantially.

The HIV/AIDS epidemic in Namibia is mature, generalized, and driven by heterosexual and mother-to-child transmission. In 2012/13, HIV prevalence among adults aged 15-49 years was estimated at 13.3% , with approximately 195,000 people living with HIV (PLHIV). New infections among young people aged 15-24 are high, with estimates that by 2015, 49% of new infections will occur among this group. The 2012 Antenatal Clinic (ANC) Survey reported HIV prevalence among pregnant women attending ANC at 18.2%, a decline from the peak ANC prevalence estimate of 22% reported in 2002. ART coverage in Namibia is estimated at 88% (CD4 <350), but will decline as the country adopts new WHO guidelines (CD4 <500). PMTCT coverage is estimated at 83%. TB is a major contributor to HIV-related mortality. With a TB notification rate of 487 cases per 100,000 population (of which 45% are co-infected with HIV) in 2013, Namibia is faced with an enormous TB/HIV burden.

Several contextual factors strongly influence HIV programming in Namibia. With its large land mass and small population, Namibia is among the most sparsely populated countries of the world (2.8 people/sq. km.). Despite rapid urbanization, Namibia is still mainly a rural (~58%) country. Regional population densities vary enormously, with almost two thirds of the population living in the northern regions and less than one tenth of the population living in the south. In 2010, nearly 60% of the population was under the age of 24, 2/3 of whom were estimated to be under the age of 18.

Based on Gross National Income per capita, the World Bank classified Namibia as an Upper Middle Income Economy (UMIC). However, as evidenced in Namibia's extremely high Gini coefficient , substantial income inequalities exist. Estimates suggest that up to 28.7% of Namibians live in poverty. Chronically high unemployment—27.4% in 2013—is an important contributing factor to elevated rates of poverty.

Despite the strength of Namibia's formal economy, the country faces several health and development challenges that are more typical of lower-income countries. Compared to other UMIC, maternal mortality



rates and under-five mortality rates are high. Lack of clinical staff limits health care service delivery, quality assurance and supportive supervision, particularly in rural areas. [REDACTED]. Same-sex sexual activities between consenting adults are illegal, as is sex work, making outreach to key populations a challenge. Gender-based violence is widespread and appears to be on the upswing. Approximately 1000 rapes are reported each year, with an estimated one third of victims of rape or attempted rape under the age of 18 (2005 figure).

Against this challenging background, the GRN has demonstrated impressive commitment to the national HIV response. With astute political leadership, the GRN aligned Namibia's National Strategic Framework (NSF) for the HIV response with other national socio-economic development strategies (e.g., National Development Plans and Vision 2030) and to international commitments (e.g., UNGASS and MDGs) to create a long-term vision for the country. Both gender and human rights were incorporated into the NSF. The mid-term review of the NSF, carried out in 2013, helped to further focus the HIV/AIDS response on the high-impact, evidence-based interventions that are the pillars of the Blueprint for an AIDS-free generation.

Administratively, as one of two GFATM Principal Recipients (the other is a civil society umbrella organization, NANASO) and recipient of other donor resources, the MOHSS manages over 50 bank accounts for donor funding, including PEPFAR. In addition, the national human resources for health (HRH) Technical Working Group (TWG) adeptly managed the absorption of donor-funded clinical and non-clinical staff, working across MOHSS directorates, with the Ministry of Finance, Office of the Prime Minister, and the Public Service Commission. Furthermore, MOHSS is ensuring alignment of donor-funded activities, including GFATM and PEPFAR, through both the health sector strategic plan and the country's fourth National Development Plan. This alignment is carried out at the Directorate level and includes detailed information on programmatic activities.

Financially, the GRN allocates slightly more than 27% of total national expenditures on health to HIV/AIDS. According to the most recent data, the GRN is funding over 60% of the national HIV/AIDS response, with PEPFAR contributing around 25% and the other 15% coming from the GFATM. In response to declining donor funding for HIV/AIDS, the GRN reacted quickly, at the highest levels, and in 2011 immediately began mobilizing funds to support the transition of major clinical inputs like commodities and healthcare worker (HCW) salaries. The NSF commits the GRN to increasing its financial contributions to the HIV/AIDS response to 70% of the costed need by 2015/16.

