

Namibia

Country Operational Plan 2019

Strategic Direction Summary

April 5, 2019



Table of Contents

1.0 Goal Statement

2.0 Epidemic, Response, and Program Context

- 2.1 Summary statistics, disease burden and country profile
- 2.2 Investment profile
- 2.3 National sustainability profile update
- 2.4 Alignment of PEPFAR investments geographically to disease burden
- 2.5 Stakeholder engagement

3.0 Geographic and population prioritization

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
- 4.2 Prevention, specifically detailing programs for priority programming
- 4.3 Additional country-specific priorities listed in the planning level letter
- 4.4 Commodities
- 4.5 Collaboration, Integration and Monitoring
- 4.6 Targets for scale-up locations and populations

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

- 5.1 COP19 programmatic priorities
- 5.2 Targets for attained and sustained locations and populations
- 5.3 Establishing service packages to meet targets in attained and sustained districts

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

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

Appendix A - Prioritization

Appendix B- Budget Profile and Resource Projections

Appendix C- Tables and Systems Investments for Section 6.0

Appendix D – Minimum Program Requirements

Appendix E – Faith and Community Initiative (as applicable)

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 |
| CADRE | Cyclical Acquired Drug Resistance Patient Monitoring (CADRE) |
| CBART | Community Based ART Program |
| CCBHS | Comprehensive Community Based Health Services |
| CDC | Centers for Disease Control and Prevention |
| CMS | Central Medical Stores |
| CODB | Cost of Doing Business |
| 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 |
| EPOA | Enhanced Peer Outreach Approach |
| EQA | External Quality Assurance |
| FAST | Funding Allocation to Strategy Tool |
| FELTP | Field Epidemiology and Laboratory Training Program (FELTP) |
| 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 |
| IBBS | 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 |
| ISME | Implementation Subject Matter Experts |

| | |
|---------|---|
| KP | Key Populations |
| LES | Locally employed staff |
| LGBTI | Lesbian, Gay, Bisexual, Transgender, Intersex |
| M&E | Monitoring and Evaluation |
| MCH | Maternal and Child Health |
| MDR | Multiple Drug Resistant |
| MDG | Millennium Development Goals |
| MER | Monitoring, Evaluation and Reporting |
| MOHSS | Ministry of Health and Social Services |
| MSM | Men who have Sex with Men |
| MTCT | Mother-To-Child Transmission |
| NAD | Namibian Dollar |
| NAMPHIA | Namibia Population-Based HIV Impact Assessment |
| NASA | National AIDS Spending Assessment |
| NDHS | Namibia Demographic and Health Survey |
| NEC | New Embassy Compound |
| NHFA | National Health Force Accounts |
| NIMART | Nurse-Initiated and Managed ART |
| NIPH | National Institute of Public Health |
| 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 |
| POC | Place of Care |
| PrEP | Pre-Exposure Prophylaxis |
| QA | Quality Assurance |
| QM | Quality Management |
| RTK | Rapid Test Kit |
| SDS | Strategic Direction Summary |
| SID | Sustainability Index Dashboard |
| SI | Strategic Information |
| 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 |
| TGW | Transgender women |
| TLD | Tenofovir/Lamivudine/Dolutegravir |
| TPT | TB Preventative Therapy |
| TWG | Technical Working Group |

| | |
|--------|--|
| UHC | Universal Health Care |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| USAID | U.S. Agency for International Development |
| USD | United States Dollars |
| USG | United States Government |
| VACS | Violence against Children Survey |
| VIA | Visualization with Acetic Acid |
| VL | Viral Load |
| VMMC | Voluntary Medical Male Circumcision |
| WHO | World Health Organization |

1.0 Goal Statement

In order to evolve the Namibia PEPFAR program to sustained epidemic control, the Country Operational Plan 19 (COP19) to be executed in FY20 will optimize locally led program implementation to reach the last, most challenging hot spots and unmet needs, setting the stage for transition to full Namibian government leadership.

As PEPFAR Namibia currently achieves our COP18 goals, the program stands on a solid platform for continued success in COP19. With Namibia estimated to have achieved 94-96-95 of the 95-95-95 goals by the end of 2018, COP19 looks deep at what needs to be strengthened to fully evolve the program in order to best sustain a controlled HIV epidemic in Namibia.

Rigorous data analyses identified nine key areas that need focus in COP19 in order to reach unmet needs. These areas are:

1. Provide focused testing to uncover the remaining 5-6% of people living with HIV (PLHIV);
2. End geographic disparities in treatment through high-quality ART coverage;
3. Ensure treatment outcomes in young people equals that of adults in order to improve viral load suppression (VLS) in children and adolescents;
4. Provide full coverage of TPT over the next two years for clients on ART to address the persistent TB epidemic;
5. Provide national cervical cancer screening, treatment and referral for women living with HIV;
6. Provide aggressive, targeted prevention services to address the continued high incidence in girls and women ages 15 to 24 through DREAMS, VMMC, and PrEP;
7. Provide unrestricted access to the treatment cascade for vulnerable and key populations;
8. Evolve high-functioning systems to match the needs of the epidemic, and
9. Develop a clear three-year plan of transition to full national ownership of the HIV program.

Additionally, as part of a robust surveillance and monitoring system, recency testing will be implemented nationally in COP19 to guide PEPFAR Namibia in defining geographic “hot spots” to allow for real time response. This will move the program into case-based surveillance as a method of sustaining the gains of the last 16 years.

Going into COP19 (in FY20), PEPFAR Namibia has all necessary policies implemented down to the site level and will be meeting all 13 minimum program requirements (Appendix D), further evidence supporting PEPFAR Namibia’s COP19 goal of ensuring the stage is set for long-term transition to full Namibian government ownership.

By the end of COP19, approximately 238,424 people will be tested; 18,168 newly identified HIV-positive people will be initiated on treatment, and 229,800 PLHIV will receive treatment services.

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 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 2.5 million people (Namibia Statistics Agency (NSA), 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 at a rate of 3.63% (CIA Fact Book 2017), and urban population is projected to surpass the rural population for the first time ever in 2019.

Namibia is an upper-middle income country with a gross national income (GNI) per capita of \$ 4,570 (World Bank, 2017), but with starkly unequal income distribution. Namibia's Gini coefficient is 0.61, while its Palma Ratio at 5.8, both among the highest in the world (UNDP HDR statistical update 2018). According to a 2012 assessment of poverty dynamics in Namibia, approximately 18% of people in Namibia live in extreme poverty (less than USD 1.90 per person per day). Unemployment is estimated at 33.4%, marginally down from 34% two years earlier (NSA Labour Force Survey 2018).

The country has 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 have also been 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 goes 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.

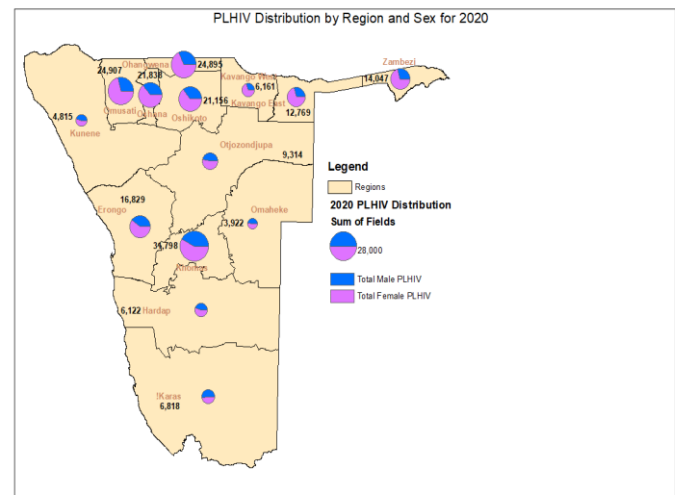
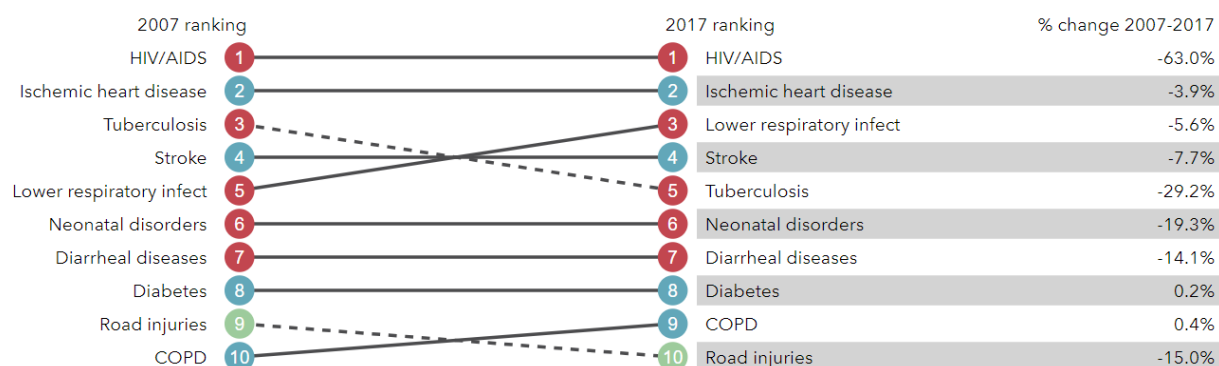


Figure 2.1.1 Distribution of Estimated PLHIV by Region and Sex for 2020

Figure 2.1.2 Top Causes of Death in Namibia (2017)



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

Namibia has been accelerating progress towards HIV epidemic control, and at the end of FY19, over 110% of the estimated 203,396 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 2016 (World Bank). The Government of the Republic of Namibia’s (GRN)’s leadership has also resulted in Namibia achieving high HIV treatment and prevention of mother-to child transmission (PMTCT) coverage levels, and rapidly adopting new international guidelines and best practices. Of note, given the high TB/HIV co-infection rate (35.5%) 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).

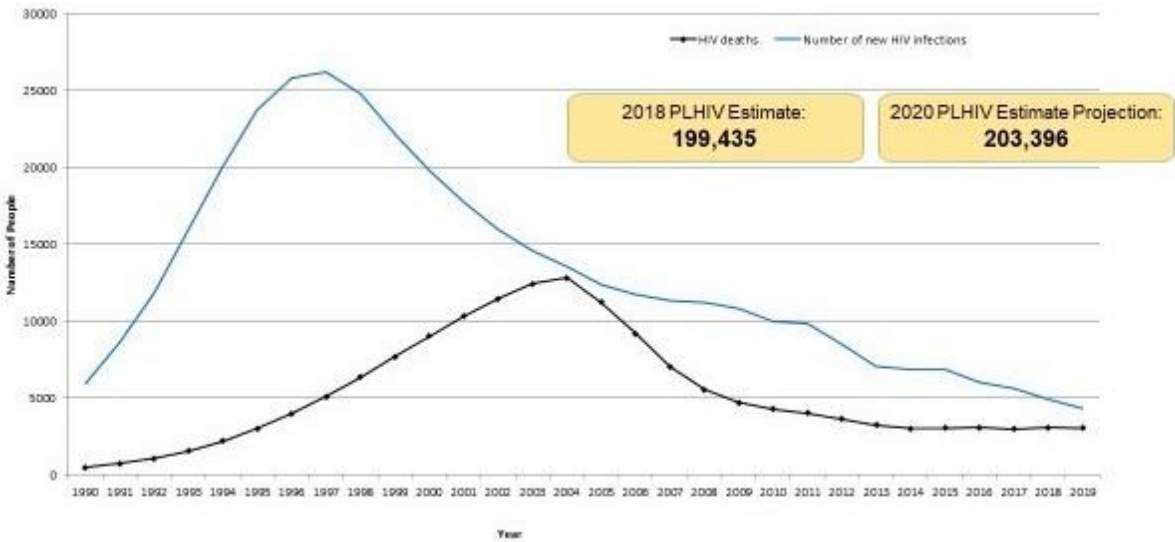
HIV Prevalence and Incidence

Namibia has a generalized HIV epidemic, with 8.1% of the general population living with HIV (2019 Spectrum Model). HIV/AIDS will be responsible for an estimated 3,952 deaths in 2019 (see Table 2.1.3), and the disease remains the leading cause of death among adults and the sixth-leading cause among children under five years of age (MOHSS Child Survival Strategy, 2014). Among adults (>25 years of age), women bear a disproportionate burden of the HIV epidemic, with a prevalence of 17.8% compared to 13.5% for men (see Table 2.1.1). Although limited data are available on sex-specific positivity rates among children, an estimated 1.0% of children under 15 years of age are HIV infected. According to the 2019 Spectrum Model, the highest proportion of estimated new infections is among women ages 15-29, accounting for 34% of new infections. Men 20-35 years old are estimated to account for 24% of the new infections.

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 (2019 Spectrum Model).

The national decrease in estimated incidence to date has been predominantly among infants and children from the successful scale up of PMTCT (2019 Spectrum Model). To maintain a steady decline in incidence, Namibia will need to fully implement ART coverage strategies, including in low burden areas with low ART coverage.

Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV



Treatment Coverage

The 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 has increased annually, rising from 75,681 in 2010 to approximately 198,090 in 2018 (see Table 2.1.2). The large majority of Namibians on ART receive it from the public sector (179,844). However, it is estimated that approximately 18,600 PLHIV in 2018 received ART from the private health sector. Disaggregated data by age and sex illustrate that the proportional treatment gap is highest among males 30-34 (Figure 2.1.4). The “Treat All” policy, which recommends ART for all PLHIV, was rolled out nationally in 2016 under updated treatment guidelines, and a further update is envisioned in FY19 to facilitate a full national roll-out of Tenofovir/Lamivudine/Dolutegravir

(TLD). Namibia has experienced incredible growth in ART coverage in the last six years, particularly among men with only 37% knowing their status in 2013, to 91% knowing their status and 87% of those being on treatment in 2018 (see Figure 2.1.5, 2.1.6).

Figure 2.1.5 National ART Coverage

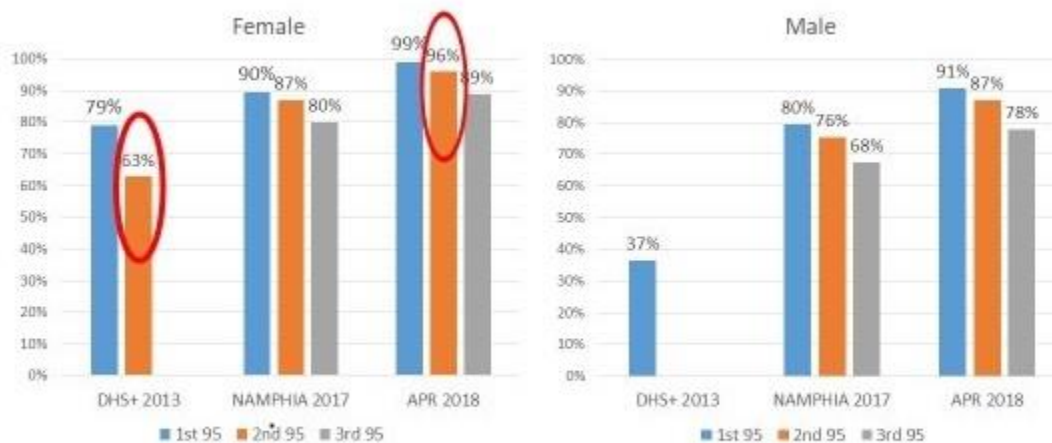
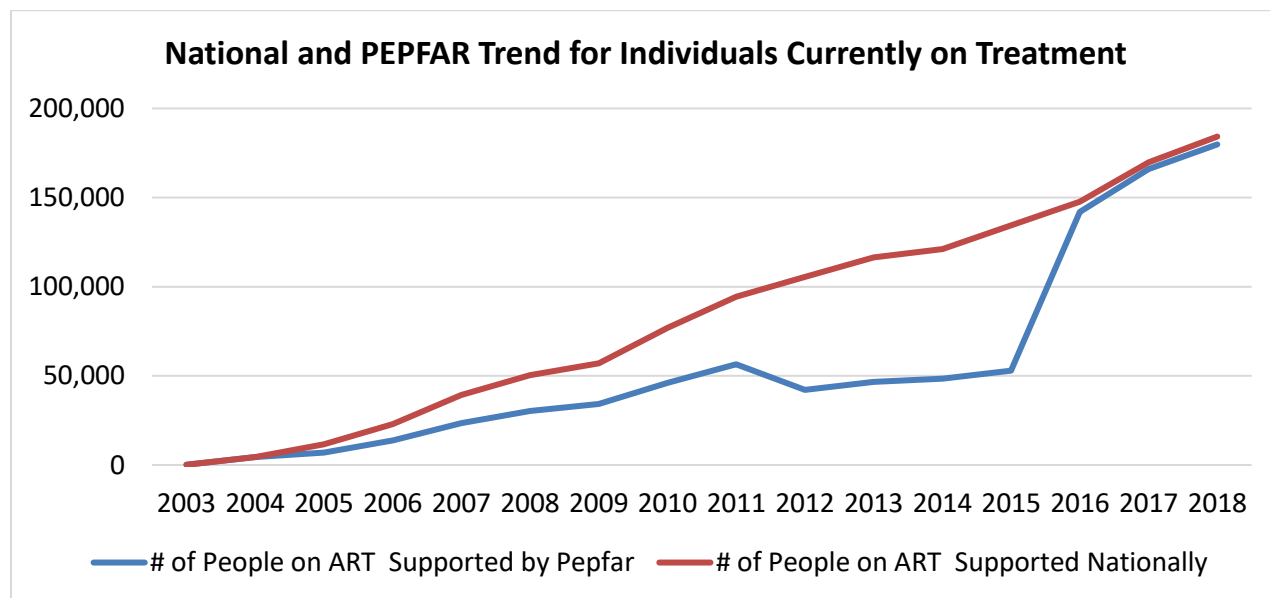


Figure 2.1.6 National and PEPFAR trend for Individuals Currently on Treatment



Prevention of Mother-to-Child Transmission (PMTCT)

The success of the PMTCT program in Namibia has resulted in a 60% reduction in new HIV infections in children. Based on the 2013 Namibia Demographic Health Survey (NDHS), antenatal clinic (ANC) coverage (at least one visit) is 97% (see Table 2.1.1), although the percentage of

pregnant women with four or more antenatal care is just 63%. Delivery in a health center is high at 87%. PMTCT and early infant diagnosis (EID) services are integrated in all public health sites. In FY18, 98% of pregnant women had known HIV status and ART coverage was 95%.

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 national policy, and is being implemented widely. Implementation, however remains a challenge as reoccurring stock outs of reagents leads to periodic interruption of processing results and backlogs. Therefore timeliness of results returned to site level is a continuing issue. EID coverage in 2017 was 70% within two months of age and 90% by 12 months (APR17). In FY18, PEPFAR Namibia supported 234 sites, addressing >90% of national PMTCT and EID needs.

TB/HIV

Namibia has one of the highest per capita TB/HIV coinfection burden in the world and is ranked by the World Health Organization (WHO) among the top 30 high TB burden countries in the world. In the 2018, the country notified 8,108 TB cases (61% male and 39% female), translating to a case notification rate (CNR) of 336/100,000. The majority of the cases were aged 25-34 years. The high case load is attributed mainly to the HIV epidemic as reflected by an HIV prevalence of 17.2% among ante-natal clinic attendees in 2016 and an HIV prevalence rate of 35% among TB patients in 2018. The rate of TB patients with known HIV status is 99% with 97% ART initiation among those who tested positive.

Drug-resistant TB is one of the greatest threats to ending TB in Namibia. The 2015/6 anti-TB drug resistance survey (DRS) showed multiple drug resistant TB (MDR-TB) prevalence of 3.9% and 8.7% among new and previously treated patients respectively. In 2018, 328 patients with multi-drug resistant (Rifampicin-resistant) TB were notified.

The recently completed TB Disease Prevalence Survey confirmed Namibia's position among the top high TB burden countries reporting the rate of bacteriologically confirmed TB as 465/100,000 (95% CI: 340-590). TB among males was significantly higher (60%) than females. HIV-positive rate was 13.5% among participants who knew their HIV status at the end of the survey (83.5%). HIV positivity rate among drug resistant TB patients was 42% and ART was initiated among 89% of these.

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 data 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 (aged 20-29 years) still lag behind in HIV testing uptake.

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 achieve a population level impact in epidemic control. The Ministry of Health and Social Services (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 and increase uptake among young people aged 15-29 years. Promotional concerts were conducted during the high VMMC season from May to September. Due to expansion of service access and demand generation efforts, the PEPFAR VMMC program has seen a 28% increase in VMMC coverage. At the end of FY18, the PEPFAR program reported a record number of circumcisions: 38,665 men (Annual Progress Report [APR] 2018). PEPFAR Namibia's COP19 target will rapidly move three priority regions (Komas, Zambezi and Oshanao) to 70% VMMC coverage.

Orphans and Vulnerable Children (OVC)

The HIV epidemic in Namibia has generated a large population of OVCs. Spectrum 2019 estimates the number of orphans who are either single or double orphaned to be 35,029. Among 15-19 year olds, 56.6% of girls and 74.2% boys had never been tested for HIV (NDHS, 2013).

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 some unable to protect themselves from HIV. Cultural norms that inhibit health seeking behaviors in men and boys also contribute to HIV risk. According to the 2013 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 of women aged 15-49 experienced sexual violence since age 15, and four percent experienced sexual violence in the 12 months prior to the survey. Women who are not employed or are 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 FY19, will provide recommendations to relevant Namibian ministries, 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 (IBBS) 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 is available for the transgender population. A new IBBS is currently being implemented in FY19. The methodology includes the use of respondent-driven sampling that is linked to peer-driven interventions for FSW and MSM/TG. Final results are expected by the end of September 2019. In FY20 PEPFAR Namibia will use the findings from the NAM-IBBS to further improve reach and link strategies for KP in Namibia.

