

Namibia

Country Operational Plan

COP 2018

Strategic Direction Summary

August 7, 2018



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Abbreviations and Acronyms

AGYW	Adolescent Girls and Young Women (aged 15-24)
ANC	Antenatal Clinic
APR	Annual Progress Report
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
CAC	Client-led Community Adherence Clubs
CBART	Community Based ART Program
CCN	Council of Churches Namibia
CDC	Centers for Disease Control and Prevention
CMS	Central Medical Stores
COP	Country Operational Plan
CSO	Civil Society Organization
DMPPT	Decision Makers Program Planning Tool
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe Women
EDT	Electronic Dispensing Tool
EID	Early Infant Diagnosis
ePMS	electronic Patient Management System
FAST	Funding Allocation to Strategy Tool
FSW	Female Sex Worker
FY	Fiscal Year
GBV	Gender-based Violence
GF	Global Fund
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	Gross National Income
GRN	Government of the Republic of Namibia
HCMS	Human Resources Capacity and Management System
HCW	Health Care Worker
HEI	HIV-exposed Infant
HIVST	HIV Self -Testing
HR	Human Resources
HRH	Human Resources for Health
HTS	HIV Testing Services
HSS	Health Systems Strengthening
IBBSS	Integrated Biological and Behavioral Surveillance Survey
ICD	International Classification of Diseases
IEC	Information, Education, and Communication
IHME	Institute of Health Metrics and Evaluation
IMs	Implementing Mechanisms
IPT	Isoniazid Preventative Therapy
KP	Key Populations
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MER	Monitoring, Evaluation and Reporting
MDG	Millennium Development Goals

MOHSS	Ministry of Health and Social Services
MSM	Men who have Sex with Men
MTCT	Mother-To-Child Transmission
NAD	Namibian Dollar
NAMAF	Namibian Association of Medical AID Funds
NAMPHIA	Namibia Population-Based HIV Impact Assessment
NASA	National AIDS Spending Assessment
NDHS	Namibia Demographic and Health Survey
NHFA	National Health Force Accounts
NIMART	Nurse-Initiated and Managed ART
NSF	National Strategic Framework
OGAC	Office of the U.S. Global AIDS Coordinator
OPD	Outpatient Departments
OVC	Orphans and Vulnerable Children
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counseling
PLACE	Priorities for Local AIDS Control Efforts
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
QA	Quality Assurance
QM	Quality Management
SDS	Strategic Direction Summary
SID	Sustainability Index Dashboard
SIMS	Site Improvement through Monitoring System
SNU	Sub-National Unit
SOP	Standard Operation Procedures
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TA	Targeted Assistance
TB	Tuberculosis
TG	Transgender
TLD	Tenofovir/Lamivudine/Dolutegravir
TPT	TB Preventative Therapy
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development
USD	United States Dollars
USG	United States Government
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

1.0 Goal Statement

The Country Operational Plan Strategic Direction Summary for U.S. fiscal year 2019 (COP18) summarizes the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Namibia's overall strategy to ensure progress toward achieving sustainable HIV epidemic control in Namibia by 2020. The overarching goals for COP18 are the following: scale up successful index testing models for case finding strategies; link people living with HIV (PLHIV) to quality treatment services; retain them on treatment through tailored patient care management; prevent new infections through targeted outreach to and medical interventions for those most at risk; increase indigenous partner capacity and expertise to deliver; and systems investments to ensure that Namibian institutions can sustainability maintain epidemic control by 2020 and beyond.

COP18 builds on the geographic and population focus defined in COP15, scaling-up of treatment through decentralizing HIV services and establishing community-based models of care in COP16, and COP17's acceleration of treatment saturation in high-burden HIV districts and evidence-based prevention strategies. With the successes to date, COP18 will be about finding the last five percent along the clinical cascade to reach the epidemic control goals of 95-95-95. That last five percent will be the most challenging, and PEPFAR Namibia proposes innovative approaches to implementation, quality monitoring, and system investments in COP18.

By the end of COP18, our goal is for all PEPFAR Sub-National Units (SNUs) and populations to achieve attained status, defined as greater than 80% of PLHIV on antiretroviral therapy (ART). Approximately 404,000 people will be tested, nearly 27,000 newly identified HIV-positive people will be initiated on treatment, and 219,000 PLHIV (90% of all PLHIV) will receive HIV treatment services.

We will scale up HIV testing services (HTS) with fidelity through index partner testing, including HIV self-testing, and use recency testing to further guide program focus. Tailored, evidence-based strategies will help find, test, and link to treatment populations with low ART coverage, namely young women and men, older men, and key populations. As shortages of Namibian skilled health care workers threaten gains to date and the overall sustainability of the program, the largest COP18 investment will go to maintaining staff at high volume ART sites and providing in-service training and on-site mentorship of newly graduating Namibian health care workers. To ensure the long-term return on our investment in Namibia, we will work with the government on supply chain and health information systems, with international implementing partners on increasing the capacity of indigenous partners, and with indigenous partners on delivering high quality results.

Our prevention activities will continue to focus on adolescent girls and young women (AGYW) and orphans and vulnerable children (OVC) and will include targeted programming on HIV and gender-based violence (GBV), voluntary medical male circumcision (VMMC), and Pre-Exposure Prophylaxis (PrEP). To support the Government of the Republic of Namibia (GRN) in eliminating

mother-to-child transmission, activities are designed to initiate 95% of HIV infected pregnant and breastfeeding women on ART.

To achieve the greatest gains with the greatest efficiency, continuous data analyses and close collaboration with the government and other stakeholders will inform our program calibrations throughout implementation and ensure mid-course corrections are both timely and supported by all involved.

2.0 Epidemic, Response, and Program Context

2.1 Summary Statistics, Disease Burden, and Country Profile

Namibia is a sparsely populated desert country of 2.4 million people (Namibia Statistics Agency, Population Projections 2011-2041) with an area twice the size of California. The population is concentrated in small urban areas scattered throughout the country, particularly in the north near the border with Angola (see Figure 2.1.1) Urbanization continues to increase rapidly at a rate of 3.63% (CIA Fact Book 2017).

Namibia is an upper-middle income country with a gross national income (GNI) per capita of \$ 4,640 (World Bank, 2016), but with starkly unequal income distribution. Namibia's Gini coefficient is 0.6100, the second highest in the world, while its Palma Ratio at 5.8 is the third-highest (UNDP HDR 2016). According to a 2012 assessment of poverty dynamics in Namibia, approximately 29% of people in Namibia are poor (living on less than 30/day Namibian Dollars (NAD)) and more than 15% are severely poor (living on less than NAD 22/day). Unemployment was estimated at 34.0% in 2016 (Namibia Statistics Agency, Namibia Labor Force survey, 2016).

The country made great strides in attaining the Millennium Development Goals (MDG) related to access to education, gender parity in education, and health. Impressive results in immunization and nutrition of children were also achieved, bringing down under-five deaths from 4,200 per year in 1990 to less than 3,000 in 2013; child mortality rates are 45.2 deaths per thousand live births (UN Inter-Agency Group for Child Mortality, 2016). Namibia launched the Sustainable Development Goals agenda in 2016, which build on the MDG and go further in addressing the root causes of poverty and the universal need for development that works for all people.

According to the Institute of Health Metrics and Evaluation (IHME), HIV/AIDS remains the leading cause of death in Namibia, as shown in Figure 2.1.2.

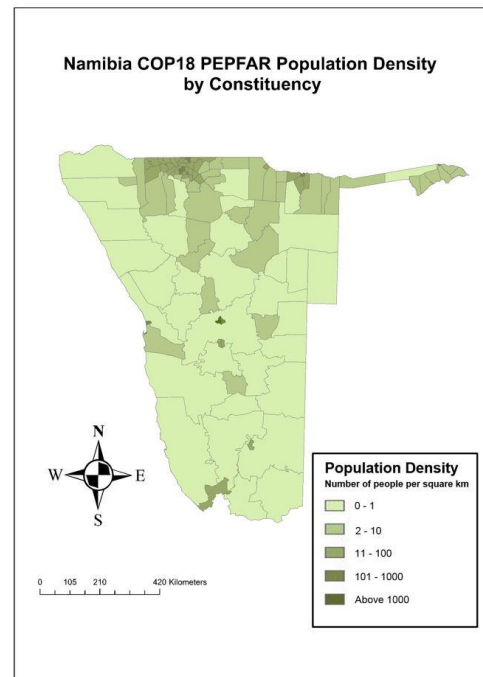
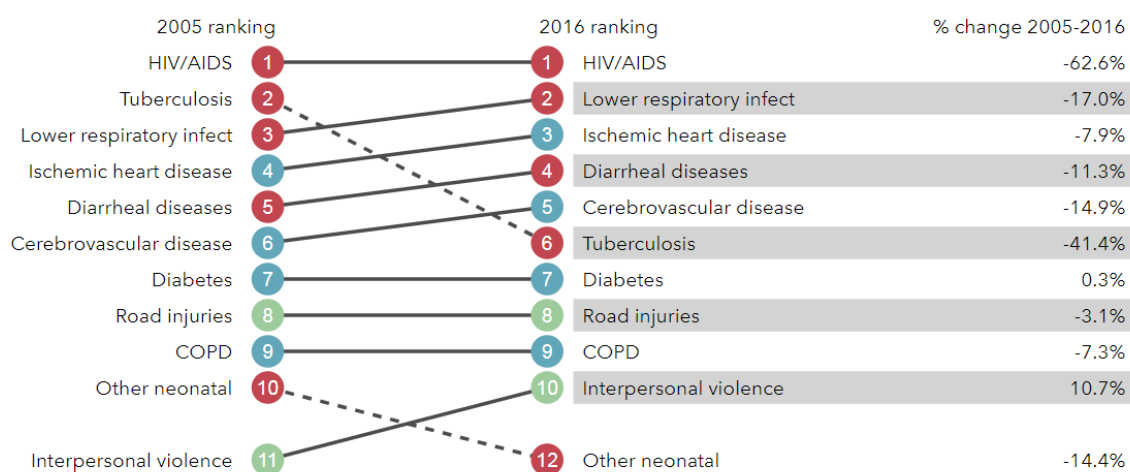


Figure 2.1.1 Population Density (per km²) in Namibia

Figure 2.1.2 Top Causes of Death in Namibia (2016)



Source: IHME, <http://www.healthdata.org/namibia>

However, Namibia has been accelerating progress towards HIV epidemic control, and at the end of fiscal year (FY) 17, over 86% of the estimated 243,803 PLHIV in Namibia will be on ART. New HIV infections have halved since 2004, and life expectancy increased by eight years from 56 in 2005 to 64 in 2013 (World Bank). The GRN's leadership also resulted in Namibia achieving high HIV treatment and prevention of mother-to child transmission (PMTCT) coverage levels, rapidly adopting new international guidelines and best practices, and shouldering the bulk of the financing for HIV programming. Of note, given the high TB/HIV co-infection rate (38%) in the country, Figure 2.1.2 may underestimate deaths due to TB because when an HIV-positive person dies from TB disease, the underlying cause of death is classified as HIV in the International Classification of Diseases system (ICD-10).

HIV Prevalence and Incidence

Namibia has a generalized HIV epidemic, with 10% of the general population living with HIV (2018 Spectrum Model). HIV/AIDS will be responsible for an estimated 4,950 deaths in 2018 (see Table 2.1.1), and the disease remains the leading cause of death among adults and the sixth-leading cause among children under five years of age (MOH Child Survival Strategy, 2014). Among adults (>25 years of age), women bear a disproportionate burden of the HIV epidemic, with a prevalence of 19.8% compared to 14.9% for men (see Table 2.1.1). Although limited data are available on sex-specific positivity rates among children, an estimated 1.2% of children under 15 years of age are HIV infected. According to the 2018 Spectrum Model, the highest proportion of estimated new infections is among women ages 15-24, accounting for 17% of new infections. Men 15-24 years old are estimated to account for 9% of the new infections (2018 Spectrum Model).

The highest estimated incidence is in areas of highest population density, including the Khomas region (where the capital, Windhoek, is situated) and six northern regions. Additionally, there are

urban hot spots with high incidence, located in coastal towns and along the main road connecting northern and southern Namibia (2018 Spectrum Model).

The national decrease in estimated incidence to date has been predominantly among infants and children from the successful scale up of PMTCT (2018 Spectrum Model). To maintain a steady decline in incidence, Namibia will need to fully implement ART coverage strategies among adults.

Treatment Coverage

The preliminary results from the Namibia Population-Based HIV Impact Assessment (NAMPHIA) survey indicate that most people who test positive for HIV start treatment and generally remain on treatment. 96% of people who report knowing their status as HIV positive also report being on ART. That is further supported by NAMPHIA laboratory data that show that 91% of people who report being on ART are confirmed to be virally suppressed. Since the introduction of ART in 2003, the number of PLHIV on ART increased annually, rising from 75,681 in 2010 to approximately 186,000 in 2017 (see Table 2.1.2). The large majority of Namibians on ART receive it from the public sector (169,081). However, according to the Ministry of Health and Social Services (MOHSS), approximately 18,600 PLHIV in 2017 received ART from the private health sector. Disaggregated data by age and sex illustrate that the proportional treatment gap is highest among males 20-29 (Figure 2.1.3). The “Treat All” policy, which recommends ART for all PLHIV, was rolled out nationally in 2016, and the national ART guidelines were revised to incorporate the “Treat All” policy in 2017. PEPFAR’s contribution will be 90% of the national total number of PLHIV expected to be on treatment by the end of COP18 (see Figure 2.1.4).

Prevention of Mother-to-Child Transmission (PMTCT)

The success of the PMTCT program in Namibia has resulted in 60% reduction in new HIV infections in children. Based on the 2013 Demographic Health Survey, antenatal clinic (ANC) coverage (at least one visit) is 97% (see Table 2.1.1) and delivery in a health center is 87%. PMTCT and early infant diagnosis (EID) services are integrated in all public health sites. In FY17, 98% of pregnant women had known HIV status and ART coverage was 98%.

According to the 2016 HIV sentinel surveillance:

- HIV prevalence in pregnant women was 17.2% (8.5% in 15-24 year olds, 24% in 25-49 year olds), a slight increase from 16.9% in 2014.
- Prevalence in pregnant women ranges from 5.2% to 32.9% across regions.
- 69% of HIV infected pregnant women at ANC had known HIV status (43% in 15-24 year olds, 77% in 25-49 year olds).
- 63% of HIV infected women were already on ART at first ANC visit (38% in 15-24 year olds and 69% in >25 year olds)

Infant HIV case identification through EID is a Namibian policy, but execution remains challenging. EID coverage in 2017 was 70% within two months of age and 90% by 12 months (APR17). In FY17, PEPFAR Namibia supported 176 sites, addressing >90% of national PMTCT and EID needs.

TB/HIV

According to the World Health Organization's (WHO) 2017 Global Tuberculosis (TB) report, Namibia has the sixth highest incidence of TB in the world, estimated at 446/100,000 population. Incidence for TB/HIV positive is estimated at 171/100,000 population, representing a 36% co-infection rate. Drug-resistant TB remains a challenge with 480 estimated multi-drug resistant Rifampicin Resistant TB cases notified in FY17, representing 12% of previously treated cases and 3% of new cases. In 2016, the country reported 387 cases of drug-resistant TB, 195 of which had multidrug-resistant TB (MDR-TB) and 10 with extensively drug-resistant TB (XDR-TB). Male patients constituted 56% of the reported DR-TB cases, while 5% of reported cases were children under the age of 15 years. In 2016, 98% of DR-TB patients were tested for HIV and 46% were co-infected. Coverage of antiretroviral therapy among DR-TB patients was 93%." Overall, children ≤14 years of age represent 17.3% of the disease burden, with similar distribution of cases for males and females. Overall, 42% of all reported TB cases were women, 58% men, with the majority of cases for both being between 25-44 years of age (WHO 2017). The rate of all TB patients with a documented HIV status has improved to 98%, and HIV infected TB patients initiating ART are at 94%. However, clinical quality improvements in some PEPFAR supported SNU's remains a priority to address gaps. Currently, documented rates for TB preventative therapy (TPT) were very low, with only 35% of PLHIV currently on treatment screened for TB. Of all PLHIV who are TB negative, only 9% initiated TPT; of all initiated TPT, only 44% completed their TPT course.

HIV Testing Services (HTS)

Namibia has made significant progress in scaling up targeted case finding strategies to all parts of the country and population groups. According to preliminary results from NAMPHIA, 86% of adults between the age of 15 and 64 years (79.6% for men and 89.5% for women) who are living with HIV know their status. This shows an improvement from the 75.6% (62.6% for men and 79.6% for women) reported from the 2013 Namibia Demographic and Health Survey (NDHS). Similar to the NDHS 2013, men (age group of 20-29 years) still lag behind in HIV testing uptake. [REDACTED]

Voluntary Medical Male Circumcision (VMMC)

Modeled national coverage for VMMC among priority age group of 15-29 years old is 35% (Decision Makers Program Planning Tool, DMPPT-2 2018), which is less than the recommended 80% target to help achieve epidemic control. The MOHSS has scaled up the implementation of an extensive VMMC demand creation campaign. As part of this campaign, PEPFAR Namibia in collaboration with MOHSS worked with a popular Namibian musician to promote the benefits of VMMC. Promotional concerts were conducted in June and July 2016 and May 2017. Due to expansion of service access and demand generation efforts, the PEPFAR VMMC program has seen a 34% increase in VMMC coverage in men

aged 15-29. At the end of FY17, the PEPFAR program reported a record number of circumcisions: 27,736 men (Annual Progress Report [APR] 2017).

Orphans and Vulnerable Children (OVC)

The HIV epidemic in Namibia has generated a large population of OVCs. Among the national 150,589 OVCs (Census, 2011), an estimated one third are HIV-related—i.e., children who are affected by HIV (one or both parent(s) living with HIV, or one or both parent(s) died from AIDS) and children who are HIV infected. Among 15-19 year olds, 56.6% of girls and 74.2% boys had never been tested for HIV (NDHS, 2013). According to UNICEF, among adolescents tested for HIV in the last 12 months, 14% of males and 29% of females received results (Children of the World, 2017). The 2016 UNICEF report on out-of-school children found that one in five children of school-going age is not in school and another 15% are at risk of dropping out. These children are from the most disadvantaged communities, which are also located in the regions with the highest HIV burden. High levels of violence, especially sexual violence within families, schools and communities put pre-adolescent and adolescent girls at particular risk of abuse, psychosocial stress and HIV infection.

Gender Inequalities

In Namibia, gender norms and gender-specific roles are deeply entrenched. Partly due to cultural and economic gender inequalities, women and girls are the most affected by the HIV epidemic, with most unable to protect themselves from HIV. Cultural norms that encourage alcohol abuse or inhibit health seeking behaviors in men and boys also contribute to HIV risk. According to the 2013 Demographic and Health Survey (DHS), one in three (32%) women aged 15-49 has experienced physical violence since age 15, and 14% of women in this age group experienced physical violence in the 12 months prior to the survey. Seven percent (7%) of women aged 15-49 experienced sexual violence since age 15, and four percent (4%) experienced sexual violence in the 12 months prior to the survey. Women who are not employed and less educated are more likely to have experienced sexual violence. While the GRN has approved a number of progressive laws and policies to address inequalities between men and women, full implementation is difficult due to limited allocation of financial and human resources. The results of the Violence Against Children Survey (VACS), scheduled to be completed in FY 19, will provide recommendations to relevant ministries in Namibia, and international and national non-governmental organizations on developing, improving and enhancing prevention and response strategies to address violence against children as part of a larger, comprehensive, multi-sectoral approach.

Key Populations

Key populations (KP) in Namibia, especially men who have sex with men (MSM), female sex workers (FSW) and transgender (TG) women are at high risk of HIV. Based on the Integrated Biological and Behavioral Surveillance Survey (IBBSS) conducted in 2013, among the estimated population of 6,508 MSM, 16% (1,054) are HIV-positive (see Table 2.1.1). Among the 8,082 FSW, 39% (3,136) are HIV-positive. No data are available for the transgender population. New data on FSW, MSM, and TG populations will be available during the implementation of COP18. Phase II of the IBBSS, scheduled to

begin in August 2018, will include respondent-driven sampling linked to peer-driven interventions for FSW and MSM/TG.

Pre-Exposure Prophylaxis (PrEP)

Namibia included PrEP in its National Strategic Framework for HIV (2017/2018-2021/2022) and granted regulatory approval for tenofovir disoproxil fumarate (Ricovir-M) in May 2017. In FY16 Namibia did not have a national PrEP program, no clients were reported on PrEP. PEPFAR Namibia provided technical assistance to support the adoption of PrEP in the national guidelines in 2016. In FY17, PEPFAR Namibia's technical and programmatic assistance resulted in a scale up of PrEP. Among the 62 clients enrolled on PrEP by the end of FY17, the majority of these early adopters were FSW and MSM. Individuals living in serodiscordant relationships were specifically targeted at ART clinics, although no monitoring and evaluation (M&E) systems were in place specifically to report these sub-populations. In COP18 PrEP program scale-up will focus on AGYW, KPs, and serodiscordant couples as well as developing a robust National PrEP M&E framework.

Programmatic and Systemic Gaps

The preliminary results from NAMPHIA show that Namibia is close to reaching epidemic control, but there are several systemic and programmatic challenges that create significant barriers to achieving sustainable epidemic control. Human resources for health (HRH) are a primary vulnerability, and Namibia requires implementation of a human resource staffing structure for the MOHSS that is responsive to the demands of the epidemic. Policy and operational interventions are also required. Other health system components that require strengthening are HIV commodity and supply chain systems, and the health information and surveillance system, particularly recent infection surveillance.