Outside of the MOHSS, institutional and community ownership of HIV program design and decisions remain inconsistent. Some line Ministries are more engaged than others, and regular coordination across Ministries is not systematic. The Ministry of Defense (MOD), with responsibility for the day to day functioning of the HIV/AIDS response in the Namibian military, continues to require support for training of service providers, mentoring of personnel, procurement of condom and laboratory equipment and providing



maintenance. Capacity across community-based and civil society organizations (CSOs) to develop and manage HIV/AIDS programs is limited, but slowly improving with PEPFAR support.

In spite of the GRN's strong political, administrative and financial commitment to HIV/AIDS, Namibia faces [REDACTED] challenges in responding to its epidemic. [REDACTED] Within the healthcare system, most senior HCW come from the southern Africa region, creating uncertainties about retention and leading to a high turn-over rate. The lack of qualified Namibians is compounded by the limited capacity within the country to train HCW. The MOHSS is engaged in a restructuring process which hopefully will increase the number of skilled staff within the public sector.

PEPFAR is the major bilateral donor supporting HIV/AIDS programming in Namibia. The GRN-PEPFAR Partnership Framework (PF) on HIV/AIDS 2010-2015 provides the context and framework within which PEPFAR engages with the GRN and other stakeholders, including civil society, the private sector, and other development partners. PEPFAR is fully aligned with priorities of GRN/NSF and focuses on supporting GRN priorities through filling gaps and building capacity. To ensure that the GRN's response is multisectoral, PEPFAR also supports civil society and the private sector. PEPFAR is also the largest in-country pool of TA available to local institutions, including the GRN, enabling PEPFAR to positively influence plans and strategies, which also builds local capacity.

After PEPFAR, the GFATM is the second major contributor to Namibia's HIV/AIDS response. PEPFAR collaborates closely with the CCM and shared Principal/Sub Recipients to ensure complementarity of programming, to avoid duplication of efforts, and to ensure that no critical gaps in programming occur during the transition of the PEPFAR program. From mid-2012 to mid-2013 the PEPFAR team worked closely with stakeholders on the development of the RCC Phase 2 grants for HIV and TB. The HIV grant included four primary service delivery areas including VMMC, PMTCT, key populations, and HIV care, support, and treatment. In addition, PEPFAR participates in the high-level Development Partner Group, the National AIDS Executive Committee, and CCM. PEPFAR is also well-represented on relevant Technical Advisory Committees and TWG, which span all program areas.

UN organizations and selected donors, including GIZ, the EU, and various other embassies provide limited multi- and bilateral support for HIV and AIDS programming in Namibia. PEPFAR and its implementing partners coordinate with these donors through ongoing meetings and committees that include the Health Development Partners Forum, the CCM, and various technical advisory groups. To ensure the efficient use of USG resources, PEPFAR leverages efforts with collaborating partners in areas of common interest. For example, PEPFAR and GIZ cooperate closely on activities to promote private sector engagement in HIV/AIDS, and the USG partners with UNICEF in assisting the GRN to roll out the Health Extension Worker program and optimize the role of extension workers in HIV/AIDS.



PEPFAR Focus in FY2014

PEPFAR's top priorities for COP14 are an intertwined set of themes that will further the Namibia NSF, the PEPFAR Blueprint for an AIDS-Free Generation, and the mission of PEPFAR Namibia. As stated in its Transition Plan, GHI Strategy, and PF, this mission is "To position Namibia to assume full responsibility for the management of its HIV program." It is agreed that PEPFAR resources during the transition period will focus on ensuring that Namibia will have the body of country specific data, technical capacity, human resources, and coordinating mechanisms required to direct and execute an HIV program that reflects the nation's priorities, consistent with reduced donor funding. As such, key priorities for COP14 include continuing the shift away from direct support for clinical services to a targeted TA program, strengthening the quality of health services at all levels, and enhancing capacity and structures.

PEPFAR/Namibia is committed to monitoring the quality of HIV programs we support and protecting PEPFAR's investments during and after USG transition through processes negotiated through the Country Health Partnership. Our unified USG approach to monitor the continuum of the response, supporting the GRN and local organizations to improve collection and utilization of data at regional levels will increase the impact of their programs to achieve epidemic control and sustainability. This effort, combined with the use of epidemiological and expenditure analysis data, will lead us to focus on priority regions in the North as well as to emphasize prevention among youth, particularly young women and girls.