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 FY18, PEPFAR Namibia achieved over 300% of the OU target with 4702 people being enrolled on PrEP. In FY19, PEPFAR Namibia's technical and programmatic assistance for accelerating the national PrEP program resulted in the development of national PrEP SOPs, training manuals and job aids as well as demand creation tools. Namibia will continue to scale up PrEP for all high risk individuals. In FY20, PrEP will be integrated as a key component of routine family planning and sexually transmitted infection (STI) services. PrEP services will also be expanded as an integral part of Index Partner Testing ensuring that HIV negative individuals who are at high risk of acquiring HIV infection are offered PrEP.

Programmatic and Systemic Gaps

The data 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) is a primary vulnerability, Namibia requires implementation of a human resource staffing structure for the MOHSS that is responsive to the demands of the epidemic. The government is hampered by the fact that there is a hiring freeze in place, meaning that adding positions is not possible. While the overall size of the civil service is high, at facility level gaps in service providers often exists and the lack of flexibility is a severe challenge to ensure the necessary HRH is available. Policy and operational interventions are 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.

| | | | | | | | | | | | | | | | |
|---|--------|-------|-----|------|-----|--|--------|-------|-----|--|--------|-------|------|--|---|
| % of Pregnant Women with at least one ANC visit | 86,235 | 103% | 390 | 0.5% | | | 35,343 | 41.0% | | | 50,502 | 58.6% | | | Namibia Program Data |
| Pregnant women needing ARVs | 12,361 | 15% | | | | | | | | | | | | | Namibia Program Data |
| Orphans (maternal, paternal, double) | 35,035 | | | | | | | | | | | | | | Spectrum, Jan 30, 2019 |
| Notified TB cases (Yr) | 8,854 | | 399 | | 420 | | 627 | | 576 | | 2555 | | 4277 | | National Tuberculosis and Leprosy Program (NTLP) 2017 Annual Report |
| % of TB cases that are HIV infected | 3,147 | 35.5% | | | | | | | | | | | | | |
| % of Males Circumcised | 77,749 | | | | | | | | | | | | | | |
| Estimated Population Size of MSM* | 6,508 | | | | | | | | | | | | | | IBBS 2013 |
| MSM HIV Prevalence | | 16.2 | | | | | | | | | | | | | IBBS 2013 |
| Estimated Population Size of FSW | 8,082 | | | | | | | | | | | | | | IBBS 2013 |
| FSW HIV Prevalence | | 38.8 | | | | | | | | | | | | | IBBS 2013 |

| | | | | | | | | | | | | | | | |
|--|-----|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Estimated Population Size of PWID | N/A | | | | | | | | | | | | | | |
| PWID HIV Prevalence | N/A | | | | | | | | | | | | | | |
| Estimated Size of Priority Populations (specify) | N/A | | | | | | | | | | | | | | |
| Estimated Size of Priority Populations Prevalence (specify) | N/A | | | | | | | | | | | | | | |

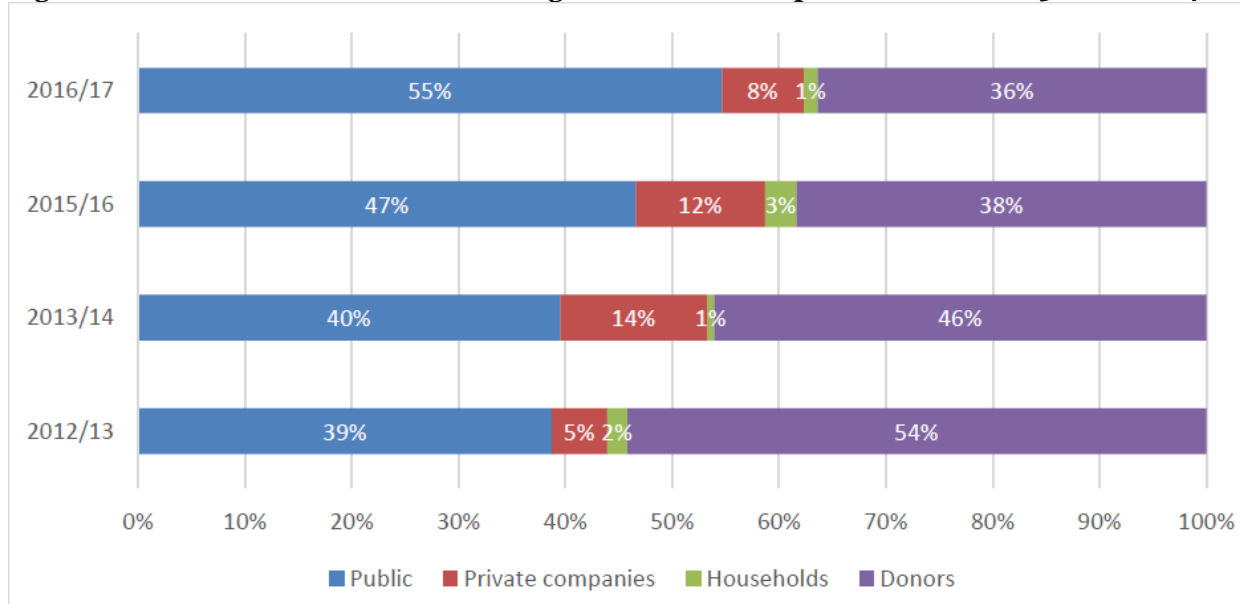
Standard Table 2.1.2

| 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 | 2,507,554 | 8.1% | 203,396 | 191,482 | 184,589 | 91% | 86% | 506,520 | 21,697 | 17,492 |
| Population <15 years | 919,769 | 1.0% | 9,501 | 8,639 | 8,639 | 91% | 86% | 38,312 | 943 | 817 |
| Men 15-24 years | 233,885 | 2.6% | 5,991 | 4,407 | 4,407 | 74% | 70% | 39,423 | 802 | 507 |
| Men 25+ years | 521,162 | 12.2% | 63,724 | 56,712 | 53,820 | 84% | 80% | 111,270 | 7,120 | 5,744 |
| Women 15-24 years | 235,770 | 5.6% | 13,107 | 9,958 | 9,689 | 74% | 70% | 115,711 | 3,624 | 2,667 |
| Women 25+ years | 596,968 | 18.9% | 113,067 | 110,906 | 107,690 | 95% | 90% | 201,804 | 9,208 | 7,756 |
| | | | | | | | | | | |
| MSM | 6508** | 16.2% | 1,054 | | | N/A | 100%*** | 3,326† | 316† | 89† |
| FSW | 8082** | 38.8% | 3,136 | | | N/A | 72%*** | 13,441† | 1,270† | 1,061† |
| PWID | N/A | | | | | | | | | |
| Priority Pop (specify) | N/A | | | | | | | | | |
| *These should be national data, if the data do not exist, PEPFAR data may be used if relevant. | | | | | | | | | | |
| Cite sources | | | | | | | | | | |
| ** Namibia IBBS 2013 | | | | | | | | | | |
| † PEPFAR program data (APR 2018) | | | | | | | | | | |
| *** Of those eligible and VL tested | | | | | | | | | | |

2.2 Investment Profile

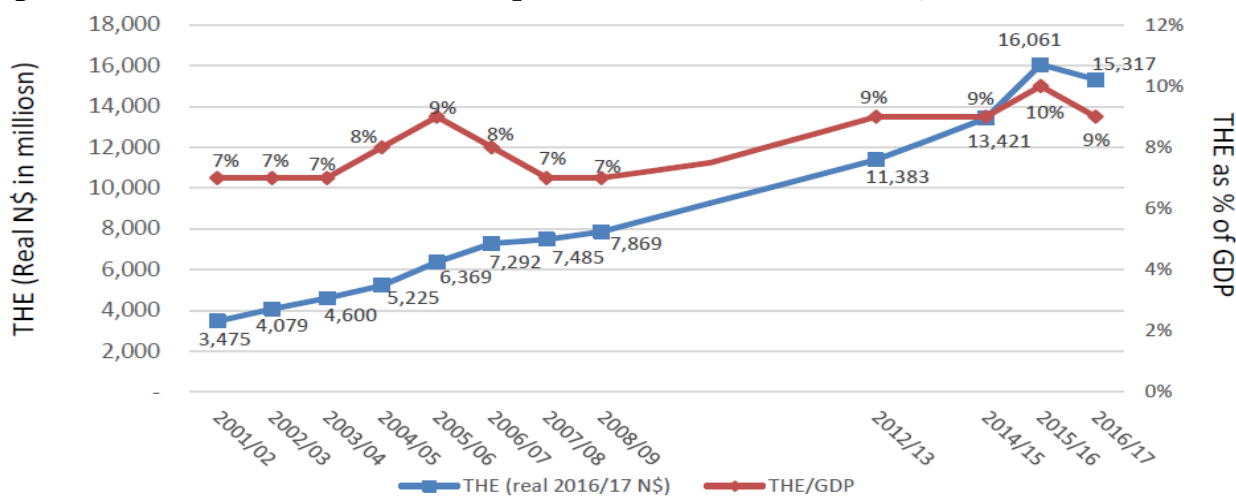
The results of the most recent National AIDS Spending Assessment (NASA), which covered the Government of Namibia financial years of 2015/16 and 2016/17, indicate that 64 percent of the HIV response was financed domestically in 2016/17, up from 62 percent in 2015/16. The largest source of domestic financing over the two years was the Government of Namibia, with 86 percent of domestic expenditure in 2016/17 and 76 percent in 2015/16. As illustrated in Figure 2.2.1 below, domestic financing of the response has steadily increased over the past several years, as donor contributions have decreased in parallel, from 54 percent in 2012/13 to 36 percent in 2016/17.

Figure 2.2.1 Trends in sources of funding for HIV/AIDS expenditures, 2012/13 - 2016/2017



The NASA exercise was conducted in conjunction with the National Health Accounts, which also covered 2015/16 and 2016/17. Analysis of expenditures from Health Accounts exercises dating back to 2001/02, indicates that total health spending in real 2016/17 Namibian dollars has increased from N\$3.5 billion in 2001/02 to N\$15.3 billion in 2016/17, an average increase of 10 percent per year (see figure 2.2.2). Total spending on health peaked in 2015/16 at N\$16.1 billion, and dropped to N\$15.3 in 2016/17. As a percentage of of gross domestic product (GDP), total health spending increased from 7 to 9 percent from 2001/02 to 2005/06, fell back to 7 percent during 2007/08 and 2008/09, and has hovered between 9 and 10 percent since.

Figure 2.2.2 Growth in Total Health Expenditures, 2001/02 - 2016/2017

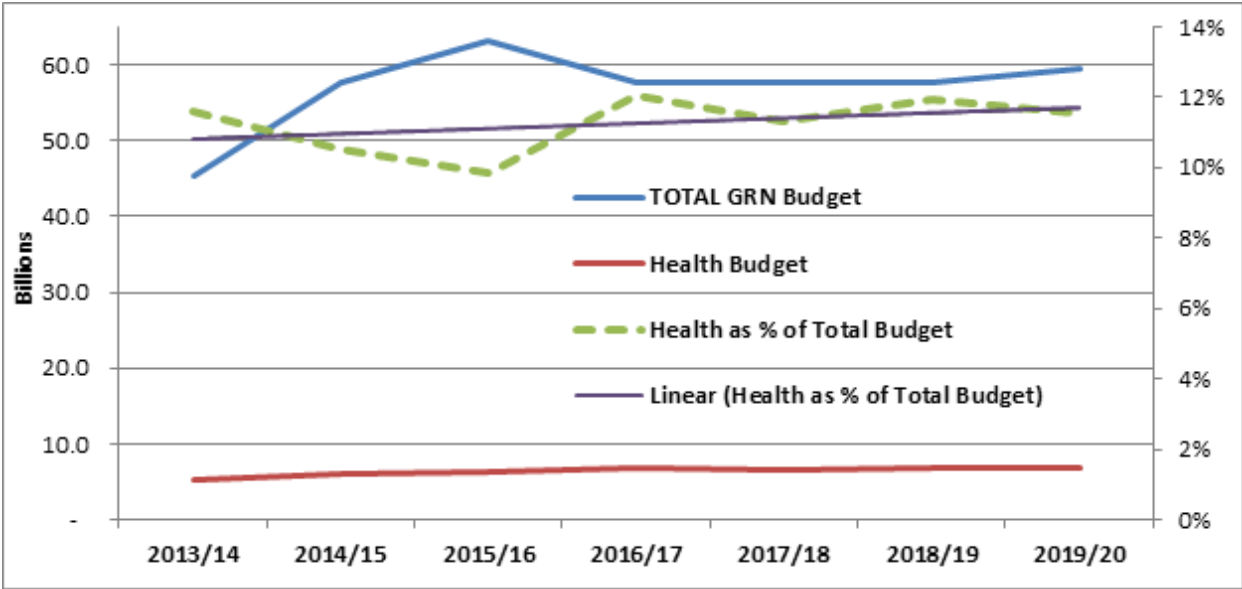


Namibia is currently in a recession, with overall GDP growth falling from 6 percent in 2015 to -0.1 percent in 2018. The recession, combined with a number of other adverse economic factors, has led to an overall decline in government spending. Despite the challenging economic environment, the Health Accounts exercise highlighted Namibia’s commitment to the health sector, and particularly the HIV response. In 2016/17, health spending accounted for 13.5 percent of overall government expenditures, slightly short of

the 15 percent target set by the Abuja Declaration, and a greater share was spent on HIV (13 percent) than any other disease. Even still, during the past two fiscal years, GRN line ministries, including the MOHSS, saw limits to hiring new personnel and budget strains that put further pressure on program operations.

Health expenditure remains the second largest government expenditure category and is expected to increase by 2.3 percent from 2019 to 2020. The GRN budget for 2019/20 demonstrates a continued commitment to spending public funds on health, with N\$6.8 billion (approximately US\$500 million) allotted for the fiscal year. This amounts to between 11 percent and 12 percent of the total GRN budget (see Figure 2.2.3).

Figure 2.2.3 Government of Namibia budget, overall and in health (in NAD), and health as a percentage of total budget, 2013/14 to 2019/20



Over the past several years, donors have gradually contributed less financing for the HIV response. They do, however, continue to play a significant role in funding Human Resources for Health (HRH), with more than 1,500 health care workers currently supported across the country. Approximately half of the supported workers are lay workers such as health assistants. Clinical staff, namely doctors and nurses, make up 17 percent of donor-supported HRH positions. Donors also fund 76 percent of HIV/AIDS-related training, putting the specialized competence of health care workers in this area at risk if donor support were to wind down. Other areas dependent on donor support are health systems strengthening and program coordination, for which donors provided 73 percent of the resources in 2016/17, with most of it going toward program management of infectious diseases, surveillance, research and evaluations.

In COP19, PEPFAR Namibia will work closely with GRN to develop a multi-year HRH transition plan that seeks to optimize core donor-funded HRH functions before ultimately transitioning them to the Namibian Government. The first step of this plan will be to identify critical functions and HRH gaps to achieve and maintain epidemic control. The second step will include support to the Ministry of Health and Social Services to develop and socialize a case for continued investments in critical HIV-related HRH to the Ministry of Finance and the broader GRN. PEPFAR will also work with GRN to model cost

scenarios to fit needed HRH within the wage bill, and will support efforts to engage the private sector and civil society organizations to fill critical functions in partnership with the GRN.

Tables 2.2.1 and 2.2.2 summarize estimates of annual investments by program area and key commodities procurements in 2017/2018. From program data which provides a narrower assessment of funding mechanisms than the broader NASA and Health Accounts assessments. The largest contributor to the HIV response in Namibia in 2017/18 was the GRN (48 percent), followed by PEPFAR at 44 percent and GF at 6 percent. The largest cost drivers for GRN were for OVCs; clinical care, treatment and support; and AGYW prevention. PEPFAR spent more than US\$30m on clinical care, treatment and support, nearly US\$11m on VMMC, and more than US\$8m on HIV testing. The majority of GF's spending was also on clinical care (60 percent), followed by AGYW prevention (12 percent) and health systems strengthening (10 percent).

In recent years, GRN has been the largest procurer of HIV-related commodities. This was the case in 2017/18, with 84% of procurement funding coming from GRN. More than half of ARVs procured during the year were funded by GRN (54 percent), with the remainder covered by GF. One hundred percent of viral load commodities, lab reagents, and other related drugs and commodities were procured by GRN. PEPFAR funded the cost of all VMMC kits and supported a small amount of rapid test kits.

In 2018/19, donors supported some emergency procurements upon request from the government, including adult ARVs (by GF), and pediatric ARVs and anti-TB medicines (by PEPFAR). Given the ongoing recession in Namibia and corresponding fiscal constraints, PEPFAR will continue to support emergency procurements on a limited basis. This includes TLD, anti-TB medicines, and small batch items that are difficult to procure, like pediatric ARVs.

Table 2.2.1 Annual Investment Profile by Program Area, in USD, 2017/18

| Program Area | Total Expenditure | % PEPFAR (Oct 2017 - Sept 2018) | % GF (Jan-Dec 2018) | % Host Country (Apr 2017 - Mar 2018) |
|--|--------------------|---------------------------------------|---------------------------|---|
| Clinical care, treatment and support | 65,067,311 | 48% | 14% | 38% |
| Community-based care, treatment, and support | 5,045,376 | 62 % | | 38% |
| PMTCT | 1,337,335 | 67% | | 33% |
| HTS | 9,155,179 | 91% | 5% | 4% |
| VMMC | 12,956,319 | 82% | 7% | 11% |
| Priority population prevention | 5,152,039 | 51% | 10% | 39% |
| AGYW Prevention | 18,412,344 | 7% | 10% | 83% |
| Key population prevention | 2,724,681 | 89% | 11% | |
| OVC | 34,284,839 | 11% | | 89% |
| Laboratory | 1,860,782 | 100% | | |
| SI, Surveys and Surveillance | 3,208,823 | 85% | 15% | |
| HSS | 8,845,181 | 42% | 17% | 40% |
| Total | 168,050,208 | | | |

Table 2.2.2 Annual Procurement Profile for Key Commodities, Apr 2017 – Mar 2018

| Commodity Category | Total Expenditure | % PEPFAR | % GF | % Host Country | % Other |
|------------------------|-------------------|----------|------|----------------|---------|
| ARVs | 24,579,923 | 0.1% | 46% | 54% | |
| Rapid test kits | 2,898,757 | 12% | | 88% | |
| Other drugs | 32,621,434 | | | 100% | |
| Lab reagents | | | | 100% | |
| Condoms | 1,705,212 | 1.5% | | 98.5% | |
| Viral Load commodities | 4,982,144 | | | 100% | |
| VMMC kits | 469,899 | 100% | | | |
| Other commodities | 8,420,605 | | | 100% | |
| Total | 75,677,975 | | | | |

Table 2.2.3 is intentionally left blank, as PEPFAR Namibia does not receive any non-PEPFAR funding or co-funding.

| Funding Source | Total USG Non-PEPFAR Resources | Non-PEPFAR Resources Co-Funding PEPFAR IMs | # Co-Funded IMs | PEPFAR COP Co-Funding Contribution | Objectives |
|------------------------------|--------------------------------|--|-----------------|------------------------------------|------------|
| USAID MCH | | | | | |
| USAID TB | | | | | |
| USAID Malaria | | | | | |
| Family Planning | | | | | |
| NIH | | | | | |
| CDC (Global Health Security) | | | | | |
| Peace Corps | | | | | |
| DOD Ebola | | | | | |
| MCC | | | | | |
| Total | | | | | |

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 |
|----------------------------------|--------------------------------|----------------------------|-------------------------------------|-----------------|------------------------------------|--|
| Other PEPFAR Central Initiatives | 977,205 | 0 | 0 | TBC | | Catalyze expansion and integration of cervical cancer screening among women with HIV receiving ART services in high volume sites |
| Other Public Private Partnership | | | | | | |
| Total | 977,205 | | | | | |

2.3 National Sustainability Profile Update

Completed every two years, the Sustainability Index Dashboard (SID) 3.0 done in 2017 used a high participatory approach and was coordinated in collaboration with the UN Program on HIV/AIDS

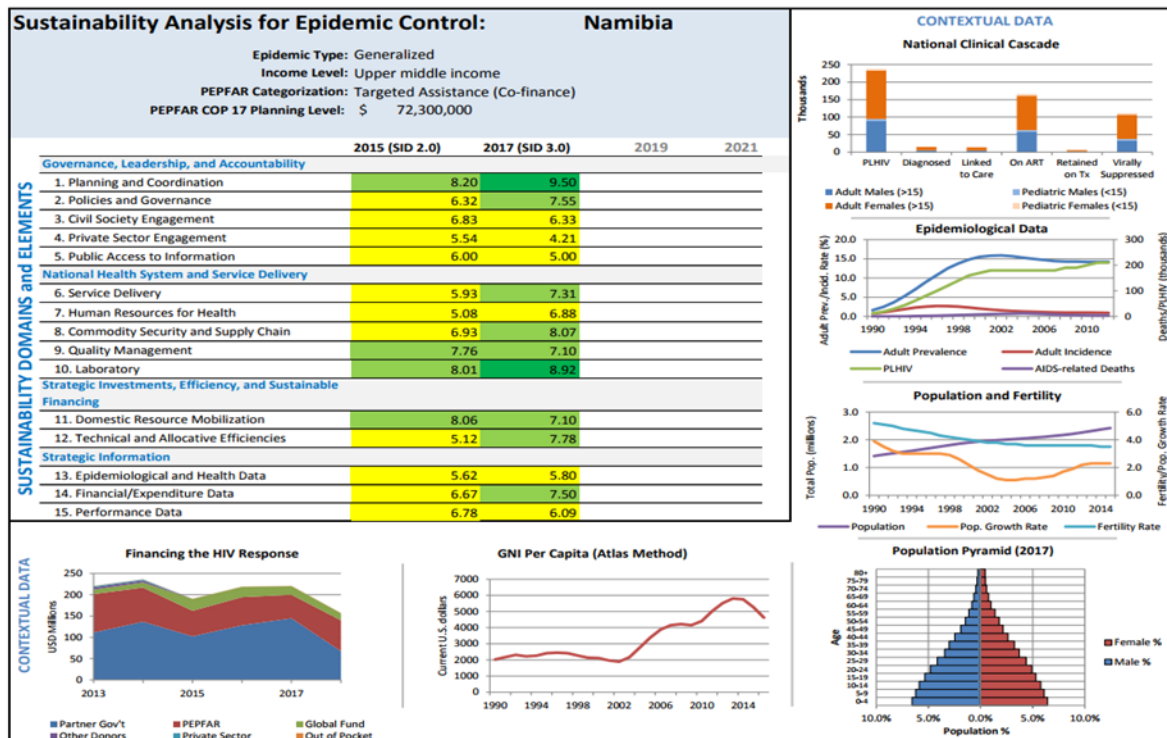
(UNAIDS). The process included a desk review of new and recent documents, followed by in-person meetings with key stakeholders. PEPFAR Namibia held a national stakeholder meeting to validate the SID with 114 participants from GRN, civil society, and the private sector. Although the SID indicated a trend towards a sustainable HIV/AIDS response for Namibia, the country has experienced three years of declining growth and is operating in a constrained fiscal environment. Six elements expressed sustainability vulnerabilities, including: HRH; public access to information; civil society engagement; private sector engagement; epidemiological and health data (see Figure 2.3.1). Of the remaining eight elements, six scored light green and two dark green, indicating that they did not exhibit any significant sustainability vulnerabilities. Two of the elements that scored well, Supply Chain and Laboratory have recently had vulnerabilities exposed, relating to their operational structure and business cases, putting the sustainability of the response at risk.

