Namibia Country Operational Plan 2022

Strategic Direction Summary

April 21 2022

Contents

***Military PSNU data are non-public**

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
CCBHS	Comprehensive Community Based Health Services
CDC	Centers for Disease Control and Prevention
CLHIV	Children Living with HIV
CMS	Central Medical Stores
CODB	Cost of Doing Business
COP	Country Operational Plan
CSO	Civil Society Organization
CXCA	Cervical Cancer
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
FSW	Female Sex Worker
FY	Fiscal Year
G2G	Government to Government
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 Capital 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
IM	Implementing Mechanism
IPV	Intimate Partner Violence
ISME	Implementation Subject Matter Expert
KP	Key Population
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 Goal
MER	Monitoring, Evaluation and Reporting
MGEPESW	Ministry of Gender Equality, Poverty Eradication and Social Welfare
MOHSS	Ministry of Health and Social Services
MSM	Men who have Sex with Men
MSYNS	Ministry of Sports, Youth and National Services
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 Department
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	Point-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 Operating Procedure
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection

TA	Technical Assistance
TB	Tuberculosis
TG	Transgender
TGW	Transgender women
TLD	Tenofovir/Lamivudine/Dolutegravir
TPT	TB Preventive Therapy
TWG	Technical Working Group
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	U.S. Agency for International Development
USD	United States Dollar
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 Vision and Goal Statement

Namibia is estimated to be at 94-97-93 as defined by the UNAIDS 95-95-95 treatment cascade, one of the first high burden countries to approach epidemic control. COP22 is about sustaining the impact of years of investment and partnership with the Namibian government and other stakeholders by employing targeted and innovative approaches to prevent new infections, reduce mortality rates, and strengthen the health system to endure the impact of unexpected external shocks, while still providing person-centered health services.

Primary gaps in HIV diagnosis continue to exist among children aged less than 9 years old, and males aged 20-34 years. Prevention measures need to be considered holistically, with particular focus on pregnant and breastfeeding women and their babies, and adolescent girls and young women, as well as facilitating improved treatment coverage and adherence among men. At the same time, the latest models show a slight increase in deaths among PLHIV, driven by co-infections with COVID-19 and TB, and key measures in COP22 will introduce and reinforce key measures to reduce mortality.

In COP22 PEPFAR Namibia's program areas form an integrated cascade across the three 95s, with the community, facility, and health system partners successfully providing comprehensive services. Additionally, COP22 demonstrates increased above site focus to improve systems and processes for sustaining impact in the long term. In its entirety, Namibia's structural sustainability model is expected to continue to increase domestic ownership, financial responsibility, and quality of care with successful outcomes.

Innovative program highlights included in COP22 that both address primary gaps in prevention and treatment and also focus on improving systems and processes for sustained impact include:

- Address case finding gaps using index testing, self-testing, and recency testing to reach priority populations (e.g. men aged 20-29).
- Improve TB case finding through improved screening and facilitating continuous access to molecular diagnostics
- Implement the MOHSS Quality Management (QM) Strategy and expand Continuous Quality Improvement collaborative initiatives to sustain program gains across the TB/HIV cascade.
- Optimize ART regimens and achieve viral load suppression in over 95% of all sub populations.
- Develop a more sustainable DREAMS program while expanding to new districts.
- Enhance sexual violence prevention and response, and HIV prevention interventions, linking at least 90% of HIV positive children to the comprehensive OVC program.
- Increase PrEP scale-up among all target populations.
- Above site sustaining impact:
    - implement laboratory network optimization and reduce turnaround time
    - facilitate movement to the latest laboratory testing platforms
    - support MOHSS efforts to improve data quality (i.e., timeliness, completeness, accuracy)
    - improve access and use of data to support the MOHSS QM strategy
    - automate processes to streamline data entry, processing, and analysis
    - ensure continuous availability of commodities at the facility level

- accelerate modernization of the supply chain
- support ongoing MOHSS restructuring process
- scale up the Human Resource Information System and use of HRH data
- strengthen MOHSS capacity to contract to non-government entities
- support interoperability of all SI systems

The goals of COP22 are evident: 1) reducing mortality among PLHIV, by improving adherence on ART, TB case finding and treatment, and COVID-19 vaccination; and 2) preventing new infections among children and AGYW through DREAMS, EMTCT and similar initiatives; and 3) increasing focus on improving systems and processes for long term sustained impact. By the end of COP22, PEPFAR Namibia will put an additional 14,958 PLHIV on treatment and ensure 191,548 of the total expected 217,378 PLHIV on treatment will be virally suppressed, reaffirming that Namibia is on a truly successful path to sustained impact.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Namibia is a sparsely populated desert country of 2.6 million people (Namibia Statistics Agency (NSA), Population Projections 2011-2041) with an area more than twice the size of Germany. The population is concentrated in small urban areas scattered throughout the country, particularly in the north near the border with Angola (see Figure 2.1.1). Urbanization continues to increase rapidly at a rate of 3.64% (CIA Factbook 2022), and urban population was projected to surpass the rural population for the first time ever in 2019.