Significant portions of the PEPFAR program have already been transitioned, including HCW salaries, commodities, and many recurrent costs. This transition began with the absorption of medical officers in December 2011 and continued with pharmacy staff, nurses, and program officers during 2012 and 2013. This absorption process was conceived, coordinated, and conducted under the leadership of the HRH TWG, which was chaired by the MOHSS. In many ways, these were the easiest parts of the program to transition, as they primarily revolve around financing and had an obvious value to GRN policymakers. Transitioning other inputs, such as training, supervision, and operational research, will be more challenging, given the lack of technical and management capacity in the country. In COP14, PEPFAR will advise stakeholders on the benefits of these essential investments to the GRN.

In July 2013, at the request of OGAC, the PEPFAR team developed a "PEPFAR Namibia Transition Planning Framework." This document detailed the successes and challenges to date of the programmatic and financial transition of the PEPFAR Namibia program. In COP14, with the transition of clinical HCW salaries and most commodities complete, PEPFAR will engage in joint planning with the GRN to identify additional programmatic elements and inputs ready for transition and the mechanism by which to do so. As PEPFAR engages in joint planning with the GRN to identify programmatic elements/inputs ready for transition, it will also work with the GRN to determine the right pace of program and financial transition,



identify the types of longer-term technical collaboration required to maintain quality, and explore potential opportunities for the GRN to outsource selected program elements and inputs to civil society and private sector entities to meet transition goals.

As the PEPFAR program has shifted away from supporting direct service delivery, efforts have increasingly focused on assisting Namibia to put in place the systems that will allow it to manage its HIV response over the long term. COP14 continues this trend. Recurrent operational costs for routine trainings, equipment purchases, and similar items will be absorbed by the MOHSS over the year. These activities will be replaced by an increased emphasis on joint planning, capacity building, quality assurance, policy development, monitoring and evaluation, and domestic financing and resource mobilization. This emphasis will be applied at various levels to strengthen the entire health system.

In addition to health systems strengthening (HSS), COP14 prioritizes capacity development as essential to successful country ownership and functioning health systems. By investing in pre-service education, faculty development, curricula development, policy development, health financing, supply chain, governance, information systems/management for HRH, and collecting and using data, PEPFAR will help build leadership capacity. HSS and capacity building elements will be integrated into all aspects of the portfolio, in line with GRN priorities regarding human and institutional development.

In COP14, PEPFAR intends to use the CHP as a vehicle for improving and documenting PEPFAR-wide joint planning with the GRN in order to achieve a successful transition and ensure long-term sustainability of the multisectoral program. PEPFAR will build on the GRN's demonstrated strong commitment to addressing Namibia's HIV epidemic, as well as the GRN-PEPFAR PF, to further transition PEPFAR investments for country-led programming.

The PEPFAR team took an initial step in this process on February 20, 2014, when, as part of the COP development process, it introduced the CHP concept to members of the PF Steering Committee, representatives from civil society and the private sector, and development and implementing partners. The PEPFAR team subsequently met with key members of the Steering Committee to provide further detail and open dialog around the formation of an oversight board or similar structure. The Steering Committee, including representatives from the MOHSS and National Planning Commission, agreed that PEPFAR would develop draft terms of reference for a new PEPFAR CHP governance body which would meet quarterly and use data to make decisions about programming. There was also discussion about a regional meeting of stakeholders from other countries engaged in financial transition, a CHP process, or those with an especially detailed PF Implementation Plan.

Because of the accelerating rate of change in the Namibia portfolio, COP14 is necessarily significantly



different from previous COPs. COP14 reflects a continuing shift from direct service delivery toward activities that strengthen, systematize, and institutionalize high quality health facility, community-based, and family-centered HIV programs. This shift is not immediately evident at the macro level, as the COP continues to support programs across the prevention, care, treatment, HSS, and SI spectrum, albeit at reduced levels of funding. Within each of the technical areas, the PEPFAR portfolio also continues to fund activities in most budget code areas. The shift in programming, while not necessarily evident in quantitative indicators such as number of budget codes supported or percent of the COP going to particular areas, however, is evident in the qualitative changes within activities. As a whole, programs have shifted from providing support for direct service delivery towards providing expertise targeted at addressing both specific gaps/needs and more general issues of program governance, leadership, and multisectoral coordination, CSO strengthening, and private sector collaboration. Under Namibia's new model, training and mentoring are more targeted, linking overlooked groups to clinical services is a focus, linkages and retention are given high priority, and data collection and use is emphasized, including at the subnational level. This shift was enabled by the transition of HCW, commodities, and supplies to the GRN. To support these shifts, COP14 also reflects greater effort within the PEPFAR team to maximize agency core competencies at the activity level to ensure that agency actions complement each other. For example, in COP14 CDC is assuming greater responsibility for treatment programming, while USAID is taking on more of the prevention portfolio.