While the SID showed improvements since 2015, PEPFAR Namibia and stakeholders agreed that several vulnerabilities would directly affect the sustainability of the national HIV response, namely, HRH and the supply chain if not addressed in the short to medium-term.

Certain categories and localities of HRH rely heavily on donor funding and expatriates to fill positions. Key HRH weaknesses in the SID 3.0 include 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 Namibia's "Treatment Acceleration Plan" remain off the MOHSS's approved staffing structure. A significant number of GF HRH positions ceased to be funded on December 31, 2017, with PEPFAR Namibia filling the gap by supporting a number of critical positions previously funded by GF.

In COP18, PEPFAR Namibia conducted an inventory of donor supported positions, as part of the process of developing a three year HRH transition plan. The compensation levels of PEPFAR Namibia supported HRH are broadly equivalent to those of government cadres, indicating that drastic differences in compensation may not pose as a significant obstacle in Namibia as in many other PEPFAR countries. There are some PEPFAR Namibia funded positions, mostly senior and chief level staff, with higher compensation than their peers in the GRN. These PEPFAR Namibia funded staff may have to accept reduced compensation if they choose to transition to a similar role with GRN.

Figure 2.3.1 Sustainability Index Dashboard (2018 SDS data)



A GRN general government hiring freeze remains in place, with special waivers required to fill key 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. In COP19, PEPFAR Namibia will move staffing resources from the regions with the highest coverage in those program areas to underperforming areas.

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. Throughout FY18 and FY19 Q1, there were no stock outs of first-line adult ARVs. Stock outs of other HIV commodities have been minimal. The GRN awarded an annual framework contract for ARVs, after a yearlong process. This development will ensure a more consistent and reliable ARV supply. In COP19, PEPFAR Namibia will support the GRN in moving towards wider use of multi-month dispensing of ARVs, characterized by routine three, six, or even 12 month refill dispensing. This reduces the burden on the supply chain management systems, particularly the distribution and storage of ARVs at the regional, district and site level. It will also reduce the frequency of patient visits to clinics for refills. A new testing algorithm has introduced less expensive RTKs, increasing availability, and reducing stock-out.

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

consultations on social contracting. In COP19, PEPFAR will work with the GRN to sub-award resources from its cooperative agreement to local partners, creating a model for future private sector and civil society engagement and partnership. 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. In COP19, PEPFAR Namibia will support the GRN to lay the groundwork for sustainable epidemic control, including defining and costing a minimum package of services and making progress toward the development of a sustainability strategy for HIV. The program will also work to review existing service modalities to identify and address program inefficiencies. This will include a focus on increasing domestic resources available for HIV, through a more prominent role for the private sector as well as for civil society organizations (CSOs) and faith-based organizations (FBOs) to deliver services to specific populations.

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 data, program managers and implementers are not able to make course adjustments for greater impact and efficiency. Epidemiological data is supported by donors and is considered a sustainability and capacity vulnerability. PEPFAR Namibia has partnered with the MOHSS to make access to data more accessible, including developing several fact sheets covering a variety of HIV/AIDS programs and activities, including a publically available summary sheet of the NAMPHIA findings. PEPFAR Namibia will work with the GRN in improving access to information through the development and management of a public health information repository.

The public laboratory system had significant vulnerabilities exposed in COP17 and COP18, which led to interruptions in some laboratory services critical to the HIV/AIDS response. PEPFAR Namibia worked with the GRN and other donors in COP18, to stabilize operations at the Namibia Institute of Pathology (NIP). PEPFAR Namibia will continue to support the operational sustainability of Namibia's public laboratory system, including the decentralization of EID testing to VL labs. Additional efforts have been made to improve laboratory services as part of the process to seek International Organization for Standardization (ISO) accreditation for more laboratories.

PEPFAR Namibia is working closely with bilateral partners and the GRN Resource Mobilization Technical Working Group (TWG), which has a focus on issues of sustainability. The TWG developed a sustainability framework to achieve Universal Health Care (UHC). The framework will support the incorporation of an HIV package of services in the national health services package. PEPFAR Namibia continues to share quarterly program performance data with stakeholders, particularly CSOs, and seeks opportunities to engage them in program performance monitoring. Under the small grants program, PEPFAR Namibia supports an average of three community level organizations annually, most of which hail from high disease burden regions of Namibia.

PEPFAR Namibia has taken significant steps to increase the participation of indigenous partners in the implementation of PEPFAR programs, with over 60% of funding going to local organizations.

2.4 Alignment of PEPFAR Investments Geographically to Disease Burden

For COP18, due to frequent population movement between districts, the Central northern communal area sub national units (SNUs; (Oshikoto, Oshana, Omusati, and Ohangwena) were clustered into one SNU, and the Kavango West and Kavango East regions were clustered into one SNU. More than 70% of COP18 funding was assigned to aggressive scale-up SNUs. All SNUs achieved attained/sustained status during FY18.

For COP19, improved program and national data has further refined our understanding of the epidemic and informed strategies to close the gaps. Figure.2.4.1 show numbers of PLHIV by region. It is important to note that the five lowest population volume regions have the highest proportion of men living with HIV (Kunene, Hardap, !Karas, Omaheke, and Otjozondupa). As PEPFAR Namibia expands support in these regions, this may help to find some of the young men who are not currently on treatment.

Figure 2.4.2 shows PLHIV and TX_CURR by region in FY19 Q1. In the highest burden regions where PEPFAR has invested the most, we see high coverage of ART (Omusati, Ohangwena, Oshikoto, Kavango West, Kavango East, Zambezi and Otjozondjupa). In the most urbanized and affluent areas, there exists a larger treatment gap than anticipated that is mostly filled by the 18,600 ART clients in the private sector (Oshana, Erongo, Khomas). Finally the regions that are low prevalence and low population but also have the lowest treatment coverage rates, these areas are where we plan to increase support with more focused technical assistance (Kunene, Omaheke, Hardap, !Karas).

Figure 2.4.3 shows the population pyramid showing gaps for People Living with HIV in case finding and viral load suppression by age and sex. The potential gaps that exist are most prominent among males 20 to 34 years of age and females 15 to 24 years of age being unaware of their HIV-positive status.

Figure 2.4.4 shows viral load coverage by region. These data demonstrate good viral load coverage rates in most regions with some potential gaps existing in regions that have received less PEPFAR support.

Figure 2.4.5 shows viral load suppression for patients on ART by region. These data demonstrate excellent on-treatment suppression rates with some room for improvement in regions where there are plans to expand PEPFAR support in COP19. Figure 2.4.6 shows NAMPHIA regional cascade and regions with lowest VL suppression.

Figure 2.4.3 Namibia Population “Pyramid” for People Living with HIV



Figure 2.4.4 Viral Load Coverage by Region FY18

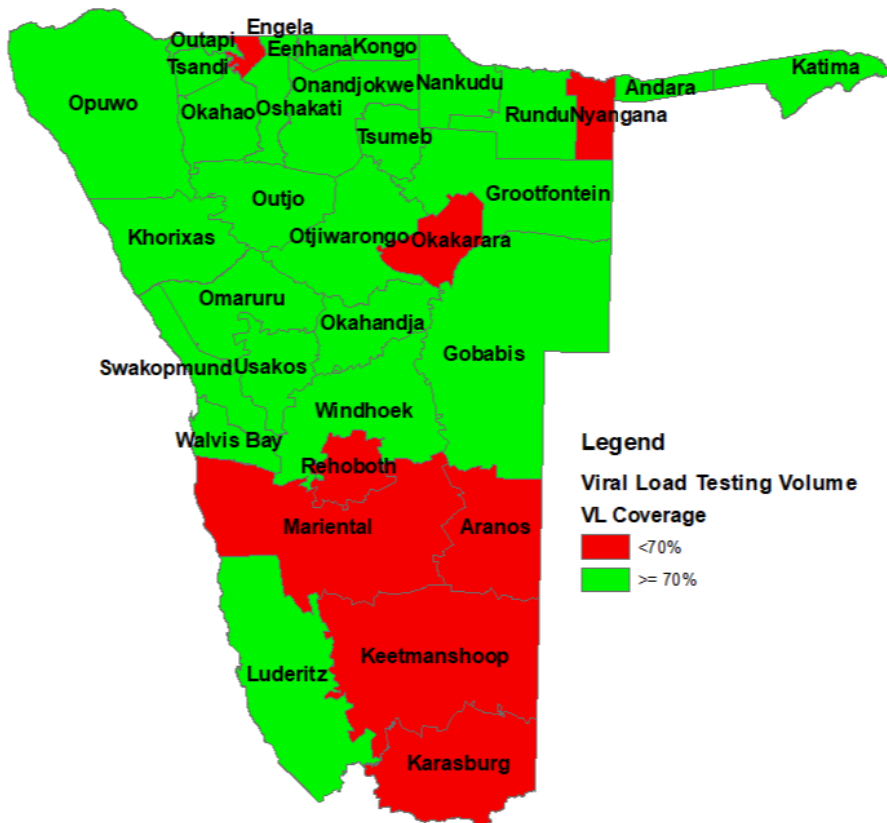


Figure 2.4.5 Viral load suppression for patients on ART by region

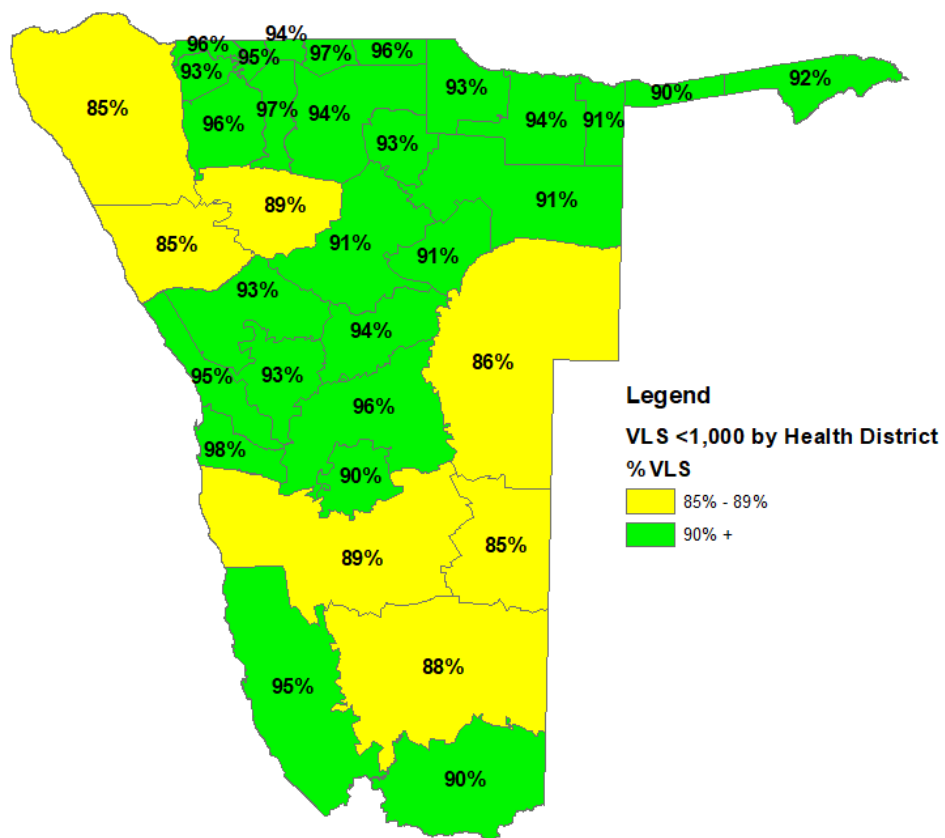
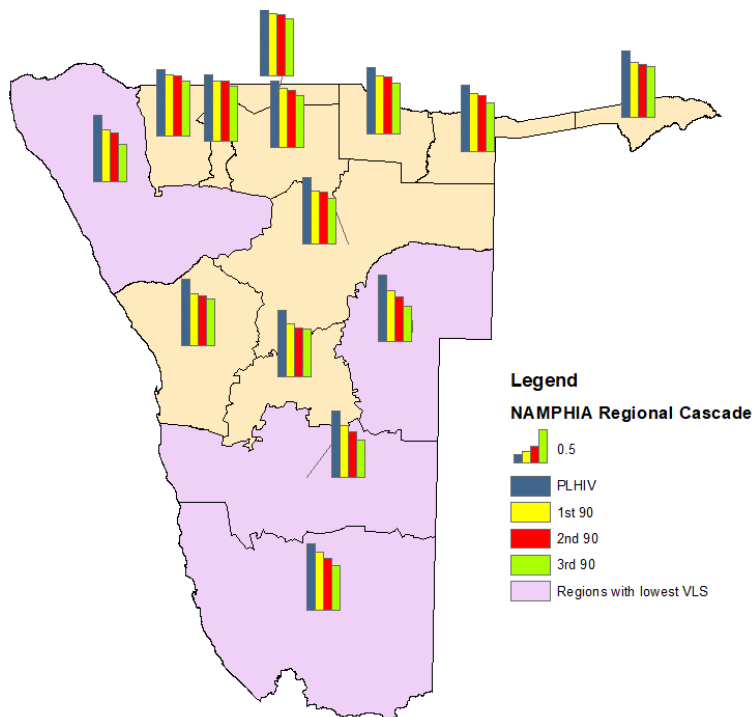


Figure 2.4.6 NAMPHIA Regional Cascade and Regions of Lowest VL Suppression



2.5 Stakeholder Engagement

Host Country Government

The strong working partnership between PEPFAR and the GRN is demonstrated through various formal engagements including regular meetings with the management team of the MOHSS, led by the Executive Director, and the leaders from the different directorates, particularly the Directorate of Special Programs (DSP). PEPFAR Namibia also participates in several TWG platforms where technical assistance is provided on a range of issues on an ongoing basis. The MOHSS takes center stage at key stakeholder forums such as periodic program reviews, and general stakeholder meetings including the development of the annual country operational plans. During the COP19 process, PEPFAR Namibia attended meetings led by DSP where the government was updated on the current program performance using the latest data and the COP19 guidance. Regular meetings were conducted with the Executive Director of the MOHSS and the DSP to update them on the COP19 process as well as participate in subsequent planning meetings including the in-person meeting held in Johannesburg.

Global Fund and Other External Donors

PEPFAR Namibia prioritizes efforts directed at mobilizing the contribution of multilateral partners in the development and implementation of the national response. PEPFAR Namibia meets with The Global Fund (GF) during their quarterly visits to Namibia and emails the Fund Portfolio Manager as needed in order to maintain open communication. The GF was specifically involved in the initial consultations including the process of developing COP19, participating in in-country meetings and attending the PEPFAR in-person meeting in Johannesburg. Working with MOHSS, PEPFAR Namibia has regularly engaged the GF team to address funding gaps in the overall response. The COP19 process sought the involvement of the UN agencies starting with hosting the in-country stakeholder consultation meeting on February 6, 2019 and having the presence of the UNAIDS team during the in-person meetings.

Civil Society/Faith-Based Organizations and Community

PEPFAR Namibia works closely with CSOs made up of implementing partners and organizations that do not receive funding. The CSOs include key populations, entities that represent PLHIV groups, Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) organizations, sex worker-led organizations, and organizations working with Orphans and Vulnerable Children.

CSOs as well as faith and community-based organizations participated in the in-country stakeholder meeting to give their inputs on the HIV response. In February, the UN hosted the COP19 review meeting and subsequently, through a peer nomination process, the CSOs selected two representatives to the in-person meeting in Johannesburg. The two nominated representatives were from organizations that offer services to key populations, with a variety of HIV testing modalities and who operate with human rights perspective. CSOs made presentations at the in-country meeting and the in-person meeting in Johannesburg providing input for the country vision for COP19, identified gaps, needs and potential challenges. Prior to travel, the two representatives engaged with broader stakeholder groups in order to gauge their perspectives and priorities to ensure they represented the collective voice of civil society appropriately.

Private Sector

PEPFAR Namibia held consultations with various private sector entities including the Namibia Association of Medical Aid Funds, and the Medical Association of Namibia (MAN) to explore opportunities to engage the private sector in the HIV/AIDS response. Private sector participants were also invited and attended the COP19 Stakeholder meeting held on February 6, 2019 and were individually consulted to provide private-sector data. PEPFAR Namibia plans additional engagements throughout the year, particularly relating to sustainable health financing.

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

PEPFAR Namibia conducted a stakeholder meeting with key populations and LGBTI led organizations on February 05, 2019. The meeting sensitized key populations and LGBTI representatives about the COP19 focus areas and conducted a dialogue on additional areas the group would like to see included. A larger national stakeholder meeting was held on February 6, 2019. Both regional and national level stakeholders were invited. In total, 100 stakeholders attended the meeting. Representatives included officials from government ministries, implementing partners, CSOs, faith and community based organizations, and UN agencies.

The wider stakeholder meeting reviewed the overall country performance for 2018. The meeting also looked at a rapid assessment of interventions and focus areas for COP18 to inform the vision for COP19. Program areas such as Treatment, TB, VMMC, HTC and Key Populations were assessed for potential scale up using approaches that proved to work on the basis of current data. The new strategies from the COP19 guidance were presented to the stakeholders, which further framed stakeholder ideas and the focus on the country's vision for sustained epidemic control.

3.0 Geographic and Population Prioritization

PLHIV burden and the unmet need for ART vary across Namibia. In COP18, based on Namibia's HIV epidemiological data, PEPFAR Namibia provided support for the high burden districts that represents approximately 95% of the disease burden with the aim to bring all sites to attained.

ART coverage by age and sex is lowest among males 20 to 34 years of age and females 15 to 24 years of age. These populations will be a priority for PEPFAR Namibia in COP19 for case finding and ART initiation. PEPFAR Namibia plans to implement targeted interventions to increase case identification and linkage to ART to fill these gaps. Compared to the 95% VLS among all populations in FY19 Q1, pediatrics, adolescents and young adults age 0 to 24 years had comparatively lower VLS rates (Figure 3.1). Slow rates of decentralization for pediatrics and adolescents, limited support for pediatrics disclosure and teen psychosocial support, and suboptimal ARV prescribing have been identified as contributing factors. Additional support for pediatric and adolescent viral load suppression will be provided nationally in COP19. (Figure 3.2).

Looking by region at the total population with HIV and the number on ART through PEPFAR support, we see the highest burden regions where PEPFAR has invested the most, high coverage across the cascade. In the most urbanized and affluent areas, there exists a larger treatment gap than anticipated that is mostly filled by the 18,600 ART clients in the private sector, which is mostly restricted to those

regions. Finally, we can see the regions that are low prevalence and low population but also have the lowest coverage rates, and these areas are also where PEPFAR Namibia will increase support with more focused technical assistance.

Index partner testing will be expanded to include all regions in COP18 for community and facility index testing. In COP19, community index testing will be conducted by The Development Aid from People to People (DAPP), Project Hope and MOHSS. Facility Index Testing will be conducted by MOHSS and Itech. Additionally, in COP19, DAPP will expand their coverage with a new model of technical assistance to the Ministry of Health to ensure community index testing is scaled up with fidelity. (Figure 3.3).

In COP19, facility based care and treatment will be shifted to create efficiencies between agencies and to be in line with Namibia’s Planning Letter. Partners will provide direct service delivery and technical assistance, leveraging resources and relative strengths from all stakeholders. This will also allow PEPFAR Namibia to target support to those lower-performing remote regions. PEPFAR will provide standard support and targeted support through MOHSS and Itech depending on the needs of the region. (Table 3.2, Figure 3.4).