Table 2.1.1 Host Country Government Results

	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	2,413,643	100	434,544	18	441,647	18	250,191	10	243,305	10	546,493	23	497,462	21	Namibia Population Projections 2011-2041
HIV Prevalence (%)		10		1.2		1.2		12		7.7		19.8		14.9	NDHS 2013
AIDS Deaths (per year)	4,950														Calculated from PLHIV estimates/ population
# PLHIV	243,803		846		856		134		159		1,901		1,054		Projected from 2018 Spectrum medium bound estimate for 2018
Incidence Rate (Yr)		0.63		N/A		N/A		0.77		0.42		0.72		0.54	Projected from 2018 Spectrum medium bound estimate for 2018
New Infections (Yr)	5,698														
Annual births	81,386	100													Namibia Population Projections 2011-2041
% of Pregnant Women with at least one ANC visit	78,944	97	395	0.5			34025	43.1			44525	56.4			Projected from NDHS 2013 ANC rates, Namibia Population Projections 2011-2041 & ANC attendance by age in HIS 2017
Pregnant women needing ARVs	12,001	15.2													Projected from 2018 Spectrum medium bound estimate for 2018
Orphans (maternal, paternal, double)	50,317														Projected from 2018 Spectrum medium bound estimate for 2018
Notified TB cases (Yr)	8,975		355	4.0	428	4.8	578	6.4	514	5.7	2,753	30.7	4,347	48.4	Program Data *(Total = 8,975, includes cases with

															undocumented age data) NLTB 2017
% of TB cases that are HIV infected	3,251	36	28	1	37	1	129	4	117	4	1,382	43	1,558	48	Includes with missing age status NLTB 2017
% of Males Circumcised	39,775									29.6				34.4	Coverage end of 2016 (DMPPT2)
Estimated Population Size of MSM*	6,508														IBBSS 2013
MSM HIV Prevalence		16.2													IBBSS 2013
Estimated Population Size of FSW	8,082														IBBSS 2013
FSW HIV Prevalence		38.8													IBBSS 2013
Estimated Population Size of PWID	N/A														
PWID HIV Prevalence	N/A														
Estimated Size of Priority Populations (specify)	See table 2.1.2														
Estimated Size of Priority Populations Prevalence (specify)	See table 2.1.2														

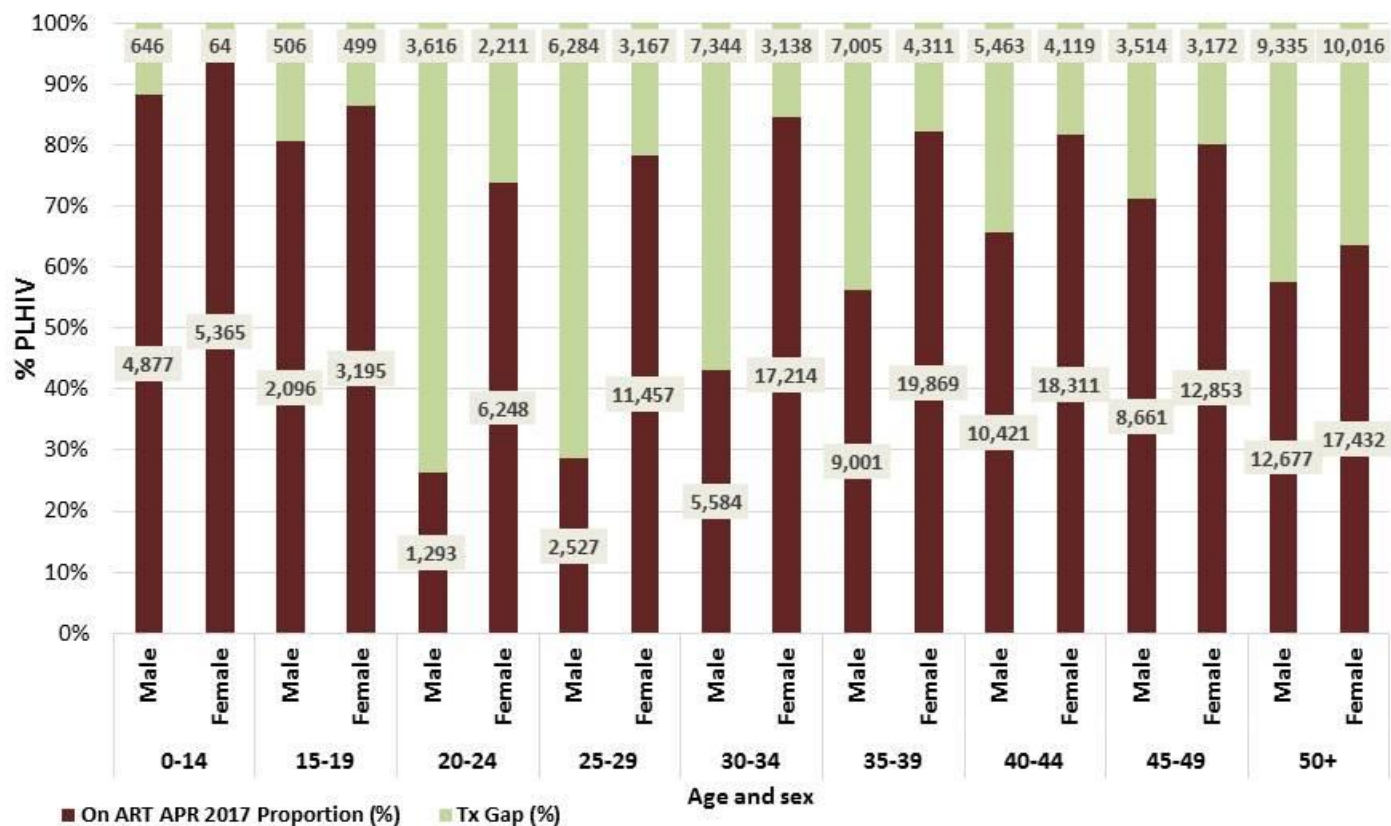
Table 2.1.2 90-90-90 Cascade: HIV Diagnosis, Treatment and Viral Suppression*

Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year			
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	2,413,643	10.1%	243,803	193,039	185,614	76.1%	87%	431,007	21,955	20,820
Population <15 years	876,192	1.2%	10,952	N/A	10,340	94.4%	76%	34,076	991	843
Men 15-24 years	243,305	3.2%	7,697	4,105	3,947	51.3%	63%	35,971	837	451
Men 25+ years	497,462	18.1%	89,861	58,414	56,167	62.5%	88%	102,072	7,072	6,651
Women 15-24 years	250,191	5.0%	12,455	9,221	8,866	71.2%	74%	91,793	2,791	2,651
Women 25+ years	546,493	22.5%	122,838	110,546	106,294	86.5%	90%	167,095	10,264	10,224
MSM	6,508	16.20%	1,054					562	73	58
FSW	8,082	38.80%	3,136					2,699	218	200
PWID										
Priority Pop (specify)										

*Spectrum, 2018

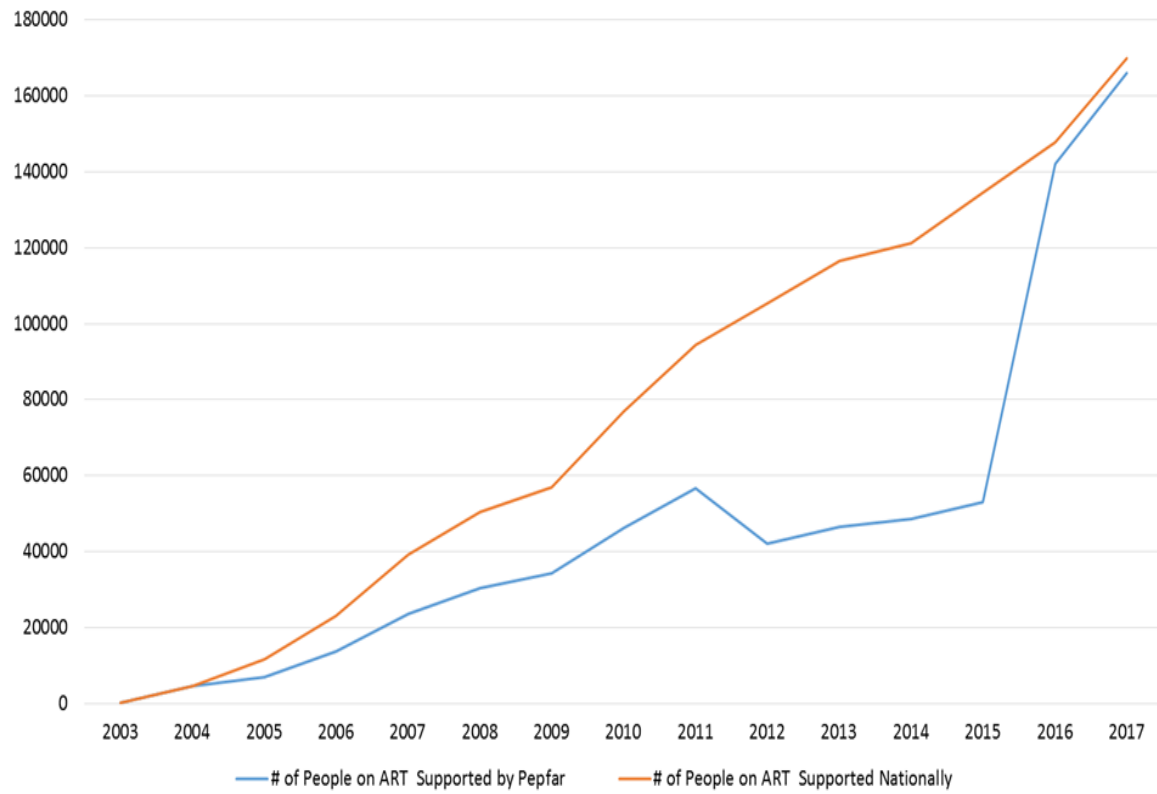
Figure 2.1.3 National ART Gap by Age and Sex

New Population and Epidemiologic Data: ART Program Data (APR 2017) Compared to 2018 PLHIV Estimates



ePMS showed 169,081 people on ART in the public sector as of September 30, 2017, but does not include private sector patients on ART, currently reported to be ~18,600 of all ages. That would be **~185,000 PLHIV on ART.**

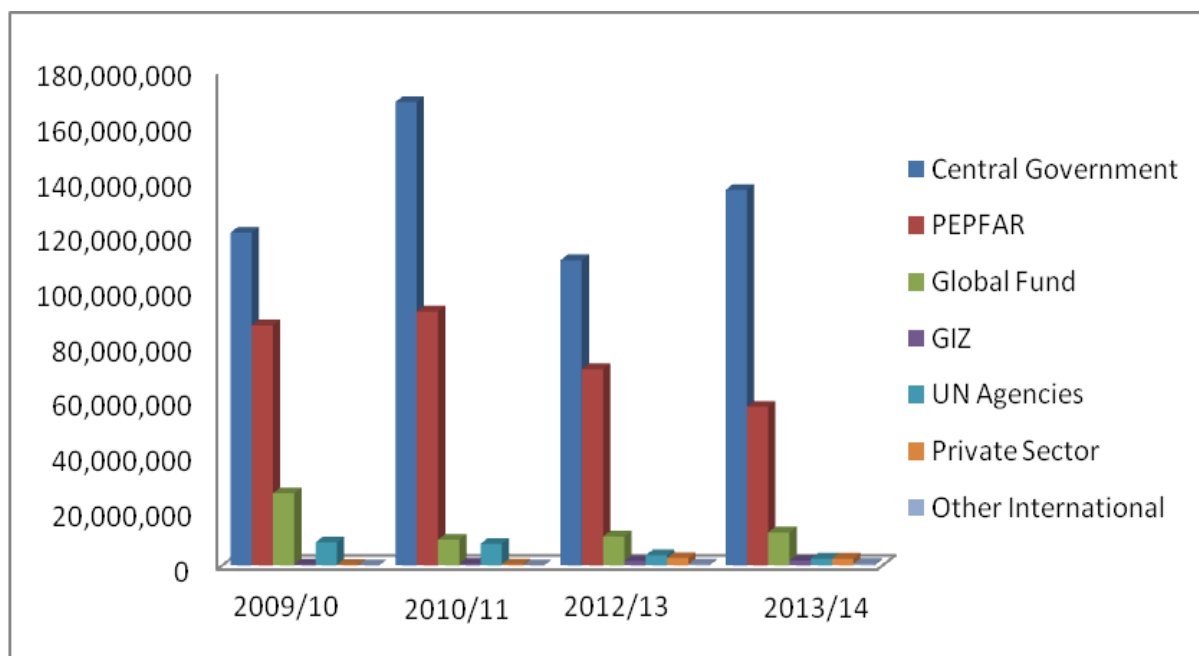
Figure 2.1.4 National and PEPFAR Trend for Individuals Currently on Treatment
National and PEPFAR Trend for Individuals Currently on Treatment



2.2 Investment Profile

Namibia completed its last National AIDS Spending Assessment (NASA) in 2013/2014. The NASA indicates that the major source of financing of the HIV response is the GRN (64%), followed by PEPFAR and the Global Fund (GF). Namibia also completed its latest National Health Accounts in 2017, covering 2014/2015. The report found that while total health spending increased from 2012/2013 to 2014/2015, HIV spending decreased from 13% to 10% of the total health spending during the same period. The findings are summarized in Figure 2.2.1 (in US Dollars (USD)).

Figure 2.2.1 HIV/AIDS Spending by Sources, 2009 – 2014



Source: National AIDS Spending Assessment (NASA), 2014

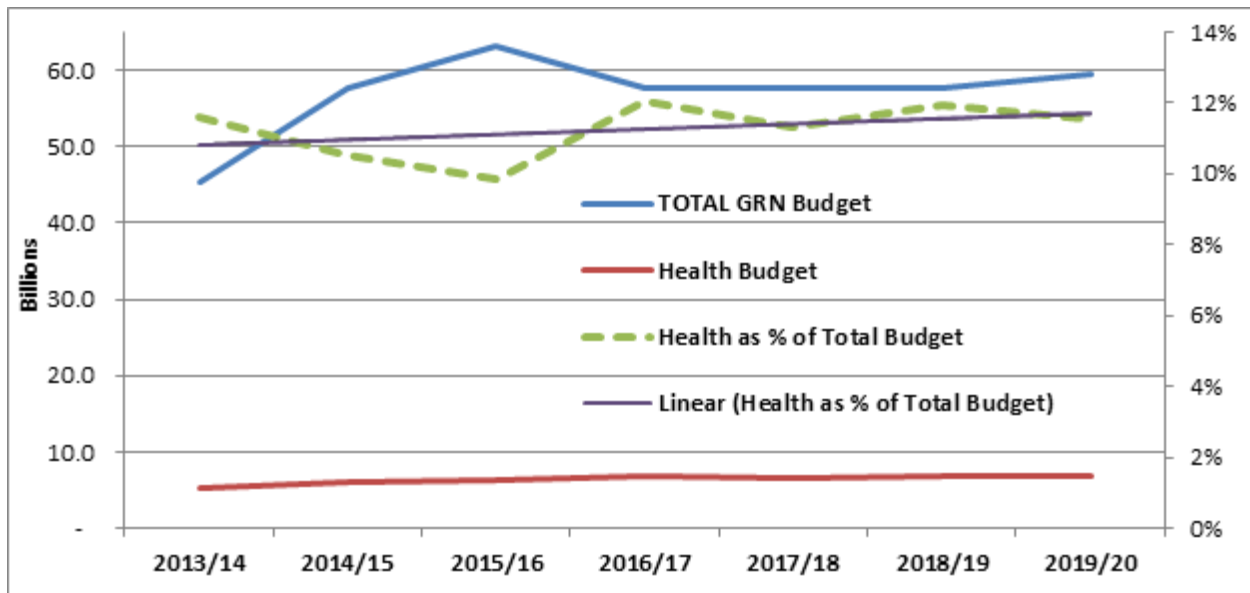
GRN spending on HIV has fluctuated over time, but is making up an increasing proportion of total HIV spending, as donor money is on the decline. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) recently signed a new grant agreement with Namibia for 2018-2020. The funding provided is two-thirds less than the previous round. The European Union also ended its 'Program for Accelerating the Reduction of Maternal and Child Mortality in Namibia' in 2017. Private sector funding is approximately 1% of the total HIV spending, although the NASA indicates that figure is an underestimate due to data limitations.

The National Health Accounts (2014/2015) highlighted Namibia's commitment to the health sector, with health spending making up 13% of the national budget, only 2% short of achieving the 15% target set by the Abuja Declaration. The GRN spent more on HIV (10%) than any other disease as a proportion of total health spending.

Despite a tight fiscal environment, the GRN remains committed to health, maintaining an

allocation of between 11% and 12% of the total GRN budget on health (see Figure 2.2.2). The 2017/18 allocation to health is approximately \$521 million. In terms of budget execution in health, the MOHSS has maintained a budget execution rate of between 96% and 105% (note: The 105% was due to the exchange rate at the time and mid-term budget review and decreased allocation for that fiscal year).

Figure 2.2.2 Government of Namibia Budget (NAD) 2013/14 to 2019/20



The 2017-2020 Mid-Term Expenditure Framework indicates that the GRN will maintain tight control of its budget, with expenditures only rising in the 2019/20 financial year. The proposed budget for 2018/2019 keeps the health budget flat at NAD 6.5 billion, slightly lower than originally envisioned in the three year rolling framework from 2017/18 to 2019/20, which foresaw a modest increase in GRN allocation to health to NAD 6.87 billion. This allocation still reaffirms the GRN commitment to health despite the tough economic environment. However, this past fiscal year GRN line ministries (including the MOHSS) saw limits to hiring new personnel and budget strains that put further pressure on operations.

Namibia’s Investment Case presented gains in reducing HIV incidence and containing costs by adopting an aggressive test and start approach, which includes improved technical efficiencies such as implementing cost-effective testing and acquiring antiretroviral drugs (ARVs) at the best global price. This scenario (indicated as “maximum” in Figures 2.2.3, 2.2.4 and 2.2.5 below) was selected by the GRN and has the potential of reducing HIV incidence to 0.1%. This is below the current estimated 0.54% among 15-49 year olds. The latest National Strategic Framework (NSF) (2017/2018-2021/2022) focuses on preventing new HIV infections and AIDS related deaths among adults and children, and has prioritized high impact programs that have the potential to contribute towards ending AIDS. A key focus is to support strategies that improve efficiency and effectiveness at all levels of the response.

Figure 2.2.3 HIV Incidence (Ages 15-49), 2015-2030 (Percent)

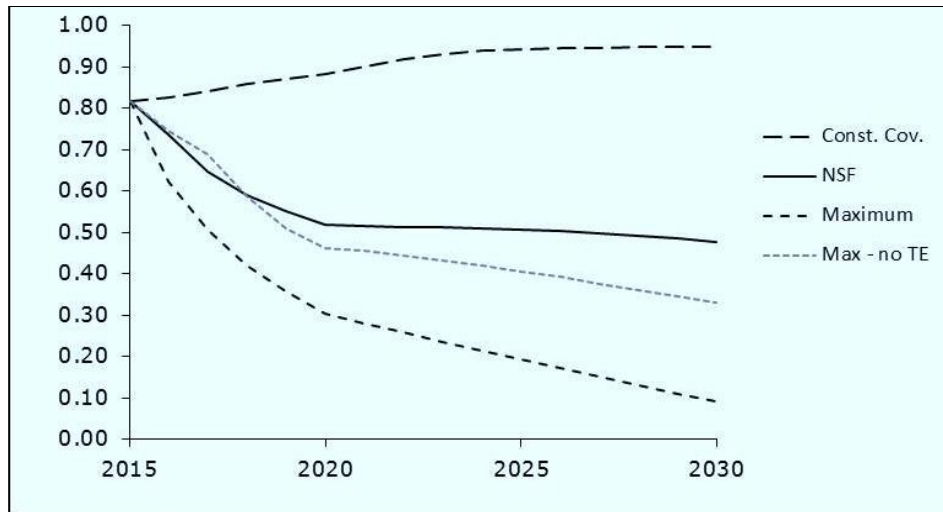


Figure 2.2.4 HIV Infections, All Ages, 2015-2030 (Units)

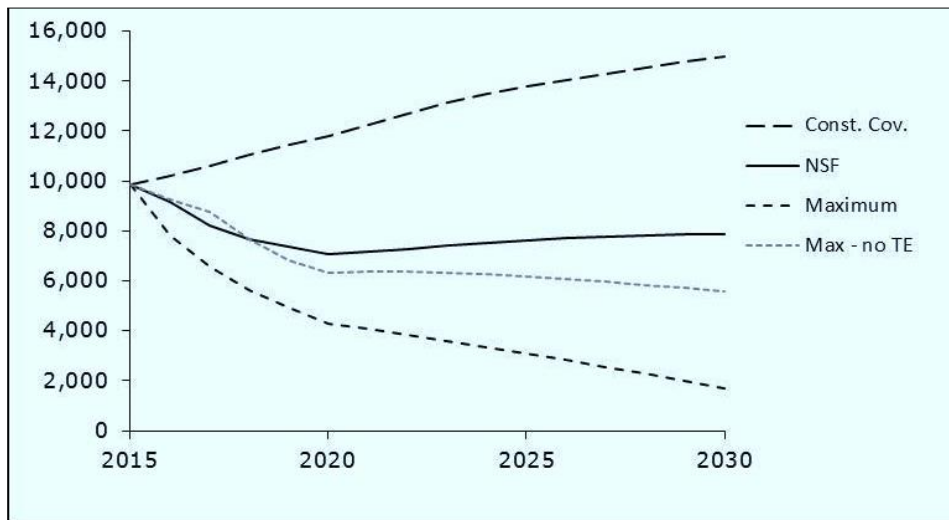


Table 3. Composition of Spending, 4 Scenarios, 2015-2030

	2015	2020	2025	2030
	(US\$ millions)			
Const. Cov.				
Total Costs	195.8	242.5	306.6	387.9
Prevention	34.1	32.9	38.3	46.5
Treatment and Care	110.2	145.5	185.9	235.9
Social and Program Enablers	20.6	26.5	33.9	43.2
Synergies with Development Sectors	30.9	37.6	48.6	62.3
NSF				
Total Costs	195.7	274.6	320.9	384.7
Prevention	34.1	50.8	50.0	60.2
Treatment and Care	110.1	158.1	191.8	227.8
Social and Program Enablers	20.6	27.6	33.3	40.5
Synergies with Development Sectors	30.9	38.1	45.8	56.2
Maximum				
Total Costs	195.6	290.1	330.4	381.6
Prevention	34.1	54.9	53.1	64.0
Treatment and Care	110.1	169.9	201.5	229.8
Social and Program Enablers	20.6	27.8	32.4	37.5
Synergies with Development Sectors	30.9	37.5	43.2	50.2
Max - no TE				
Total Costs	195.6	282.3	330.8	399.3
Prevention	34.1	55.0	53.5	65.0
Treatment and Care	110.1	161.1	198.8	240.4
Social and Program Enablers	20.6	27.9	33.6	40.6
Synergies with Development Sectors	30.9	38.4	45.0	53.2
	(Percent of GDP)			
Total Costs				
Const. Cov.	1.52	1.47	1.47	1.48
NSF	1.52	1.66	1.53	1.46
Maximum	1.52	1.75	1.57	1.44

Source: Namibia Investment Case, UNAIDS, 2016

Inadequate HRH (both in absolute numbers and from geographic mal-distribution) remains a major vulnerability to the HIV response. While 80% of Namibian doctors work in the private sector, only 20% of the population seeks health care through the private sector (Namibian Association of Medical AID Funds, NAMAFA, 2012). Through its partners, the United States Government (USG) assists Namibia in increasing its HRH capacity. In the last four years, and with PEPFAR support, the human and institutional capacity development in Namibia was enhanced with the launch of the country's first medical school and pharmacy degree training programs at the University of Namibia and the Bachelor degree programs in biomedical sciences and logistics at Namibia University of Science and Technology (formerly the Polytechnic of Namibia). The MOHSS also has enhanced its nursing and public health trainings at their National Health Training Centre. In the mid- to long-term, the HRH crisis will be addressed through increased local training and decreased reliance on staff importation. PEPFAR's "Treatment Acceleration Plan" (COP 15/16) addresses the short-term HRH gaps in support of the GRN's HIV response related to delays in obtaining work permits and registration with appropriate health professions authority due to a huge backlog of applicants. The reduction in GF support has necessitated the expiry of contracts for 147 health professionals, some of them in hard to staff remote areas due to lack of staff accommodation or transport.