PEPFAR Namibia's COP14 funding level letter outlined several priorities that have been addressed in COP14. Some priorities were discussed above; others include:

Staffing: As described in COP14 M&O narratives, agencies have reviewed their staffing patterns vis-a-vis core competencies and are making adjustments. Given the rapidly evolving nature of the Namibia program and its impact on staffing, COP14 proposes to repurpose five LES positions and one USDH position, and request one new LES position. The repurposed positions will enhance internal management and technical capacity to better meet the current needs of the program. Incumbents to the repurposed positions will be mentored with the goal of transferring future program leadership. The requested new staff position, the Quality Improvement Technical Advisor, fills a critical capacity gap within the PEPFAR interagency team. This twinned position will result in an intensified focus on quality management, in line with global guidance in the PEPFAR Quality Strategy and PEPFAR Linkages, Engagement, and Retention Strategy. As PEPFAR Namibia moves forward with the development of a CHP and as the pace of transition steadies, the PEPFAR team intends to closely analyze medium- to long-term staffing priorities and needs, determine the appropriate pattern for a TA model focused on capacity building and systems strengthening, and develop a staffing vision, trajectory and plan for the next several years. As part of this process, PEPFAR Namibia requests headquarters support over the coming year via greater routine communication and in-country technical assistance to develop the strategy.

Use of expenditure analysis (EA): PEPFAR appreciates the EA initiative and has found it a useful exercise,



both in terms of gaining clarity on overall PEPFAR program expenditures and building local capacity for financial analysis. The PEPFAR team is committed to utilizing EA data as part of the 'basket' of financial data that it uses to inform strategic investment decisions. However, in Namibia's transition context, EA data will require adjustment to allow direct application in budgeting and program planning.

Preliminary results for Namibia validated important strategic priorities on which PEPFAR COP14 is focused. For example, EA expenditures for COP 12 showed that the bulk of USG funding for HSS occurred at the national level. As outlined in COP 14, PEPFAR plans to focus increasingly on strengthening sub-national capacities and systems to enhance country capacity to plan, implement, and manage the multisectoral response. Program area expenditures also illustrated greater levels of expenditure on facility rather than community-based treatment, care and support. As part of its ongoing effort on transition, PEPFAR plans to increase focus on community-based treatment, care and support during COP14. The team believes that EA data affirms its planned approaches, particularly related to community-based services.

As acknowledged in the EA addendum to COP guidance, the use of EA for budget building on TA-related programming will not be a straightforward exercise. In this regard, PEPFAR's rapid evolution in Namibia to a TA model makes the direct applicability of EA unit expenditure data to build budgets challenging, as major qualitative shifts in the nature of the program may be difficult to capture in the EA data. Moreover, because PEPFAR contributes a relatively small—and declining—portion of HIV/AIDS expenditures, especially for MOHSS facility-based clinical services, EA data may not directly support budget planning for the MOHSS. That said, further, clarity on USG expenditures gained through the EA will ultimately enable PEPFAR to continue to improve the efficiency of its programs.

While it may not use EA data for deriving unit costs, PEPFAR Namibia has been able to utilize the data as part of its package of information for planning. In addition to using EA and epidemiological and program data, the team reviews GRN's plans and gap analyses, particularly those which highlight financial needs. It also conducts real-time analysis of expenditure within mechanisms, down to the activity and input levels. Finally, the team routinely triangulates quantitative data from ongoing program analyses and national databases with qualitative information to make decisions about TA and financial investments. Together, these activities support PEPFAR to make evidence-driven choices about how to best maximize the impact of dollars in Namibia.