In COP18, PEPFAR Namibia supported community-based organizations to implement community ART in some regions (Community-Based ART (CBART)), Community Adherence Clubs (CACs), Community Adherence Refill Groups (CARGs)). In March 2019 the CBARTs SOP was standardized and the model name changed to Comprehensive Community Based Health Services (CCBHS) to reflect all forms of outreach (i.e, standalone ART specific and Combined PHC-ART outreach models). Community refill groups models previously named differently by different partners, were also standardized under one name: Community Adherence Groups (CAGs).

In COP19, regions previously not supported for community ART delivery will receive PEPFAR support through the MOHSS to scale up Community-Based Care & Treatment. (Figure 3.5).

Figure 3.1. Viral Load Suppression Rates by Age/Sex, Namibia HY19 Q1 (N=162,107)

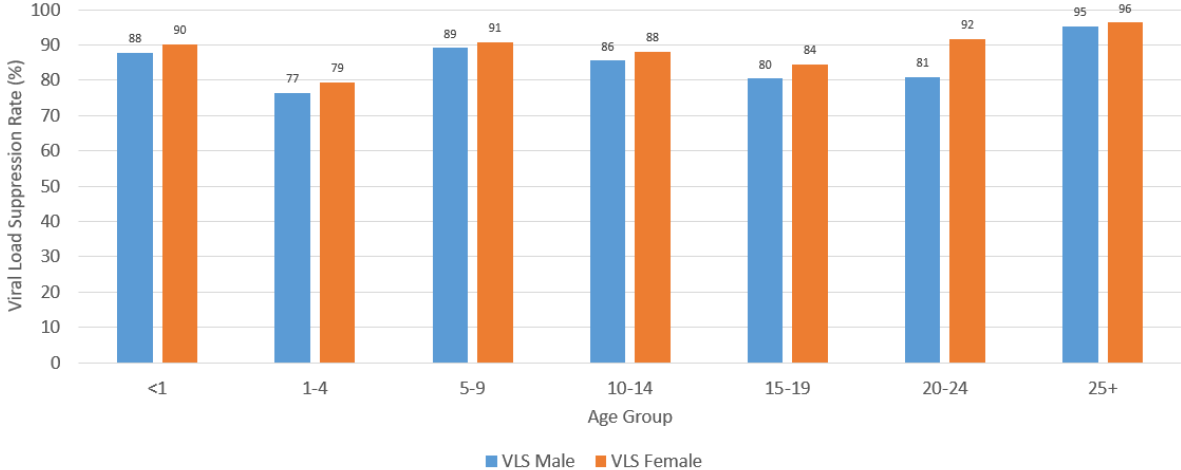


Figure 3.2 Regions with the lowest proportion of PLHIV viral load suppression

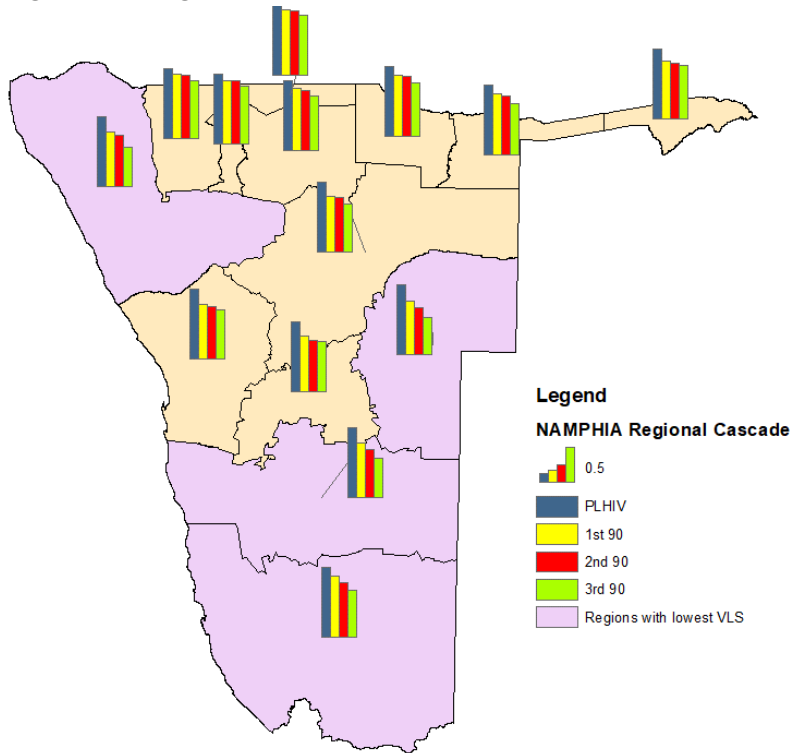


Figure 3.3 Index Partner Testing: Expansion from COP18 to COP19

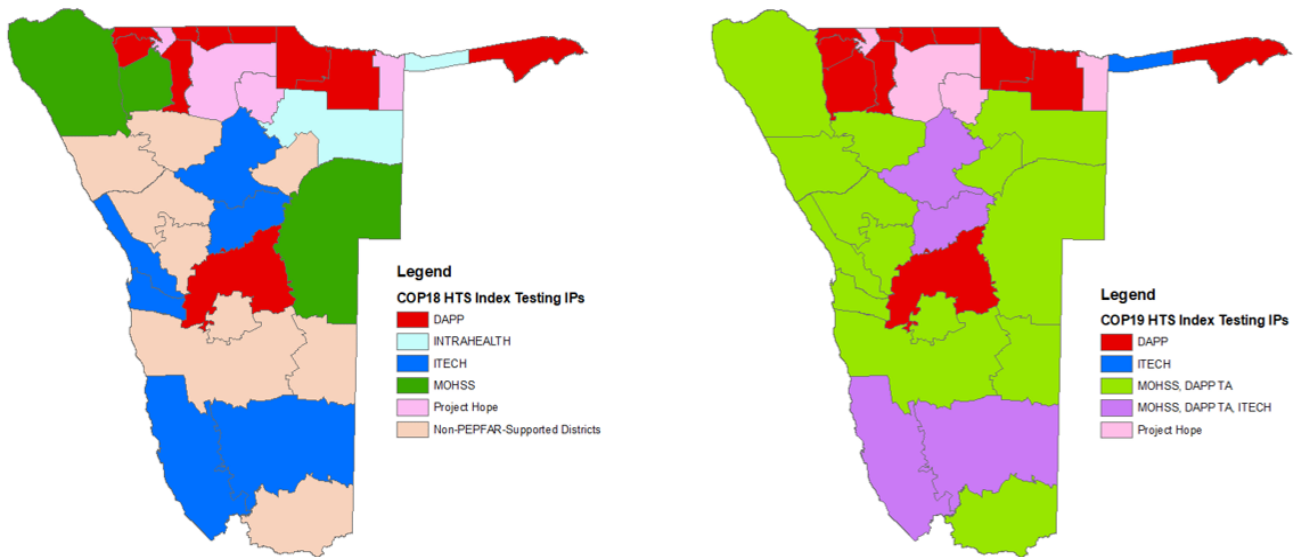


Figure 3.4 COP19 Agency and IP Allocation: Facility-Based Care & Treatment

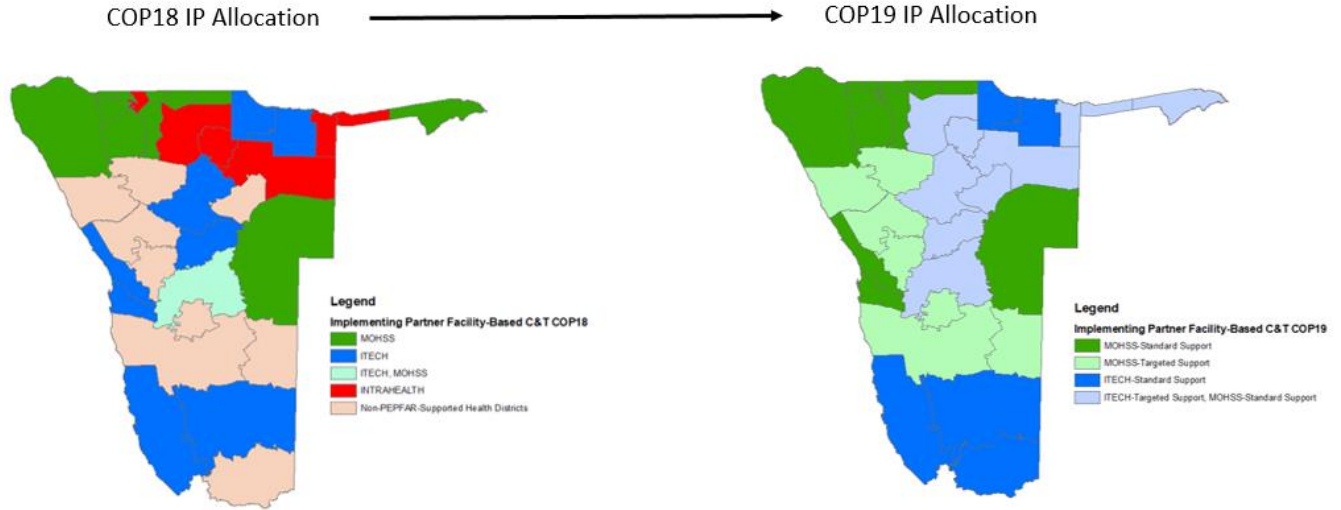
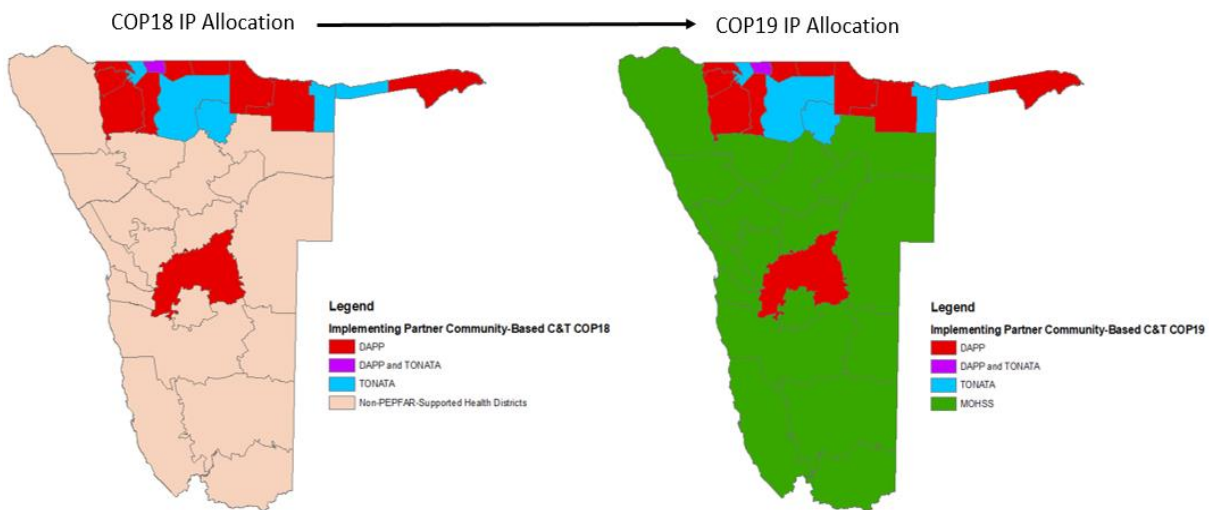


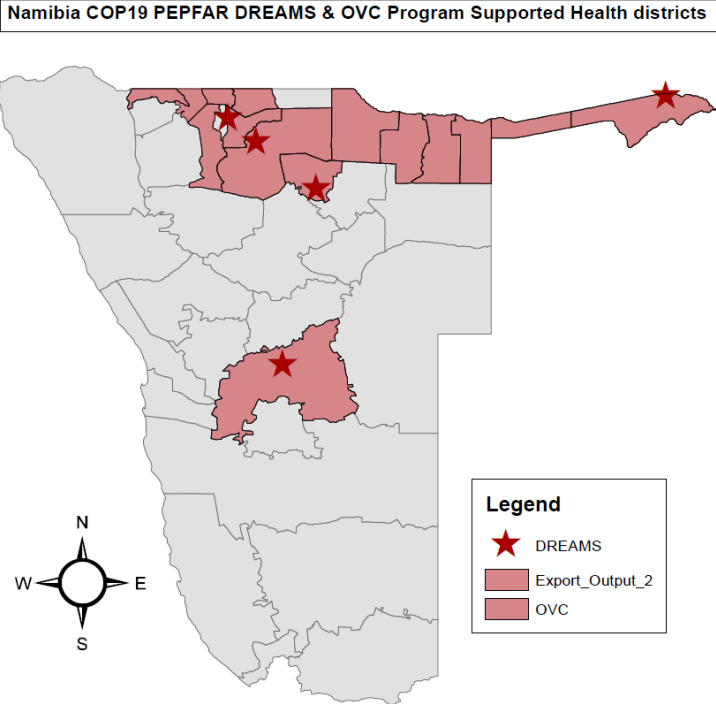
Figure 3.5 COP19 Agency and IP Allocation: Community-Based Care and Treatment



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. OVC activities will be implemented in 15 districts with an overlap of OVC implementation in five Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe Women (DREAMS) districts. OVC activities are aligned to geographic areas of the highest HIV burden and greatest unmet ART needs for children and adult populations. DREAMS interventions will continue in five districts with high HIV prevalence rates, high prevalence of GBV rates and high teen pregnancy rates: Katima Mulilo, Omuhiya,

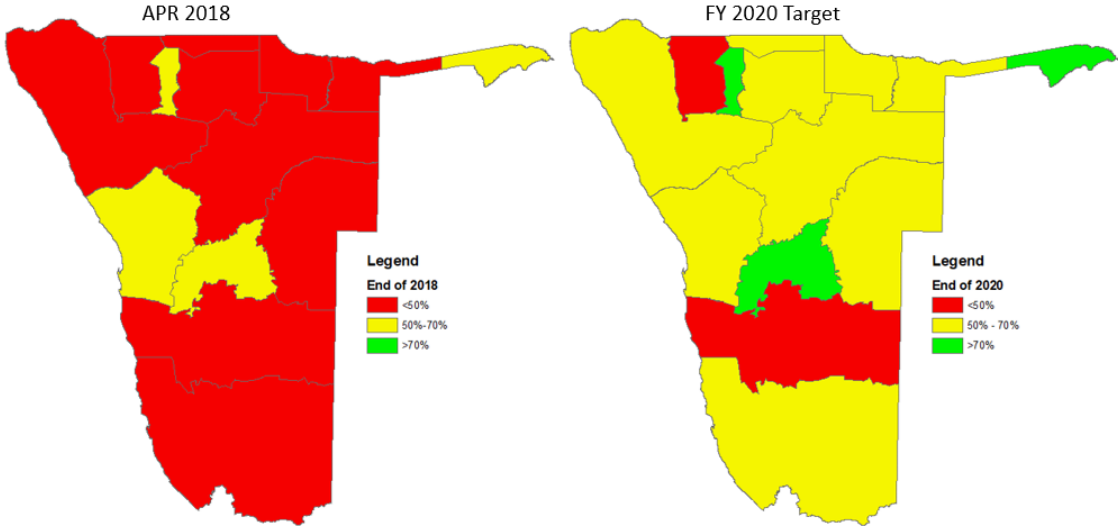
Onandjokwe, Tsumeb, and Windhoek. DREAMS activities will target AGYW ages 9-24 in an effort to decrease the HIV incidence and ultimately keep them HIV-negative. In these districts, PEPFAR Namibia will ensure layered age-appropriate programming up to age 24(Figure 3.6).

Figure 3.6 DREAMS and OVC Program Supported Health Districts



As a result of PEPFAR support to the MOHSS, national VMMC coverage among young men aged 15-29 years old has increased from 35% in 2017 to 42% by the end of calendar year 2018. Regions with direct PEPFAR support recorded some of the highest coverage: Windhoek (Khomas region 57%), Katima Mulilo (Zambezi Region 65%), Oshakati (Oshana region 57%), Swakopmund and Walvis Bay (Erongo region 52%) (DMPPT, Version 2.0, 2018). Newly supported regions had low VMMC coverage; Rosh Pinah and Luderitz (!Karas region 30%) and Oshikuku, Onandjokwe and Tsumeb (Oshikoto region 22%). In FY19, PEPFAR Namibia expanded support for VMMC programs in areas where GF services have decreased. COP19, FY20 activities will focus on the provision of HRH support, demand creation and quality management and quality improvement for a rapid VMMC scale up in all priority regions. It is expected that the ambitious FY20 OU target will rapidly move three priority regions (Khomas, Zambezi and Oshana) to 70% VMMC coverage by the end of 2020. (Figure 3.7).

Figure 3.7 VMMC Coverage from APR 2018 and Targets for FY 2020



In FY19, Peace Corps Namibia will continue to place Health Volunteers in mostly high-burden priority regions including Kavango East and West, Ohangwena, Oshikoto, and Zambezi. In addition, Volunteers will be placed in the hitherto non-PEPFAR priority regions of; Hardap and !Karas. Peace Corps Volunteers will be placed with the MOHSS, Ministry of Education, Arts and Culture, community health facilities, and non-governmental organizations to support evidence-based preventative care, support and treatment activities targeting OVC, 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, and target the previously unsupported and underperforming regions. (Tables 3.1, 3.2).

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) | # of SNU COP18 (FY19) | Total PLHIV | COP19 (FY20) |
|---------------------|-------------------------|-----------------------|-----------------------|-------------|----------------|
| Attained | 10,444 | 2 Districts | 12 Districts | 203,396 | All 14 Regions |
| Scale-up Saturation | 114,737 | 11 Districts | | | |
| Scale-up Aggressive | 10,153 | 3 Districts | | | |
| Sustained | 22,177 | 8 Districts | | | |
| Central Support | 9,124 | 9 Districts | 9 Districts | | |

Table 3.2 PEPFAR Namibia COP Priority Areas Over Time

| COP15 | COP16 | COP17 | COP18 | COP19 |
|--------------|---------------|-------------------------------------|--------------------------------|--------------|
| !Karas | !Nami#nus | !Nami#nus - Rosh Pinah Cluster | !Nami#nus - Rosh Pinah Cluster | !Karas** |
| | Rosh Pinah | | Keetmanshoop | |
| | Keetmanshoop | Keetmanshoop | Keetmanshoop | |
| | Karasburg | Karasburg | Karasburg | |
| Erongo | Omaruru | Omaruru | Omaruru | Erongo |
| | Usakos | Usakos | Usakos | |
| | Swakopmund | Walvis Bay-Swakopmund Cluster | Walvis Bay-Swakopmund Cluster | |
| | Walvis Bay | | | |
| Hardap | Mariental | Mariental | Mariental | Hardap** |
| | Rehoboth | Rehoboth | Rehoboth | |
| Kavango East | Andara | Andara | Kavango | Kavango East |
| | Nyangana | Nyangana | | |
| | Rundu | Rundu-Ncamangoro-Nkurenkuru Cluster | | |
| Kavango West | Ncamangoro | | | Kavango West |
| | Nkurenkuru | | | |
| Khomas | Windhoek | Windhoek | Windhoek | Khomas |
| Kunene | Khorixas | Khorixas | Khorixas | Kunene** |
| | Opuwo | Opuwo | Opuwo | |
| | Outjo | Outjo | Outjo | |
| Omaheke | Gobabis | Gobabis | Gobabis | Omaheke** |
| Ohangwena | Eenhana | Eenhana-Engela-Okongo Cluster | Namibia Cluster 1 | Ohangwena |
| | Engela | | | |
| | Okongo | | | |
| Omusati | Okahao | Okahao-Tsandi Cluster | | Omusati |
| | Tsandi | | | |
| | Outapi | Outapi | | |
| | Oshikuku | Oshikuku | | |
| Oshana | Ondangwa | Oshakati -Ondangwa Cluster | Oshana | |
| | Oshakati | | | |
| Oshikoto | Omuthiya | Omuthiya-Onandjokwe Cluster | | Oshikoto |
| | Onandjokwe | | | |
| | Tsumeb | | Tsumeb | |
| Otjozondjupa | Grootfontein | Grootfontein | Grootfontein | Otjozondjupa |
| | Okahandja | Okahandja | Okahandja | |
| | Okakarara | Okakarara | Okakarara | |
| | Otjiwarongo | Otjiwarongo | Otjiwarongo | |
| | Tsumkwe | Tsumkwe | Tsumkwe | |
| Zambezi | Katima Mulilo | Katima Mulilo | Katima Mulilo | Zambezi |

Bold black text = PEPFAR priority regions/districts/clusters Blue text = Attained
 Red Text = PEPFAR priority hotspots **Expanded TA support

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 ensuring viral suppression

HIV Case Finding

In FY18, PEPFAR Namibia identified 21,695 HIV positive persons, more than previous fiscal years enabling Namibia to move even closer to epidemic control. In Namibia more than 94% of PLHIV know their status. Data suggest that the remaining gap in testing may be highest among men 20 to 34 years of age. PEPFAR Namibia has also identified four low volume regions (Kunene, Hardap, !Karas and Omaheke), not previously supported by PEPFAR that have higher volumes of men living with HIV compared to higher volume regions. Case finding results by sex, age, geography and modality show that for FY18, index partner testing in both the community and facilities as well as PITC modalities were successful in finding HIV positive men in PEPFAR-supported regions. The number of HIV positives and yield by modality for FY19, Q1, show that the Index Partner Testing modality has the highest yield among testing modalities while other PITC produces the highest total number of positives, yet yield remains sub-optimal. The HIV testing yield for FY19 Q 1 is higher among men older than 30 years than women and younger men. PEPFAR Namibia is already finding men and by further expanding index partner testing to all community and facility partners, and refining PITC to screen for the highest risk individuals, the yield will continue to rise, further closing the gap among positives yet to be identified. These modalities will be delivered at scale and with fidelity in COP 19 to reduce testing volume and increase yields. In COP19, PEPFAR Namibia will expand to reach the four lower volume regions, with increasing pressure to close the final gap for case-finding especially among men.