Tables 2.2.1 and 2.2.2 summarize annual investments by program area and procurements for key commodities (Source: NASA, 2014). GRN financed 64% of the HIV response, PEPFAR financed 27% and GF financed 6%. ARVs were procured primarily by GRN (85%) and GF financed the remaining 15%. PEPFAR covered the cost of all VMMC kits. GRN is in the process of updating NASA and given the budget austerity issues experienced in Namibia, these proportions can be expected to change.

Table 2.2.1 Annual Investment Profile by Program Area					
Program Area	Total Expenditure	% PEPFAR	% GF	% GRN	% Other
Clinical care, treatment and support	33,737,892	26%	14%	55%	5%
Community-based care	3,502,622				
PMTCT	951,012	32%	9%	58%	2%
HTS	19,253,796				
VMMC	642,409				
Priority population prevention	12,723,170				
Key population prevention	1,360,639				
OVC	37,993,024	6%	0.7%	94%	
Laboratory	181,112				
SI, Surveys and Surveillance	1,545,164	63%		37%	
HSS	101,455,789	34%	6%	60%	0.3%
Total	213,346,629	27%	6%	64%	3%

Table 2.2.2 Annual Procurement Profile for Key Commodities					
Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	21,367,708		15%	85%	
Rapid test kits	2,076,783			100%	
Other drugs	32,163,838			100%	
Condoms	1,623,935			100%	
Viral Load commodities				100%	
VMMC kits	445,844	100%			
Other commodities	8,562,772				
Total	66,240,880				

Standard Table 2.2.3 is intentionally left blank, as PEPFAR Namibia does not receive any non-PEPFAR funding or co-funding. Table 2.2.4 summarizes funding that PEPFAR Namibia is receiving through central initiatives or other non-COP resources.

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP						
Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
Cervical Cancer	\$2,000,000	o	o	TBC		Catalyze expansion and integration of cervical cancer screening among women with HIV receiving ART services in high volume sites
Total	\$2,000,000					

2.3 National Sustainability Profile Update

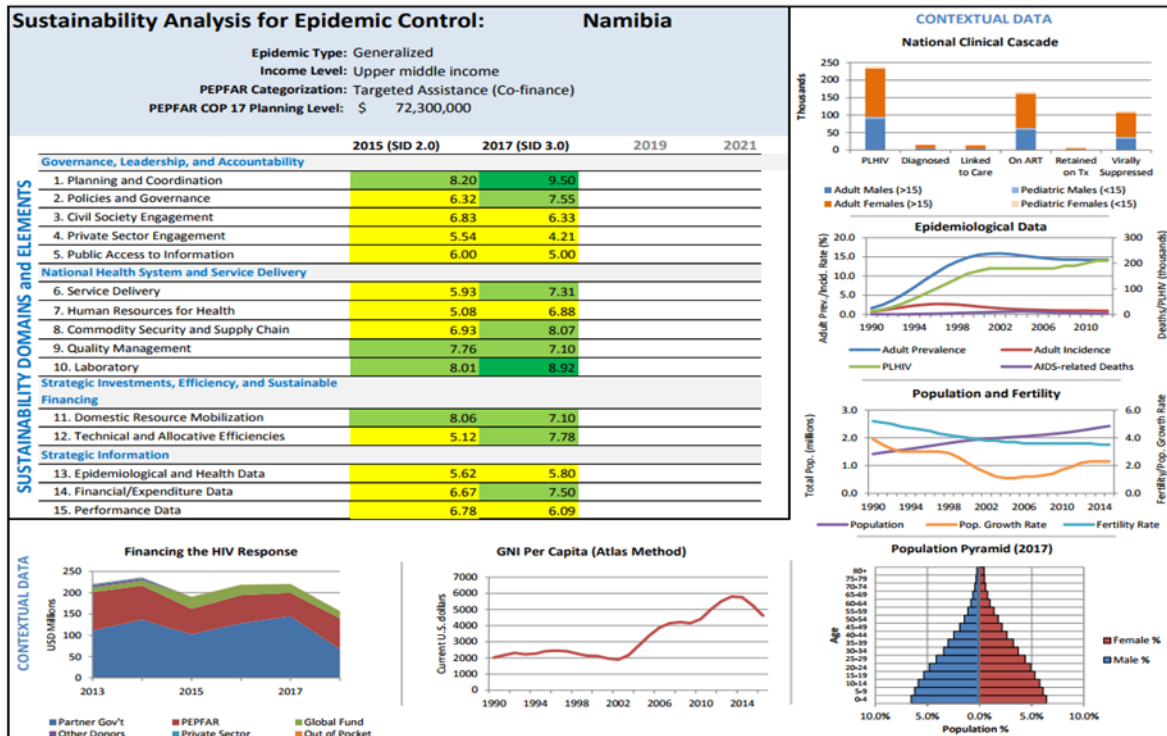
The 2017 Sustainability Index and Dashboard (SID) 3.0 was completed using a highly participatory approach and in collaboration with the Joint United Nations Programme on HIV/AIDS (UNAIDS). The process included a desk review of new or recent documents, followed by input meetings with key stakeholders. PEPFAR held a national stakeholder meeting to validate the SID. A total of 114 participants from GRN, civil society, and the private sector attended. The SID indicates that Namibia is moving towards sustainability, although the current stringent fiscal environment is bound to affect this progress. Seven elements expressed sustainability vulnerabilities, including: commodity security and supply chain; HRH; public access to information civil society engagement; private sector engagement; epidemiological and health data; and performance data (see Figure 2.3.1). The remaining seven elements scored light green and did not express significant sustainability vulnerabilities.

While the SID showed improvements since 2015, PEPFAR and stakeholders noted that the questions for the domains and elements do not tell the whole story. Participants agreed that several vulnerabilities would directly impact the sustainability of the national HIV response - namely, HRH and the supply chain - if not addressed in the short to medium-term.

HRH is reaching a crisis level, with most health facilities below the WHO recommended doctor-to-patient ratio. Key HRH weaknesses in the SID 3.0 included: inadequate distribution of health workers across all facilities and across the public and private sector; the lack of a plan to transition donor-supported HRH to the GRN; and, not fully using HR data for HRH planning and management. A number of health professionals hired by donors as part of PEPFAR's "Treatment

Acceleration Plan” remain off the MOHSS’ approved staffing structure and a significant number of GF HRH positions ceased to be funded on December 31, 2017.

Figure 2.3.1 Sustainability Index Dashboard



Additionally, the current fiscal and budgetary situation has led to a government-wide general hiring freeze that remains in place, with special waivers required to fill positions. The MOHSS has sought to manage the hiring freeze by repurposing positions from areas that are sufficiently staffed or over staffed to areas of critical need. Namibia’s health training universities and institutions continue to produce medical doctors, nurses, and pharmacists, but they are relatively small in number and graduates do not have specialized or practical experience.

The SID identified several weaknesses in the supply chain, most notably stock outs and low stock for critical commodities and medicines (including ARVs and HIV rapid test kits, RTKs). A new procurement act requires waivers for procurements not covered by centrally processed contracts. The GRN is in the process of awarding annual framework contracts for ARVs, which will provide a consistent and reliable ARV supply.

The SID 3.0 assessment revealed a lack of robust engagement of and missed opportunities with both civil society and the private sector. Stakeholders voiced concern that civil society organizations previously implementing GF projects would no longer be able to participate in the response due to lack of funding and staff. Civil society is keen to formalize avenues of support from the GRN, and has started consultations on social contracting. The GRN promulgated a

Public-Private Partnership Act in 2017, which can provide a platform for the private sector to engage the government on specific projects, and activities, in the public health sphere.

Access to information remains a weak point in the response. This includes access to information and data within the MOHSS for improved program analysis. Without these data, program managers and implementers are not able to make course adjustments for greater impact and efficiency. Epidemiological data are supported by donors and is considered a sustainability and capacity vulnerability.

Through its stakeholder engagement and sustainability interagency technical teams (ITTs), PEPFAR Namibia has initiated several activities that will be ongoing in COP18 to strengthen engagement with civil society and the private sector. Additional engagement with the private sector includes discussions with the Namibia Association of Medical Aid Funds (NAMAF), who coordinates medical aid in Namibia. Their inclusion of HIV-related prevention and treatment services into the standard insurance packages improves access and revision of tariffs makes services more affordable. Other activities include working with private health service providers on VMMC, and exploring avenues for private pharmacy dispensing of publically procured ART.

PEPFAR Namibia is working closely with bilateral partners and the newly formed GRN Resource Mobilization Technical Working Group (TWG) around issues of sustainability. With funding from the Sustainable Finance Initiative, a consultant is working with this TWG to support their development of a sustainability framework and plan. UNAIDS has committed to help build capacity of CSOs and encourages the use of government sub-awards to CSOs, starting with CSOs aligned with the HIV/AIDS umbrella organization, Namibia Network of AIDS Service Organizations (NANASO). PEPFAR Namibia will continue to share quarterly program performance data with stakeholders, particularly CSOs, and seek opportunities to engage them in program performance monitoring. Under the small grants program, PEPFAR will develop grant announcements for indigenous CSO applicants to address these and similar issues.

PEPFAR Namibia will work in close collaboration with GRN to ensure that results of surveys and studies are widely disseminated to all stakeholders, including the private sector and civil society, to support the country's knowledge management efforts. This is a strategic area that both PEPFAR and the GF have committed to support.

2.4 Alignment of PEPFAR Investments Geographically to Disease Burden

PEPFAR Namibia is categorized as a co-financing, targeted service delivery program. COP14 represented a pivot in geographic focus and expenditure on interventions to achieve epidemic control. COP15 focused activities to the highest burden regions, with increased site-level spending in these regions, in an effort to achieve saturation and improve the continuum of care cascade. For COP16, PEPFAR Namibia's analyses of epidemiological and programmatic data

verified the high-burden areas and the appropriate resource allocation. Three SNUs were added for COP17 implementation. Rosh Pinah and !Nami#nus were added because of their high labor forces involved in mining, migrant male population, and high HIV prevalence among pregnant women age 15-24. And, Opuwo was added because of an increased number of AIDS-related deaths. For COP18, improved program and national data further refined our understanding of the epidemic and informed strategies to close the gaps. Due to frequent population movement between districts, the Central northern communal area SNUs (Oshikoto, Oshana, Omusati, and Ohangwena) are clustered into one SNU, and the Kavango West and Kavango East regions are clustered into one SNU. Appendix A, SNU prioritization, provides further details.

More than 70% of COP18 funding is assigned to aggressive scale-up SNUs. There are several SNUs that will achieve attained/sustained status during FY18, which would allow resources to be redirected to aggressive scale-up saturation SNUs without requiring additional funding. The following figures show percent of PLHIV by health district, the ART coverage gap by SNU and by age and sex, percent treatment coverage, and viral load monitoring coverage.

Figure 2.4.1 A

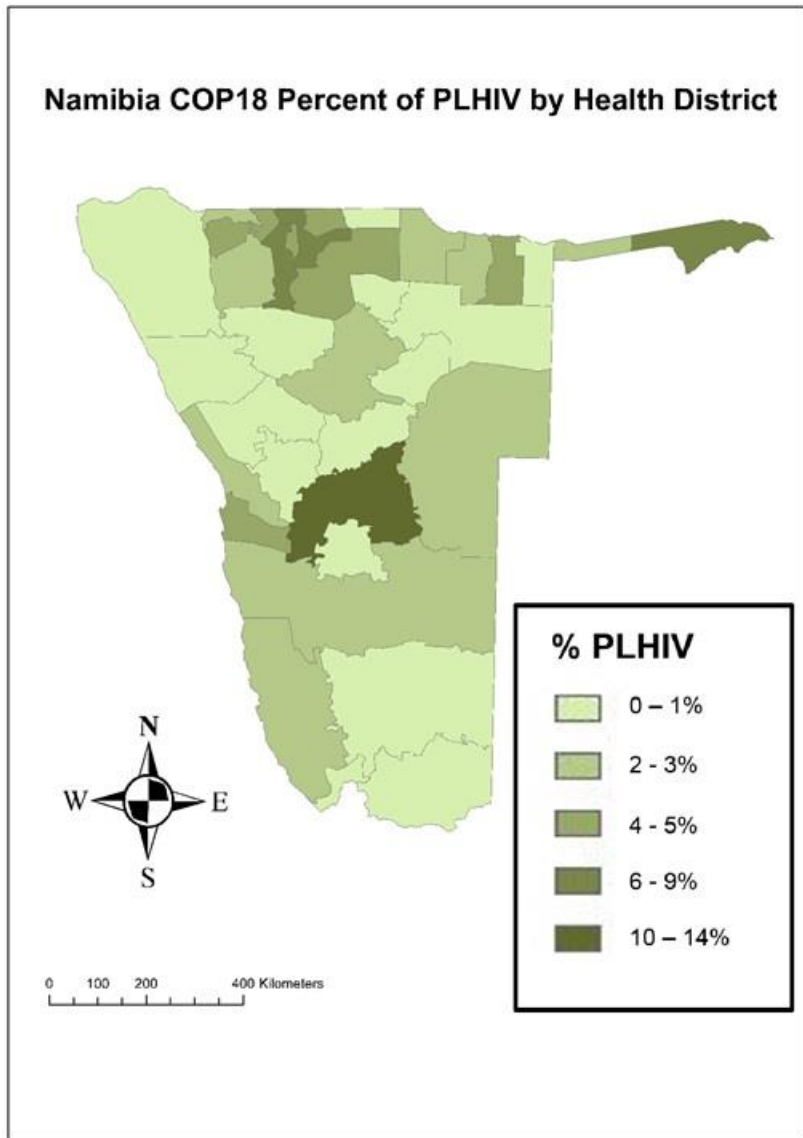


Figure 2.4.1 B

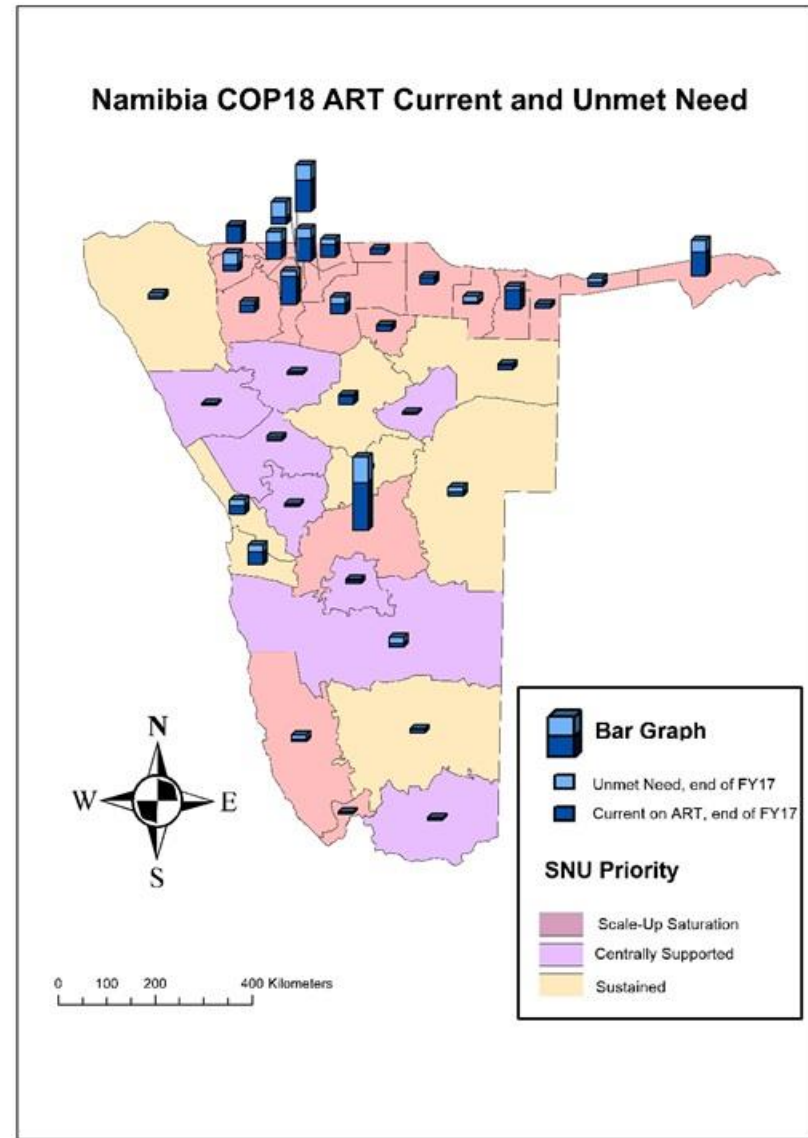


Figure 2.4.1 C

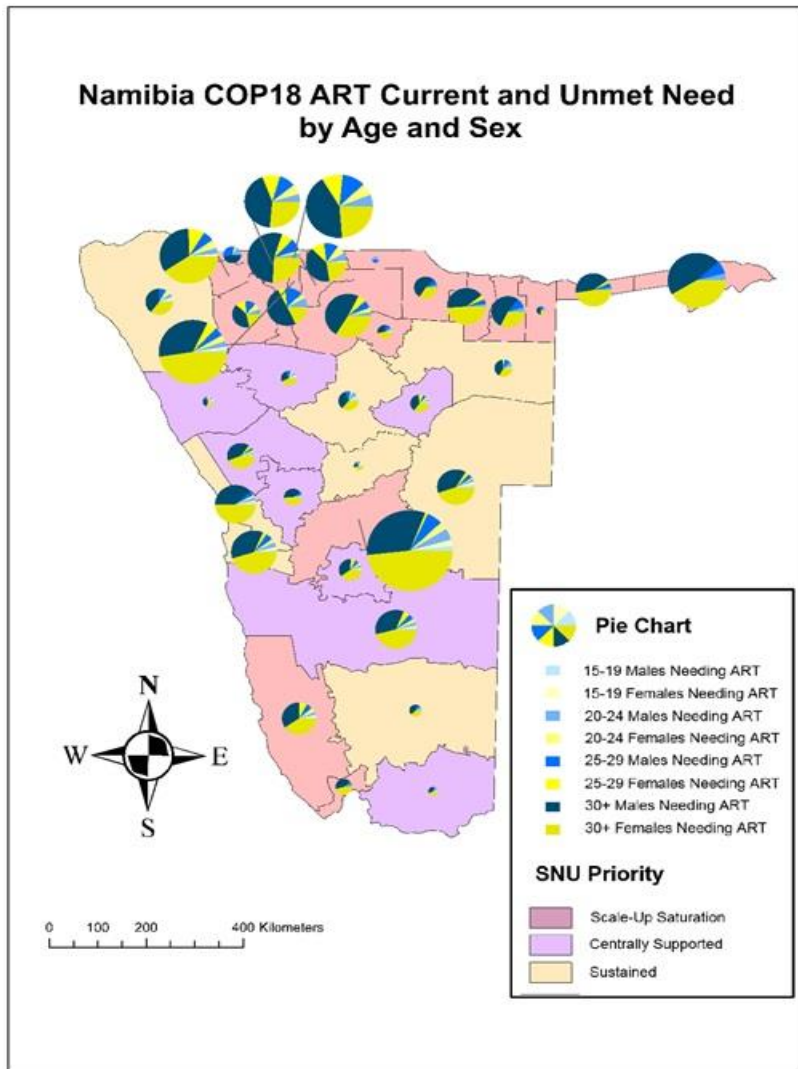
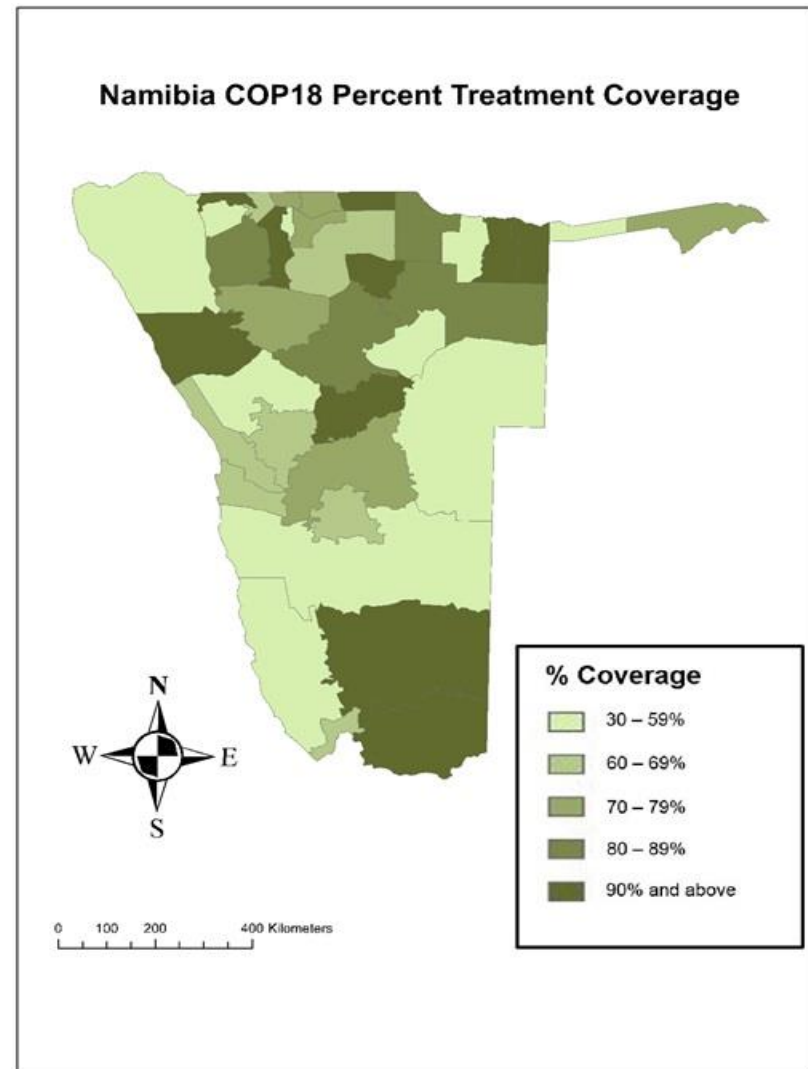


Figure 2.4.1 D



2.5 Stakeholder Engagement

Host Country Government

PEPFAR Namibia continues to work in partnership with the GRN through regular meetings (weekly, bi-weekly, and monthly) with the management staff of MOHSS, including meetings with the Permanent Secretary and directors of its various directorates. PEPFAR Namibia participates in a wide range of government-led technical working groups (TWGs). Through these TWGs, PEPFAR Namibia provides technical assistance in a diverse range of areas and ensures continued and ongoing interactions with MOHSS.