Epidemiological data: DHS 2013 results were not ready at the time of COP14 planning and as such could not be utilized as recommended in the COP14 letter. The same is true for IBBSS results, for which only preliminary data were available late in the process. However, analyses conducted in 2013 in various program areas did inform COP14 priorities. For example, the first ever analysis of routine HTC data in



Namibia was done in conjunction with the MOHSS and helped the country decide that National Testing Days were no longer a cost-effective investment. That realization allowed PEPFAR to divest from that activity along with the MOHSS. In addition, because of USG support for an assessment of over counter (OTC) rapid test kits (RTK), the GRN has decided to develop an OTC RTK Self-Testing Regulatory Framework and Policy to guide HTC expansion through the private sector.

Prevention: As detailed in the Prevention and Treatment TANs, PEPFAR prevention activities are aligned with the GRN's Combination Prevention Strategy and advance the pillars of PEPFAR's Blueprint for achieving an AIDS-free generation. With its overarching aim of advancing a country-owned, evidence-based response that supports long-term reductions in new infections, PEPFAR prevention programs and TA will build country capacity to expand access to services, promote increased utilization of high-impact prevention services and behaviors, and strengthen the policies, systems and human and institutional capacities needed to support country prevention goals. PEPFAR-supported prevention activities are planned, implemented, and monitored in close collaboration with the GRN. In addition to advancing country implementation of the six prevention programs prioritized in the NSF, PEPFAR will support targeted prevention activities for key populations, increase prevention program targeting of adolescents and youth given increasing levels of risk behaviors and rates of infection among this group, strengthen country strategic information systems, and increase the knowledge base on combination prevention.

Budget Planning: In September 2012, PEPFAR developed a three-year rolling planning budget by technical area and budget code. The approach was modeled on the GRN's national Medium-Term Expenditure Framework, which sets an official budget for the next year and notional budgets for the following two, with annual review. The PEPFAR rolling budget provides proposed proportional allocations of investments for the three years. Using the proportions for COP14, and based on the OGAC-provided planned COP14 funding level of \$60 million, the Coordination Office calculated an initial planning level for each technical area and budget code, then disaggregated this budget level by agency, based on percent of budget code funding the agency received in COP12. Agencies were then provided with their planning levels by budget code. This is the same approach used to great effect in COP13, producing a harmonized program portfolio with minimal stress. This approach is also in line with the official COP14 guidance recommending "more strategic top-down budgeting."

Agency technical staff then allocated funding across implementing partners according to strategic priorities. Interagency technical teams met to review proposed funding to partners across the technical area and vet technical approaches. Rationale, proposed funding by partner and requests for adjustments were presented by interagency technical teams to management at a Policy and Operations Meeting on January 30, 2014. The Policy and Ops Teams subsequently approved the proposed funding by partner.



With an informal understanding that the maximum amount of pipeline possible should be applied, agencies met internally to review pipeline and propose an amount of pipeline to be applied at the partner level. Other factors considered in this process included other sources of funding (GRN, GFATM, other donors), the mid-term review of NSF with its identification of priorities, and funding available through PEPFAR central initiatives. Because each PEPFAR agency in Namibia had to take different factors (including HQ policies) into consideration when applying pipeline, Namibia's COP14 includes a Supplemental Document that details each agency's methodology.

Finally, an interagency team reviewed the overall proposed COP14 budget and application of pipeline. While the team was provided a COP14 planning budget of \$60 million, due to the use of pipeline, only \$51,601,391 is requested in new funds.

Progress and Future

COP14 directly contributes to the PF focus on sustainability, systems strengthening, and capacity development. As articulated earlier, these priorities will form the backbone of the CHP, to be developed during COP14.

Over the past year, significant progress was made in each of these priority areas, leading to even greater country ownership. The transition of financing for HRH and commodities was mostly completed and will be largely finished under COP14. Inroads are being made on transitioning other operational costs such as travel, supplies, training, and lab monitoring services to the GRN, although additional advocacy is needed to move this forward.