In COP19, PEPFAR Namibia will optimize case finding by: 1) continuing to scale up index partner testing; 2) refining PITC strategy; and 3) scaling up recency testing to identify populations and geographies where active transmission is occurring.

Scale up Index Partner Testing

In COP 18, the Namibian Government committed to implement Index Partner Testing at scale in Circular 12 of 2019 in all districts and with all facility and community partners. The training and tools to implement index testing at scale is already underway. DAPP's Index Partner Testing model is being brought to scale in COP 18 by providing the MOHSS and all PEPFAR testing partners with technical support to deliver Index Partner Testing with efficiency and fidelity. This will ensure that all newly identified positives are treated as an index case. Ensuring the safety of patients through intimate partner violence screening is a critical component to index testing and will be tracked by all partners pre- and post-index testing.

Refine Provider Initiated Testing and Counseling

In the same circular, GRN committed to implement a Provider Initiated Testing screening tool for

adults and children especially in Outpatients and Inpatients Departments in all public health facilities. The PITC screening tool will reduce testing among those with low risk and prioritize high-risk groups including those who have not tested regularly and have risky sexual behaviors. Routine testing will continue for STI, TB patients, pregnant and breastfeeding women, and children diagnosed with malnutrition. This strategy will reduce PITC volumes and increase testing yield within public health facilities.

Scale up Recency Testing

As the country nears epidemic control, recency testing will be scaled up from five high burden districts in COP18 to provision of recency results to all HIV positives identified in PEPFAR-supported sites in COP19. This rollout will ensure that all newly diagnosed and eligible persons who present for ART initiation will have a known recency status. To account for this increase, an additional 27,000 recency tests will be procured and existing partnerships will be leveraged for support in technical assistance, training, and monitoring. Additionally, Namibia will work on integrating the recency test for recent infection (RTRI), as the confirmatory test into the retesting algorithm at ART facilities and building fields into existing MoHSS tools, to ensure the systematic and ongoing collection of recency data. These results will enable the program to map transmission hotspots, which can then be targeted with prevention and treatment services to disrupt further transmission, by employing limited mobile/outreach services including index testing services.

Immediate ART initiation

Namibia has successfully implemented test and treat at health facilities in all districts since 2016. Given the latest estimates of Namibia's progress towards meeting the UN Fast track targets, of the 94% of PLHIV diagnosed with HIV, 96% were on treatment, which is an indication that Namibia is successful in linking those who test HIV positive to treatment. In FY19 Q1, PEPFAR Namibia achieved 89% linkage of newly identified positives to treatment within the quarter, which is consistent with linkage rates previously achieved for FY18 Q3 and Q4. Programmatically, PEPFAR Namibia is able to achieve consistently high linkage rates through active linkage mechanisms, whereby healthcare providers physically escort patients for ART initiation and follow up patients to ensure that positives are started on ART. PEPFAR Namibia's goal is to achieve overall linkage rates of 95% or more for COP19. The same-day ART initiation data for APR18 showed significant improvements in policy implementation, which shows that from Q1 FY18 to Q4 FY18, same-day linkage increased from 42% to 74%.

HIV testing in community settings, however, continued to face some delays in ART initiation. In March 2019, PEPFAR supported MOHSS to standardize the guidelines for ART initiation in community-based testing models across all districts and across all implementing partners. The newly adopted SOPs provide for adoption of the Community Test & Treat SOP, which includes guidance on the use of "ART Starter Packs" for Community Testing Partners with NIMART trained nurses. With this adoption, after confirmation of HIV diagnosis, ART will be initiated immediately through ART starter packs at testing service points that include OPDs, in-patient

wards, and community testing points. Importantly, patients who receive ART Starter Packs will be carefully followed up to make sure they are successfully linked to ART facilities.

In COP19, the program will bring to scale some key interventions to further boost linkage rates to achieve 95% by:

- Ensuring same-day ART initiation;
- Maintaining physical escorting of patients from testing to ART sites;
- Following up all new positive patients to ensure linkage to ART facilities; and
- Finalizing and implementing ART Starter Packs for community partners;

Retention on Lifelong Treatment

Looking at 12 month retention in APR FY18, results show that 54% of all sites had retention greater than 85%, while 16% of sites were between 75-84%, and a further 30% of sites had retention less than 75%. Of note, the majority of the poor performing sites were not PEPFAR supported as of end of FY18.

High on the priority lists of retention interventions is the intensified implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and community ART models (see section 4.3). 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 Collaboratives such as NAMLIVE will be implemented in lower performing sites to improve retention, along with standardization of lost to follow up patient tracking.

Viral Load Suppression

Namibia continues to be successful in achieving excellent VL suppression results (>90%) across most districts. However, NAMPHIA and recent program data revealed four regions (!Karas Kunene, Omaheke and Hardarp) that have historically been low burden regions, but all have relatively poor ART coverage and relatively poor viral load suppression. In order to start closing the remaining gap to reaching full epidemic control, an intensified and targeted focus will need to be implemented in COP19. The PEPFAR Namibia COP19 vision for maintaining and improving viral load suppression includes: 1) Optimizing ARV regimens; 2) Improving Retention through Patient-Centered Models; and 3) improving viral load monitoring.

Optimizing ARV regimens will be a critical component to achieving durable viral load suppression. Namibia will be fully transitioning to TLD in COP19 (see section 4.3), as the national ART guidelines will be updated and include TLD as the first-line regimen for all eligible populations, while remaining NVP-based regimens will be quickly phased out. The country will limit treatment interruptions by improving retention on ART. Retention will be improved by scaling up multi-month scripting/dispensing, standardizing and optimizing community models of care such as CBARTS and CACs, and by standardizing and strengthening lost to follow up tracking systems. Viral load monitoring will be improved by providing place of care VL testing for

pregnant and breastfeeding women with GeneXpert machines, scaling QI Collaboratives, and positive messaging through Undetectable=Untransmissible (U=U) campaigns. Additionally, in COP19, we plan to continually provide surveillance of HIV drug resistance through cyclic acquired HIV drug resistance monitoring, thus further strengthening Namibia's capacity to select appropriate optimized ART regimens for patients failing their treatment. With the proposed targeted interventions to improve those few regions that are lagging behind, the aim is to achieve 95% VLS across all districts in Namibia by the end of COP19.

4.2 Prevention, specifically detailing programs for priority programming:

HIV Prevention and Risk Avoidance for AGYW and OVC

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

In Q4 of COP17, the OVC program reached 29,016 beneficiaries, compared to its target of 35,460. Of those reached, 22,144 were OVC under 18. The OVC program implements an HIV risk assessment for OVC and as a result, in Q4, 95% of OVC under 18 reached had a known HIV status and all children reported as HIV positive were on treatment. PEPFAR Namibia will continue to support case management, deployment of healthcare workers (HCW) as well as tools and training to strengthen layering to address comprehensive needs of children, caregivers, and/or families. One of the important pivots that the OVC program made in COP17 was the deployment of HCW in health facilities to facilitate identification of HIV positive children, children of HIV positive caregivers, teenage mothers or pregnant teenagers, and children of other priority populations and link them to both OVC and health services and this will be continued through COP18 and into COP19.

In COP19, a key focus will be on ensuring that the PEPFAR primary prevention of sexual violence and HIV modules for 9-14 year olds are integrated in various packages that are used in the OVC and DREAMS program. PEPFAR Namibia will implement violence risk assessments as well as reporting experiences of violence at home and school for OVC. Additional support will go towards strengthening disclosure for children and adults living with HIV. Parenting programs, specifically the Families Matter! program, focusing on decreasing violence against children and promoting positive parenting to reduce adolescent HIV risk behaviors, will continue be implemented. Through the OVC program, there will be an emphasis on reaching boys using specific curriculum such as Peace Corps Boys Respecting Others (BRO), Youth Exploring and Achieving in Health (YEAH) and Girls and Guys Leading Our World (GLOW). Household economic strengthening interventions to mitigate the impact of HIV will be conducted.

In COP19, PEPFAR will continue to work with GRN and partners to saturate DREAMS districts by engaging with new schools to reach at-risk girls; increase number of safe spaces, and support Peace Corps Volunteer placement in DREAMS districts. PEPFAR Namibia will also continue to formalize the community norm change program. In COP19, PEPFAR Namibia plans to reach saturation of DREAMS package of services for 80% of eligible AGYW in all current SNUUs. PEPFAR Namibia will continue to support rapid implementation of a layered DREAMS package of services. At-risk AGYW are enrolled and provided a primary package of interventions that was defined in COP17. Interventions will also include adolescent-friendly sexual and reproductive health (SRH) services and partner notification referral to HTS or ART. AGYW and OVC will also be linked to other non-clinical interventions such as economic strengthening, social grants, education support, etc. In Q4 of COP 17, PEPFAR Namibia made strides in ensuring that DREAMS layering, tracking and reporting systems called The DREAMS Machine (TDM) was developed using the RedCap system. This is successfully continuing in COP18 and will be further progressed in COP19.

In COP19, PEPFAR will continue to 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 continue to increase the number of HIV infected OVC 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. The OVC program will continue to strengthen collaboration with the pediatric program and also strengthen engagement with PMTCT platforms currently being implemented. PEPFAR Namibia will continue to provide technical assistance to GRN on social welfare grants, development of a standardized case management system, social welfare training and service networks, and monitoring and evaluation (M&E) systems. PEPFAR Namibia will also continue to provide capacity building to local Namibian OVC CSOs in COP19.

In COP19, targets will remain unchanged for PP-PREV at 58.129. OVC targets will be 34,716 and have been re-allocated to age bands to be able to reach an increased number of the younger age groups (10-17). GEN_GBV target in COP19 is 2000 and PrEP New target is 16,017 in COP 19.

Children and Adolescents

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, and according to the last NDHS in 2013, the average age of sexual debut in Namibia is between 13-14 years old. Additionally, among adolescent girls, intergenerational relationships continue to keep the HIV incidence among this age group high.

Children and adolescents living with HIV are not achieving the same success as their adult counterparts in Namibia, and as Namibia moves towards reaching sustained epidemic control, no population can be left behind. Namibia's overall national average for viral suppression among adults >25 years of age is 95%. However, children and adolescents are behind with national average around 85% and even lower in the 1-4 year old age group at 78%. Additionally, when looking at site-level data, there are clear discrepancies in districts in VLS, with districts not previously supported by PEPFAR being the lowest performing. Targeted support through clinical mentors will begin in COP18 in order to start identifying why children are doing worse in these districts and what mentorship and training to HCW can be provided to start improving pediatric outcomes. Additionally, with nearly 30% of all CLHIV still on AZT/3TC/NVP, PEPFAR Namibia is working with the mentors to start transitioning all children off NVP-based regimens as soon possible to start improving suppression rates, and by COP19, all eligible children will be receiving a DTG-based regimen when appropriate.

Realizing that youth in Namibia are falling behind their adult counterparts, there is a need to take action to involve the youth more in their care, and in the decision-making about the quality of care they receive. Learning from best practices from other countries in COP19, a community adolescent treatment supporter (CATS) approach will be adapted that will enable youth peer mentors to work across the clinical cascades to improve overall outcomes. Additionally, a national youth advisory board will be established to involve young people in high-level decision making that affects the quality of services they receive, and ensuring that they are child and adolescent friendly. Finally, to address the training gap in Namibia, three model clinics for pediatric care will be established to allow short-term attachments for nurses, doctors and social workers, to receive further focused pediatric HIV training including ART training, psychosocial support, and nutritional support. The aim is to allow capacity building across all cadres, to work with the unique needs that children and adolescents living with HIV have. PEPFAR Namibia's goal in COP19 is to improve the clinical cascade across the 95-95-95 for all children and adolescents living with HIV, by implementing the mentioned activities and optimizing ART regimen in COP19 to achieve better VLS among youth in Namibia.

Key Populations

In FY18, programmatic data revealed that increasingly more FSW and MSM are reached with HIV prevention messages through interpersonal communication and risk reduction. Though referral and linkage to life saving ART for those who have been diagnosed remained a challenge (overall only 70% of all KPs diagnosed with HIV were successfully linked on treatment).

In Q1 FY19, PEPFAR Namibia demonstrated improvements in linkage to treatment for FSW at 78%. However there are gaps in linkage to treatment among MSM (61% compared to 73% in FY18) and TGW (60% compared to 39% in FY18). The improvement in linkage to treatment is a direct result of active partner management for focused and intensified peer education and referral. PEPFAR Namibia used the findings from the Priorities for Local AIDS Control Efforts (PLACE) study as well as formative assessment and dialogue during the PLACE study to facilitate and optimize targeting of high-risk individuals and development of a clear referral pathway. In

FY20 PEPFAR Namibia will use the findings from the NAM-IBBS to further improve reach and link strategies for KP in Namibia.

In COP19, PEPFAR Namibia will expand high quality HIV prevention services for key populations to cover two more districts (Otjiwarongo and Gobabis) in addition to the current seven districts (Walvis Bay, Katima Mulilo, Oshikango, Oshakati, Rundu, Keetmanshoop, and Windhoek). This expansion of services is in response to stakeholder feedback from a key population activity design conference in October 2018. Deliberate effort will be made to reach MSM and TGW who continue to lag behind. Programmatic intervention will include engaging MSM and TGW-specific local CSOs and building their capacity, and training of peer educators and case workers within their networks to reach individuals. TGW 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. The enhanced peer outreach approach will be adopted specifically for TGW and MSM. Enhanced Peer Outreach Approach (EPOA) has been proven to increase reach, testing, and linkage among key populations. In FY19, EPOA will be implemented in all districts to facilitate reach to social networks and individuals that have not been reached by the program and link them to clinical services including HTS and ART.

Programmatic approaches to improve HTS yield and increase case finding strategies for key populations in COP19 will build on current activities being supported in COP18. These include optimized HTS among social networks and for individuals who have interacted several times with the program through screening for risk. Assisted HIVST to complement outreach moonlight services will be delivered to reach hidden populations. HIV self-testing (HIVST) will also be delivered through a new social media platform that targets MSM and TGW. PEPFAR Namibia will also expand social network testing and index partner testing for all eligible key populations in line with the national guidelines. The program will continue to expand coverage of PrEP by promoting PrEP through peer education and social media, and facilitating uptake among all groups, particularly MSM and TGW.

To strengthen linkage to care and minimize missed opportunities for treatment, PEPFAR will collaborate with MOHSS and designated health facilities to ensure KPs also receive same-day ART initiation and starter pack ART during outreach programs and moonlight sessions. Self-selected and trusted peer navigators from FSW, MSM and TGW communities will be trained to facilitate linkage to care for newly diagnosed. They will also facilitate retention to treatment for those who are defaulting by supporting adherence counseling and training loss to follow up. In COP19, PEPFAR will link the case management data base with the electronic patient management system (ePMS) to track patients' outcomes such as viral load for key populations who access treatment from public health facilities.

Institutional and technical capacity building activities for CSOs from the LGBTI community will form the foundation of PEPFAR Namibia's programming in COP19. KP organizations will also support violence response and monitoring among key populations. Programmatic work with key

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

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). PEPFAR Namibia's primary objective is to support MOHSS to increase coverage of VMMC services in priority districts. As a result of PEPFAR support to the MOHSS in FY18, national VMMC coverage among young men aged 15-29 years old increased to 42% by the end of calendar year 2018. Regions with direct PEPFAR support recorded some of the highest coverage: Windhoek (Khomas region 57%), Katima Mulilo (Zambezi Region 65%), Oshakati (Oshana region 57%), Swakopmund and Walvis Bay (Erongo region 52%) (DMPPT, Version 2.0, 2018).

In FY20, PEPFAR Namibia will build on existing strategies and activities implemented in FY19 to increase national VMMC coverage. Overall the OU target for FY20 is 50,203. Priority regions will include 10 of the 14 regions: Khomas, Hardap, Erongo, !Karas, Oshikoto, Oshana, Ohangwena, Omusati, Zambezi and Kavango East regions.

PEPFAR Namibia's COP19 target will rapidly move three priority regions (Khomas, Zambezi and Oshana) to 70% coverage of VMMC. VMMC services in Khomas, Zambezi and Oshikoto regions will complement PEPFAR Namibia's DREAMS program in these region. As part of the comprehensive package of services for DREAMS, young men will be referred for VMMC.

PEPFAR Namibia will continue to support context specific, scientifically proven and human-centered demand creation targeting for young men aged 15+, particularly through work with Namibian institutions, traditional leaders and churches. 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 will also support practical and feasible ways to mitigate physical barriers to uptake of VMMC services.

PEPFAR Namibia will also support proficiency assessment for clinicians and quality management (QM) and quality assurance (QA) in COP19. In Q1 FY19, PEPFAR Namibia supported the adoption of the continuous quality improvement tools by MOHSS. In FY20 an external quality assurance (EQA) will be supported and QA/QM activities will focus on formation of VMMC Continuous Quality Assurance teams at service delivery sites to ensure continuous quality improvement and safety of clients, health workers, and the community. PEPFAR will also support MOHSS to adopt and contextualize the WHO/PEPFAR adverse event management protocols for VMMC adverse events.

By the end of FY19, all PEPFAR-supported VMMC sites will have moved to the dorsal slit technique in line with the SGAC cable. In FY20 additional TA will be provided to ensure the entire national program, including the Global Fund-supported activities, shifts to the dorsal slit method of circumcision. All new VMMC services providers will be trained on the dorsal slit

method and refresher training of existing cadres will continue in FY20. PEPFAR Namibia will monitor strict adherence to non-usage of the forceps guided technique in boys under the age of 15 or those with immature penile anatomy.

In FY19, PEPFAR Namibia will finalize the field validation of the Shang Ring device. In FY20, the program will continue to support surveillance monitoring for use of the Shang Ring device.

PrEP

In FY18, PEPFAR Namibia achieved over 300% of the overall OU target for PrEP, reaching more than 4,712 high risk individuals 15+years old. By the end of Q1 FY19, PEPFAR supported MOHSS to finalize and adopt PrEP standard operating procedures, training materials and demand creation tools. PEPFAR Namibia's target for PrEP in COP19 is 16,017. Namibia is clearly succeeding in reaching KPs, serodiscordant couples and AGYW through the different programs.

In COP 19, PEPFAR Namibia will continue to expand PrEP services and will focus on the scale up of PrEP in three key priority areas. PrEP will be scaled up at 1. ANC to provide services to high risk HIV negative pregnant and breastfeeding women further reducing new infections among this vulnerable population and reducing MTCT; 2. PrEP will be integrated as a key component of routine family planning and STI services; and 3. PrEP services will also be expanded as an integral part of Index Partner Testing ensuring that HIV negative individuals who are at high risk of acquiring HIV infection are offered PrEP. Clinical and community arms providing index partner services have begun receiving training in COP 18 to refer HIV negative clients to PrEP services; this will be at scale and fully integrated by the start of COP19.

PEPFAR Namibia will continue to support the implementation of operations research to gather insights from Namibia's national PrEP expansion, with a particular focus on adherence. Results from this research will generate practical knowledge and insights into demand creation and adherence counseling, especially for AGYW, FSW, MSM, and TGW.

4.3 Additional country-specific priorities listed in the planning level letter

TLD Transition Completion and ARV Regimen Optimization (NVP phase out)

The MOHSS is leading the preparation of the TLD transition, and at a meeting conducted in February 2019, agreed on transitioning all eligible patients (including children and women of child-bearing age) to TLD beginning in October 2019. The national ART guidelines will be updated and will now include TLD as the first-line regimen for all eligible populations. This transition is intended to be rapid and is projected to run over nine months with a target date for conclusion being June 30 2020. To support the transition, PEPFAR allotted \$288,000 in COP18 and \$300,000 in COP19 for TLD procurement to complement the Namibian government's ongoing procurement of first-line drugs. The COP19 procurement will include 90-day bottles of TLD to facilitate multi-month scripting.

In terms of ARV optimization, PEPFAR Namibia will support MOHSS to rapidly and vigorously phase out the use of NVP-based first line ART regimens among both adults and children.

PEPFAR and MoHSS will no longer procure Nevirapine-based ARVs in COP19. It is projected that the remaining NVP stock (approx. 32,000 bottles), after the start of transition to DTG, may be disposed of or used up and should be depleted by March 2020.

Multi-Month Scripting and Dispensing, including Other Models of Differentiated Care

Different models of community ART delivery (i.e. Patient-led and HCW-led) continues to be scaled up. In FY19 Q1, a total of 8,801 were reached through HCW community outreach delivery models (CBARTs) and close to 5,000 patients on ART were reached via the patient-led Community Adherence Groups (CAGs).

Across the cascade, the data shows that patients who are actively engaged in CBART models do very well. Preliminary results from the CBART Evaluation Study conducted by PEPFAR Namibia in the Okongo and Eenhana districts showed very high retention rates among patients followed up at CBARTs and even at 60 months, retention rates were above 90%. Interestingly, these outcomes were similar even among pediatrics, with retention rates of 98.6% and 96.9% at 12 months and 60 months respectively. This represents a large improvement compared to retention rates at the facility level. Additionally, the same evaluation showed viral load suppression was 97% in adult and 87.4% among pediatrics enrolled in the CBART model. This is actually higher than the national suppression level from the 2017 NAMPHIA results of 86.2%, and also higher than viral load suppression level seen at some fixed facilities.