Global Fund and Other External Donors

Engagement with multilateral partners is routine and ongoing. Development partners attend PEPFAR stakeholder meetings and were part of the national COP18 development consultation meeting in Windhoek. Regular meetings with the GF Country Team occur by phone and in person when they are in Namibia. Following the end of the 2016-2018 GF grant and the delay in the start of the new grant, PEPFAR Namibia has been closely engaging with GF and MOHSS to address areas that will be affected, particularly HRH, to coordinate technical assistance and interventions to leverage each other's strengths and avoid duplication. PEPFAR Namibia provided feedback about the Regional Planning Meeting at the Health Development Partners' meeting held on 28 February.

Civil Society/Faith-Based Organizations and Community

PEPFAR Namibia works closely with civil society organizations (CSOs), including implementing partners and organizations that do not receive PEPFAR funding. The CSOs include sex worker organizations, Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) organizations, and entities that represent people living with HIV (PLHIV). Civil society was represented at the Regional Planning Meeting held in Johannesburg. Prior to travel, the two representatives (one from an LGBTI organization and one from PLHIV organization) engaged with broader stakeholder groups in order to gauge their perspectives and priorities to ensure they represented the collective voice of civil society appropriately. Civil society representatives were selected through a peer-nomination process.

Faith-based organizations were invited to the stakeholder meetings. To ensure the voice of FBOs was heard, PEPFAR Namibia wrote to the Council of Churches Namibia to ask for feedback about the HIV response in Namibia. The Churches in Namibia (CCN) is an umbrella body that facilitates and supports church members to implement projects through local churches and within the different communities in Namibia. CCN facilitated a home-based care and youth HIV prevention program through the GF. The program was implemented in 10 regions. CCN responded with input on challenges and needs.

Private Sector

PEPFAR Namibia requested input from private sector via written correspondence to and in-person meetings with the NAMAf and the Clinician Society of Namibia. PEPFAR Namibia plans additional engagement throughout the year. There is currently an effort to facilitate private sector reporting on key indicators, which are not currently reported through the government reporting systems.

Combined Stakeholder Engagement (Government, External Donors, Civil Society, and Private Sector)

PEPFAR Namibia convened a series of stakeholder meetings to incorporate a broad range of perspectives into our COP18 development. These meetings included:

- A national stakeholder meeting on February, 1, 2018 to launch the development of COP18. More than 120 national-level participants attended the meeting.
- Regional stakeholder consultations held on 14 February in the Kavango Region and as part of a Regional AIDS Coordinating Committee (RACOC) meeting in the Omusati Region. A total of 58 participants attended these meetings, and one participant provided written input.

The objectives of the stakeholder meetings were to:

- review 2017 accomplishments and remaining challenges;
- discuss the HIV transmission cycle in Namibia and interventions that can break the cycle;
- present new strategies from the COP18 guidance;
- outline the COP18 development process and timeline; and,
- brainstorm innovations for COP18 through discussions of the current data.

The meetings were attended by representatives from government ministries, implementing partners, CSOs, private sector partners, and bilateral organizations. Participants represented organizations serving geographic areas with the highest HIV burden, key affected populations, umbrella network groups, youth groups, advocacy groups, and organizations that focus on women's rights and health.

Following the three meetings, PEPFAR Namibia provided meeting reports to stakeholders and posted them on the U.S. Embassy website. The U.S. Embassy Facebook and Twitter accounts served as vehicles to communicate with stakeholder organizations to encourage awareness about the COP18 development process. Subsequent to the meetings, PEPFAR Namibia also requested stakeholders provide any additional feedback from those who attended, or from groups that had been unable to attend. PEPFAR Namibia encouraged stakeholder participation through these channels as a means of ongoing communication, especially targeting the youth-led organizations and groups.

In addition to the national and regional stakeholder meetings, PEPFAR Namibia attended the MOHSS Directorate of Special Programs weekly management meeting on February 12, 2018. PEPFAR Namibia updated the government on data analyses and program approaches for COP18.

The draft COP18 Strategic Direction Summary (SDS) was sent to all stakeholders, including CSOs and implementing partners, with a request for input prior to submission. Stakeholder input is incorporated into this final version of the document.

3.0 Geographic and Population Prioritization

HIV prevalence, PLHIV burden, and the unmet need for ART vary across Namibia. In COP 18, based on Namibia’s HIV epidemiological data, PEPFAR Namibia will provide support for the high burden districts that represent approximately 95% of the disease burden and bring all sites to attained (see Table 3.1 and Figure 3.1). In COP15, PEPFAR Namibia pivoted from regional targeted assistance (TA) to a site-based approach in the seven regions with the highest unmet ART needs and in eight urban hotspots. In COP17, PEPFAR is supporting continued treatment scale up and other HIV services in 175 ART facilities, in 18 districts and urban hotspots, including differentiated service delivery and TA sites. PEPFAR Namibia introduced clustering by combining districts where patients move between districts for treatment (Table 3.2). In COP 18, PEPFAR Namibia expanded clustering, after extensive data analysis, to four densely populated mobile northern regions, consisting of Ohangwena, Omusati, Oshana, and Oshikoto to form Namibia Cluster 1. Kavango East and Kavango West were also combined to form a Kavango cluster.

Namibia has eight urban hotspots outside the priority districts and clusters with high concentrations of key populations and high-volume ART sites (1,200+ patients) (see Table 3.2). Identified high TB case rates and/or multi-drug resistant TB burden are in some urban hotspots in the south and west of the country, where population density is lower than in the north. Special focus on these urban hot spots will ensure a continuum of prevention, care, and treatment services to achieve ART saturation.

ART coverage by age and sex is lowest among young men aged 15-29. This age group will be a priority for PEPFAR Namibia in COP18 for case finding and retention in treatment. Young men aged 15- 29 were found to have low knowledge of their HIV status and low viral load suppression. Slow rates of decentralization for pediatrics and adolescents, and limited support for pediatrics disclosure and teen psychosocial support have been identified as contributing factors. PEPFAR Namibia plans to implement targeted interventions to increase case identification and linkage to ART to reach saturation.

Table 3.1 Current Status of ART Saturation and Progress Towards 95-95-95 Across all SNUs

Prioritization Area	# Current on ART (FY17)	# of SNU COP17 (FY18)	Total PLHIV	# of SNU COP18 (FY19)
Attained	10,444	2	229,189	12
Scale-up Saturation	114,737	11		
Scale-up Aggressive	10,153	3		
Sustained	22,177	8		
Central Support	9,124	9	14,613	9

Table 3.2 PEPFAR Namibia COP Priority Areas Over Time

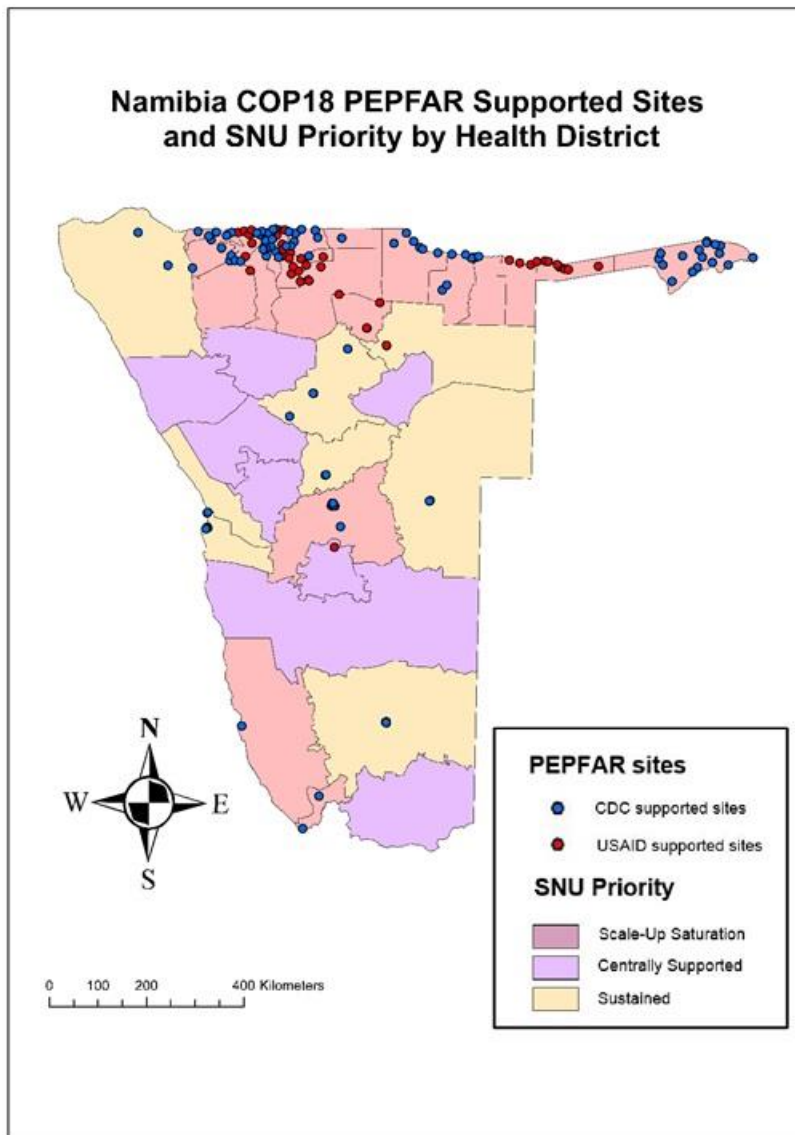
COP15	COP16	COP17	COP18
!Karas	!Nami#nus	!Nami#nus - Rosh Pinah Cluster	!Nami#nus - Rosh Pinah Cluster
	Rosh Pinah		
	Keetmanshoop	Keetmanshoop	Keetmanshoop
	Karasburg	Karasburg	Karasburg
Erongo	Omaruru	Omaruru	Omaruru
	Usakos	Usakos	Usakos
	Swakopmund	Walvis Bay- Swakopmund Cluster	Walvis Bay- Swakopmund Cluster
	Walvis Bay		
Hardap	Mariental	Mariental	Mariental
	Rehoboth	Rehoboth	Rehoboth
Kavango East	Andara	Andara	Kavango
	Nyangana	Nyangana	
	Rundu	Rundu-Ncamangoro-Nkurenkuru Cluster	
Kavango West	Ncamangoro		
	Nkurenkuru		
Khomas	Windhoek	Windhoek	
Kunene	Khorixas	Khorixas	Khorixas
	Opuwo	Opuwo	Opuwo
	Outjo	Outjo	Outjo
Omaheke	Gobabis	Gobabis	Gobabis
Ohangwena	Eenhana	Eenhana-Engela-Okongo Cluster	Namibia Cluster 1
	Engela		
	Okongo		
Omusati	Okahao	Okahao-Tsandi Cluster	
	Tsandi	Outapi	
	Outapi		
	Oshikuku		
Oshana	Ondangwa	Oshakati -Ondangwa Cluster	
	Oshakati		
Oshikoto	Omuthiya	Omuthiya-Onandjokwe Cluster	
	Onandjokwe		
	Tsumeb	Tsumeb	
Otjozondjupa	Grootfontein	Grootfontein	Grootfontein
	Okahandja	Okahandja	Okahandja
	Okakarara	Okakarara	Okakarara
	Otjiwarongo	Otjiwarongo	Otjiwarongo
	Tsumkwe	Tsumkwe	Tsumkwe
Zambezi	Katima Mulilo	Katima Mulilo	Katima Mulilo

*Bold black text = PEPFAR priority regions/districts/clusters

*Blue text = Attained

*Red Text = PEPFAR priority hotspots

Figure 3.1 Map of SNU Priority and PEPFAR Support Sites



The geographic focus in the areas with highest burden and unmet need will align all PEPFAR activities for OVC, AGYW, PLHIV, key populations, and other priority populations to create a synergistic impact. Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe Women (DREAMS)-like interventions will continue in five districts with high HIV prevalence rates, high prevalence of GBV and teen pregnancy rates: Katima Mulilo, Omuthiya, Onandjokwe, Tsumeb, and Windhoek. DREAMS-like activities will target AGYW ages 9-24 in an effort to decrease the HIV incidence and ultimately keep them HIV-negative. PEPFAR Namibia will also ensure that AGYW receive HIV and GBV risk reduction interventions from multiple sources. In these districts, PEPFAR Namibia will ensure layered age-appropriate programming up to age 24.

Namibia has yet to attain national saturation (80% coverage) among 15-24 year old men for the VMMC program. While the national coverage for VMMC among priority age group of 15-29 years old is 35% (DMPPT-2 2018), PEPFAR supported regions have higher VMMC coverage; the percentages in COP17 regions were, Zambezi – 50%, Khomas – 45%, Erongo – 44% and Karas 21%. In COP 18, PEPFAR Namibia will continue to support VMMC programs in the above regions and provide additional support in Cluster 1, where GF services will decrease in FY18. PEPFAR will provide HRH support (such as hiring nurses, clinical officers, data clerks, and operational costs) for VMMC teams to conduct both fixed and outreach-based VMMC services. VMMC services in Cluster 1, Zambezi and Khomas regions will also complement PEPFAR Namibia’s DREAMS programs in these SNUs.

Peace Corps will place health volunteers in high-burden priority districts in FY19, especially Kavango, Ohangwena, Oshikoto, and Zambezi. They will work under the auspices of MOHSS, Ministry of Education, community health facilities, and non-governmental organizations to support evidence-based prevent, care, support and treatment activities targeting OVCs, AGYW, boys and young men, as well as affected communities and caregivers.

Together, these decisions of geographic and priority populations will provide direct services and technical assistance to the highest burden regions and highest risk groups. The detailed design plans presented by PEPFAR Namibia in the COP18 SDS are to ensure Namibia is able to achieve 95-95-95 by 2020.

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

4.1 Finding the Missing, Getting Them on Treatment, and Retaining Them

HIV Case Finding

During the period of FY16 and 17, PEPFAR Namibia scaled-up high-yield targeted HIV testing activities, specifically the index partner testing approach. The proportion of HIV positive cases identified through index partner testing rapidly increased from 5% in Q1 of FY16 to 23.0% in Q4 of FY17. PEPFAR Namibia also made a strategic decision to scale-down support for low yield and less efficient HIV testing strategies, such as community-based door-to-door testing during FY18. Furthermore, special multi-disease screening activities were implemented in selected high volume hospital out-patient departments (OPDs) as well as through mobile outreach services to serve as a platform to increase HIV case finding among men (the “surge strategy”).

The methodological shift in HIV case finding resulted in a significant increase of HTS_POS reported from almost all priority SNUs and population groups. HIV case finding among adult men and women age 25-49 years increased by 30% and among AGYW and young men age 15-24 years it increased by 20%. The “surge strategy” alone increased the uptake of HTS among adult men by 35% within selected hospitals, compared to routine provider-initiated testing and counseling (PITC) reports. Overall, in FY17, the number of HIV positive cases identified at PEPFAR-supported sites was 170% more than those identified in FY16.

Based on the success of index partner testing in FY17 implementation, PEPFAR Namibia is scaling up this modality among all partners. Our target is to identify at least 30% of all new HIV diagnoses through the use of index partner testing in COP18. PEPFAR Namibia also will support optimization of PITC among ANC/sexually transmitted infection (STI)/family planning attendees, persons with presumptive TB, and in-patient hospital wards. PEPFAR will continue to support targeted testing campaigns to reach adult men through multi-disease screening activities at OPDs and targeted workplace testing events. PEPFAR will support HIV self-testing (HIVST) as an integral part of index partner testing (see section 4.3). Once cases are identified, ART will be initiated immediately through comprehensive implementation of "Same-day ART Policy" which also includes use of ART starter packs for remotely located communities.

PEPFAR Namibia will support 177 of the 367 GRN sites that offer testing during COP18, 95% of which will be located in scale-up saturation SNUs. No HIV testing targets will be set for centrally supported and attained SNUs. PEPFAR supports these SNUs in the form of technical assistance and provision of limited HRH. In COP18, PEPFAR also will support implementation of HIV recency testing among newly diagnosed clients to guide program focus.

PEPFAR will invest in important program enablers, such as health worker standard operating procedures (SOP) training; advocacy to reduce stigma and discrimination at the national and community levels; promoting the rights and voices of marginalized groups; strengthening partner management; and, improving data management and reporting. PEPFAR will support continuous quality monitoring and data quality assurance (QA) activities for HIV case finding. In addition, PEPFAR will support implementation of quality management programs to maintain high levels of linkage to ART and reduce specific patient-level barriers for linkage to ART for different high risk populations, such as MSM, FSW, and TG women. Partners will be encouraged to scale-up best practices documented by Development Aid People to People (DAPP), which entails individualized community-based tracking and follow-up of newly diagnosed PLHIV. This resulted in 80% timely linkage to ART (i.e., within 4 weeks).

Getting PLHIV on Treatment and Retaining Them

NAMPHIA data indicate that approximately 86% of all PLHIV in Namibia know their HIV status and 83% of all PLHIV are on ART. These data also show that 77% of all PLHIV are virally suppressed. The GRN has a vision of ensuring that 95% of all PLHIV will know their status by end of FY19. The plan also is to ensure that 90% of all PLHIV will be on ART and 86% of all PLHIV will be virally suppressed by end of FY19.

In order to achieve the targets described above, PEPFAR Namibia will augment existing strategies to ensure PLHIV are initiated and retained on ART. Many of the other strategies will apply to all populations while a few population-specific strategies will ensure that all population groups achieve saturation by end of FY19. These overall and population-specific strategies are described below.

Overall Treatment and Retention Strategies for All Populations

Namibia is highly successful in both linkage and retention. However, one of the key threats Namibia faces is the shortage of skilled health care workers employed in the public health facilities to provide ART services. PEPFAR Namibia's largest COP18 investment therefore will be directed at maintaining the HRH support at high volume ART sites and the roving staff at lower volume sites, and filling critical HRH gaps. To ensure sustainability of the HR support to ART services and reduce dependency on expatriate staff, resources will be provided for in-service training of newly graduated Namibia health workforce. On-site mentorship by clinical and nurse mentors will continue to be supported to ensure site level capacity building to assure high quality ART services are provided. Quality improvement collaborates will be implemented in lower performing sites to improve specific program outcomes.

Transitioning to Tenofovir/Lamivudine/Dolutegravir (TLD) will assist in retaining people on ART, and differentiated and decentralized care will be scaled up to improve access to ART initiation and retention in care (see section 4.3).

Other system level strategies (see Table 6) in scaling up treatment include:

- Provide support for laboratory sample referral and specimen transportation systems from decentralized HIV delivery sites to the Namibia Institute of Pathology Laboratory hubs;
- Continue to support GRN plans for a long-term HRH strategy initiated in COP17, such as the implementation of the National Health Workforce Accounts (NHWA) and the institutionalization of Human Capital Management System (HCMS) databases, which will help manage the human resources (HR) even distribution of staffing and tracking of HR training and needs;
- Deliver technical support to the MOHSS Pharmaceutical Services section and central medical stores (CMS) to conduct mentoring, provide supportive supervision, and utilize information systems to reduce stock outs. Assistance to pharmacy workforce on the Tenofovir/Lamivudine/Dolutegravir (TLD) transition;
- Allocate specialist supply chain management personnel to support CMS in the delivery of HIV supply chain management services, in close coordination with the GF's inputs to the CMS turnaround strategy;
- Continue implementation of facility electronic stock cards to reduce stock-outs and product rationing at decentralized sites.

Specific Case Finding and Retention Strategies for Children 0-14 Years

In FY17, PEPFAR supported the GRN in pediatric case finding and ART treatment services. NAMPHIA data show that approximately 9,000 children are living with HIV in Namibia, lower than the 14,700 in previous estimates. In FY17, 801 pediatric HIV cases were identified and initiated on ART. Testing among HIV exposed infants (EID) was 70% within two months and increased to 90% by one year of infant's age. PITC was expanded to increase testing among pediatric in- and out-patients. Initially, the rollout of nurse-initiated and managed antiretroviral treatment (NIMART) and differentiated ART service delivery efforts were limited to adults, resulting in limited availability of pediatric services beyond main ART clinics.

The FY 17 (Q1-Q4) program performance showed 95% (10,340 of 10,952) ART coverage among children in most SNU's and a 76% viral load (VL) suppression rate. Despite the high ART coverage, challenges in pediatric treatment services include lower levels of VL suppression than in adults, the need for improved linkages between pediatric treatment services and OVC programs, limited decentralization due to lack of confidence among nurses in pediatric ART at lower level health facilities, and the need to strengthen/expand targeted PITC for children. Compared to adults, pediatric clients have lower adherence and retention rates, higher loss to follow-up, and service quality remains a key challenge. Furthermore, while the National Guidelines for ART (2016) include differentiated service models for adults, children are not included.

During COP18, PEPFAR Namibia will continue to support pediatric HIV case identification and ART initiation in all supported SNUs to achieve 100% coverage of pediatric treatment and improve the quality of pediatric treatment services through the following:

- Expand PMTCT electronic system for cohort monitoring of HIV-exposed infants (HEIs) and testing of mothers during breastfeeding;
- Expand targeted testing strategies for children at routine immunization visits and among those needing nutrition counseling;
- Ensure all children of HIV infected adults are tested (family tree approach in ART, PMTCT, and FSW programs);
- Accelerate pediatric ART decentralization;
- Ensure optimal pediatric fixed dose combinations formulations are available;
- Increase training on timely disclosure (include guardians/treatment supporters in final disclosure process);
- Standardize and expand access to teen clubs (starts at age ten with disclosure);
- Integrate and implement differentiated care models for children (e.g. family-centered ART care, community-based ART program (CBART), and linkage to OVC programs);
- Provide mentorship and targeted training in pediatric HIV prevention, care, and treatment;
- Expand quality improvement/retention activities to include pediatric services.

Specific Strategies for Young Girls and Young Men Aged 15-24 Years

Program data show that proportionally the lowest treatment coverage rate is among young women and men aged 15-24 years, with 61% of all PLHIV in this age group currently on ART. Furthermore this age group has the lowest retention and viral load suppression rates (65.4% for young women and 60.7% for young men according to NAMPHIA data).