Collaboration and joint planning with the GRN was strengthened through exercises such as:

- Completing national and regional cost VMMC strategic and operational plans
- Revising national HIV treatment guidelines
- Approving an EMTCT National Strategy
- Developing a National HIV Counseling and Testing Strategic Plan
- Revising national TB guidelines
- Conducting the mid-term review of the 2nd National Strategic Plan for TB
- Developing a TB/HIV and Xpert implementation plan
- Completing a HIS roadmap and HIRD structure
- Launching the national Health Extension Worker Program
- Completing the D2D HTC pilot, report, and abstracts
- Launching the NPHL policy and strategic plan
- Completing the IBBSS Phase I



- Launching a regional HIV clinical data review program
- Strengthening and conducting TSSV
- Approving the FELTP curriculum and hosting a second scientific conference

These joint technical achievements, coupled with the technical support, training, mentoring, and other assistance provided by PEPFAR strengthened systems and technical capacity within Namibia at many levels. Nevertheless, as we look towards COP15 and the continued transition toward country ownership through the CHP, the major challenge will continue to be HR constraints. HR constraints in the public sector include high vacancy rates, particularly at the regional level, recruitment and retention challenges, and an outdated staffing establishment that places considerable emphasis on the roles and responsibilities of clinical staff, particularly medical officers, but limited emphasis on the use of CSOs and community-based HCW cadres. At the service delivery level, public health care services are based on an outdated minimum district services package that is largely facility based, with minimal outreach and mobile health services, and insufficient use of CSO and private sector outlets. There are also considerable challenges with ensuring access to care, given the geographic size of Namibia and many poor Namibians' lack of transportation.

Given the long-term nature of HR development, as the GRN and PEPFAR engage in joint transition and sustainability planning, HR constraints will need to be carefully considered and realistic timelines developed for transitioning planning, leadership and management. Ongoing monitoring will be critical, as will discussion and the inclusion of practical contingency plans—and long-term plans for technical cooperation.

In terms of a trajectory for next year and beyond, the PEPFAR Namibia team continues to believe that a COP15 budget of \$45 million is appropriate. However, given Namibia's profound long-term capacity needs, model as a country ownership success, and the potential for it to be one of the first countries to achieve an AIDS-free generation, it is hoped that FY15 will be the last year of a budget decrease and that \$45 million will be the COP plateau point for at least three years. The team anticipates that in this period the proportion of funding allocated to the program and M&O budgets will remain relatively stable.

Program Overview

Prevention: Over the next two years, PEPFAR will support the GRN's Combination Prevention Strategy through activities that build country capacity to expand access to services, promote increased utilization of high impact prevention services and behaviors, and strengthen the policies, systems and human and institutional capacities needed to support Namibia's prevention goals. In addition, PEPFAR will directly support targeted prevention activities for key populations and strengthen country strategic information systems.



Specifically, PEPFAR will continue to support implementation of HTC at MOHSS facilities, MOD clinics, at the country's six FBO hospitals, and at the community level through training and mentoring, supportive supervision, the promotion of quality assurance and strengthening referrals. Increased focus will be given to reaching out to adolescents and young adults to link them with treatment, care, and support services. Activities will build the capacity of CSOs to support HTC among key populations and other risk groups. PEPFAR will also advance country-led implementation of evidence-based social and behavioral change, condom promotion, and stigma reduction activities using small group, outreach, and community mobilization approaches. To build country capacity to expand, supervise, and sustain quality VMMC services, PEPFAR will support delivery of services in two regions, promote private sector engagement in the delivery of these services, and promote increased use of services through community level demand creation and social mobilization. PEPFAR will also support implementation of the National EMTCT Strategy, facilitate ongoing review and adaptation of national PMTCT guidelines, and enhance country systems and capacities to increase access to these services through GRN and private sector mobile clinics, outreach interventions and community system strengthening activities.

As part of a long term strategy to carefully transition procurement of medical consumables and laboratory reagents for the MOD, COP14 will support training on supply chain and inventory management to ensure undisrupted supplies of needed items at all targeted sites within MOD. Additionally, procurement of camouflage condoms will begin to be co-shared between PEPFAR and MOD, [REDACTED].

Treatment: In February 2014 the MOHSS launched new HIV treatment guidelines in response to revised 2013 WHO recommendations. The new guidelines expand ART eligibility, including universal ("test and treat") eligibility for pregnant women, children <15 years of age, TB or hepatitis co-infected patients, and sero-positive individuals in sero-discordant relationships. Additionally, general eligibility for those not included in the aforementioned "test and treat" categories will be eligible at a CD4 cell count threshold of 500. These changes are expected to substantially increase the number of persons on ART requiring an array of both facility- and community-based care services.