Regarding multi-month dispensing for stable patients, PEPFAR Namibia reviewed EDT dispensing data for 109,048 patients who picked up their medicines during FY18. The data revealed that most patients picked up their medicines 6-9 times per year. The goal is to reduce this frequency to about 2-4 times per year for the majority of stable patients.

PEPFAR Namibia supported MOHSS in March 2019 to standardize the guidelines for differentiated care models across all districts and across all implementing partners. These newly adopted SOPs will be rolled out beginning FY19 and further scaled up during COP19 implementation. The Fast track ART Refill Model (FARM) is now standardized, providing the opportunity for stable patients to be dispensed with 6 months of medications at once. To facilitate the smooth implementation of this new MOHSS guidance, PEPFAR Namibia will procure the initial 90-day TLD packages therefore helping to simplify the logistics for multi-month dispensing.

Addressing Low ART and VL Coverage in 4 Low Burden Regions

Although most regions have been performing very well in terms of ART coverage and viral suppression, there are four regions that have been underperforming due to lack of support as previous years have been focusing on high-burden regions (!Karas Hardap, Kunene, and Omaheke). PEPFAR Namibia will provide targeted support to these areas to order to improve quality of clinical services to achieve improved viral load outcomes.

Specifically, PEPFAR will provide targeted support for direct service delivery in transmission hot spots which will include targeted Human Resource for Health (HRH) support to select high volume sites. In addition, improving quality of services through targeted mentorship will be a top priority for these regions. PEPFAR Namibia will do this by leveraging MOHSS and GF resources to enhance the functioning of the current GF supported mentors in these low burden regions. Currently, the GF funded mentors are not well resourced and remained largely stationed at regional offices with no capacity to be able to fully support the sites in these regions.

Strengthening public private partnership with large employers in hot spots will be another intervention that will be supported by PEPFAR Namibia in COP19. Creating a healthy work force and improving synergies between the state health sector and private employers will be further enhanced. Aussenkehr is a prime example of this potential synergy as over 25,000 men (mostly from the high burden northern regions of Namibia) migrate for 6 months of the year in search of seasonal work at privately-owned grape farms in this area. A significant number of these seasonal workers are on ART and find it challenging to receive their services from the small, poorly resourced public health clinic located in that area. These patients are often then counted as lost to follow up from their original ART sites while at the same time they are not routinely capture in the data systems at the transit site (Aussenkehr). PEPFAR Namibia will provide support to enable this clinic and others like it to support the migrant workers with services while collaborating with the home clinics of the workers in ensuring that all records are kept up to date.

TB Preventive Treatment for TB/HIV Co-Infected Populations

Program data shows that the rate of documentation of TB patients with a known HIV status has improved to 99%, and 97% of HIV infected TB patients initiating ART. However, FY18 program data demonstrated that only 48% of PLHIV were screened for TB, of which 12% initiated TPT and 89% completed their TPT course. PEPFAR Namibia's COP19 vision for TB/HIV includes scaling up TPT as high priority (see Section 4.3), improving TB diagnostics, and strengthening the TB screening and treatment cascade. The goal is to decrease morbidity and mortality among co-infected individuals which is critical for sustained epidemic control. The aggressive scale up of TPT will be accomplished by utilizing the strong clinical mentorship network, scaling up the QI collaborative, ensuring uninterrupted supply and distribution of TPT, and introducing rifapentine (3HP). Additionally, TPT job aids will be developed for staff and patient literacy tools will be developed. Other priorities will include improving TB diagnostic testing, by supporting the use of Xpert MTB/RIF Ultra to improve the sensitivity as well and introduction of TB LAM test, to improve timely initiation of TB treatment to patients who are presenting the advanced HIV disease. In addition, PEPFAR Namibia will also strengthen the TB screening and treatment cascade.

Namibia's COP19 targets are extremely aggressive and will require a major programmatic pivot across all regions. A TPT commodity earmark of \$459,435 has been included. PEPFAR Namibia will utilize the strong network of ART clinical mentorship and oversight to reach this target and the NAMLIVE QI collaborative in order to ensure PLHIV are initiated on isoniazid and complete

their course. TPT targets for COP19 is 82,127 and of note, resources will be invested for 15% of patients to receive 3HP. COP19 will also strengthen TB/HIV data capture, recording, and reporting.

Border Epidemic

Namibia has a growing population of non-Namibians accessing health services along its borders. Although there are user fees for some health services, the policy is clear not to deny services to patients on the basis of their inability to pay the user fees, especially for HIV care services. In COP18, PEPFAR Namibia is already supporting many service delivery points along the northern border. Health system and service delivery challenges limiting seamless access, utilization of services and availability of strategic information for planning, decision-making, quality management, and tracking patient level data to determine health outcomes.

In COP19, PEPFAR Namibia will optimize services alongside the Namibian border with the goal of improving health outcomes for non-Namibians seeking and accessing services at service delivery points alongside the border and to decrease HIV incidence in Namibia. The focus will be increased optimizing barrier-free services for these communities.

PEPFAR Namibia will scale up high quality, high yield case finding services in communities near the border in five key regions, namely Omusati, Oshana, Ohangwena, Kavango West, and Kavango East, inclusive of providing self-testing kits to newly diagnosed non-Namibians which they can give to sexual partners or family members. Care and treatment services will include uninterrupted ARV refill, retention interventions, viral load monitoring, and multi-month prescribing and dispensing to reduce cross-border burdens for the clients. TB preventive therapy and cervical cancer screening will be provided at fixed sites and through community outreach services. Health system strengthening will include adequate HRH and commodity assistance while continuing to support cooperative meetings between the national governments. PEPFAR Namibia will continue to ensure HIV and related services such as ANC, and TB client services including HIV testing and treatment and prevention, are provided free-of charge in the public sector for Namibians and non-Namibians. Finally, strategic information will also be strengthened, to gather patient-level data management, monitoring and reporting, and documentation of non-Namibians accessing services in Namibia.

Improve Access to HIV Services in Prisons

In the last mile to achieving sustained epidemic control, the Government of Namibia with PEPFAR support is prioritizing reaching people in prisons with case finding, same day ART initiation, and retention interventions. Namibia has an estimated prison population of 200 prisoners per 100,000 population and has 13 correctional facilities. Quality epidemiological and programmatic data from prisons settings is limited, however it is estimated that 13% of the people in prison are believed to be living with HIV. The Namibia Correctional Service Health Policy, launched in May 2016 provides opportunities to strengthen the health system and improve health outcomes in prison settings.

In COP19, services to prisons will be supported through the MOHSS implementing mechanism to leverage resources and other opportunities within the MOHSS for support to prisons. Historically, people in prisons were escorted to the public MOHSS facilities for HIV testing and related services. But over the years, MOHSS established a system and partnership with Ministry of Safety and Security's Correctional Services for healthcare service delivery to inmates within the prison settings. The correctional facilities procure HIV testing kits and ARVs through the MOHSS procurement systems. The support in COP19 will include but not be limited to improving HIV case-based surveillance through recency testing services, utilizing a community of trained peer inmates as navigators to optimize case finding, direct linkage to care and referral to VMMC services, and PrEP. PEPFAR Namibia will support treatment and care services including adherence interventions such as Directly Observed Antiretroviral Therapy (DART). In addition, PEPFAR Namibia will improve patient treatment and viral load literacy, STI screening, TB screening and preventive therapy, and linkage to public health facilities upon release from custody. Patient level data quality management, monitoring and reporting systems will also be improved with installation of EDT and ePMS for patient monitoring at the correctional facilities. The clinical mentoring program will be extended to nurses and medical officers providing services at all 13 correctional facilities, with data review and joint planning with MOHSS for standardization and sustainability.

Case-Based Surveillance and Monitoring of Morbidity and Mortality

Namibia is improving the interoperability of its data systems to enhance its ability for case-based surveillance. Among systems that directly support HIV services, the primary systems include ePMS, EDT, the HIV Testing Services (HTS) register, MediTech for VLS, and PTracker for tracking mother-baby pairs for HIV positive women. Each system now has the capability of recording the ART number, which will allow for case-based surveillance across all of these systems. Correct recording of the ART number is currently a challenge that PEPFAR Namibia is supporting MOHSS in addressing this fiscal year through mentorship and monitoring of the utilization of the ART number across all of these HIV-related systems. Currently, PEPFAR Namibia is working through MOHSS and implementing partners engaged in tracking patients who are lost to follow up to standardize and strengthen tracking outcomes, enabling PEPFAR Namibia to report on TX_ML, as well as advancement toward full use of a unique patient identifier (UPI).

In COP19, PEPFAR Namibia will support MOHSS in establishing a unique health identifier that would be used for all patients accessing public sector facilities and not be specific for HIV patients. This would serve multiple purposes, as it would allow ART patients to be tracked across all data systems within the MOHSS, enhancing what is currently available for only HIV-related systems. Additionally, it would allow for incorporation of a health identifier into the e-Death system that categorizes all deaths in Namibia using ICD-11 codes and will assist with mortality tracking for TX_ML.

Common Elements Treatment Approach (CETA)

In COP 19, PEPFAR Namibia will support the Ministry of Health to introduce mental health care into HIV services. The Common Elements Treatment Approach (CETA) will be used, which is an

integrated program fully delivered by lay providers and designed for low-resource settings. PEPFAR will support CETA in selected high volume clinics to provide mental health support for adolescents and adults. CETA experts will be brought in to train facilitators and trainers and provide continuous on the job training via supportive supervision and weekly skype calls throughout the first few months of implementation.

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

In FY18, birth testing for high risk infants was taken to scale nationally, and prophylaxis given with AZT and NVP is given for six week for infants that meet the criteria, decreasing the overall number of infants infected during pregnancy, labor and the delivery time period. However, gaps remain in mother to child transmission, and site level analysis of all EID positive results in FY18 indicated that of the 220 HIV+ infants identified under 12 months of age, 74% of them became infected during the breastfeeding period. New investments are needed to strengthen HIV testing, adherence to ART, and tracking mothers who are lost to follow-up during this time period. In COP19, PEPFAR Namibia plans to implement place of care (POC) VL testing for pregnant and breastfeeding women at high volume sites, along with POC EID for identified high risk infants. Mental health screening at ANC and PHC will be taken to scale, to help identify women at risk for defaulting. By strengthening community linkages for pregnant and breast feeding women to actively track and engage women, PEPFAR Namibia will identify social issues that might be inhibiting success in viral suppression. PEPFAR Namibia will also be increasing the numbers of HIV-negative women starting PrEP at family planning clinics, and ANC visits during pregnancy and maintained and monitored on PrEP throughout the breastfeeding period. Finally, Ptracker surveillance will be scaled up to all ANC sites nationally. Since Namibia has a highly mobile population, this will allow better tracking of women across all regions and SNU. With this strategy in mind, Namibia hopes to achieve Gold Status this year for eMTCT, and will work on implementation of activities in the Namibian eMTCT Road Map for national and global validation of eMTCT by end of FY20.

4.4 Commodities

PEPFAR Namibia currently supports MOHSS, and particularly the Central Medical Stores (CMS), to prevent maldistribution, stockouts, and wastage of HIV-related commodities. This support will continue in COP19, the ultimate aim of which is to avoid HIV service interruptions. The program will focus on improved supply chain strategy and planning, supporting efforts to optimize treatment regimens and strengthening in-country procurement and tender management systems through framework contracts and pooled procurement. PEPFAR Namibia will also continue to strengthen GRN inventory management with electronic tools that facilitate dispensing, site-level stock reporting, and pharmaceutical expenditure tracking. Furthermore, PEPFAR Namibia will work to improve site-level capacity to provide differentiated service delivery, namely the expanded rollout of multi-month ARV dispensing and community ART initiatives.

In October 2019, Namibia will begin a nine-month transition to TLD as the first-line regimen for patients newly initiating ART and for individuals on first-line treatment that are virologically

suppressed. Patients on nevirapine-containing regimens will be the priority for TLD transitioning. To support the transition, PEPFAR has allotted \$300,000 in COP19 for TLD procurement to complement the Namibian government's ongoing procurement of first-line drugs.

With few pediatric ARV patients, the Namibian government has struggled to locate suppliers for small batches of drugs. In COP19, PEPFAR Namibia will procure 15,000 bottles of dolutegravir 50mg tablets; 5,000 boxes of Lopinavir/ritonavir 40mg/10mg granules sachets; 5,000 bottles of Zidovudine 240mg/ml solution; 120 boxes of raltegravir 100mg granules sachets, and 400 bottles of darunavir 75mg tablets.

In COP19, PEPFAR Namibia will also procure anti-TB drugs to address recent shortages, including 12,500 bottles of isoniazid 300mg and 8,000 packs of pyridoxine 50mg. Additionally, PEPFAR Namibia will procure 12,372 packs of isoniazid and rifapentine (3HP) 150mg to support the introduction of shorter-course TB regimens. To support the VMMC program in COP19, the program will procure 35,000 disposable VMMC surgical kits and supplies for multi-use (450 reusable kits, 10 autoclaves, and 10 Diathermy machines with accessories).

PEPFAR Namibia will also procure 80,000 HIVSTs and 27,000 HIV recency tests. Laboratory support will include the procurement of 1,000 urine LAM assays, and GeneXpert cartridges (400 VL, 400 EID, and 1,300 Ultra).

4.5 Collaboration, Integration and Monitoring

Working with host government structures and international implementing partners to increase the capacity of indigenous partners will be a key area for COP19 collaboration, integration and monitoring. Approximately 64% of PEPFAR Namibia funds are currently allocated to indigenous organizations and are expected to increase to 74% once the to-be-determined (TBD) mechanisms are awarded, compared to 55% in COP18. During the COP19 implementation period, there are plans for the PEPFAR Namibia portfolio to deliver 80% of total program funding to indigenous organizations by COP20 and 85% by COP21. PEPFAR will accomplish this objective through the following:

- Increasing the delivery of direct HIV services, along with non-direct services provided at site level, through local organizations;
- Support local partners to establish sufficient capacity, capability, and durability and impact through transition planning mandates in cooperative agreements with international partners; and
- Pursuing new agreements 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, civil society organizations, private sector and other key donors/agencies, including the Global Fund, UN, U.S. Treasury, and World Bank, PEPFAR Namibia will support the GRN to determine data needs for data integration from legacy systems

to an integrated system and provide support for necessary assessments and analyses to create and implement a national HIV response sustainability plan. In FY 2018/2019, HRH planning and analysis, social contracting, efficiency technical assistance and studies, and a public health expenditure review have been completed and the results will inform COP 19 implementation to for HRH support and to develop a three-year strategy to transition HRH functions. Furthermore, PEPFAR will support integration of sample referral and result reporting in the GRN systems.

PEPFAR Namibia will continue its strong history of working collaboratively across all agencies grounded in active engagement, in particular both bi-weekly executive and senior management meetings led by the PEPFAR Office to ensure coordination and open communication. Interagency coordination will also further implementation of agency portfolio realignment by technical areas and ensure service continuity as agency shifts move to completion of program area realignment in December 2019.

PEPFAR Namibia and its agencies are represented in the Health Development Partners group, a coordinating body led by WHO and comprised of multilateral and bilateral partners. Collaboration is also strengthened through a strong presence by all agencies 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 and activities, in particular to avoid duplication on HRH deployment and ARV procurement.

CDC and USAID conduct active management of implementing mechanisms via in-person meetings with partners, agency project officers, and respective technical advisors. Reviews of quarterly national and SNU performance against MER and custom indicators and an analysis of SNU and site-level data are conducted. The interagency team will also continue a weekly review of innovative strategies for optimal scale-up of index partner testing nationwide and use of unique patient identifiers among PLHIV. Reviews also focus on quarterly disbursements, accruals and upcoming expenditures, and SIMS findings. Feedback or technical direction is provided during these meetings.

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

The interagency team will also improve service delivery quality and efficiency by scaling-up implementation of differentiated service delivery models such as CBART, multi-month dispensing of ARVs, and phasing-out of NVP-containing regimens. The use of Table 6 and the Funding Allocation to Strategy Tool (FAST) ensures that targeted above-site activities are mapped to optimize country systems to govern and manage the HIV response by focusing on key programmatic barriers.

4.6 Targets for scale-up locations and populations

PEPFAR Namibia does not have any scale up locations.

Standard Table 4.6.2

| Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Attained Districts (2019 SDS) | | | | |
|---|--------------------------------|-----------------------------------|-----------|-------------------|
| Target Populations [Specify age bands for focus] | Population Size Estimate | Current Coverage (Expected) | VMMC_CIRC | Expected Coverage |
| | (SNUs) | FY19 | (in FY20) | (in FY20) |
| Male Population, Age 15-29 | 6,521 | 64% | 1,942 | 80% |
| Male Population, Age 15-29 | 29,408 | 37% | 5,664 | 80% |
| Male Population, Age 15-29 | 3,656 | 28% | 989 | 80% |
| Male Population, Age 15-29 | 20,833 | 65% | 1,006 | 80% |
| Male Population, Age 15-29 | 61,590 | 61% | 14,729 | 80% |
| Male Population, Age 15-29 | 39,092 | 40% | 7,381 | 80% |
| Male Population, Age 15-29 | 21,849 | 51% | 5,101 | 80% |
| Male Population, Age 15-29 | 35,847 | 50% | 6,526 | 80% |
| Male Population, Age 15-29 | 16,968 | 40% | 3,889 | 80% |
| Male Population, Age 15-29 | 25,666 | 54% | 2,976 | 80% |

Target Populations for Prevention Interventions

Little information is available about the global 95-95-95 UNAIDS targets for key populations in Namibia. Reaching key populations is critical for sustainable HIV epidemic control in Namibia. The PEPFAR COP20 target for KP_PREV in the scale-up districts has taken into consideration the population size estimates from the 2013 IBBS and program data from seven districts. Findings from the 2018 PLACE study has also been used to validate size estimates for MSM and FSW in Windhoek. It is expected the second IBBS that is currently being supported by PEPFAR Namibia will further strengthen national size estimates for FSW, MSM and TGW.

Overall, the COP18 targets align with the goal of reaching 90% of the estimated key populations through a peer driven intervention and linkage to clinical services that include HTS, PrEP and ART. Other vulnerable groups will be reached along side reaching key populations with HIV preventions. These include children living with key populations in hot spots and other high risk groups, such as sea farers at the coast.

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. The PLACE study estimates the population at about 3,594. The population of MSM is estimated to be much lower in Windhoek (1,033). Program data shows that more FSWs are being reached in other seven major districts: Windhoek, Walvis Bay, Katima Mulilo, Rundu, Oshakati, Keetmanshoop, and Oshikango.

Standard Table 4.6.3

| Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control | | | |
|---|---|------------------------------------|--------------------|
| Target Populations | Population Size Estimate (scale-up SNUs) | Coverage Goal (in FY20) | FY20 Target |
| FSW (KP_PREV) | *8,082 | 90% | 16,646 |
| MSM (KP_PREV) | N/A | 90% | 3,371 |
| TG Women (KP_PREV) | N/A | 90% | - |
| AGYW (PP_PREV) | **102,832 | 90% (Eligible high risk) | 52,058 |

*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 HIV exposed infants (HEI)). The target for OVC served is based on the estimated number of orphans and vulnerable children from the 2019 Spectrum and 2019 population projections. An anticipated 80% of all OVC infected and affected by HIV in all implementation sites will need specific HIV-related services within facilities and communities. These services include HTS, violence and HIV prevention, psychosocial counseling, referrals to care and treatment, support for ART adherence, retention and HIV disclosure.

In COP19, PEPFAR Namibia will reach a total of 34,719 OVC in all implementation SNUs, of which 10,361 will be in DREAMS SNUs. Targets have dropped slightly from 37,107 in COP18 to 34,719 partly because the Peace Corps reach has been adjusted downwards to allow for the adaptations to the new indicator definitions and focus on quality assurance for OVC beneficiaries as well as reporting. Generally however, targets have remained flatlined in most SNUS but have been re-allocated to be able to reach an increased number of 10-17 years. The graduation rate has been set to five percent.

HIV risk assessment will be conducted to ensure that 100% of all 32,253 OVC under 18 have a known HIV status. One hundred percent of OVC infected with HIV in PEPFAR Namibia-supported sites will be linked to treatment and have their viral load monitored.

Standard Table 4.6.4.

| Table 4.6.4 Targets for OVC and Linkages to HIV Services | | | |
|---|--|---|--|
| 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* |
| Andara | 736 | 730 | 657 |
| Eenhana | 2,899 | 2,873 | 2,585 |
| Engela | 5,566 | 5,517 | 4,965 |
| Katima Mulilo | 7,289 | 7,225 | 6,691 |
| Nankudu | 511 | 506 | 454 |
| Nkurenkuru | 161 | 160 | 146 |
| Nyangana | 703 | 696 | 652 |
| Omuthiya | 2,123 | 2,105 | 2,048 |
| Onandjokwe | 3,625 | 3,593 | 3,508 |
| Oshakati | 2,421 | 2,400 | 2,157 |
| Oshikuku | 1,023 | 1,014 | 912 |
| Outapi | 84 | 83 | 74 |
| Rundu | 2,319 | 2,299 | 2,067 |
| Tsumeb | 2,467 | 2,445 | 2,383 |
| Windhoek | 3,101 | 3,074 | 2,954 |
| Total | 35,028 | 34,719 | 32,253 |

4.7 Cervical Cancer Program Plans

The National Cervical Cancer Screening and Prevention Guidelines were finalized in March 2018, and formally launched by MOHSS in September 2018. Since that time, focused attention has been on training, capacity building, and procurement of equipment. Namibia hosted the first ever Visualization with Acetic Acid (VIA) training in October 2018, in which four primary health centers and one ART center were trained in Windhoek. Services started at those sites immediately. Additional training was held in Windhoek in November for medical officers in Khomas region to provide supportive supervision to VIA and cryotherapy procedures being conducted in Khomas. Roll out to the northern regions started in February with training of six high volume ART centers (Oshikuku, Onandjokwe, Omuthiya, Engela, Ondangwa, Eenhana). To date, a total of 41 registered nurses and nine medical officers have been trained on VIA and cryotherapy. Equipment has been procured for a total of 17 ART centers, and site set up and training for these sites are underway. By the end of FY19, all 17 ART centers will be providing services. The goal for the end of COP19/FY20 is to have established 35 ART centers utilizing VIA and cryotherapy, which would be enough sites established to reach our goal of 50% TX_CURR in women 25-49.