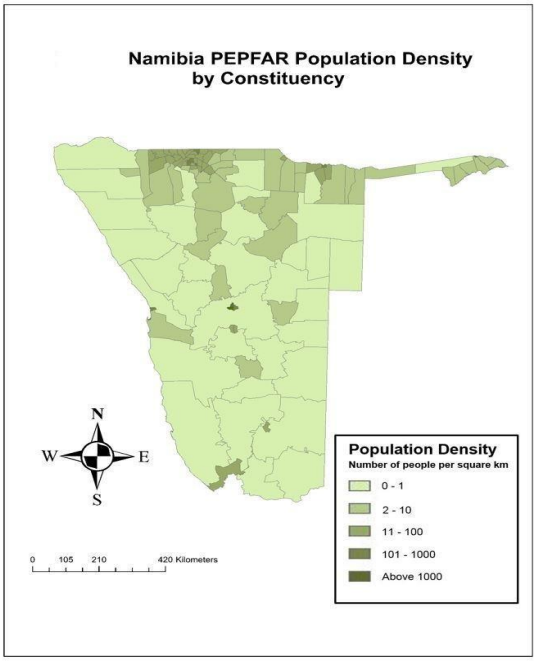


Figure 2.1.1 Population Density by Constituency

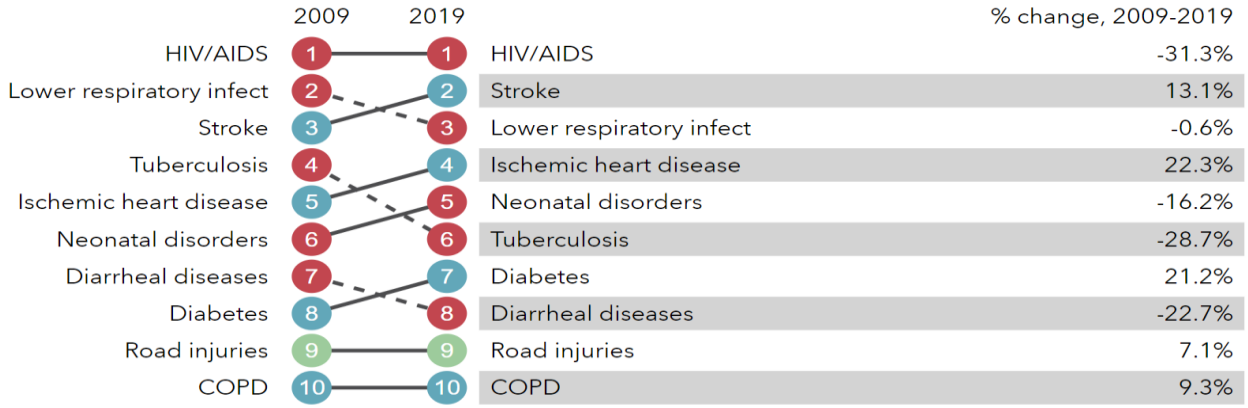
Namibia is an upper-middle income country with a gross national income (GNI) per capita of $ 9,190 (World Bank, 2020), but with starkly unequal income distribution. Namibia's Gini coefficient is 0.59, while its Palma Ratio at 5.8, both near the highest in the world (UNDP HDR statistical update 2020). According to a 2012 assessment of poverty dynamics in Namibia, approximately 29% of people in Namibia are poor (living on less than 30/day Namibian Dollars (NAD) and more than 15% are severely poor (living on less than NAD 22/day). Unemployment is estimated at 33.4%, down from 34% two years earlier (NSA Labor Force Survey 2018).

The country made great strides in attaining the Millennium Development Goals (MDGs) related to access to education, gender parity in education, and health. Namibia achieved impressive results in immunization and nutrition of children, bringing down under-five deaths from 4,200 per year in 1990 to less than 3,000 in 2013: child mortality rates were 45.2 deaths per thousand live births in 2016 (UN Inter-Agency Group for Child Mortality, 2016). Namibia launched the Sustainable

Development Goals agenda in 2016, which builds on the MDGs 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.