The overarching focus of PEPFAR assistance in treatment is to provide technical and program support to enable Namibia to expand access to and coverage of services, assist the MOHSS to improve quality and oversight of treatment programs, advance the efficient delivery and sustainability of treatment services, and strengthen linkages between community-based services and treatment programs. Accordingly, during COP 14 and 15, PEPFAR will use modeling, operational, and financial data to assist the MOHSS in developing costed implementation plans and estimate projected GRN program resource needs for comprehensive treatment programming. PEPFAR will also continue to provide TA to the MOHSS to enhance supply chain management systems and performance.



Care and Support: In COP14, PEPFAR will support activities that strengthen, systematize, and institutionalize community-based, community-centric care and support programs that support program goals. With a priority on providing a continuum of integrated services, PEPFAR programs will deepen GRN and CSO leadership and capacity to expand access to and quality of facility and community-based care and support services, enhance service efficiency and effectiveness, and integrate HIV and other services to increase access to a comprehensive package of interventions. To this end, PEPFAR will assist country institutions and community organizations to operationalize national, standardized HIV care and treatment guidelines, with particular attention to building the capacity of CSOs and the GRN to collaboratively implement and monitor a family-centered model of community- and home-based care. Support for the health extension worker program will be central to this effort. PEPFAR will also strengthen the MOHSS Nutrition Unit to facilitate the final integration of NACS programming into clinic and community-based care and treatment services.

For pediatric care and support, PEPFAR will support the MOHSS to implement anticipated new guidelines supporting universal access for children <15 years of age through assistance for training, quality assurance, supervision and mentorship, as well as monitoring and evaluation. PEPFAR will also continue to provide training of HCW in EID and assist the MOHSS in making PITC more effective. PEPFAR will support MOHSS efforts to improve all aspects of TB/HIV including HIV testing of TB patients, "Three I's" with emphasis on scale up TB infection control efforts through training, the development of infection control plans, the drafting of TB IC education materials, and timely provision of ART to all TB co-infected patients. PEPFAR will also facilitate continued implementation of the GeneXpert roll-out plan, including support for procurement of equipment, training of HCW, quality assurance, routine monitoring, and robust evaluation. PEPFAR support for OVC programs will focus on enabling family, community and governments to address the socio-economic needs of OVC by increasing access to and utilization of services that increase child resilience to HIV/AIDS. PEPFAR will work with the GRN/MGECW at sub-national levels to implement policies and standards for OVC and will specifically support activities to link childhood victims of sexual violence with support and services.

Governance and Systems: In COP14 and 15, PEPFAR will focus on ensuring that the GRN has the body of strategic and program data, technical and institutional capacity, leadership, human and financial resources, enabling policies, systems and coordinating structures, required to assume full responsibility to plan, finance, manage and monitor the HIV/AIDS response, in collaboration with civil society, including PLHIV and key and other priority populations, and the private sector, through targeted activities to build leadership and strengthen governance of the multisectoral program. Under Strategic Information, key activities that will indirectly support and inform delivery of quality clinical services include secondary analyses of the 2013 DHS data (including the first-ever HIV biomarker), implementation of the TB drug resistance survey and HIV drug resistance surveys, launch of an HIV incidence sentinel surveillance system, operational research on



community- and facility-based services, and assistance to the MOHSS to develop a country-wide program for regional-level HIV clinical data reviews.

GHI, Program Integration, Central Initiatives and other considerations

The two main goals of Namibia's GHI strategy are to expand the accessibility and quality of health services, while supporting the ongoing transition process. Service integration, use of community-based organizations and HR cadres to expand outreach, and ongoing TA to enhance prevention program implementation remain priorities of the team. To advance service integration, PEPFAR engages on issues related to MCH, nutrition, and SRH, among others, through national TWGs and collaboration with stakeholders working in these fields. PEPFAR works closely with the GFATM, both the in-country team and the Geneva-based group, as well as the UN family and other health sector partners through official coordination structures (e.g., CCM, TACs, TWGs, HDP Forum). Joint planning occurs in these structures, as well as with the MOHSS. For VMMC, trilateral discussions (MOHSS, PEPFAR, and GFATM) produced a harmonized approach to scaling-up services, with PEPFAR taking the lead in two regions, GFATM in five, and the MOHSS in seven.