Additionally, along with scale up of screening services, Namibia is working diligently to decentralize treatment services to women identified as having invasive pre-cancerous lesions. Prior to this past October 2018, only one hospital in the country was providing colposcopy services – Windhoek Central Hospital. This led to incredibly long wait times for an appointment, and often far distances to be traveled for women to get treatment. Since October, PEPFAR Namibia has established three additional treatment centers (Onandjokwe, Eenhana, and Katima Mulilo). The plan by the end of COP18 is to have ten treatment sites established in ten district hospitals through the country, bringing treatment services closer to the patient population in need. Medical Officer training for the loop electrosurgical excision procedure (LEEP) is underway and is being implemented and supervised by the Senior Medical Advisor on the project. To date, 12 Medical Officers have received training and supervision on LEEP.

GRN has been supportive in this effort to roll out screen and treat services. However, several policy issues stand in the way of rapid scale up and sustainability. Currently, the Health Professions Council has rejected the ability of enrolled nurses to perform VIA and cryotherapy. This has sustainability concerns, as registered nurses often are on a rotational basis, and therefore may be trained one week on VIA but moved to a different clinic or department the next week. Enrolled nurses are a vital part of sustainability and success of this initiative, as they stay in their communities and have time to really reach the women most in need. PEPFAR Namibia will continue to apply for expanded scope of work for enrolled nurses to perform VIA and cryotherapy to ensure sustainability of the program.

4.8 Viral Load and Early Infant Diagnosis Optimization POC Testing

Namibia Institute of Pathology (NIP) has 40 laboratories providing services to public health facilities, including eight laboratories with viral load testing capacity, one with infant virological testing capacity and 33 laboratories with a GeneXpert platforms capable of conducting testing for TB as well as HIV. NIP funding challenges became critical in 2018 due to disputes regarding charging to the Ministry of Health and resulting unpaid bills to suppliers. Even with NIP challenges, quality assurance benchmarks for prioritized PEPFAR laboratory services were maintained for HIV rapid testing, TB diagnostics, and others. Fortunately, months of interruptions for key diagnostic and monitoring tests are now mainly resolved, with PEPFAR Namibia playing an important role in providing momentum to resolve these issues.

During COP19, further optimization of access to VL, EID and TB testing will continue to be a priority. Decentralization of EID testing to existing laboratories with compatible platforms currently utilized for VL testing is a key step in optimizing access to EID testing. Broader utilization of existing near point of care (POC) platforms is another key step. GeneXpert platforms, already in use country wide for TB testing, can be further leveraged to fill gaps not only in VL testing in target populations (such as pregnant and breast feeding women to reduce transmission), but also with EID testing, particularly at high volume sites. GeneXpert platforms can also be utilized in priority regions to reach groups with lower levels of viral suppression.

Cyclical Acquired Drug Resistance Patient Monitoring (CADRE)

In COP 19 Namibia, along with its TLD roll-out, will carry out lab-based Cyclical Acquired Drug Resistance patient monitoring (CADRE) in order to optimize VL suppression. This routine patient monitoring will allow the program to obtain accurate estimates for acquired drug resistance in both children and adults, monitor emerging resistance to Dolutegravir and provide information about best second and third-line options. The methodology employed will leverage routinely collected VL samples, and thus can be performed with less financial and personnel resources than previously employed clinic-based surveys. There are plans to conduct pre-survey assessment and database strengthening in COP18, start data collection in Q2 of COP18 and have results in Q4.

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

5.1 COP19 Programmatic Priorities

If program approaches and activities to meet COP19 priorities differ from those described in sections 4.1 – 4.8 for attained and sustained locations and populations, please describe those differences here. Namibia no longer has any distinction between these geographies, due to progress toward epidemic control.

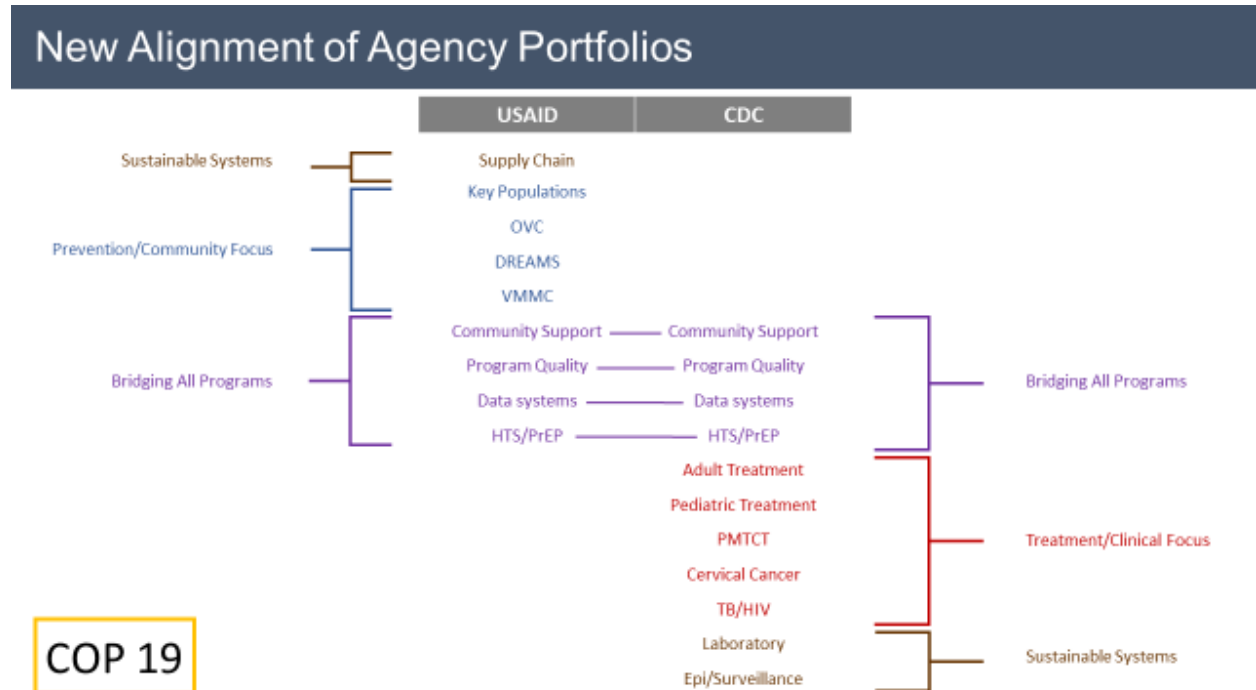
6.0 Program Support Necessary to Achieve Sustained Epidemic Control

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. The key system barriers, 2017 SID element scores, and expected outcomes identified for prioritization in COP19 are presented in Table 6. These included barriers identified from the 2017 SID assessment that are still not fully addressed, such as HRH gaps, service quality issues identified from SIMS assessments, data quality issues, and a weak supply chain system with recurrent stock outs of essential commodities. The country is in its third year of economic recession affecting the MOHSS buying power and ability to hire HRH for service delivery. In COP19, the systems investments strategy summarized in Table 6, 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. The USG systems support and leverage GRN, GF, and other partners' investments. For each approach, PEPFAR Namibia has defined expected outcomes, a baseline, and measurable benchmarks against which progress will be measured each year.

PEPFAR Namibia will undertake a major shift in COP19 to improve how programs are overseen and look forward into sustained epidemic control. In COP 18, PEPFAR Namibia's agencies had

joint responsibility for a number of program areas. The new alignment will be focused and efficient, allowing agencies to concentrate on the most challenging areas of needed performance in a streamlined way. As before, some elements bridge all program areas, and PEPFAR Namibia will be focused on ensuring these areas are consistent across the country. There is an interagency task team working on the logistics of the transition, and Q1 of COP19 will have overlapping funding to ensure smooth handover of responsibilities (see figure 6.1 below).

Figure 6.1 COP19 Alignment of Agency Portfolios



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; detailed key barriers and strategies are outlined in Table 6 and SRE, Appendix C.

HRH

A key component of the health financing dialogue is HRH. A significant contributor to the success of PEPFAR in Namibia has been the gap-filling of health workers to support critical HIV services. In FY18, PEPFAR and Global Fund together supported more than 1500 health workers. Lay workers encompassed half of the donor-supported workforce, but clinical staff incurred a higher cost.

As Namibia moves closer to the 95-95-95 goals for epidemic control, PEPFAR Namibia’s vision for a sustainable model of HRH will be part of a three-year transition plan to national ownership of the HIV program. Early stages of a detailed analysis are underway to map out the ideal structure for Namibia’s HIV program going forward. The priorities for COP19 are identifying the critical functions that need support to achieve and maintain epidemic control and then to reorient the

PEPFAR-supported HRH investment toward those functions and to build an evidence-based investment case for HRH to justify domestic investment in HRH for HIV. Findings from the HRH analysis will be used to update the phased HRH strategy to transition core HRH function to the GRN, including cost scenarios to fit the wage bill as well as the potential to look into the private sector and CSOs social contracting for service delivery.

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 the COP19 system level activities. In addition, in order to sustain PEPFAR/USG investments in the HIV response, PEPFAR Namibia will assist the MOHSS to develop a national HRH strategy, including deployment, training, and use of a national HRH database. In addition, PEPFAR Namibia will continue efforts to move positions away from places where coverage has reached saturation, and directing those resources to the districts and sites that are lagging behind.

Also as part of the three-year transition plan, PEPFAR Namibia continues to engage in building local capacity for ultimate full transition to a domestically led and executed HIV program. Providing in-depth clinical, policy, and programmatic technical assistance at all levels, as well as issuing small grants to CSOs, PEPFAR Namibia aims to ensure both at national level and local-led partners on the ground are fully capacitated to execute on a sustained, controlled HIV program in Namibia.

Forecasting, Procurement and Supply Chain Management

Regarding supply chain, the Namibian government must be acknowledged for its strong financial commitment to ensuring HIV commodity security in the country, for Namibians and non-Namibians alike. Through all of FY18 and FY19 Q1, there were no stock outs of first-line adult ARVs. Stock outs of other HIV and related commodities have occurred, and PEPFAR Namibia and Global Fund have played an important role in filling gaps when needed. PEPFAR partners and UN agencies have proposed for consideration by the Namibian government to procure ARVs and other medicines via global pooled procurement mechanisms. The analysis highlight potential savings estimated at US\$4.4 million annually. The Ministry of Health is currently expressing high interest in the use of pooled procurement for specific HIV commodities following this analysis. In COP19, PEPFAR Namibia will focus on, strategy and planning to ensure success in the planned ARV transitions, and in forecasting for longer multi-month dispensing.

Laboratory systems

In COP19 PEPFAR will strengthening laboratory system, quality management and HRH for scale of recency testing, and other surveys and for uninterrupted site level service delivery for viral load monitoring and EID.

Management of sub-awards

PEPFAR Namibia is committed to increase funding to indigenous organizations. In COP19, resources are allocated to enable MOHSS as the major provider of services in the public sector to sub-awards to local entities, including social contracting with CSOs.

Information Systems, Surveys, Surveillance, Evaluations and Research

Strategic information and epidemiological data exists, but fragmented data systems impede decision-making and limit transparency and accountability from individual HCWs to national policy-makers. In order to address the gaps, PEPFAR Namibia's focus in COP19 are to implement unique identifier for patients across all health data systems and case-based surveillance, as outline in section 4.3, while also standardizing the DQA SOP, finalizing Quantum ePMS, and conducting intensified data quality assessment at site level. Goals will be to strengthen the interoperability of data systems, support capacity building (including a field epidemiology and laboratory training program (FELTP) and a National Institute of Public Health (NIPH)), and update policies and guidelines and improve public access to information. PEPFAR Namibia will also conduct surveys, evaluations and operational research, including:

- Surveys
 - Strengthening strategic information for KP in Namibia (second IBBS);
 - Establishing HIV recent infection surveillance among persons newly diagnosed; using the HIV rapid recency assay;
 - Completing the Namibia Violence against Children Survey (VACS);
 - Provide technical assistance for Namibia Census 2021;
 - Support national scale-up of Tracking with Recency Assays to Control the Epidemic (TRACE);
- 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;
 - Identifying enablers and barriers to HIV self-testing in key populations.

These investments will lead to reduced reliance on donor support for surveillance and related activities.

7.0 Staffing Plan

PEPFAR Namibia's COP 19 vision for achieving epidemic control employs an agile and adaptive approach to management, operations and staffing that is aligned with PEPFAR Namibia's focus on efficiency and realignment of agency portfolios. PEPFAR Namibia USG agencies conducted a review during COP19 to examine the agency staffing footprint and associated technical and operational functions. Analysis indicated a need to repurpose existing staff through revised position descriptions, fill all vacant positions, transition to locally employed staff (LES) positions when feasible, and shift operational resources as USAID pivots towards prevention and CDC focuses on care and treatment.

In line with these findings, the team made the following changes to existing positions:

- All four CDC international-hire Non Personal Service Contractor's (non-PSC) positions were converted into Locally Employed Staff (LES) positions, including the HIV Treatment Advisor, Workforce Management Officer, Science Program Advisor and Strategic Information (SI) Advisor. This change creates a more sustainable and cost-effective staffing footprint as CDC increases facility SIMS coverage, especially for the central and southern regions that are outside of current CDC field officers' designation.
- USAID's LES TB/HIV Advisor position will be repurposed to focus on community-based care and treatment and biomedical HIV prevention activities.
- USAID's vacant LES SI Advisor position is being repurposed to a Supply Chain Specialist. This new position will provide necessary technical assistance to Central Medical Stores for continuous supply of commodities.
- One of CDC's LES Strategic Information positions was updated with additional responsibilities in M&E and is envisaged to become a team lead in the SI Branch. The position is currently under active recruitment and it is anticipated to start in May 2019.
- CDC's LES VMMC Advisor position will be repurposed to cover Care and Treatment activities in line with the agency pivot.
- CDC's LES Budget Analyst position was repurposed as a Grants and Finance Assistant position which will cover finance and extramural activities and will increase partner oversight and management.
- CDC's US Direct Hire (USDH) Biostatistician position will be repurposed to a Laboratory Advisor position while statistical activities will be added to existing SI positions. The lab position will provide technical assistance to MOHSS laboratory services to strengthen lab systems, as well as scale up recency testing and other prevention testing activities.

While no new positions are requested in COP 19, there are seven vacant positions, which the team is actively working to fill, including:

- CDC's USDH Grants and Finance Assistant position, which is under active recruitment; Shortlisting was done in March and the recruitment process is expected to be completed in April 2019;
- The four CDC LES position descriptions repurposed above (HIV Treatment Advisor, Workforce Management Officer, Science Program Advisor and SI Advisor) are currently under classification;
- USAID's Supervisory Health Development Officer (Health Office Director) position has an incumbent arriving in September 2019;
- USAID's Health and Population Development Officer (Deputy Health Director) position is on the bid list.

In terms of the cost of doing business (CODB), there is a 5% decrease from \$15.9 million in COP 18 to \$15.1 million in COP 19. The largest efficiency gain was with CDC, whose CODB decreased by 8%, mostly due to the change in four positions from international hire (non-PSC) to LES,

representing a cost savings of \$1.7 million. This reduction in the CODB was achieved despite New Embassy Compound (NEC) costs in FY20, and an increased travel budget for additional SIMS visits required for CDC's expanded care and treatment portfolio. As per the General Services Administration Fleet Minimum Vehicle Replacement Standards, CDC will replace two of its older vehicles, which will be placed in CDC's northern field offices. USAID's CODB also decreased by 2%, which is mostly attributable to a 13% reduction in USAID regional support costs for PEPFAR Namibia activities, as well as a 9% decrease in non-International Cooperative Administrative Support Services (ICASS) costs following the completion of office renovations. Peace Corps, on the other hand, had a 12% increase in CODB as the overall number of PEPFAR funded Volunteers increased from 30 to 40 (33%), along with associated increases in volunteer living and travel allowances.

As PEPFAR Namibia works towards the overarching goals for COP19, there is an anticipated request for assistance from Implementation Subject Matter Experts (ISME) on innovative approaches in the following areas:

- Integrate mental health into existing program;
- DREAMS saturation analysis;
- HIV sustainability strategy;
- HRH transition plan;
- Establishing a Unique Identifier beyond the patient ART number;
- Systematizing mortality surveillance;

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

| COP15 SNU | SNU Priority COP 15 | Achievement APR COP15 | COP16 SNU | SNU Priority COP16 | Expected Achievement COP16 | COP17 SNU | SNU Priority COP17 | COP17 Target: (APR18) | COP18 SNU | SNU Priority COP18 | COP18 Target: (APR19) | COP19 SNU | SNU Priority COP19 |
|-----------|---------------------|-----------------------|---------------|--------------------|----------------------------|-----------------------------|--------------------|-----------------------|---------------------------|--------------------|-----------------------|-----------|--------------------|
| !Karas | 2 Hot spots | 55% | Andara | Scale Up Agg | 63% | Nyangan a | Attained | 100% | Namibia Cluster 1 | Scale Up Sat | 90% | !Karas | Attained |
| Erongo | 2 Hot spots | 59% | Eenhana | Scale Up Agg | 72% | Outapi | Attained | 100% | Kavango East-West Cluster | Scale Up Agg | 90% | Erongo | Attained |
| Hardap | Non-PEP FAR | 47% | Engela | Scale Up Agg | 72% | Okahao-Tsandi Cluster | Scale Up Sat | 81% | Tsumeb | Scale Up Sat | 90% | Hardap | Attained |
| Kavango | Priority | 84% | Katima Mulilo | Scale Up Agg | 62% | Oshakati - Ondangwa Cluster | Scale Up Sat | 81% | Windhoek | Scale Up Sat | 90% | Kavango | Attained |
| Khomas | Priority | 61% | Ncaman goro | Scale Up Agg | 92% | Oshikuku | Scale Up Sat | 100% | Katima Mulilo | Scale Up Agg | 90% | Khomas | Attained |
| Kunene | Non-PEP FAR | 48% | Nkurenkuru | Scale Up Agg | 92% | Tsumeb | Scale Up Sat | 90% | Walvisba y | Sustained | 90% | Kunene | Attained |

| | | | | | | | | | | | | | |
|--------------|-------------|------|------------|--------------|------|-------------------------------------|--------------|------|------------------------------|-----------|------|--------------|----------|
| Ohangwena | Priority | 64% | Nyangan a | Scale Up Agg | 161% | Windhoek | Scale Up Sat | 80% | !Nami#nus-Rosh Pinah Cluster | Sustained | 90% | Ohangwena | Attained |
| Omaheke | Hot spot | 56% | Omuthiya | Scale Up Agg | 105% | Andara | Scale Up Agg | 90% | Gobabis | Sustained | 90% | Omaheke | Attained |
| Omusati | Priority | 91% | Ondangwa | Scale Up Agg | 76% | Engela-Eenhana - Okongo Cluster | Scale Up Agg | 82% | Grootfontein | Sustained | 99% | Omusati | Attained |
| Oshana | Priority | 80% | Tsandi | Scale Up Agg | 62% | Katima Mulilo | Scale Up Agg | 73% | Keetmanshoop | Sustained | 92% | Oshana | Attained |
| Oshikoto | Priority | 110% | Okahao | Scale Up Sat | 62% | Ncamangoro-Nkurenkuru-Rundu Cluster | Scale Up Agg | 97% | Okahandja | Sustained | 100% | Oshikoto | Attained |
| Otjozondjupa | 3 Hot spots | 56% | Onandjokwe | Scale Up Sat | 105% | Omuthiya-Onandjokwe Cluster | Scale Up Agg | 109% | Opuwo | Sustained | 90% | Otjozondjupa | Attained |
| Zambezi | Priority | 53% | Oshakati | Scale Up Sat | 76% | !Nami#nus-Rosh Pinah Cluster | Sustained | 45% | Otjiwarongo | Sustained | 90% | Zambezi | Attained |
| | | | Oshikuku | Scale Up Sat | 90% | Gobabis | Sustained | 50% | Swakopmund | Sustained | 90% | | |

| | | | | | | | | | | | | | |
|--|--|--|--------------|--------------|------|-------------------------------|----------------|-----|-----------|----------------|----|--|--|
| | | | Outapi | Scale Up Sat | 181% | Grootfontein | Sustained | 65% | Karasburg | Ctrl Supported | 0% | | |
| | | | Rundu | Scale Up Sat | 92% | Keetmanshoop | Sustained | 83% | Khorixas | Ctrl Supported | 0% | | |
| | | | Tsumeb | Scale Up Sat | 166% | Okahandja | Sustained | 90% | Mariental | Ctrl Supported | 0% | | |
| | | | Windhoek | Scale Up 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% | | | | | |