Fig 2.1.2. Top Causes of Death in Namibia (2019)



	% change, 2009-2019
HIV/AIDS	-31.3%
Stroke	13.1%
Lower respiratory infect	-0.6%
Ischemic heart disease	22.3%
Neonatal disorders	-16.2%
Tuberculosis	-28.7%
Diabetes	21.2%
Diarrheal diseases	-22.7%
Road injuries	7.1%
COPD	9.3%

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

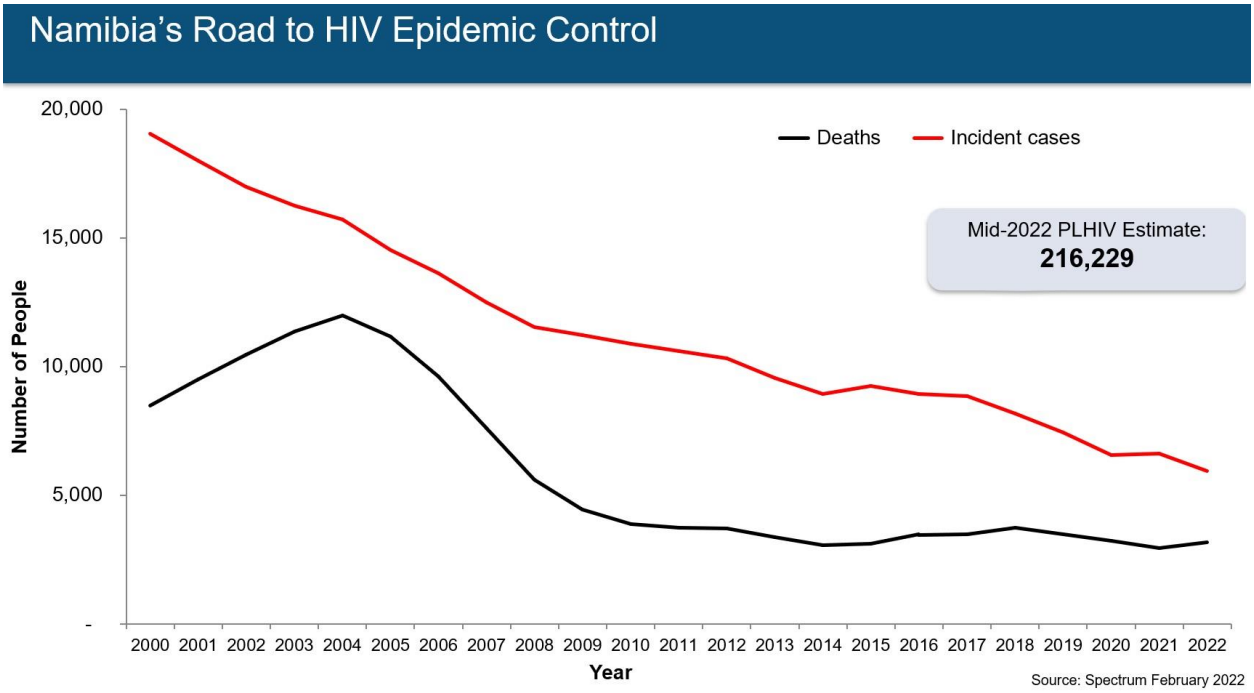
Namibia has been accelerating progress towards HIV epidemic control, and at the end of fiscal year (FY) 21, over 97% of the estimated 215,889 PLHIV in Namibia will be on ART.
New HIV infections have halved since 2004, and life expectancy increased by seven years, from 56 in 2005 to 63 in 2019 (World Bank). The Government of the Republic of Namibia's (GRN) 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 tuberculosis (TB)/HIV co-infection rate (32%) 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). ICD-11 coding training has been completed at the sub-national level and physicians have largely caught up with the backlog of uncertified deaths in the e-death data system, which upon completion would precipitate a comprehensive mortality analysis