The biggest bottleneck to increasing treatment coverage in this age group is the low knowledge of HIV status. PEPFAR Namibia will continue to increase routine screening for adolescents and young adults in the OVC program to identify high risk adolescents and young people. PEPFAR Namibia will expand youth-friendly clinical services, including the provision of targeted support through peer educators and expert patients (Community Adolescent Treatment Supporters-model). Services will continue to increase decentralization to ensure improved ART access and retention in this age group. For both sexes, the use of starter packs will increase rates of linkage by providing same day initiation and active linkage to treatment.

Strategies targeted to young women will include increasing efficient case finding strategies by targeting family planning and STI clinics to increase testing from these sites. We will also expand index partner testing among men age 20-39, the age group that is known to be the sexual partners of women 15-24 years of age. For young women who are pregnant, retention in PMTCT and continued testing throughout the breastfeeding period will be achieved with active tracking via the P-tracker tool and the scale-up of 'mentor mothers' in clinics with the greatest retention

challenges. By targeting pregnant young women we will increase linkages back into the OVC program for the at risk young mother and her newborn creating better linkages for her as a learner mother and linking her to the complete social grant package.

In COP 18, young men will be targeted for testing via VMMC and active engagement as the partners of AGYW. In addition, increased screening at STI clinics will target high risk young men.

Specific Strategies for Older Young Women and Men Aged 25 – 35 Years

Although ART coverage estimates show higher ART coverage, in general, for older women and men, there remains a major gap in adults under 35 years of age. Again, the biggest bottleneck to ART is low knowledge of HIV status. Data show that for those who know their ART status, more than 90% are successfully linked to ART. Increasing ART coverage in this age group will be driven by improved and increased HIV case finding through testing. ART will be initiated immediately through ART starter packs at testing service points that include OPDs, in-patient wards, and community testing points.

Retention will be strengthened through the expanded implementation of differentiated models of care, which will include the expansion of facility and community adherence clubs (see section 4.3).

Specific Strategies for Adult Women: Preventing Mother-to-Child Transmission (PMTCT)

According to the 2016 HIV sentinel surveillance, HIV prevalence in pregnant women was 17.2% (8.5% in 15-24 year olds, 24% in 25-49 year olds). HIV prevalence ranged from 5.2% to 32.9% across districts. In FY17, HIV testing and ART coverage among pregnant women in ANC settings was 98% for both. The main challenges in Namibia include lack of a robust M&E system to measure retention and conduct cohort analysis in maternal and child health (MCH) settings. While maintaining support for PMTCT interventions for case identification and same day ART initiation, in FY19, PEPFAR Namibia also will focus on interventions to increase and measure adherence, retention, and VL suppression among pregnant and breastfeeding women. Support will include:

- Routinely offering PITC in MCH settings for pregnant and breastfeeding women (re-testing during pregnancy and after delivery; at 6 weeks; and every 6 months until cessation of breastfeeding);
- Implementing same day ART initiation for HIV positive pregnant and breastfeeding women;
- Conducting systematic follow-up and care of mother-infant pairs using facility and community-based systems;
- Mentoring and targeted training of health workers in PMTCT/EID, including ART initiation, management, and maternal viral load monitoring;
- Targeting information, education, and communication (IEC) to promote adherence, retention, and VL suppression in PMTCT program;
- Strengthening partner testing through index partner testing;

- Expanding implementation of PMTCT electronic M&E system to enable cohort monitoring and analysis to measure final outcomes;
- Implementing QA systems for PMTCT within the MOHSS QA activities and conducting regular program and data reviews.

Specific Strategies for TB/HIV Co-Infected Populations

Program data shows that the rate of TB patients with a documented HIV status has improved to 98% and 94% of HIV infected TB patients initiating ART. However, FY17 program data demonstrated that only 35% of PLHIV were screened for TB, of which 9% initiated TPT, and 44% of those who initiated completed TPT. COP18 will focus on identifying initiating and supporting full completion of TPT in eligible PLHIV. Another strategy is to offer HTS to TB presumptive cases, using a two-pronged approach, with the goal of increasing HIV testing in individuals with symptoms consistent with TB, while also strengthening and integrating TB screening into existing HTS approaches.

The scaling up of interventions to maximize TB_STAT, TB_ART, TB_PREV, TX_TB, as well as HTS for TB presumptive is critical to prevent TB-related mortality. COP18 will support strengthening of TB/HIV collaborative activities focusing on:

- Attaining high TB screening coverage in PLHIV, including TPT initiation and completion;
- Providing TA to maintain high coverage of HIV testing and ART initiation for TB patients;
- Improving TB/HIV data capture, recording, and reporting through intensified supervision, mentoring, training, updating of reporting tools, and development of SOPs;
- Intensifying health care worker (HCW) training and mentoring through Project ECHO, as well as other dedicated didactic training sessions;
- Supporting reporting and screening matrixes for HIV testing for TB presumptive clients, including children and direct contacts and family members of confirmed TB clients;
- Integrating TB and HIV services to improve linkages to care, to maximize efficiency of service provision, and to improve treatment adherence and retention;
- Prioritizing HCW screening for TB and linking HCWs positive for TB or HIV to care;
- Supporting minor facility modifications and infection control improvements;
- Supporting TA for the ongoing TB DPS and adding new TB drugs into the essential medicine list.

4.2 Prevention, Specifically Detailing Programs for Priority Programming

HIV Prevention and Risk Avoidance for AGYW and OVC

PEPFAR-supported OVC activities are implemented in partnership with the Ministry of Gender Equality and Child Welfare, MOHSS, and Ministry of Education and align to geographic areas of the highest HIV burden and greatest unmet ART needs for children and adult populations. The activities ensure that OVC and their caregivers receive PEPFAR assistance, in addition to national strategies for support.

PEPFAR Namibia will implement the OVC program within four SNU's (see Table 4.6.4, page 45). OVC targets increased from 35,460 to 36,081, and the overall COP18 OVC targets include increases to account for AGYW within DREAMS districts. In Q4 of COP16, the OVC program reached 23,718 persons, compared to its target of 18,700. Of those reached, 13,198 were OVC under 18. The ambitious increase in targets from 18,700 in COP16 to 36,081 in COP18 is as a result of need to intensify reach to OVC in the HIV-burdened geographic sites to reach them with HIV services. In COP18, PEPFAR will coordinate with GRN to screen and register children for the OVC program. PEPFAR will continue to implement and strengthen the index (HIV infected) client-based household recruitment process. The OVC program will also increase the number of HIV infected OVC aged 10-17 reached by working collaboratively with clinics to identify HIV infected children using the electronic dispensing tool (EDT) list and then offering family enrollment into the OVC program. This will provide the psychosocial and family support these children need, in addition to the clinical care provided by health facilities. The program will also work with local Namibian HIV support groups and networks at implementing sites to identify children of support group members and at-risk children and link them to testing and treatment services.

For at-risk and/or HIV+ AGYW and OVC, PEPFAR Namibia will support adolescent-friendly sexual and reproductive health services and ensure that OVC aged 14-17 have access to a comprehensive package of prevention and treatment services. We will implement risk reduction activities for 9-14 year olds, violence risk assessments and support disclosure and reporting experiences of violence at home and school. Parenting programs focusing on decreasing violence against children and promoting positive parenting to reduce adolescent HIV risk behaviors will also be implemented.

PEPFAR Namibia will continue to support case management, as well as tools and training to strengthen layering to address comprehensive needs of children, caregivers, and/or families. Recognizing that the needs of children, caregivers, and/or families vary at different stages of life, PEPFAR Namibia's needs-based approach includes an assessment at enrollment and then quarterly assessments to determine the types of support needed, which include:

- Strengthening linkages to socio-economic support through household savings schemes;
- Cash transfers and income-generating projects;
- Improving access to social welfare grants;
- Supporting birth registration;
- Education support;
- Parenting programs; and
- Targeted support to keep at-risk AGYW and OVC in school.

PEPFAR Namibia will continue to provide capacity building to the GRN and local Namibian CSOs around OVC in COP18. PEPFAR Namibia will continue to provide technical assistance to the GRN on social welfare grants, development of a standardized case management system, social welfare training and service networks and M&E systems, data availability and utilization.

OVC activities are implemented to align to the Child Care and Protection Act (not yet in force), the National Agenda for Children (under revision), and the NSF. Through OVC activities, children with HIV and their care providers will be linked and referred to HTS, prevention, pediatric care, treatment, nutritional support, education, household economic strengthening, and psychosocial support.

To keep AGYW HIV negative, PEPFAR Namibia will support implementation of a layered DREAMS-like core package of services in select districts, including HIV and GBV prevention, provision of post-GBV care, age-appropriate condom promotion, and provision of PrEP to those at risk. Interventions also will include adolescent-friendly sexual and reproductive health (SRH) services and partner notification referral to HTS or ART. Through the DREAMS program, PEPFAR will strategically focus on risk avoidance activities for 9-14 year old girls and risk reduction for 15-24 year old girls. In COP18, DREAMS-like activities will reach scale and expansion will be possible for key activities, such as increasing reach for Families Matter!, introducing targeted evidence-based GBV prevention programming, and further expanding PrEP. For boys and young men, PEPFAR Namibia will continue to scale-up VMMC.

Children

Mother-to-Child Transmission (MTCT) of HIV remains the main mode of infection in children, and an effective PMTCT program is critical to prevent new HIV infections in this age group. In PEPFAR supported sites in FY 17, 11,967 infants were born to HIV infected mothers. Of these, 98% of mothers received ART, almost 100% of children received ARV prophylaxis, and 90% were tested for HIV by 12 months of age. The program data in FY17 estimates a MTCT of 2% at six weeks, increasing to 4% during the breastfeeding period [REDACTED]. According to DHS 2013, 10% of males and 5% of females are sexually active by the age of 15 (DHS2013). Approximately 49% of children are exclusively breastfed for the first six months of life (DHS 2013). Challenges to prevent HIV infections in children include: continued high HIV prevalence among pregnant women, new maternal infections during pregnancy and breastfeeding periods, and low rates of exclusive breastfeeding among HIV + mothers. Many children in Namibia are at risk of physical and sexual abuse.

In FY19, PEPFAR Namibia will continue supporting PMTCT and ART activities aimed at the following: 1) prevention of infections among reproductive age groups; 2) case finding, timely ART initiation, cohort monitoring, and monitoring VL suppression in pregnant and breastfeeding women; and, 3) provision of effective infant ARV prophylaxis, cohort monitoring, and timely/regular HIV tests for children identified to be at risk. In addition, promotion of HIV prevention interventions for older children will be integrated into HTS, DREAMS, OVC, PMTCT, and Adult ART programs.

In FY19, 95% (10,901) of all infants born to HIV positive mothers in PEPFAR-supported areas will be tested for HIV. Of these, 80% will be tested within two months and increasing to 95% by 12

months of infant's age. Additionally, 13,165 older children will be tested through other testing modalities. All identified HIV positive children will be linked to ART in line with same day initiation and ART decentralization policies.

Key Populations

In FY17 programmatic data revealed that although FSW and MSM are reached with HIV prevention messages through interpersonal communication, referral to testing and linkage to care for those who have been diagnosed remained a challenge (only 33% of all KPs diagnosed with HIV were on treatment). Moreover, the gap is even larger for transgender females. This highlights the gaps in reach and access to services by key populations in Namibia.

By the end of Q1 FY18, PEPFAR Namibia increased case finding strategies and linkage to care among key populations. Linkage to care increased from 33% at the end of Fy17 to 79% in Q1 FY18. This is a direct result of focused and intensified peer education and referral during implementation of the Priorities for Local AIDS Control Efforts (PLACE) study. Formative assessment and dialogue during the PLACE study implementation facilitated optimized targeting of high risk individuals and development of a clear referral pathway.

In FY19, PEPFAR Namibia will support programmatic intervention to expand high quality HIV prevention services for key populations in seven districts (Walvis Bay, Katima Mulilo, Oshikango, Oshakati, Keetmanshoop, and Windhoek). Deliberate effort will be made to reach MSM and TG females who continue to lag behind. Programmatic intervention will include increasing the number and training of peer educator and case workers to reach hidden sub-groups among KPs. TG females and MSM peer educators will be trained and deployed to become agents to reach their peers and link them to clinical services at KP-friendly facilities. Specifically, for TG females and MSM, PEPFAR will adopt the enhanced peer outreach approach (EPOA). EPOA has been proven to increase reach, testing, and linkage among key populations. In FY19, EPOA will be implemented in districts that continue to have low linkage to treatment among TG females and MSM. Additional support will be provided to support violence prevention among KPs. Individuals reached during community outreach will be offered HTS. When not feasible, such as during moonlight sessions, HIVST kits will be distributed. Referrals will be facilitated for additional clinical services such as family planning, STI screening, and treatment. All individuals reached will be enrolled into case management, where active referral for PrEP will be facilitated for individuals who are eligible.

To strengthen linkage to care and minimize missed opportunities for treatment, PEPFAR will collaborate with MOHSS and designated health facilities to support same-day ART initiation during outreach programs and moonlight sessions. Where HTS services are not available, outreach activities also will support the distribution of HIVST.

In FY19, PEPFAR Namibia will continue to support CSOs from the LGBTI community. The CSOs will lead the HIV response to increase treatment coverage among KPs through facilitating peer education, peer outreach, and referral to care and treatment. Programmatic work with KPs will

be a focus area for increasing the number and quality of local Namibian organizations funded as implementing partners.

VMMC

To reach men with HIV prevention services, PEPFAR Namibia will support the MOHSS to increase coverage and uptake of VMMC services in priority districts. As a result of PEPFAR support to the MOHSS, national VMMC coverage among young men aged 15-29 years old increased 20% between 2016 and 2017 (29%-35%). By the end of FY18, the national VMMC coverage among 15-29 years old (the priority age group) will be 47%. The greatest increase in coverage will be achieved in districts where PEPFAR supports direct service delivery of VMMC services. These include Windhoek (Khomas region 77%), Katima Mulilo (Zambezi Region 75%), Oshakati (Oshana region 69%), Swakopmund and Walvis Bay (Erongo region 65%) (DMPPT, Version 2.0, 2018).

To improve national VMMC coverage, PEPFAR Namibia will support the MOHSS to expand services in SNUs that were previously supported by the GF. These include districts in Cluster 1: Oshakati, Engela, Omuthiya, Onandjokwe, and Tsumeb. PEPFAR Namibia will support nurses, clinical officers and data clerks to expand VMMC programs in these districts. By the end of FY19, 17,414 circumcisions will be provided in these districts. PEPFAR Namibia's expansion of VMMC services in Cluster 1 SNU is to fill the gaps as a result of the GFATM fund reduction to Namibia and is consistent with the requirements of Namibia's COP18 funding letter. Targets in the new scale-up districts are: Omuthiya 2,438, Onandjokwe 2,438, Eenana 3,000, and Tsumeb 1,219. Overall the OU target for FY19 will be 54,308, representing a 25% increase in target from FY18. Within the Cluster 1 districts, the VMMC program will complement PEPFAR Namibia's DREAMS program in the region. As part of the comprehensive package of services for DREAMS, young men will be referred for VMMC.

PEPFAR Namibia will support demand creation targeting young men aged 15-29 years, particularly through work with Namibian institutions. These include: public messaging, peer promotion by recently circumcised men, improving facility setup to increase privacy, community mobilization, and engagement of female partners.

PEPFAR Namibia also will support quality management (QM) and QA in FY19. QA/QM activities will focus on formation of VMMC Continuous Quality Assurance teams at service delivery sites to ensure continuous quality improvement safety of clients, health workers, and the community.

Further consultation is underway for the VMMC National Guidelines to shift from the forceps guided technique to the dorsal slit procedure to reduce the risk of adverse events. All new VMMC services providers will be trained on the dorsal slit method and refresher training of existing cadres will continue in FY19. PEPFAR Namibia will monitor strict adherence to non-usage of forceps guided technique in boys under the age of 15 or those with immature penile anatomy.

In FY19, PEPFAR Namibia will support the field validation of the Shang Ring device. Results from this evaluation will inform and guide future scale-up of the non-surgical device circumcision procedure to minimize adverse events and expand the options available to clients and clinicians.

PrEP

MOHSS adopted the use of PrEP in its National Guidelines in 2016. PEPFAR Namibia supported the registration of tenofovir disoproxil fumarate (Ricovir-M) by the Namibia Pharmaceutical Regulatory board and implementation of demonstration projects of PrEP for key populations. In FY18, implementation of PrEP has expanded to include all individuals who are at substantial risk of acquiring HIV in line with the national guidelines.

In COP18, PEPFAR Namibia will scale up PrEP, primarily through local Namibian organizations, among high risk AGYW at STI clinics, ANCs, and SRH clinic and other high risk individuals, consistent with the National Guidelines. Active referral for PrEP will be supported through case management for key populations. Overall 4,760 people will be enrolled on PrEP in FY19 (1,167 AGYW and 638 key populations). Although the KP program reaches other high risk men, such as truck drivers and seafarers, the target for PrEP among KP is set to reach only the high risk FSW, MSM and TG females who exhibit vulnerability (such as low condom use with clients and substance use). PEPFAR will support the development of PrEP manuals, M&E systems and promotional materials, as well as community mobilization to dispel misconceptions around PrEP. Other support includes health workers training and context specific workflow re-orientation at facilities to ensure easy access to PrEP by clients.

PEPFAR Namibia also will support the implementation of an operations research to gather insights from Namibia's national PrEP expansion. Results from this research will generate practical knowledge and skills through implementation to support adherence, especially for AGYW and TG people.

4.3 Additional Country-Specific Priorities Listed in the Planning Level Letter

Same Day Initiation

Linkage to ART remained above 90% during FY16 and 17. This was achieved largely due to the "Treat All" and "Same-day ART" policies implemented by the MOHSS. PEPFAR Namibia will strengthen its support for 100% linkage and same day ART initiation of all 29,329 newly diagnosed PLHIV by end of FY19, and prioritize continued monitoring of time-to-initiation among all implementing partners, particularly in Windhoek and Nankudu districts through regular review of site level performance data by implementing partner, age and sex.

A deeper analysis of time-to-ART initiation reveals that 60% of newly diagnosed PLHIV are initiated within the first week of HIV diagnosis. Another 25-30% of patients were initiated on ART within 7-30 days after diagnosis. In COP18, PEPFAR Namibia will support efforts to increase the proportion of PLHIV who are initiated on the same day of HIV diagnosis through health worker training on the need for routine patient escort between testing and treatment sites and improved documentation of unique ART numbers. Every case identified will be monitored

monthly and implementing partners will receive quarterly feedback. Partners doing community-based testing will be provided with starter packs to give to newly identified positives, while linking these patients to the closest ART site.

Community-Based ART

PEPFAR has supported implementation of successful community-based ART delivery models in Namibia since 2007. In COP18, PEPFAR will support the scale-up of various models including client-led community adherence clubs and groups (CACs & CASGs) to increase ART self-management. Current evaluations of CBART and CAC models will provide valuable insight for expanding them to more districts and populations, such as for KPs, men, and adolescents. SOPs and monitoring tools will be finalized by the end of FY18.

PEPFAR Namibia will support the decentralization of HIV treatment services to communities through two approaches: 1) Active linkages and providing starter packs to newly diagnosed patients through community-based health workers and provider-led outreach services; and 2) Empowering and engaging community health workers, such as expert patients, adherence clubs, and support groups to assist in managing stable patients through the delivery of medicines, the provision of social support and education, and ensuring linkages to clinics for severe cases.

Human Resources for Health (HRH)

MOHSS issued a circular in 2017 that stated the hiring of local staff should be prioritized over the renewal of foreign national and retiring staff contracts. As a major component of our sustainability work to ensure the government is fully prepared to maintain epidemic control in the near-term, in COP18, PEPFAR Namibia will support internships to increase the experience of newly graduated staff (doctors, nurses and pharmacists) in the field of HIV. PEPFAR Namibia will continue to support GRN plans for a long-term HRH strategy initiated in COP17, such as the implementation of the NHWA and institutionalization of HCMS, which will provide critical information to improve the management of HR supply, distribution of staff, and tracking of HR training and needs. These activities will allow clear data-driven planning for HRH and assure the assignment of staff to areas with the greatest need and HRH gaps. In addition, PEPFAR will also continue salary support for critical positions (nurses, doctors, pharmacists, pharmacist assistants, data clerks, health assistants (HIV testers) and other community-based cadres) including those formerly supported under the expired GF grants.

In COP16, PEPFAR Namibia conducted analyses of the HRH gaps at PEPFAR supported sites that were needed to scale-up the treatment coverage. In COP16 through the Treatment Acceleration Plan (TAP) and COP funding we provided salary support for a total of 1,243 health and lay workers (see Table 4.3.1). Health workers included 31 medical officers and clinical mentors, 65 registered nurses, 45 enrolled nurses, 6 pharmacists, and 30 pharmacist assistants.

In COP17 implementation, PEPFAR Namibia is currently supporting the MOHSS staffing gaps through continued support of TAP and COP17 Performance Funds. PEPFAR Namibia is providing

salary support for a total of 1,373 care providers (260 health and 1,166 lay workers). The health cadres include 23 medical officers and clinical mentors, 134 registered nurses and nurse mentors, 52 enrolled nurses, 11 pharmacists, and 41 pharmacist assistants.

During the current COP implementation (COP17), PEPFAR Namibia is picking up an additional 48 critical GF positions (CDC 33 and USAID 15), including 14 medical officers, 2 nurse mentors, 8 registered nurses, 5 enrolled nurses, 3 pharmacists, 3 pharmacist assistants, and 14 data clerks and M&E officers. Some of PEPFAR Namibia's existing funds and an additional investment outside of COP17 were identified to pay the salaries for these GF positions for the period of March 1, 2018 to September 30, 2018. In COP18, PEPFAR Namibia will continue HRH support for a total of 1,457 (311 health and 1,146 lay workers) at clinical sites and non-clinical work with OVC to achieve 95-95-95 targets. In comparison with COP17, in COP18 there will be a net decrease of the absolute numbers of lay workers and non-clinical OVC services. The rationale for change in lay workers is due to team reoriented to the geographic focus for community-based implementing partners to avoid duplication.

Number of Health and Lay Workers Supported	COP16	COP17	COP18
Health	182	260	311
Lay*	1061	1,166	1,146
Total HR	1,243	1,426	1,457
*Lay workers include: non-clinical staff such as community counselors and testers, data clerks, social workers, management support staff, Adherence counselors, etc.			

HRH Investment: The PEPFAR Namibia team used the S/GAC Expenditure Analysis (FY17) to project the HRH cost in COP18, summarized in the table below.