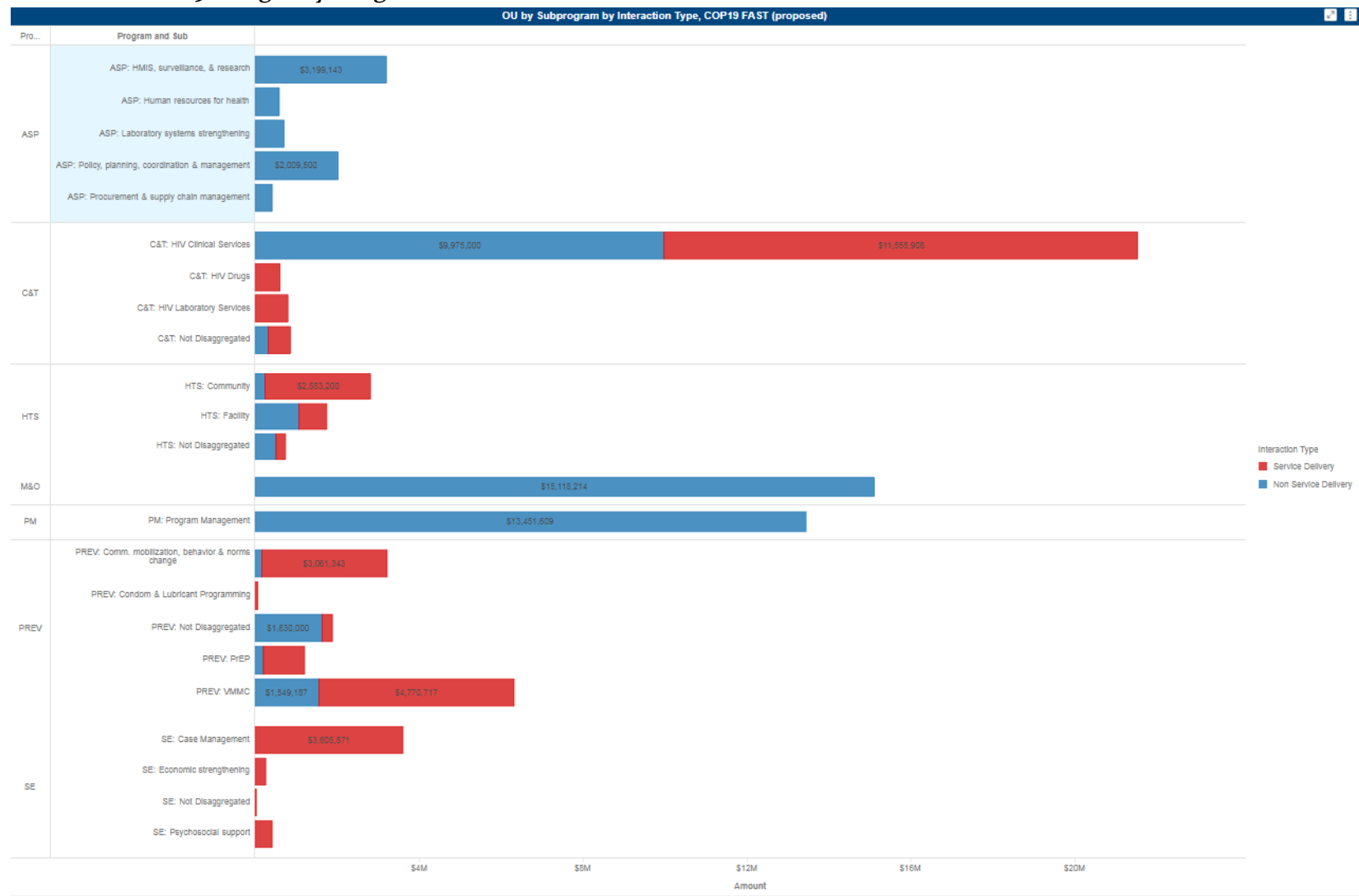
| | | | | | | | | | | | | | |
|--|--|--|-----------------|-----------------------|-----|---------------|-----------------------|----|--|--|--|--|--|
| | | | Otjiwaro ngo | Sustai ned | 53% | Okakara ra | Ctrl Suppo rted | o% | | | | | |
| | | | Rehobot h | Sustai ned | 58% | Omarur u | Ctrl Suppo rted | o% | | | | | |
| | | | Swakop mund | Sustai ned | 79% | Outjo | Ctrl Suppo rted | o% | | | | | |
| | | | Walvis Bay | Sustai ned | 79% | Usakos | Ctrl Suppo rted | o% | | | | | |
| | | | Karasbur g | Ctrl Suppo rted | o% | | | | | | | | |
| | | | Khorixas | Ctrl Suppo rted | o% | | | | | | | | |
| | | | Marienta l | Ctrl Suppo rted | o% | | | | | | | | |
| | | | Okakara ra | Ctrl Suppo rted | o% | | | | | | | | |
| | | | Omarur u | Ctrl Suppo rted | o% | | | | | | | | |
| | | | Opuwo | Ctrl Suppo rted | 44% | | | | | | | | |
| | | | Outjo | Ctrl Suppo rted | o% | | | | | | | | |

| | | | | | | | | | | | | | |
|--|--|--|------------|----------------|-----|--|--|--|--|--|--|--|--|
| | | | 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 19) | Additional patients required for 80% ART coverage | Target current on ART (APR FY20) <i>TX_CURR</i> | Newly initiated (APR FY 20) <i>TX_NEW</i> | ART Coverage (APR 20) |
| Attained | 203,396 | 224,694 | 0 | 229,800 | 18,168 | 113% |
| Sustained | | | | | | |
| Central Support | | | | | | |
| Total | 203,396 | 224,694 | 0 | 229,800 | 18,168 | 113% |

APPENDIX B – Budget Profile and Resource Projections

Table B.1.1 COP19 Budget by Program Area



| Table B.1.2 COP19 Total Planning Level | | |
|---|----------------------|----------------------|
| Applied Pipeline | New Funding | Total Spend |
| \$US | \$US | \$US |
| \$ 10,854,694 | \$ 70,622,511 | \$ 81,477,205 |

*Data included in Table B.1.2 should match FACTS Info records, and can be double-checked by running the “Summary of Planned Funding by Agency” report.

| Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only) | |
|---|-------------------------|
| PEPFAR Budget Code | Amount Allocated |
| CIRC | \$8,238,642 |
| HBHC | \$6,890,627 |
| HKID | \$4,762,651 |
| HLAB | \$1,094,069 |
| HTXD | \$938,949 |
| HTXS | \$18,355,097 |
| HVAB | \$3,734,574 |
| HVCT | \$4,745,245 |
| HVMS | \$6,469,301 |
| HVOP | \$1,759,605 |
| HVSI | \$2,258,223 |
| HVTB | \$3,295,217 |
| MTCT | \$112,229 |
| OHSS | \$1,925,184 |
| PDCS | \$2,737,490 |
| PDTX | \$3,305,408 |
| CIRC | \$8,238,642 |
| HBHC | \$6,890,627 |
| HKID | \$4,762,651 |

*Data included in Table B.2.2 should match FACTS Info records, and can be double-checked by running the “Summary of Planned Funding by Budget Code” report

B.2 Resource Projections

Epidemiological and Program Data Analysis

PEPFAR Namibia SI team, the budget team especially the Expenditure Reporting team and the 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, HIV incidence and ART unmet need. Similarly, the team also looked at the availability as well as lack of data reporting systems from the private sector and how it can be addressed. Moreover, the team made use of the PEPFAR-supported Small Area Estimation, the latest SID and the NAMPHIA results to better understand the epidemic. The latest Spectrum data were also used as well as the National AIDS Spending Assessment conducted by MOHSS to determine the expenditure per category. The team analyzed these data by age, sex disaggregation and program area of expenditure to determine areas' thresholds for coverage by considering the number of PLHIV, ART coverage, HTS and yield, VMMC, pre-exposure prophylaxis, cervical cancer screening amongst HIV positive clients and retention on ART.

The team also reviewed programmatic data on VL suppression by age, sex, and geography. In addition, the partners currently funded by PEPFAR's capacity was assessed in order to determine the possibility of expansion to other geographic areas or scale down when needed. Also, the modes operandi (direct service delivery or technical assistance) for each partner and how best it will contribute to epidemic control was considered during this process. Based on these analyses, the team allocated targets by district, Partner, and classified sites, and determined the resources needed. Similarly, PEPFAR Namibia being tasked with strengthening its services along side the northern borders, the team tried to estimate the magnitude of such services. Expansion of community based ART having proven to contribute to better patients outcomes, budgeting for such services interms of the need for HRH was also considered. 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 services.

The team also looked at the impact of the GF's reduction of resources as well as the change in focus area for the USG partners on the service provision and how this can be realigned in order to minimize loss of expertise as well as to prevent disruption of services.

Gap Analysis

PEPFAR Namibia continues to work closely with stakeholders, particularly GRN representatives, Bilaterals and CSOs to identify gaps and bottlenecks and mutually recommended solutions to address these gaps. During COP19 planning consultation meetings with stakeholders, the participants were presented with the achievements and challenges with COP18 implementation as well as soliciting their inputs into COP19 priority areas based on the gaps identified. PEPFAR Namibia and GRN recognized that specific gaps to address

the continuum of HIV services vary by district and program, and the strategies have been adjusted to meet the specific needs accordingly.

Funding Allocation to Strategy Tool (FAST)

The interventions as identified through COP17 expenditure reporting were used as the basis for funding activities in COP19 in order to fill the identified gaps. However, not all the interventions that were applicable in COP17 were identified as priorities in COP19.

Thereof, new interventions were identified and others discontinued in line with the implementing mechanism's (IMs) focus in COP19. The total base budget of \$80,977,205 is inclusive of \$977,205 dedicated to cervical cancer screening, DREAMS funding of \$10,000,000, \$500,000 for recency testing and \$8,273,173 for VMMC. Activities with appropriate budget codes were allocated to IMs with the highest probability of achieving PEPFAR targets taking into consideration the earmarks to be met as well as efficiencies and sustainability.

APPENDIX D– Minimum Program Requirements

| | COP18 | COP19 |
|---|-------|-------|
| Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups. | √ | √ |
| Adoption and implementation of differentiated service delivery models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents. | √ | √ |
| Completion of TLD transition, incl. consideration for women of childbearing potential and adolescents, & removal of NVP-based regimens. | | √ |
| Scale up of Index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established. | √ | √ |
| TB preventive treatment (TPT) for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package. | √ | √ |
| Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. | √ | √ |
| Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC and TB services, affecting access to HIV testing and treatment and prevention. | √ | √ |

| | | |
|--|---|---|
| Completion of VL/EID optimization activities and ongoing monitoring to ensure reduced morbidity/mortality across age, sex, & risk groups. | √ | √ |
| Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. | | √ |
| Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management. | √ | √ |
| Evidence of resource commitments by host governments with year after year increases. | √ | √ |
| Clear evidence of agency progress toward local, indigenous partner prime funding. | √ | √ |
| Scale up of unique identifier for patients across all sites. | | √ |

APPENDIX E – Addressing Gaps to Epidemic Control including through Communities of Faith

PEPFAR Namibia has no faith-based organizations receiving PEPFAR central funding. PEPFAR Namibia however, continues to engage FBO's wherever possible. For example, in 2017 and 2018, the CDC cooperative agreement with UNICEF included a knowledge and sensitization workshop for faith leaders in Oshana. In each year, these funds were used to train 40 religious leaders in communities where CDC is providing support for routine care and treatment. These workshops were designed to improve the knowledge base of religious leaders to ensure they are able to work positively with youth in their church communities.

Tables and Systems Investments for Section 6.o

Table 6-E (Entry of Above Site Programs Activities)

| Funding Agency | PrimePartner | COP19 Program Area | COP19 Beneficiary | Activity Budget | COP19 Activity Category | Key Systems Barrier | Intervention Start | Intervention End | COP19 Benchmark |
|----------------|---|-------------------------------------|---|-----------------|-------------------------------------|---|--------------------|------------------|---|
| HHS/CDC | Regents of the University of California, San Francisco, The | ASP: HMIS, surveillance, & research | Key Pops: Not disaggregated | \$ 52,500 | Surveillance | Outdated national policies and guideline for the conducting and dissemination of research, surveys, surveillance and evaluations | COP17 | COP19 | IBSS Study Report Completed and result disseminated |
| HHS/CDC | Regents of the University of California, San Francisco, The | ASP: HMIS, surveillance, & research | Pregnant & Breastfeeding Women: Not disaggregated | \$ 105,000 | HMIS systems | Fragmented data systems impede decision-making and limit transparency and accountability from individual HCWs to national policy-makers | COP17 | COP21 | 95% of sites with P-Tracker reporting |
| HHS/CDC | NAMIBIA INSTITUTE OF PATHOLOGY | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 150,000.00 | Surveillance | Fragmented data systems impede decision-making and limit transparency and accountability from individual HCWs to national policy-makers | COP18 | COP19 | 100% of patients diagnosed with HIV tested for recency nationally |
| HHS/CDC | UNIVERSITY OF WASHINGTON | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 72,000 | Program and data quality management | Fragmented data systems impede decision-making and limit transparency and accountability from individual HCWs to national policy-makers | COP19 | COP20 | fully operational case-based surveillance |
| HHS/CDC | Unicef | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 75,000 | Surveillance | Outdated national policies and guideline for the conducting and dissemination of research, surveys, surveillance and evaluations | COP18 | COP19 | VACS study Report completed and result disseminated |
| HHS/CDC | World Health Organization | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 65,000 | HMIS systems | Fragmented data systems impede decision-making and limit transparency and accountability from individual HCWs to national policy-makers | COP18 | COP20 | Mortality surveillance M&E System fully rolled out to 100% of sites |
| HHS/CDC | POTENTIAL NAMIBIA RECRUITMENT CONSULTANCY CC | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 257,393 | Program and data quality management | Fragmented data systems impede decision-making and limit transparency and accountability from individual HCWs to national policy-makers | COP17 | COP21 | 100 % of MoHSS supported sites reporting for MER indicators |

Table 6-E (Entry of Above Site Programs Activities)

| Funding Agency | PrimePartner | COP19 Program Area | COP19 Beneficiary | Activity Budget | COP19 Activity Category | Key Systems Barrier | Intervention Start | Intervention End | COP19 Benchmark |
|----------------|---|--|-------------------------------------|-----------------|--|---|--------------------|------------------|---|
| HHS/CDC | POTENTIAL NAMIBIA RECRUITMENT CONSULTANCY CC | ASP: Policy, planning, coordination & management | Non-Targeted Pop: Not disaggregated | \$ 672,500 | Oversight, technical assistance, and supervision to subnational levels | Limited capacity for public financial management and ability to manage sub-awards | COP17 | COP21 | 95% expenditure of COAG budget for FY20 reported |
| HHS/CDC | NAMIBIA INSTITUTE OF PATHOLOGY | ASP: Laboratory systems strengthening | Non-Targeted Pop: Not disaggregated | \$ 700,000 | Lab quality improvement and assurance | Weak laboratory systems to support site level service delivery | COP17 | COP21 | 95% % of sites achieve 90% Proficiency Panel results concordance |
| HHS/CDC | UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 44,000 | Program and data quality management | Insufficient domestic resources to fully finance the HIV response | COP19 | COP19 | All Districts and regional developed and utilise estimates reports, increased Strategic plans implementations amongst the Cities. |
| USAID | Chemonics International, Inc. | ASP: Procurement & supply chain management | Non-Targeted Pop: Not disaggregated | \$ 400,000 | Forecasting, supply chain plan, budget, and implementation | Weak forecasting, supply planning, procurement, and stock management | COP17 | COP21 | 92% reporting; 0% stockouts for ARVs and RTKs |
| HHS/CDC | UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 18,250 | Program and data quality management | Fragmented data systems impede decision-making and limit transparency and accountability from individual HCWs to national policy-makers | COP19 | COP19 | 90% of Private sector entities report through the public sector |
| HHS/CDC | MINISTRY OF HEALTH AND SOCIAL SERVICES | ASP: Human resources for health | Non-Targeted Pop: Not disaggregated | \$ 150,000 | HRH recruitment and retention | Limited quantity and capacity of GRN-funded Human Resources for Health | COP19 | COP21 | % of PEPFAR Support sites or spoke site that got 3 and or more visit by a Mentor |
| HHS/CDC | MINISTRY OF HEALTH AND SOCIAL SERVICES | ASP: Policy, planning, coordination & management | Non-Targeted Pop: Not disaggregated | \$ 250,000 | Clinical guidelines, policies for service delivery | Outdated national policies and guideline for the conducting and dissemination of research, surveys, surveillance and evaluations | COP19 | COP21 | TLD and Recency adopted in the national guideline |
| HHS/CDC | MINISTRY OF HEALTH AND SOCIAL SERVICES | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 100,000 | Program and data quality management | Fragmented data systems impede decision-making and limit transparency and accountability from individual HCWs to national policy-makers | COP19 | COP21 | 95% of sites with P-Tracker reporting |
| HHS/CDC | MINISTRY OF HEALTH AND SOCIAL SERVICES | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 80,000 | Program and data quality management | Limited coordination and management of in-service trainings | COP19 | COP21 | Plans for establishment of NIPH completed |

Table 6-E (Entry of Above Site Programs Activities)

| Funding Agency | PrimePartner | COP19 Program Area | COP19 Beneficiary | Activity Budget | COP19 Activity Category | Key Systems Barrier | Intervention Start | Intervention End | COP19 Benchmark |
|----------------|--|--|--------------------------------------|-----------------|---|---|--------------------|------------------|---|
| HHS/CDC | MINISTRY OF HEALTH AND SOCIAL SERVICES | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 50,000 | Surveillance | Outdated national policies and guideline for the conducting and dissemination of research, surveys, surveillance and evaluations | COP19 | COP21 | 100% of HIV positive screened by recency Test |
| HHS/CDC | MINISTRY OF HEALTH AND SOCIAL SERVICES | ASP: Human resources for health | Non-Targeted Pop: Not disaggregated | \$ 250,000 | Institutionalization of in-service training | Limited coordination and management of in-service trainings | COP19 | COP21 | Training Transition Plan developed |
| HHS/CDC | MINISTRY OF HEALTH AND SOCIAL SERVICES | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 250,000 | Program and data quality management | Limited coordination and management of in-service trainings | COP19 | COP21 | 5 graduates |
| HHS/CDC | MINISTRY OF HEALTH AND SOCIAL SERVICES | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 50,000 | Program and data quality management | Outdated national policies and guideline for the conducting and dissemination of research, surveys, surveillance and evaluations | COP19 | COP19 | Research Policy Revision Drafted |
| HHS/CDC | MINISTRY OF HEALTH AND SOCIAL SERVICES | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 50,000 | HMIS systems | Fragmented data systems impede decision-making and limit transparency and accountability from individual HCWs to national policy-makers | COP19 | COP21 | 95 % of sites rolled-out DHIS2 |
| HHS/CDC | MINISTRY OF HEALTH AND SOCIAL SERVICES | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 220,000 | Program and data quality management | Fragmented data systems impede decision-making and limit transparency and accountability from individual HCWs to national policy-makers | COP19 | COP21 | 100% of ART sites completed a DQA |
| USAID | PROJECT HOPE NAMIBIA | ASP: Policy, planning, coordination & management | OVC & care givers: Not disaggregated | \$ 200,000 | Service organization and management systems | Fragmented data systems impede decision-making and limit transparency and accountability from individual HCWs to national policy-makers | COP17 | COP19 | 90% registered |
| USAID | INTRAHEALTH INTERNATIONAL, INC. | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 540,000 | HMIS systems | Fragmented data systems impede decision-making and limit transparency and accountability from individual HCWs to national policy-makers | COP17 | COP19 | 100% |

Table 6-E (Entry of Above Site Programs Activities)

| Funding Agency | PrimePartner | COP19 Program Area | COP19 Beneficiary | Activity Budget | COP19 Activity Category | Key Systems Barrier | Intervention Start | Intervention End | COP19 Benchmark |
|----------------|-------------------------------|--|--------------------------------------|-----------------|--|---|--------------------|------------------|---|
| USAID | Chemonics International, Inc. | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 100,000 | HMIS systems | Weak forecasting, supply planning, procurement, and stock management | COP18 | COP21 | 100% of major ART and PHC sites |
| USAID | Chemonics International, Inc. | ASP: Policy, planning, coordination & management | Non-Targeted Pop: Not disaggregated | \$ 100,000 | Clinical guidelines, policies for service delivery | Weak forecasting, supply planning, procurement, and stock management | COP18 | COP20 | 85% TLD |
| USAID | PROJECT HOPE NAMIBIA | ASP: Policy, planning, coordination & management | OVC & care givers: Not disaggregated | \$ 100,000 | Training in coordination and management of health systems | Limited quantity and capacity of GRN-funded Human Resources for Health | COP18 | COP19 | Curriculum developed. Rollout training to HWs at DREAMS sites |
| USAID | PROJECT HOPE NAMIBIA | ASP: Policy, planning, coordination & management | OVC & care givers: Not disaggregated | \$ 100,000 | Service organization and management systems | Weak forecasting, supply planning, procurement, and stock management | COP18 | COP19 | Strategy developed |
| USAID | PROJECT HOPE NAMIBIA | ASP: Policy, planning, coordination & management | OVC & care givers: Not disaggregated | \$ 100,000 | Oversight, technical assistance, and supervision to subnational levels | Limited quantity and capacity of GRN-funded Human Resources for Health | COP18 | COP19 | Guidelines developed. Rollout training to HWs at DREAMS sites |
| USAID | Population Council, Inc., The | ASP: Policy, planning, coordination & management | Males: Adult men | \$ 170,000 | National strategic plans, operational plans and budgets | Fragmented data systems impede decision-making and limit transparency and accountability from individual HCWs to national policy-makers | COP17 | COP21 | DMPPT updated for FY20 with refined VMMC targeting |