HIV Prevalence and Incidence

Namibia has a generalized HIV epidemic, with 8.45% of the general population living with HIV (2022 Spectrum Model). HIV/AIDS will be responsible for an estimated 3,165 deaths in 2022 (see Table 2.1.1), and the disease remains the leading cause of death among adults and children under five years of age (Republic of Namibia Report on Mortality and Causes of Death, 2016-2017 Edition 1). Among adults (>25 years of age), women bear a disproportionate burden of the HIV epidemic, with a prevalence of 19.16% compared to 13.46% for men (see Table 2.1.1). Although data are only now becoming available on sex-specific positivity rates among children, the infection rates are identical for females and males at an estimated 0.77%. Female children under 15 years of age account for 3.2% of new infections per year, similar to male children 3.3%. According to the 2022 Spectrum Model, the highest proportion of estimated new infections is among women older than 25 years, accounting for 33.1% of new infections, followed by women 15-24 years at 28.8% of new

infections and then men older than 25 years old at 23.8% of the new infections per year (2022 Spectrum Model).

Figure 2.1.3 Trending Towards Epidemic Control



Treatment Coverage

The results from the 2017 Namibia Population-Based HIV Impact Assessment (NAMPHIA) survey indicate that most people who test positive for HIV start treatment and generally remain on treatment. Ninety seven percent of people aware of their HIV-positive status were on antiretroviral therapy (ART). Of those, NAMPHIA laboratory data confirms that 91% of people who report being on ART are virally suppressed. Since the introduction of ART in 2003, the number of PLHIV on ART has increased annually, from 75,681 in 2010 to approximately 195,677 in 2022 (see Table 2.1.2). Data disaggregated by age and sex illustrate that the proportional treatment gap is highest among young men 15-24 and older men 25+ years. Namibia has made incredible strides in its HIV/AIDS response, with a treatment coverage of 97% among PLHIV knowing their status by December 2021 (including private sector on treatment). However, treatment coverage variations exist by district. While almost all districts now have estimated ART coverage exceeding 80%, there are a few districts such as Windhoek and Rosh Pinah which lag significantly behind others.

Prevention of Mother-to-Child Transmission (PMTCT)

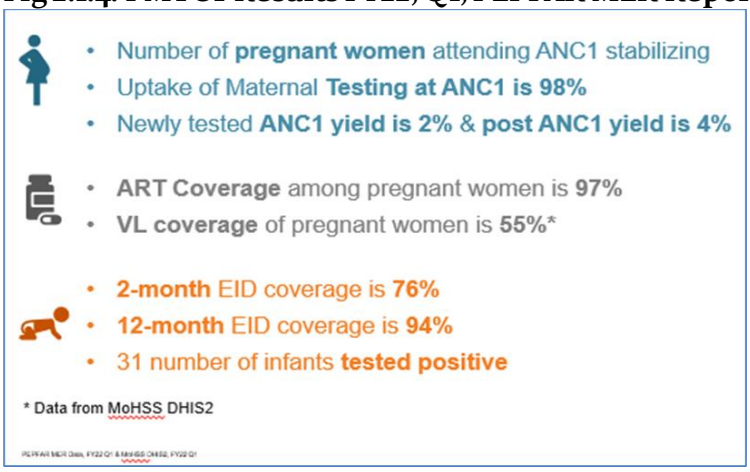
During the height of COVID-19, there was a 17% increase in the number of pregnant women attending antenatal care (ANC) sites. As of FY21 Q3, this number began to decrease, and as of FY22 Q1, the numbers are returning to pre-COVID numbers. In FY22 Q1, data shows there is high uptake of maternal testing at ANC1 at 98%. For pregnant women newly tested at ANC1, the testing yield is 2%; for women who were negative at ANC1 and retested in the maternal period,

the testing yield is 4% yield. ART coverage among pregnant women continues to be high at 97%, with a documented viral load coverage at 55% (note this low number may be a documentation issue and is being interrogated). EID coverage for 2-months is 75% and 12-month coverage is 94%. And in Q1, 31 infants tested positive (Figure 2.1.4). Infant HIV case identification through EID is a Namibian policy, but execution remains a challenge. Documentation of an infant's final HIV outcome is poor. In FY21, PEPFAR Namibia supported 284 sites, addressing >90% of national PMTCT and EID needs.

Maternal retesting continues to lag behind the recommended schedule. According to the national guidelines, a woman who is pregnant or breastfeeding should be re-tested every three months until the cessation of breastfeeding. Currently, only 3% of pregnant and breastfeeding women (PBFW) were documented as retested, defined by at least one test since they tested negative at ANC1. This is likely to be due to poor documentation, or slow uptake of this guideline and the challenges PBFW experience that may create barriers to getting easily tested. MOHSS PMTCT program data gives a higher number for retesting at 30%; the national program is currently undergoing data verification to assess the accuracy of the data. In order to adequately capture seroconversion rates and prevent mother-to-child transmission, there is need to scale both retesting and documentation. The low rate of retesting is of major concern, as these mothers are at substantially higher risk of transmitting HIV to their infants. Increased efforts are needed to diagnose pregnant women earlier so they can start ART with enough time to reach viral suppression before delivery.