COP Cycle	COP14	COP15	COP16	COP17*	COP18
Funding Sources	COP	COP	TAP + COP	TAP + COP	COP
Personnel Cost	\$9,826,356	\$8,919,455	\$15,477,869	\$15,477,869	\$16,763,167

* Estimated Expenditures in FY18

Self-Testing

In COP18, HIVST will be integrated into national practice. The initial phase of PEPFAR-supported implementation will target young people (15-24 years), adult men 25 years and older and key populations (MSM and FSWs). Testing will be offered at HIVST corners at OPDs in public health facilities, tertiary education institutions, mobile outreach, mines and other community settings, particularly men in informal settlements. PEPFAR Namibia will also scale-up self-testing as part of index partner testing. PEPFAR Namibia supports case workers, experienced peers and health care workers to distribute HIVST kits demonstrate use of kits to clients. The program will monitor HIVST uptake, yield and linkage to care through implementing partner reported HIVST monitoring, evaluation, and reporting (MER) indicators.

In FY19, results from the PLACE study will be used to explore existing networks of TG females. Through TG female-led CSOs, these networks will be used to reach TG females and distribute HIVST as an entry point to increase coverage of HTS among hardest to reach groups.

TB/HIV

The National TB Guidelines (2012), ART Guidelines (2016), and MOHSS HCW training curricula all include recommendations for TB preventative therapy (TPT), and isoniazid preventative therapy (IPT) registers, cards and stamps for documentation that TPT is being utilized. However, at the end of FY17, only 35% of patients on ART were reported as screened for TB, of which 9% initiated IPT and 44% of those completed the nine month course of isoniazid. In COP18, PEPFAR Namibia will support scale-up of interventions to improve TPT in ART settings by incorporating TB prevention activities into the existing quality improvement collaborative, Namibia Project on Retention of Patients on ART (NAMPROPA). Clinical and nurse mentors will also continue to support site-level monitoring, and in-service training of health care workers on TPT provision. PEPFAR Namibia also will support the revision of the National TB Guidelines, provide ongoing support for TB infection control activities, and support Project ECHO (an established telehealth network that supports the TB and HIV provider community in Namibia). PEPFAR Namibia also will support HRH at facility and community levels to ensure a proportion of staff members' time is dedicated to TPT activities. PEPFAR will continue to support MOHSS through technical assistance for TB, TB/HIV and M&E activities. System level investments include development of a TB/HIV training curriculum for providers and managers, programmatic management of drug-resistant TB, introducing new drugs to treat drug-resistant TB case, and ongoing support for the first TB prevalence survey in Namibia. The focus will be on supporting data cleaning, analysis and report writing of the survey findings, including HTS results. Findings will be used to assist with improving targeted TB/HIV interventions

VMMC

PEPFAR Namibia will continue to support scale up services to circumcise 54,308 men with particular focus on the 15-29 age group in high HIV burden priority regions using a mixed model of static and mobile sites. PEPFAR support will be expanded to the regions previously supported by GF, Omusati, Ohangwena and Oshikoto (which include the districts of Oshakati, Engela,

Eenhana, Omuthiya, Onandjokwe, and Tsumeb). Further consultation is underway for the VMMC National Guidelines to shift from the forceps guided circumcision to the dorsal slit procedure to reduce the risk of adverse events. Use of the dorsal slit procedure instead of forceps guided VMMC among young boys aged 10-14 years or older boys with immature penile anatomy will be strictly enforced and monitored to reduce risk of adverse events. Resources will be allocated to introduce and evaluate the innovative Shang Ring non-surgical device for circumcision to provide alternative choice of surgical methods and improve program efficiency and reduce chances of VMMC adverse events.

HIV Incidence Surveillance

PEPFAR Namibia will introduce HIV Recency Infection Surveillance for newly diagnosed PLHIV through the use of HIV rapid recency assay in five high-volume sites to allow identification of pockets of new HIV infections and provide targeted prevention interventions.

4.4 Commodities

To accelerate uptake of ART, Namibia will transition to TLD as a first line regimen for adults and adolescents newly initiating ART and those already on ART as of January 1, 2019. GF is expected to utilize its budget allotted for ARV procurement (\$3,000,000) to complement TLD procurement. In COP18, PEPFAR Namibia will support the procurement of 40,000 bottles to cover a period of three months.

In the previous year, Namibia experienced an inconsistent supply of HIV testing kits. In COP 18, PEPFAR Namibia has set aside resources for “stop-gap” or emergency procurement. The GRN is in the process of changing to a less expensive, but equally efficient testing algorithm expected to be in place by August. The significant cost savings achieved by this change will help ensure long term sustainability in the HIV commodities sector.

In COP 18, PEPFAR Namibia will support the procurement of 60,000 HIVST. PEPFAR Namibia will support the procurement of 29,750 VMMC surgical kits and reusable supplies to meet the ambitious VMMC target for COP18. While the overall data on HIV medicine fulfillment rates have improved, concerns remain regarding supply chain capacity gaps. PEPFAR Namibia will continue to provide above-site TA to improve the Namibian supply chain for HIV.

4.5 Collaboration, Integration, and Monitoring

A key area of collaboration, integration and monitoring for COP18 will be working with international implementing partners to increase the capacity of indigenous partners, and with indigenous partners on delivering high quality results. Approximately 48% of PEPFAR Namibia funds currently go to indigenous organizations, defined as local partner organizations that do not have external or international overhead costs. Throughout the implementation of COP 18, we will set PEPFAR Namibia up to deliver 75% of total program funding to indigenous organizations in

COP19 and 90% in COP20. This overall initiative will increase the capacity, expertise, and service quality of indigenous organizations; support the sustainability of the overall HIV/AIDS response; and, improve efficiencies through lower overhead costs. We will accomplish this objective through the following:

- Increasing the number of sub-grants to indigenous organizations to increase implementation responsibilities;
- Including capacity building and transition planning mandates in cooperative agreements with international partners to improve the ability of indigenous organizations to deliver quality services; and,
- Pursuing new agreements primarily through indigenous partners by using the PEPFAR waiver (HIV/AIDS Expedited Procurement Procedures, EPP) and/or limiting competition to local organizations, as legally appropriate.

In coordination with the GRN and other key donors/agencies, including the Global Fund, UN, U.S. Treasury, and World Bank, we will work with the GRN to determine the data needs and provide support for assessments and analyses needed to create and implement a sustainability plan for the national HIV response. Current work is ongoing in HRH planning and analysis, social contracting, efficiency technical assistance and studies, and a public health expenditure review, which should be completed in FY 2018. Results will inform the HIV/AIDS Sustainability Plan.

In coordination with other donors, we will review data, assessments, and capacity of the government's sustainability plan, which should be delivered in July 2018. PEPFAR Namibia will continue its strong history of working collaboratively across all agencies via active engagement, central to which are the bi-weekly (separate) executive and senior management meetings led by the PEPFAR Office to ensure coordination and open communication.

PEPFAR and its agencies are represented in the Health Development Partners group, a coordinating body led by WHO and comprised of multilateral and bilateral partners. External collaboration is strengthened through a strong presence on technical working groups within the MOHSS.

PEPFAR holds a seat on the GF Country Coordination Mechanism and directly collaborates and coordinates with the GF Portfolio Manager and Namibia Team in Geneva to assure alignment of priorities, activities and avoid duplication.

The Centers for Disease Control and Prevention (CDC) and the U.S. Agency for International Development (USAID) conduct active management of implementing mechanisms via in-person meeting with the partner, agency project officer, and respective technical advisors. A review is done of quarterly national and SNU performance against MER and custom indicators and an analysis of SNU and site-level data. The review also focuses on quarterly disbursements, accruals

and upcoming expenditures, and SIMS findings (where relevant). Feedback or technical direction is provided during these meetings.

Interagency IP feedback meetings improve site-level knowledge and share performance progress. Site-level monitoring is improving through active SIMS follow-up, written plans to address weaknesses and follow-up visits with all partners.

The use of Table 6 and the Funding Allocation to Strategy Tool (FAST) ensures that all above-site activities are mapped to key programmatic barriers and are designed to generate the necessary evidence to support or change programmatic activities.

4.6 Targets for Scale-Up Locations and Populations

ART - Entry Stream Target Setting Process and Assumptions

The total number of PLHIV in Namibia by end of FY19 is estimated at 243,803 using the UNAIDS Spectrum Estimates. For COP17, the PEPFAR Namibia treatment current target was 193,218 and the planned Tx_Curr target for COP18 is 218,945, while Tx_New is 26,875. In FY18 all PEPFAR-supported SNUs are classified as scale-up saturation and these are all anticipated to achieve attained status by end of FY19.

To achieve the FY19 Tx_New target of 26,875, it is assumed that a total of 23,058 new positives will be identified through the various facility and community-based targeted testing strategies; mainly index partner testing and provider-initiated testing and counseling. At least 90% of these newly identified positives are anticipated to be successfully linked to ART. It is also assumed that an additional 2,681 will be newly initiated on ART through the PMTCT program. Universal PITC is offered to TB cases with unknown HIV status, and in FY19 it is anticipated that 1,881 new and known HIV-positive TB cases will be on ART through the TB program. Lastly, about 1,344 previously diagnosed positives not yet on ART are expected to be initiated in FY19. Based on historical program data, the VMMC program does not yield a significant number of positives and no targets for Tx_New were set for VMMC.

In developing the COP18 treatment targets, PEPFAR Namibia is committed to ensure that all PEPFAR-supported SNUs, mostly in the high-burden northern regions of Namibia, will achieve attained status (i.e., saturation across all age, including 20-24 year olds, and sex bands) by the end of FY19. As previously noted, the largest treatment gap continues to be among males 30+ and youths aged 20-24 years and FY19 targets are calculated to reach saturation in all age/sex groups.

Regarding Tx_Current FY19 targets, the overall assumptions for retention on ART used for FY19 target calculation was 93% in year 1 of treatment and 95% in subsequent years of treatment. This is based on ARV refill data from the EDT. Retention estimates obtained from the electronic Patient Management System (ePMS) underestimate accurate retention due to delayed data entry

from patient care booklets into the ePMS, patients transiently receiving ART at other sites, and the effect of silent patient transfers. At each visit, health care providers capture patient follow-up information in paper-based patient care booklets. Data entry clerks transcribe this information and enter the data into the ePMS, including the date of the next appointment. However, many of the sites have a large data entry backlog resulting in under reporting of retention within the electronic patient management systems. The EDT captures ARV refill data and the data are entered into this system every time a patient picks up their ARVs, which provides a more accurate estimate.

Given the mobility of PLHIV in the northern regions and the fact that people seek HIV services across district lines, two major clusters were created for PEPFAR programming for those districts targeted to achieve “attained” status by end of FY19, combining contiguous regions as follows:

- **Namibia Cluster 1** combining all districts within four regions (Oshana, Oshikoto, Omusati and Ohangwena)
- **Kavango East –West Cluster** combining all of the districts within two regions (Kavango East and Kavango West)

These two major clusters, combined with 11 additional standalone districts -- Windhoek, Katima Mulilo, Walvis Bay, Swakopmund, Otjiwarongo, Luderitz, Gobabis, Opuwo, Grootfontein, Okahandja and Keetmanshoop --constitute the geographic areas targeted for attainment by end of FY19. These geographic areas will collectively contribute 100% of the total 218,945 FY19 treatment current target. Similarly, these districts will contribute 100% of the 26,875 FY19 PEPFAR TX_NEW targets, which demonstrates PEPFAR Namibia’s continued focus on the geographic areas with the greatest burden and need.

PMTCT- Entry Stream Target Setting Process and Assumptions

In FY19, PEPFAR-supported sites will provide ANC services to 75,317 pregnant women and 95% (71,551) will receive HIV tests, including 62,924 newly tested for HIV and 8,627 known HIV positive at entry at ANC settings. Approximately 11,475 (2,848 new) HIV infected pregnant women will be identified representing about 16% of all pregnant women. The 2016 HIV National Sentinel Survey reported that >63% of HIV infected pregnant women were already receiving ART and FY17 data showed 75% receiving ART. PEPFAR Namibia will target 2,681 of the identified HIV infected pregnant women for new ART initiation. In total, 10,901 (8,220 already on ART) HIV infected pregnant women will receive ART in PEPFAR supported sites in FY19. Achieving these targets will enable the country to achieve ≥95% of HIV infected pregnant women receiving ART.

Children 0-14 years - Entry Stream Target Setting Process and Assumptions

In FY19, 95% (10,901) of all infants born to HIV positive mothers in PEPFAR-supported areas will be tested for HIV. Of these, 80% will be tested within two months and increasing to 95% by 12 months of infant’s age. Applying the FY17 yield of 2.2%, 239 HEIs will be HIV infected and 95% (227) will be initiated on ART. Through other targeted pediatric testing modalities, 13,647 will be

tested for HIV and estimated 363 will be identified HIV positive. Of these, 90% (324) will be initiated on ART leading to a total of 551 children (0-14 years) newly initiated on ART in FY19 [REDACTED]. In FY19 there will be 10,340 children living with HIV and PEPFAR Namibia's treatment current target is 10,032. With PEPFAR support to achieve these targets, the country will attain $\geq 95\%$ of children living with HIV receiving ART.

HTS - Entry Stream Target Setting Process and Assumptions

COP18 targets for HTS_TST and HTS_POS are indicated in Table 4.6.1. Column 3 shows the number of expected PLHIV to be newly initiated on ART, which is estimated at 26,875. To achieve this, it is assumed that a total of 26,667 new HIV positives (adult and children) will be identified through the various facility and community-based targeted testing strategies with an estimated 95% linkage rate to ART. Close to 90% (23,050) of these clients are expected to be identified through various HIV testing modalities implemented both in the health facility as well as community. It is estimated that an additional 2,681 will be newly identified through the ANC/PMTCT program, and 178 will be identified through new diagnosis of HIV in TB patients. Screening for HIV in presumptive TB patients also will be widely scaled up throughout PEPFAR supported SNU during COP18 as an additional source of new HIV diagnoses. It's expected that about 5-7% (about 1,625) of the total newly initiated patients on ART during COP18 will have been previously diagnosed but not put on ART.

Building on our success during Annual Program Report 2016 and 2017, PEPFAR Namibia has set targets for HIV case identification using three main testing modalities, index partner testing, optimization of PITC at OPDs and in-patient PITC. Accordingly, an ambitious target of 8,664 (32.5%) of all 26,667 new HIV diagnosis among adults will be made using index partner testing. Through support to optimize PITC at OPDs, we expect to identify about 5,083 (about 20.0%) of HIV all positive cases. In-patient PITC will help identify about 3,111 (11.7%) of HIV positive cases. The remaining 3,102 (11.7%) and 3,062 (11.5%) will be identified using community-based PITC and facility-based voluntary counseling and testing implemented among priority population groups such as young people, AGYWs and key populations, respectively.

Entry Streams for ART Enrollment	Tested for HIV (APR FY19) <i>HTS_TST</i>	Newly Identified Positive (APR FY19) <i>HTS_TST_POS</i>	Newly Initiated on ART (APR FY 19) <i>TX_NEW</i>
Total Men	109,593	9,331	9,477
Total Women	258,036	16,734	16,847
Total Children (<15)	24,548	602	551

Adults			
TB Patients	4,298	178	169
Pregnant Women	62,924	2,848	2,681
VMMC clients	13,165	0	0
Key populations	8,775	1,083	856
Priority Populations	48,467	20,606	19,710
Other Testing	30,000	1,350	1,283
Previously diagnosed and/or in care	0	0	1,625
Pediatrics (<15)			
HIV Exposed Infants	10,901	239	227
Other pediatric testing	13,647	363	324
Previously diagnosed and/or in care	0	0	0

VMMC - Entry Stream Target Setting Process and Assumptions

In FY18, all PEPFAR-supported SNUs in Namibia are classified as scale-p saturation and are expected to transition to attained districts by the end of FY19. As with the plan in FY18, the estimated number of male circumcision clients who are HIV infected are assumed to be incorporated within the overall HTS POS estimates because the data pack does not generate a separate entry stream of positives from the VMMC program (see Other Testing category in Table 4.1.1).

In FY17, PEPFAR Namibia provided TA to the MOHSS to update the national VMMC targets using the Decision Makers Program Planning Tool (DMPPT Version 2.0) for all geographic areas based on FY17 annual program results. PEPFAR Namibia used the outputs from this tool, in addition to the data pack, as a basis for setting targets for FY19. Furthermore, given the discontinuation of the GF support in some districts, PEPFAR Namibia will be picking up service delivery support in some of those geographic areas in FY19.

With the exception of the Kavango East and West (44%) and the Namibia Cluster 1 (45%), VMMC coverage among 15-29 year olds in most PEPFAR-supported SNUs will be expected to approach 80% among 15-29 year males by end of FY19. The FY19 VMMC targets by SNU are shown in Table 4.6.2 and the aggregate PEPFAR target will increase from 43,603 in FY18 to 54,308 in FY19 reflecting a 25% increase in total targets. The increase in targets includes the expansion into geographic regions previously supported by GF, in line with guidance in Namibia's COP18 planning letter. The MOHSS VMMC policy recommends the inclusion of young boys aged 10-14 years as part of the VMMC program. While PEPFAR will provide support for services to this age group, the program will not set specific targets for the 10-14 age groups in FY19. This is consistent with the continued PEPFAR program focus on the priority 15-29 year age group.

With the anticipated achievement of saturation among 15-29 year olds in several PEPFAR supported SNUs by APR19, we anticipate continuing transitioning resources from saturated SNUs to Namibia Cluster 1 and the Kavango East-West Cluster in FY20.

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Attained Districts					
SNU	Target Populations [Specify age bands for focus]	Population Size Estimate	Current Coverage (Expected)	VMMC_CIRC	Expected Coverage
		(SNUs)	FY18	(in FY19)	(in FY19)
	Total/Average	419,678		54,308	
Namibia Cluster 1	Male Population, Age 15-29	134,640	32%	18,264	45%
Windhoek	Male Population, Age 15-29	113,450	58%	24,339	79%
Kavango East-West Cluster	Male Population, Age 15-29	34,793	44%	0	44%
Katima Mulilo	Male Population, Age 15-29	21,394	63%	3,742	80%
Walvis Bay	Male Population, Age 15-29	15,860	65%	2,457	80%
Swakopmund	Male Population, Age 15-29	21,790	67%	2,062	77%
Otjiwarongo	Male Population, Age 15-29	9,188	0%	0	0%
Luderitz	Male Population, Age 15-29	9,360	45%	3,444	80%
Gobabis	Male Population, Age 15-29	8,169	0%	0	0%
Opuwo	Male Population, Age 15-29	8,219	0%	0	0%
Grootfontein	Male Population, Age 15-29	5,162	0%	0	0%
Mariental	Male Population, Age 15-29	5,723	0%	0	0%
Rehoboth	Male Population, Age 15-29	5,800	0%	0	0%
Okahandja	Male Population, Age 15-29	3,628	0%	0	0%
Omaruru	Male Population, Age 15-29	3,559	0%	0	0%
Okakarara	Male Population, Age 15-29	3,375	0%	0	0%
Outjo	Male Population, Age 15-29	3,215	0%	0	0%
Keetmanshoop	Male Population, Age 15-29	5,563	0%	0	0%

Target Populations for Prevention Interventions

Reaching key populations is critical for sustainable HIV epidemic control in Namibia. PEPFAR Namibia set the COP18 targets for KP_PREV in the scale-up districts by taking into consideration the population size estimates from the 2013 IBBS. In addition, case workers in the program completed micro-mapping and size estimation activities, which helped set targets for this year. Size estimation from the 2013 IBBS will be updated in Windhoek using data from the PLACE study that was concluded in December 2017. National size estimates will be updated during the second round of IBBS to be implemented in FY18 and FY19. Overall, the COP18 targets align with the goal of reaching 90% of the estimated key populations in these areas.

Through a peer driven intervention, PEPFAR will reach key populations with an evidence-based comprehensive package of services for key populations. These include risk reduction and HIV prevention education, condom promotion, lubricant distribution, STI screening and treatment, as well as HTS, and linkage to care and treatment. In FY19, PEPFAR Namibia will expand the program reach among MSM and TG females using case workers and peers who come from within their community. This will support referrals for clinical services that include HTS, PrEP and ART.

Peer educator training in FY19 will include identifying, screening, and referral of children of FSW to OVC programs. The OVC program will provide a pathway through which these children will receive comprehensive support including knowing their HIV status and linkage to treatment.

Size estimation for KPs remains a challenge. The IBBS conducted in 2013 reported the number of FSW in Namibia to be around 8,082. The population of FSW in Windhoek was estimated at 1,800-3,400. Preliminary report from a PLACE study that was done in late 2017 estimates the population at about 3,594. The population of MSM is estimated to be much lower in Windhoek (1,033). However, program data shows that more FSWs are being reached in six major towns: Windhoek, Walvis Bay, Katima Mulilo, Oshakati, Keetmanshoop, and Oshikango. In FY17 APR, PEPFAR Namibia reached 8,464 FSW in these towns. The majority of the FSW reached may not be self-identifying during surveys.

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY18)	FY19 Target
FSW (KP_PREV)	*8,082	80%	10,986
MSM (KP_PREV)	N/A	80%	3,915
TG Women (KP_PREV)	N/A	80%	45
AGYW (PP_PREV)	**102,832	80% (Eligible high risk)	30,000

*IBBS 2013

**2018 Projected Population for girls 10-24 years old (Oshikoto, Zambezi and Khomas)

OVC and Pediatric - Entry Stream Target Setting Process and Assumptions

OVC targets include Children Living with HIV ages 0-15 and HIV-affected children (e.g., children of PLHIV including HEI). The target for OVC served is based on the estimated number of

orphans and vulnerable children from the 2018 Spectrum. An anticipated 80% of all OVC infected and affected by HIV in PEPFAR Namibia-supported locations will need specific HIV-related services within facilities and communities. These services include HTS, HIV prevention, psychosocial counseling, referrals to care and treatment, support for ART adherence, retention and HIV disclosure.

In COP18, PEPFAR Namibia will reach a total of 36,081 OVC in PEPFAR supported SNU, of which 10,434 will be in DREAMS-like locations/sites. Screening of OVC will be strengthened to ensure that 100% know their HIV status, to improve upon the 37% of OVC in FY 17 with unknown HIV status. 100% of OVC infected with HIV in PEPFAR Namibia-supported sites will be linked to treatment and have their viral load monitored.

SNU	Estimated # of Orphans and Vulnerable Children***	Target # of active OVC (FY19Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY19 Target) OVC*
Namibia Cluster 1	67,646	20,930	16,744
Windhoek	19,285	3,032	2,425
Kavango East-West Cluster	10,258	4,924	3,939
Katima Mulilo	6,527	7,196	5,757
TOTAL	103,716	36,082	28,865

*The target is 85% of all OVC_SERV knows their HIV Status

***Data from Spectrum 2018 on estimates of Orphans

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Population

5.1 COP18 Programmatic Priorities

In addition to programmatic priorities described in sections 4.1-4.4 for attained and sustained locations and populations, PEPFAR Namibia will implement comprehensive, wellness-based health care services that address a broad range of health needs of PLHIV on life-long treatment. The service packages include integrating health promotion and wellness for stable patients and data-driven, quality improvement methodologies to address gaps in the provision of high quality HIV services.