PEPFAR Namibia benefits from funding from several central initiatives, including:

Strategic Information Central Initiative (\$1,000,000): Significant progress has been made against all three objectives of this initiative: (i) strengthen and inform the strategic planning process for integrated health information system in Namibia; (ii) identify human capacity needs and address HR gaps with respect to the planning, managing, and utilizing data of the health information system in Namibia, and (iii) implement activities that ensure that information systems are in alignment with the integrated HIS strategy and policy. Direct results of the initiative include: (a) Namibia HIS Strategy drafted; (b) HIS Skills Audit, Competency Framework Design and Capacity Needs Assessment all initiated; (c) a GRN Master Facility List developed; (d) HIS Standards environmental scan completed; (e) workshop to plan transitioning to a uniform diagnosis coding convention linked to unique patient identifiers organized; (f) process to review the indicator data set commenced; (g) proposal to transition from DHIS 1.4 to DHIS 2.x submitted and awaiting final approval from the MoHSS; and (h) prototype of a central health data dashboard based on a central health data warehouse developed. All activities outlined above are aligned with MoHSS National Strategic Plan HIS components. Primary outcomes for HIS strengthening continue to be integrated and inter-operable HIS systems, training and placement of HIS HR to ensure sustainability of the system and enhanced data quality and data use. In December 2013, USG Namibia submitted the SI Central Initiative Phase II proposal. Funding under this second phase is critical to support implementation of activities as outlined in the MoHSS Strategic Plan.

Gender Challenge Fund (GCF) Initiative (\$1,000,000 central funding; \$500,000 match): GCF



activities focus on reducing Gender Based Violence (GBV) and coercion through a two-pronged approach: (1) TA to strengthen local capacities of the MGECW to coordinate, monitor and advocate for broad implementation of the National Gender and GBV Plan of Action, prevent and respond to GBV, and build field staff skills in providing services and referrals for victims of GBV, and (2) comprehensive community awareness-raising and sensitization on GBV in Kavango and Hardap, targeting adolescents and adults through existing structures such as schools, churches, traditional leaders. Anticipated outcomes include: strengthened capacity of MGECW to coordinate gender programs; and improvements in knowledge, attitudes and behaviors on GBV that lead to increased community leadership on GBV retention and referral.

To date, GCF has reached hundreds of individuals with community-based awareness-raising sessions on: harmful gender norms; GBV drivers and how harmful norms place individuals at risk; accessing GBV services; and ways communities can address GBV, support victims and contribute to a decrease in violence. Family strengthening and child protection programs are working with boys, girls and parents to develop and maintain healthy, gender-equitable relationships, recognize GBV and seek help to respond to GBV. GCH is also working with the faith-based sector, CBOs, regional government officials and community leaders to build their capacity to address GBV in their communities. GCF is assisting the MGECW to develop a GBV data base that tracks cases of GBV and to introduce a GBV helpline to counsel and refer adults and adolescents on GBV.

Country Collaboration Initiative (\$996,675): Namibia has been a recipient of CCI funds since 2011. Activities where PEPFAR has a lead role have worked well, but activities that require significant effort from the MOHSS or GFATM have moved more slowly due to capacity gaps. PEPFAR has learned to recalibrate expectations and to seek advocacy from GFATM Geneva when needed. The USG's more robust focus during COP14 on strengthening institutional capacities of government and CSOs to manage, implement and monitor the HIV/AIDS program will contribute significantly to improving the performance of GFATM grants. Building on USG assistance during the past year to enable the NANASO to lead the development of the GFATM HIV Phase 2 Grant application and engage sub-recipients in technical proposal writing to ensure representation of civil society input, during COP14, PEPFAR will continue to provide organizational capacity development TA to NANASO and sub-recipients to improve their effectiveness and efficiency in performing as Global Fund recipients. TA will support the review of grant systems, evaluations of capacity and identification of gaps, and capacity development support, including training, to ensure that grants are implemented per GFATM requirements and contribute to planned program results. In COP14 PEPFAR will also work to revitalize the Secretariat of the CCM, which will then allow currently stalled activities on joint planning, harmonization of indicators, and joint oversight to move forward.

TB/HIV Central Initiative (\$6,626,997): Per OGAC direction, modest revisions to the TB/HIV Initiative workplan/budget were ma

Approved