The age/sex ART gap analysis, using program and epidemiological estimates, reveals that, proportionally, the lowest ART coverage and viral load suppression outcomes are among young women and men in the 15-29 year age group. This is mainly due to the low percentage of this age group knowing their HIV status. The highest programmatic priority is to implement targeted strategies for HIV case identification and immediate linkage to ART for this age group. Key interventions include the use of HIVST; provider-initiated testing and counseling; index partner testing and models, such as the Community Adolescent Treatment Supporters; use of patient navigators (expert patients) to decrease the “no show” rate; and increased work through local Namibian implementing partners.

To ensure immediate ART initiation, these strategies will be linked with the issuance of ART starter packs at HIV testing service points, which PEPFAR Namibia will support delivery of in COP18. The issuance of ART starter packs will shorten the wait times for new patient first clinic visits and increase the likelihood of appointment completion using case managers and patient navigators. This intervention, coupled with case management intake and expert patient follow-up for new patients prior to their visit at the ART clinic is expected to increase linkage to care and treatment.

Age-specific and youth friendly adherence support groups (facility and community-based), combined with the introduction of new efficacious and better-tolerated dolutegravir-based regimens, will be used to enhance ART adherence, retention in care, and achievement of viral load suppression. In COP18, PEPFAR Namibia will continue supporting the MOHSS structures in implementing differentiated service delivery models that reduce clinical visits to every six months for stable patients and expands the decentralization of HIV treatment services to community levels.

PEPFAR Namibia will support the decentralization of HIV treatment services to communities through two approaches: 1) Active linkages and providing starter packs to newly diagnosed patients through community-based health workers and provider-led outreach services; and,

2) Empowering and engaging community health workers, such as expert patients, adherence clubs, and support groups to assist in managing stable patients through the delivery of medicines, the provision of social support and education, and ensuring linkages to clinics for severe cases.

PEPFAR Namibia will systematically monitor, assess and immediately resolve problems encountered by PLHIV on life-long treatment that limits their ability to adhere to their regimen and remain virally suppressed. PEPFAR Namibia, in collaboration with MOHSS and local Namibian CSOs, will ensure that the HIV services meet the HIV prevention and treatment needs of everyone, especially hard to reach populations. At attained and sustained locations, PEPFAR Namibia will update the electronic patient monitoring systems, strengthen strategic information for routine upward reporting of results, strengthen HIV response optimization and provide technical support to improve efficiencies in supply chain management that will eventually sustain epidemic control.

PEPFAR Namibia will work with MOHSS and local indigenous organizations to ensure HIV services are sustained once epidemic control is achieved through:

- Training of health care workers to efficiently identify and treat patients at site levels;
- Updating and improving data reporting systems;
- Working with the government to update its HRH strategy and HRH data systems;
- Decentralizing and integrating HIV services into other health programs;
- Improving and integrating HIV commodities supply chain systems with other essential medicines.

Furthermore, PEPFAR Namibia will support assessments of private health sector providers on various possibilities for engagement in the national response, from VMMC to HIV treatment and ARV distribution.

5.2 Targets for Attained and Sustained Locations and Populations

To reach epidemic control, PEPFAR Namibia will accelerate progress toward attainment for all genders, ages, and risk groups in all SNUs. In the attained and sustained locations and populations, the focus will be on refining the missing HIV and non-HIV service packages to accelerate and sustain progress while documenting impact, promoting shared responsibility with host government and local indigenous organizations, strengthening the national and regional contributions through joint PEPFAR-GRN implementation of the national strategic framework, and integrating data alignment/import and improving supply chain management.

At the end of COP18, all SNUs in PEPFAR supported geographic locations and populations will achieve attained status. 23,050 people will be identified as HIV positive by the expanded and focused counseling and testing of 403, 874 individuals. In CO 18, PEPFAR Namibia will support the host government to initiate 26,875 individuals on HIV treatment and provide HIV treatment services for about 218,945 PLHIV (90% of all PLHIV in the country). This coverage will lead

Namibia to attain the 95-95-95 target that achieves epidemic control and maintains more than 80% ART coverage level in the attained districts.

In developing the FY19 treatment targets, PEPFAR Namibia will commit to maintaining or exceeding the achieved status in the attained and sustained SNU. By the end of FY19, with the assumption that most districts would have attained status, PEPFAR Namibia will continue supporting some SNU to maintain progress towards attainment for districts. The SNU expected to achieve “attained” status at the end of COP18 are Namibia Cluster 1, Windhoek, Kavango East-West districts and Katima Mulilo. Collectively, for the FY19, eight SNUⁱ will achieve sustained status and these SNU will contribute 32,509 (14.8%) of the total 218,945 treatment current. Similarly, for the FY19 newly identified HIV positive targets, these districts will contribute 2,585 (11%) of the 23,058. With this strategic plan for target setting, PEPFAR Namibia will continue to focus efforts in the geographic areas with the greatest burden and need.

Attained Support Volume by Group		Expected result APR 18	Expected result APR 19
HIV testing (all populations)	<i>HTS_TST</i>	346,354	342,014
HIV positives (all populations)	<i>HTS_TST_POS</i>	22,771	20,303
Treatment new	<i>TX_NEW</i>	28,417	23,421
Current on ART	<i>TX_CURR</i>	170,001	183,946
OVC	<i>OVC_SERV</i>	35,460	36,081
Key populations	<i>KP_PREV</i>	13,212	13,208

*Calculations for targets for clinical services should be based on maintaining 80% ART coverage levels in the attained districts. [Current Retention + (Passive HTC_POS * Linkage)]/PLHIV = 80% ART Coverage

Sustained Support Volume by Group		Expected result APR 18	Expected result APR 19
HIV testing in PMTCT sites	<i>PMTCT_STAT</i>	8,899	10,671
HTS (only sustained ART sites in FY 17)	<i>HTS_TST/HTS_TST_POS</i>	37,615/4,165	45,508/2,585
Current on ART	<i>TX_CURR</i>	30,865	32,509
OVC	<i>OVC_SERV</i>	250	0

Walvis Bay, Swakopmund, Otjiwarongo, Luderitz, Gobabis, Grootfontein, Okahandja and Keetmanshoop

5.3 Establishing Service Packages to Meet Targets in Attained and Sustained Districts

PEPFAR Namibia established service packages for the attained and sustained districts which consist of a mix of approaches to reach the last individuals that are not yet diagnosed or treated for HIV, especially in hard to reach population groups.

Prioritized activities for attained locations and populations include:

- Ensuring quality surveillance, program monitoring, and laboratory systems;
- Promoting clinical services and retention;
- Strengthening demand creation for HIV prevention interventions;
- Continuing outreach, prevention, testing, and clinical services for key populations; and
- Implementing comprehensive, wellness-based health care services.

Prioritized activities for sustained locations and populations include:

- Targeting HIV testing and counseling;
- Providing care services for PLHIV including nutrition assessment and counseling, and cervical cancer screening for all PLHIV women older than 30 years;
- Providing treatment services including routine clinic visits, ARV refills, and a basic care package; and
- Ensuring essential laboratory services, specifically viral load testing for PLHIV.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Despite the progress made toward epidemic control in Namibia, there are still some system level challenges that need to be addressed in order to achieve sustained epidemic control. In COP18, the systems investments strategy summarized in Table 6 (Appendix C) was developed in conjunction with identified site level approaches to ensure that, together, they address epidemic control priorities and form a lasting foundation for a sustainable future. System level gaps were identified through MER, SIMS visits/reports and the SID 3.0. The USG systems support and leverage GRN, GF and other partners' investments. For each approach, we have defined expected outcomes, a baseline, and measurable benchmarks against which our progress will be measured each year.

Following is a summary of identified key system barriers and types of activities that will be supported by system level investments aimed at addressing them.

HRH

The importance of providing training and mentoring to health care workers who will now be newly graduated Namibian nurses, doctors and pharmacists is a consistent cross-cutting theme in our COP18 system level activities. In addition, in order to sustain PEPFAR/USG investments in the HIV response, we will assist the MOHSS in the development of a National HRH strategy, deployment, and training and HRH database.

Testing, Linkage to ART and PrEP

NAMPHIA data show a linkage to ART of 96%. However, improvements are needed in EID, HTS services among men, same day ART initiation, linkage to ART for KP, TB TPT services, and commodity security at site level. Categories of proposed activities include training and mentoring of health care workers, development of IEC materials for demand creation and job aids, targeted community outreach testing, and technical assistance to the CMS for supply chain and commodity security.

ART, Retention and VL Suppression

The systems investments required to address the identified gaps for same day ART initiation, retention and VL suppression include the following: implementation of quality improvement, trainings, technical assistance to MOHSS and KP-led local Namibian organizations; development of IEC materials; and, supply chain strengthening and improved commodity security at decentralized facility levels.

Information Systems, Surveys, Surveillance, Evaluations and Research

Strategic information and epidemiological data exists, but challenges remain to consistent, high quality and complete data. In order to address the gaps, PEPFAR will conduct intensified data quality assessment at site level, strengthen the interoperability of data systems, support capacity

building, and update policies and guidelines. We will also conduct surveys, evaluations and operational research, including:

- Surveys
 - Strengthening strategic information for KP in Namibia (second IBBSS)
 - National survey on acquired HIV drug resistance among PLHIV receiving ART (early Transition to TLD)
 - Establishing HIV recent infection surveillance among persons newly diagnosed using the HIV rapid recency assay
- Evaluations
 - Evaluation of DREAMS programming - reaching the most vulnerable
 - Cost-effectiveness analysis of ART delivery of services to achieve viral suppression in Namibia
- Research
 - Evaluating key areas of the PrEP program including adherence; attitudes towards adherence; impact on sexual activity and behavior; attitudes around high-risk behaviors, etc.; and assessing gaps in understanding about PrEP.

7.0 USG Management, Operations, and Staffing Plan to Achieve Stated Goals

PEPFAR Namibia conducted an interagency review during COP18 development to examine the USG staffing footprint and alignment to HIV epidemic control. Analysis indicated close alignment and broadly successful implementation of technical and operational functions in COP17. There are no significant staffing changes proposed in COP18.

In order to maximize effectiveness and efficiencies, USG staff made every effort to fill all current vacancies. Similarly, vacant position descriptions were reviewed, and repurposed in one instance, to align with the strategic objectives. During COP17, the agencies conducted an internal reorganization to optimize both agency and interagency performance to yield strong results.

In order to maintain efficiency and continuity of services, the team made the following decisions:

- Secure short term technical assistance for PEPFAR gaps in PrEP policy and scale-up, DREAMS start-up, and USAID procurement activities.
- USAID repurposed a vacant program assistant position to a Health Communications/Outreach Specialist to support the demand generation needs to bring men in for testing and treatment and expand DREAMS-like social and behavioral messaging in priority areas.
- CDC will fill a vacant Prevention Advisor position to strengthen PEPFAR's assistance to Namibia's efforts to implement HTS and PrEP scale-up. Currently, the Monitoring, Evaluation and Research Advisor and Maternal and Child Health Technical Lead Advisor are temporarily filling the gap of this vacant position.
- CDC will repurpose a Medical Officer position from TB/HIV to HIV Care and Treatment, and the TB/HIV position will be filled with a locally employed staff.
- At CDC, a PMTCT Advisor position was enhanced to strengthen the pediatric component as a result of technical assistance requirements of the MOHSS.

All CDC field office positions in Oshana, Zambezi and Kavango East regions are filled and fully operational. In addition, in April 2017, USAID's three new Regional Advisors for Performance Monitoring started their regional duties, sharing CDC office spaces in Oshana and Kavango East. These staffs' main responsibilities are to facilitate capacity building and quality management of epidemic control of which SIMS is a component. In order to increase SIMS coverage, especially for the regions that are outside the field officer's designation, the head office's technical and non-technical staff was capacitated to conduct SIMS visits as per the predetermined schedule.

CDC has two vacancies of more than six months: the Prevention Advisor and the TB/HIV Medical Officer. These positions were advertised more than twice in 2016 but, due to a failure to attract qualified candidates, the positions were reclassified as Third Country National positions. As the positions were originally advertised so long ago, CDC was advised to re-advertise the positions in

country in 2017. Subsequently, the positions were re-advertised in December 2017 and January 2018 respectively.

Peace Corps and USAID each have one vacant position for more than six months. The Peace Corps position of HIV Coordinator is in active recruitment. The USAID position is repurposed, as stated above, and will be recruited following COP18 approval.

No new positions are requested in COP18.

USG does not expect any major changes to the cost of doing business, which would impact staffing or operations. The existing vacant positions were budgeted for in COP17 and therefore the expenditure related to hiring of these staff is expected to be relatively the same.

The slight increase of 3% on the management and operations budget is associated to forecasted cost escalation attributable to Post Local Compensation Package and foreign exchange rates between the USD and NAD. In addition, with the arrival of a new PEPFAR coordinator, the housing and associated relocation costs will increase, as the current incumbent is a part of a tandem couple and the position benefits from cost-sharing.

Regarding costs of transportation for all regional office staff, these were met through non-ICASS motor vehicles or third party transportation contracts in COP17. In COP18, to support field operations, CDC and USAID will procure three motor vehicles to replace older vehicles for the safety of personnel.

Areas for Subject Matter Expertise

As PEPFAR Namibia works towards our overarching goals for COP18, we will appreciate the assistance of Implementation Subject Matter Experts to provide guidance on innovative approaches in the following areas:

- Sustainability
- HRH
- Unique identifiers
- TLD transition
- Bidirectional facility-community linkages to HIV treatment
- Early infant diagnosis
- Pediatric viral load suppression

APPENDIX A -- PRIORITIZATION

Table A.1 SNU Prioritization

COP ₁₅ SNU	SNU Priority COP ₁₅	Achievement APR COP ₁₅	COP ₁₆ SNU	SNU Priority COP ₁₆	Expected Achievement COP ₁₆	COP ₁₇ SNU	SNU Priority COP ₁₇	COP ₁₇ Target: (APR ₁₈)	COP ₁₈ SNU	SNU Priority COP ₁₈	COP ₁₈ Target: (APR ₁₉)
!Karas	2 Hot spots	55%	Andara	ScaleUp Agg	63%	Nyangana	Attained	100%	Namibia Cluster 1	ScaleUp Sat	90%
Erongo	2 Hot spots	59%	Eenhana	ScaleUp Agg	72%	Outapi	Attained	100%	Kavango East-West Cluster	ScaleUp Agg	90%
Hardap	Non-PEPFAR	47%	Engela	ScaleUp Agg	72%	Okahao-Tsandi Cluster	ScaleUp Sat	81%	Tsumeb	ScaleUp Sat	90%
Kavango	Priority	84%	Katima Mulilo	ScaleUp Agg	62%	Oshakati-Ondangwa Cluster	ScaleUp Sat	81%	Windhoek	ScaleUp Sat	90%
Khomas	Priority	61%	Ncamangoro	ScaleUp Agg	92%	Oshikuku	ScaleUp Sat	100%	Katima Mulilo	ScaleUp Agg	90%
Kunene	Non-PEPFAR	48%	Nkurenkuru	ScaleUp Agg	92%	Tsumeb	ScaleUp Sat	90%	Walvisbay	Sustained	90%
Ohangwena	Priority	64%	Nyangana	ScaleUp Agg	161%	Windhoek	ScaleUp Sat	80%	!Nami#nus-Rosh Pinah Cluster	Sustained	90%
Omaheke	Hot spot	56%	Omuthiya	ScaleUp Agg	105%	Andara	ScaleUp Agg	90%	Gobabis	Sustained	90%
Omusati	Priority	91%	Ondangwa	ScaleUp Agg	76%	Engela-Eenhana-Okongo Cluster	ScaleUp Agg	82%	Grootfontein	Sustained	99%
Oshana	Priority	80%	Tsandi	ScaleUp Agg	62%	Katima Mulilo	ScaleUp Agg	73%	Keetmanshoop	Sustained	92%

Oshikoto	Priority	110%	Okahao	ScaleUp Sat	62%	Ncamangoro-Nkurenkuru-Rundu Cluster	ScaleUp Agg	97%	Okahandja	Sustained	100%
Otjozondjupa	3 Hot spots	56%	Onandjokwe	ScaleUp Sat	105%	Omuthiya-Onandjokwe Cluster	ScaleUp Agg	109%	Opuwo	Sustained	90%
Zambezi	Priority	53%	Oshakati	ScaleUp Sat	76%	!Nami#nus-Rosh Pinah Cluster	Sustained	45%	Otjiwarongo	Sustained	90%
			Oshikuku	ScaleUp Sat	90%	Gobabis	Sustained	50%	Swakopmund	Sustained	90%
			Outapi	ScaleUp Sat	181%	Grootfontein	Sustained	65%	Karasburg	Ctrl Supported	0%
			Rundu	ScaleUp Sat	92%	Keetmanshoop	Sustained	83%	Khorixas	Ctrl Supported	0%
			Tsumeb	ScaleUp Sat	166%	Okahandja	Sustained	90%	Mariental	Ctrl Supported	0%
			Windhoek	ScaleUp Sat	76%	Opuwo	Sustained	48%	Okakarara	Ctrl Supported	0%
			!Nami#nus	Sustained	41%	Otjiwarongo	Sustained	50%	Omaruru	Ctrl Supported	0%
			Gobabis	Sustained	60%	Rehoboth	Sustained	50%	Outjo	Ctrl Supported	0%
			Grootfontein	Sustained	59%	Walvis Bay-Swakopmund Cluster	Sustained	77%	Rehoboth	Ctrl Supported	0%
			Keetmanshoop	Sustained	81%	Karasburg	Ctrl Supported	0%	Tsumkwe	Ctrl Supported	0%
			Okahandja	Sustained	89%	Khorixas	Ctrl Supported	0%	Usakos	Ctrl Supported	0%
			Okongo	Sustained	72%	Mariental	Ctrl Supported	0%			
			Otjiwarongo	Sustained	53%	Okakarara	Ctrl Supported	0%			
			Rehoboth	Sustained	58%	Omaruru	Ctrl Supported	0%			
			Swakopmund	Sustained	79%	Outjo	Ctrl Supported	0%			

			Walvis Bay	Sustained	79%	Usakos	Ctrl Supported	0%			
			Karasburg	Ctrl Supported	0%						
			Khorixas	Ctrl Supported	0%						
			Mariental	Ctrl Supported	0%						
			Okakarara	Ctrl Supported	0%						
			Omaruru	Ctrl Supported	0%						
			Opuwo	Ctrl Supported	44%						
			Outjo	Ctrl Supported	0%						
			Rosh Pinah	Ctrl Supported	41%						
			Tsumkwe	Ctrl Supported	0%						
			Usakos	Ctrl Supported	0%						

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	Expected current on ART (APR FY 18)	Additional patients required for 80% ART coverage	Target current on ART (APR FY19) <i>TX_CURR</i>	Newly initiated (APR FY 19) <i>TX_NEW</i>	ART Coverage (APR 19)
Attained	195,064	170,001	0	183,946	23,421	90%
Sustained	34,125	30,865	0	32,509	3,296	93%
Central Support	14,613	2,458	2,106	2,490	158	90%
Total	243,803	203,324	2,106	218,945	26,875	91%

APPENDIX B – Budget Profile and Resource Projections

B1. COP 18 Planned Spending

Table B.1.1 COP18 Budget by Approach and Program Area

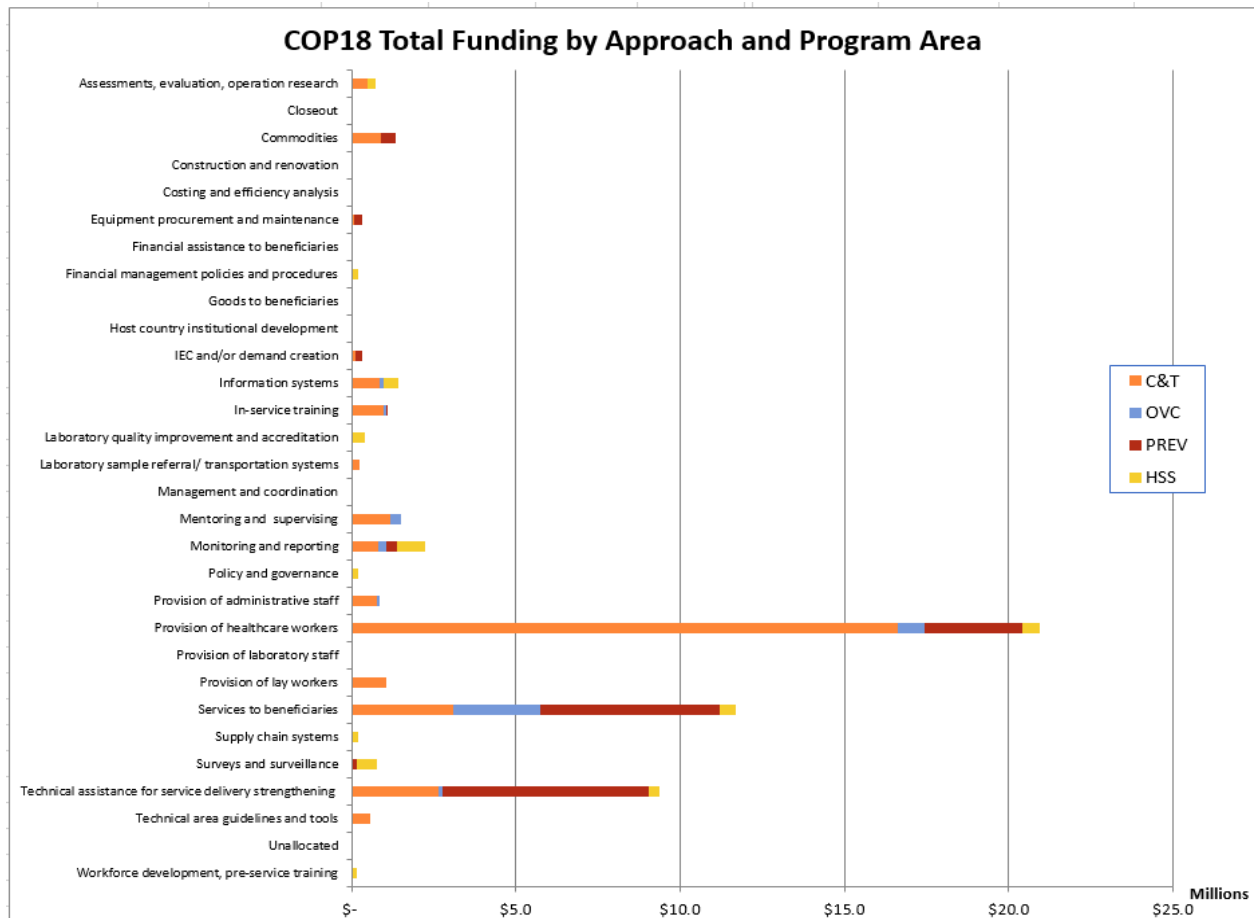


Table B.1.2 COP 18 Total Planning Level

Applied Pipeline	New Funding	Total Spend
\$US 3,222,711	\$US 68,366,289	\$US 71,589,000

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$639,195
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	\$2,838,343
HVOP	Other Sexual Prevention	\$4,593,712
IDUP	Injecting and Non-Injecting Drug Use	\$ 0
HMBL	Blood Safety	\$ 0
HMIN	Injection Safety	\$ 0
CIRC	Male Circumcision	\$9,082,662
HVCT	Counseling and Testing	\$3,332,165
HBHC	Adult Care and Support	\$2,242,531
PDCS	Pediatric Care and Support	\$862,452
HKID	Orphans and Vulnerable Children	\$4,457,223
HTXS	Adult Treatment	\$22,671,464
HTXD	ARV Drugs	\$461,404
PDTX	Pediatric Treatment	\$2,870,843
HVTB	TB/HIV Care	\$3,552,483
HLAB	Lab	\$488,296
HVSI	Strategic Information	\$3,136,087
OHSS	Health Systems Strengthening	\$1,707,909
HVMS	Management and Operations	\$5,429,520
TOTAL		\$68,366,289

B.2 Resource Projections

Epidemiological and Program Data Analysis

The PEPFAR Namibia SI team and Interagency Technical Teams began the prioritization process with an in-depth analysis of epidemiological and programmatic data to identify district-level geographic high-burden areas based on the volume of disease burden, highest prevalence, and ART unmet need. In addition to the study results that were available during COP17, the team made use of the PEPFAR-supported Small Area Estimation and the latest HIV Sentinel Survey Report (2016) and the preliminary NAMPHIA to better understand the epidemic. Similarly, the latest Spectrum data were also used. The team analyzed these data by age and sex disaggregation to determine areas' thresholds for coverage by considering the number of PLHIV, ART coverage, HTS and yield, and retention on ART. We also reviewed programmatic data on VL suppression by age, sex, and geography. Based on these analyses, the team allocated targets by district, classified sites, and determined the resources needed. Similarly, PEPFAR Namibia determined whether to continue supporting the same districts, if additional districts should be added (either as a whole or as a hot spot), and level of support for each district. The team conducted further analyses to determine which facilities and/or community sites should receive support for HTS, PMTCT, OVC, VMMC, key population interventions, and DREAMS-like services.

The team also looked at the impact of the GF's reduction of resources on the current service provision within the PEPFAR supported districts. The vacant positions were classified in terms of priority and the team determined the positions to prioritize for inclusion in COP18.

Gap Analysis

During the COP18 process, PEPFAR Namibia worked closely with stakeholders, particularly GRN representatives and CSOs to identify gaps and bottlenecks and recommend solutions to address these gaps. During planning consultation meetings with stakeholders, we conducted a national HIV program gap analysis and completed the SID exercise. PEPFAR Namibia and GRN recognize specific gaps to address the continuum of HIV services vary by district and the strategies have been adjusted to meet the specific needs of the districts.

Funding Allocation to Strategy Tool (FAST)

Strategic objectives formed the basis for allocating funds to the different implementing mechanisms (IMs), with a focus on filling the identified gaps. As a result, some of the strategic objectives used in COP 17 discontinued while new strategic objectives were developed to better address the challenges and barriers to sustainable epidemic control. The total base budget of \$66,487,500 is inclusive of DREAMS-like funding of \$10,000,000. Additional funding for VMMC of \$5,101,500 was not included in earmark calculations. High-burden districts, sites, and activities were allocated to budget areas and subsequently apportioned to the IMs with the highest probability of achieving PEPFAR targets.

APPENDIX C – Tables and Systems Investments for Section 6.0

Attached in a separate document.

Table 6 Attachment

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity	Key Systems Barrier	Related SID 3.0 Element
1	HHS/CDC	WHO	C&T	Strengthen clinical guidance, oversight and operations	Technical area guidelines and tools	Provide Technical Assistance to the MOHSS in updating ART and HTS guidelines and implementation plan	Limited capacity for operationalization of normative guidelines	Policies and governance
2	HHS/CDC	Expansion of HIV/AIDS, STI & TB Laboratory Activities	C&T	Support specimen collection and referral system	Laboratory sample referral/transportation systems	Support specimens transport between healthyh facilities and NIP Laboratory hubs	Lack of adequate specimen transport system and timely return of results	Laboratory
3	HHS/CDC	Expansion of HIV/AIDS, STI & TB Laboratory Activities	HSS	Support laboratory services delivery and continuous quality improvement	Laboratory quality improvement and accreditation	Implementation of continuous quality improvement	Limited implementation of Laboratory Continuous Quality Improvement systems	Laboratory
4	USAID	Global Health Supply Chain-Procurement Supply Management	HSS	Strengthen the national health system	Policy and governance	Above-service delivery technical support to Pharmaceutical Services section of Min of Health Tertiary Care Services Directorate and CMS to conduct mentoring, supportive supervision and utilization of information systems to improve readiness and reduce stockouts. Assistance to TLD transition with pharmacy workforce.	HIV commodity security at site level	#8 Commodity Security and Supply Chain
5	USAID	Technical Support to PEPFAR Programs in Southern Africa	C&T	Strengthen care and treatment support systems (above site level)	Assessments, evaluation, operation research	Above-service delivery - Assessment conducted under MOHSS to optimize PrEP service delivery for young persons based on findings from young persons, current PrEP clients, health care workers and public health specialists.	Young persons HIV testing and linkage to PrEP and ART	#6 Service Delivery

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
1	7.55	Guidelines updated	2 years	Number of HIV care and treatment guidelines revised	2016 ART guidelines, 2012 HTS guidelines, 2013 HIV DR strategy	TLD tranistion strategy, Revision of HTS guidelines, updating HIV DR strategy
2	8.92	specimen transport system and timely return of laboratory results	2 years	Laboratory results turn around time	7 days	4 days
3	8.92	Laboratory Continuous Quality Improvement implemented and maintained at all testing sites	2 years	Laboratory accreditation and QA indicators	0.8	100%
4	8.07 (Light Green)	Improved HIV commodity security of RTK and ART (including TLD transition)	1 year	% of pts on TLD and legacy regimen	No pts on TLD	90% of pts on TLD, 10% of pts on legacy regimens
5	7.50(Light Green)	Pts at substantial risk for HIV acquisition linked to PrEP; 100% of newly diagnosed young persons with HIV initiate treatment on the same day initiated	1 year	no data available for PrEP	280 pts initiated on PrEP as of Q1FY18.	Assessment completed

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
1		Revised ART guidelines, implementation plan			
2		3days			
3		100%			
4					
5					

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity	Key Systems Barrier	Related SID 3.0 Element
6	HHS/CDC	Expansion of HIV/AIDS, STI & TB Laboratory Activities	PREV	Increase provision of Gender Based Violence(GBV) HIV prevention services for adolescent Girls and young women	Surveys and surveillance	Support quality of HIV testing and incidence testing in DREAMS implementation sites	Gaps in epi and health data	Epidemiology and Health data
7	HHS/CDC	Improving the Quality of Namibia's Essential Health Services and Systems (IQ-NEHSS)	HSS	Strengthen the national health system (CoAg management)	Financial management policies and procedures	Program management and coordination (Financial support to the administration of the Cooperative Agreement Unit within the Ministry of Health and Social Services, funding goes toward quarterly COAG Review meetings and site visits; external Audits and Asset verifications; COAG financial management systems, softwares, renewal and maintenance)	Limited capacity for CoAg management	Technical and Allocative Efficiencies
8	HHS/CDC	Improving the Quality of Namibia's Essential Health Services and Systems (IQ-NEHSS)	HSS	Strengthen the national health system (FELTP)	Workforce development, pre-service training	Provide Support to the Field Epidemiology and Laboratory Training (FELTP) program to build country capacity for Survey, Surveillance and evaluation	Limited Epi HR capacity	Human Resources for Health
9	HHS/CDC	Improving the Quality of Namibia's Essential Health Services and Systems (IQ-NEHSS)	HSS	Strengthen the national health system (DHIS2, HISP, RME)	Information systems	Support further roll-out of the DHIS2 with integrated HIV modules	Gaps in data collection and reporting (M&E)	Epidemiology and Health Data

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
6	5.8		1 year	RT QA indicators, incidence testing report	zero	RT QA performance >80%, and incidence data available for DREAMS implementation sites
7	7.5	Improved program implementation and monitoring	1 year	EA data, MER indicator, Financial reports	Audit report	Improved accountability
8	6.88	Improved HIV disease surveillance	2 years	# of Epi graduates in intermediate and advanced levels	10 graduates	15 graduates
9	5.8	Improved site level reporting of routine health indicators	2 years	% of identified/targeted sites where DHIS2 has been implemented	50% of hospitals and health facilities	75% of hospitals and health centers

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
6					
7					
8		20 graduates			
9		100% hospitals and health facilities			

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity	Key Systems Barrier	Related SID 3.0 Element
10	HHS/CDC	UNAIDS	HSS	Fast tracking the key populations response (develop National key population monitoring framework)	Policy and governance	Development of national key population monitoring frame work linked to the national framewrok 2017/18-2021/22	Key population prevalence data from host GRN not disaggregated by key population (FSW, MSM, TG) and Key population data not always reported using the routine system but implementing partners	Epidemiology and Health data , Performance data
11	HHS/CDC	Namibia Mechanism for Public Health Assistance, Capacity, and Technical Support (NAM-PHACTS)	HSS	Strengthen the National Health System and data from key population(conducting IBBSS 2)	Surveys and surveillance	Above-site - Provide technical support to the collection and analysis of IBBSS data for key populations in additional clusters of study started in prior year	Inadequate information on key populations	Epidemiology and Health data
12	USAID	USAID HIV Clinical Services Technical Assistance Project	HSS	Strengthen health system (human resources for health)	Policy and governance	Above site - Technical support to Min of Health to National Health Workforce Account and development of National HRH strategy to sustain PEPFAR/USG investments in HIV response.	Lack of HRH strategy for adequate HRH supply, deployment, training and HRH data to sustain HIV response	#7 HRH

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
10	5.8 and 6.09	National key population Monitoring framework developed	1 year	National Key population Monitoring framemork completed	zero	National monitoring framework complete
11	5.8	IBBSS data available for programming	1 year	IBBSS completed	IBBSS not completed	IBBSS completed and diseminated
12	6.88(Yellow)	MOHSS utilizes updated strategy to train, deploy and institutionalize the HRH data base for planning out year staffing	1year	National HRH Strategy updated and dadisemmenated	Draft HRH strategy	MOHSS HR planning and budgeting reflect updated HRH strategy

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
10					
11					
12					

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity	Key Systems Barrier	Related SID 3.0 Element
13	USAID	USAID HIV Clinical Services Technical Assistance Project	C&T	EPMS/QUANTUM deployment- Strengthen care and treatment support systems (above site level)	Information systems	Above-service delivery - Deployment of revised EPMS/Quantum information system to improve patient outcomes. Deployment consists of skilled staff to migrate patient data from legacy EPMS, training services, technical troubleshooting and equip all major health districts and high volume ART facilities to track HIV patient care and ARV dispensing service.	Lack of updated and Interoperability of legacy ART patient monitoring system(epMS)	#13 Epidemiological and Health Data
14	USAID	Strengthening HIV Prevention for Key Populations	C&T	Key population - Strengthen care and treatment support systems (above site level)	Technical area guidelines and tools	Above-service delivery - Technical support to Min of Health and key population-led organizations to conduct same-day initiation of ART for newly diagnosed individuals with HIV.	Same day initiation during KP outreach	#6 Service Delivery
15	USAID	Strengthening HIV Prevention for Key Populations	HSS	Key population - Strengthen health system (health information and surveillance)	Surveys and surveillance	Above-site - Provide technical support to the collection and analysis of IBSS data for key populations in additional clusters of study started in prior year	Inadequate information on key populations	#13 Epidemiological and Health Data
16	USAID	Challenge TB Fund	C&T	Strengthen care and treatment support systems (above site level)	IEC and/or demand creation	Training, mentoring of health care workers to support implementation of the TPT	TB/HIV retention and adherence	#6 Service Delivery
17	USAID	Challenge TB Fund	C&T	Strengthen care and treatment support systems (above site level)	Information systems	Above-service delivery - Data Quality, Analysis and Reporting to improve TPT implementation	Lack of interoperability of TB pt management systems with DHIS	#6 Service Delivery

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
13	6.63(Yellow)	100 % of high volume HIV service delivery sites to utilize updated ePMS(ePMS Quantum)	3 years	Percentage of facilities utilizing updated ePMS	5% of high volume sites utilizing EPMS Quantum	50 % of high volume sites utilizing updated ePMS
14	7.50(Light Green)	100 % of KP pts diagnosed and initiated to ART during outreach	1 year	% pts diagnosed during outreach initiated on ART	33 % ART initiation by KP	100% same day ART initiation by KP identified during outreach
15	5.80 (Yellow)	IBBSS data available for programming	1 year	IBBSS completed	IBBSS not completed	IBBSS completed and disseminated
16	7.50(Light Green)	Increased uptake of TPT	2 years	% pts with improved awareness of TB preventive therapy	30% of pts on TPT	80% of PLHIV screened for TB will start IPT, of which 70% will complete IPT
17	5.80 (Yellow)	100 % of high volume sites with updated TB pt management system	2 years	% of high volume sites utilizing TB pt management system	Zero	65 % of high volume sites on TB/HIV pt management system

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
13		75 % of high volume sites utilizing updated ePMS		100 % of high volume sites utilizing updated ePMS	
14					
15					
16		100% of eligible HIV pts on TPT			
17		100% of high volume sites on TB/HIV pt management system			

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity	Key Systems Barrier	Related SID 3.0 Element
18	USAID	Challenge TB Fund	C&T	Strengthen care and treatment support systems (above site level)	Policy and governance	Above-service delivery - Health promotion activities in health facilities to support implementation of the TPT	Limited implementation of job aid for TB/HIV diagnostics	#6 Service Delivery
19	USAID	Adherence & Retention Project	OVC	Increase access to prevention, care and treatment services for OVC and caregivers	Information systems	Above-service delivery - Technical support to Min. of Child Welfare to deploy an eCase Management system to high HIV burden regions to identify and link vulnerable children to GBV prevention and care, HIV testing, VMMC and treatment	HTS; VLS; No available information on vulnerable children	#13 Epidemiological and Health Data
20	USAID	<Placeholder - 70249 Namibia USAID>	HSS	Strengthen HIV supply chain (HIV commodity security including TLD)	Supply chain systems	Provision of specialist supply chain management personnel to support Central Medical Stores provision of SCM services in support of HIV response conducted in coordination with The Global Fund inputs to the CMS turn around strategy.	Restructuring of MOHSS HIV supply chain including central medical stores	#8 Commodity Security and Supply Chain
21	USAID	<Placeholder - 70249 Namibia USAID>	C&T	Strengthen care and treatment support systems (above site level)	Information systems	Above-service delivery - Continued implementation of facility electronic stock cards to reduce stock-outs or product rationing at decentralized sites.	Gaps in site and above-site HIV commodity distribution, stock management and consumption data to increase efficiency	#8 Commodity Security and Supply Chain

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
18	7.10 (Light Green)	Improved TB interventions among ART patients	1 year	% compliance to TB Treatment Guidelines for IPT at high volume sites	30% of pts on TPT	80% of PLHIV screened for TB will start IPT, of which 70% will complete IPT
19	5.80 (Yellow)	100% of MGECW social workers equipped with e-CaseManagement system to manage vulnerable children	2 years	MGECW DHIS reports caseload and case outcomes	Baseline data not available	35 % of cases administrated through the eCaseManagement system by end of COP18
20	8.07 (Light Green)	Central Medical Stores Turn-around strategy implemented in two years	2 years	% HIV commodities procured and distributed to sites in comparison to forecasted needs	13,383 pts at risk of stock out of ARV as of 1/1/2018	5,000 pts at risk of stock out of ARV
21	8.07 (Light Green)	Improved HIV commodity planning, site-level stock management practices and reporting of ART	1 year	% of high volume sites reporting on facility electronic stock card in timely fashion	83 % of high volume sites	100 % of high volume sites

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
18					
19		60% of cases administrated through the eCaseManagement system by end of COP18			
20		2,000 pts at risk of stock out of ARV			
21					

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity	Key Systems Barrier	Related SID 3.0 Element
22	HHS/CDC	Improving the Quality of Namibia's Essential Health Services and Systems (IQ-NEHSS)	HSS	Establishing HIV Recent Infection Surveillance Among Persons Newly Diagnosed with HIV Using the HIV Rapid Recency Assay	Assessments, evaluation, operation research	Support the establishing HIV Recent Infection Surveillance Among Persons Newly Diagnosed with HIV Using the HIV Rapid Recency Assay	Gaps in epi and health data	Epidemiology and Health Data
23	HHS/CDC	Expansion of HIV/AIDS, STI & TB Laboratory Activities	C&T	Establishing HIV Recent Infection Surveillance Among Persons Newly Diagnosed with HIV Using the HIV Rapid Recency Assay	Assessments, evaluation, operation research	Implement HIV recency testing at selected sites	Gaps in epi and health data	Epidemiology and Health data
24	HHS/CDC	Improving the Quality of Namibia's Essential Health Services and Systems (IQ-NEHSS)	PREV	Increase provision of HIV prevention for key and priority populations (VMMC)	IEC and/or demand creation	Support production of IEC and demand creation materials to increase VMMC uptake	Low uptake of VMM,C services	Service Delivery
25	HHS/CDC	Improving the Quality of Namibia's Essential Health Services and Systems (IQ-NEHSS)	PREV	Strengthen system for Combination prevention strategies (above site level) DREAMS	IEC and/or demand creation	Support production of IEC and demand creation materials to increase uptake to DREAMS package of services.	Lack of awareness of services for GBV prevention and post violence care	Service Delivery
26	HHS/CDC	Improving the Quality of Namibia's Essential Health Services and Systems (IQ-NEHSS)	HSS	Strengthen the national health system (Policy and guidelines for surveys, surveillance, research and evaluation)	Policy and governance	Provide support MOHSS to revise Research policy and clinical trial guidelines for improve in-country approval process of PEPFAR supported Survey-Surveillance, research and Evalaution activities (SRE)	Outdated national policies and guideline for research, surveys, surveillance and evaluations	Policies and Governance
27	HHS/CDC	Improving the Quality of Namibia's Essential Health Services and Systems (IQ-NEHSS)	C&T	Increase Antiretroviral Therapy (ART) coverage	IEC and/or demand creation	Support production of IEC and demand creation to increase EID within the first 6 months of birth	Gaps in EID uptake	Service Delivery

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
22	5.8	Surveillance system for recent HIV infection implemented	2 years	% of newly HIV diagnosed tested for HIV recency	Recency testing currently not used in any sites	50% of all newly diagnosed tested for HIV recency
23	5.8	Surveillance system for recent HIV infection implemented	2 years	% of newly HIV diagnosed tested for HIV recency		50% of all newly diagnosed tested for HIV recency
24	7.5	Increased uptake for VMMC services among males 15- 29 years old	1 year	% increase in VMMC Coverage	VMMC coverage at the end of FY17 among boys 15-29 years was 35% (source: DMPPT2)	68 % increase in VMMC coverage in males 15- 29 years old
25	7.5	increased awareness of services for GBV prevention and post violence care	1 year	PP_PREV reached	NA	IEC materials completely printed and distributed. IEC material drafted and submitted for printing
26	7.55	national policies and guideline for research, surveys, surveillance and evaluations updated	1 year	policies and guidelines updated	Research and clinical trial guidelines not revised	new guidelines drafted and approved by the Permanent Secretary-Ministry of Health and Social services
27	7.5	Improve EID uptake	1 year	# of EID tests	70% EID testing coverage	95% EID testing coverage

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22		75% of all newly diagnosed tested for HIV recency			
23		75% of all newly diagnosed tested for HIV recency			
24					
25					
26					
27					

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity	Key Systems Barrier	Related SID 3.0 Element
28	HHS/CDC	Improving the Quality of Namibia's Essential Health Services and Systems (IQ-NEHSS)	C&T	Increase TB and TB/HIV prevention, diagnosis and treatment	Laboratory sample referral/transportation systems	Support Laboratory sample referral and transportation systems from decentralized HIV delivery sites to district lab	Lack of adequate specimen transport system and timely return of results	Laboratory
29	HHS/CDC	<Placeholder - 70228 Namibia HHS/CDC>	C&T	Increase Antiretroviral Therapy (ART) coverage (Cost effectiveness analysis study)	Assessments, evaluation, operation research	Determine the impact of adherence enhancement tool, ARVS and healthy me. To understand and contrast engagement and ART adherence experiences of patients	Gaps in epi and health data	Service delivery
30	HHS/CDC	Namibia Mechanism for Public Health Assistance, Capacity, and Technical Support (NAM-PHACTS)	PREV	Increase provision of Gender Based Violence(GBV) HIV prevention services for adolescent Girls and young women (DREAMS) (Evaluation of dreams)	Surveys and surveillance	Determine if DREAMS programs are reaching the most vulnerable girls and if DREAMS is retaining participants to achieve layering	Gaps in program coverage data	Service delivery data
31	HHS/CDC	Expansion of HIV/AIDS, STI & TB Laboratory Activities	HSS	Establishing HIV Recent Infection Surveillance Among Persons Newly Diagnosed with HIV Using the HIV Rapid Recency Assay	Assessments, evaluation, operation research	Implement HIV recency testing at selected sites	Gaps in epi and health data	Epidemiology and Health data

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
28	8.92	specimen transport system and timely return of laboratory results	2 years	Laboratory results turn around time	7 days	4 days
29	7.5	Improved tools for supporting adherence and viral load suppression among adults and adolescents on ART	1 year	no data available for Adherence enhancement	no data available for Adherence enhancement	Complete qualitative and quantitative evaluation with developed action plan for improving adherence enhancement using the adult adherence enhancement tool.
30	7.5	Improve targeting and retention in DREAMS	1 year	% of at -risk AGYW reached by DREAMS at end of FY18	No baseline data	Complete qualitative and quantitative evaluation with developed action plan for improving program reach to the most at-risk girls.
31	5.8	Surveillance system for recent HIV infection implemented	2 years	% of newly HIV diagnosed tested for HIV recency	Missing info	50% of all newly diagnosed tested for HIV recency

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28		3 days			
29					
30					
31		75% of all newly diagnosed tested for HIV recency			