To address the current program gaps, the implementation of facility-level QI activities at 35 high volume PMTCT sites began in February 2022. The aim of this QI collaborative is to increase maternal retesting, viral load testing, early infant testing, and final-outcome testing and documentation. In COP22, PEPFAR Namibia will expand these QI activities to more sites and include PrEP initiations among HIV-negative PBFW. Also, the community partner is increasing the scope of their mother-baby follow-up program to help trace leaks in the PMTCT cascade. Namibia will scale the MBFU program to all 14 regions. In addition, the facility partner is monitoring all PBFW with a high VL or interruption in treatment (IIT) and formalizing a collaboration with the community partner to prioritize community tracing of these women and re-engage them in care promptly. Facility tracking and community tracing of PBFW ensuring linkage to ART, adherence to ART, & VL testing will be scaled. One of the major COP22 goals is to improve data availability and use to understand and address current program gaps and eliminate mother-to-child transmission in Namibia. A program solution that will address this is to scale P-Tracker to every site and have it used by the facility to monitor their own PMTCT program. Addressing gaps at the local level will have the greatest impact.

Fig 2.1.4. PMTCT Results FY22, Q1, PEPFAR MER Reporting & MOHSS reporting



TB/HIV

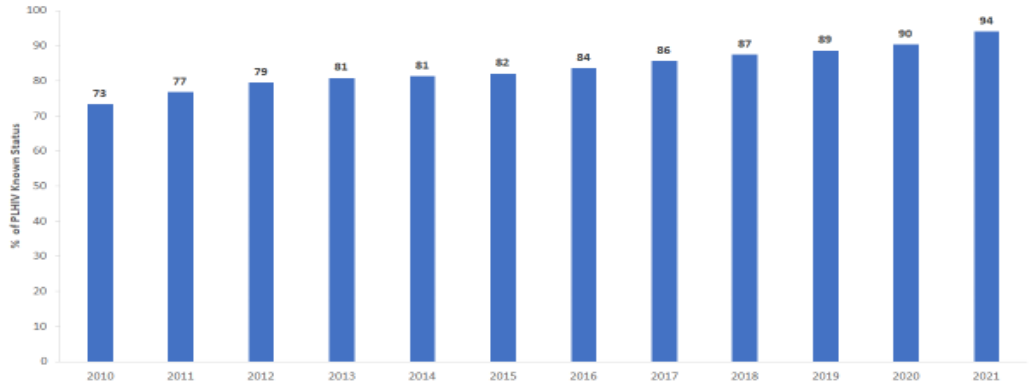
Namibia has one of the highest incidences of TB per capita and is ranked by the World Health Organization (WHO) among the top 30 high TB and TB/HIV burden countries in the world. The 2018 TB Disease Prevalence Survey (DPS) confirmed the high incidence of TB, reporting the rate of bacteriologically confirmed TB as 465/100,000 (95% CI: 340-590). In 2020, the country recorded 6,537 TB cases (57% adult male, 33% adult females, and 10% children with a case notification rate (CNR) of 263/100,000. Most of the cases were aged 25-44 years. The high case load is attributed mainly to the HIV epidemic as reflected by an HIV prevalence rate of 31% among TB patients in 2020. In FY21, the rate of TB patients with known HIV status was 99% with 97% ART initiation among those who tested HIV-positive. The WHO estimates of disease burden for 2020, indicates a TB treatment coverage of 56% in Namibia.

Drug-resistant TB (DR-TB) is one of the greatest threats to ending TB in Namibia. The last anti-TB drug resistance survey (DRS) in 2015/6 showed MDR-TB prevalence of 3.9% and 8.7% among new and previously treated patients, respectively. In 2020, a total of 218 patients with DR-TB were notified. Of these, 214 cases were notified as having confirmed drug-resistant and an additional four (4) patients were started on second line anti-TB treatment on clinical diagnosis. In 2020, 99% of DR-TB had known HIV status. Out of those patients, 38% were HIV-positive, and 99% of HIV-positive DR-TB patients were on ART.

HIV Testing Services (HTS)

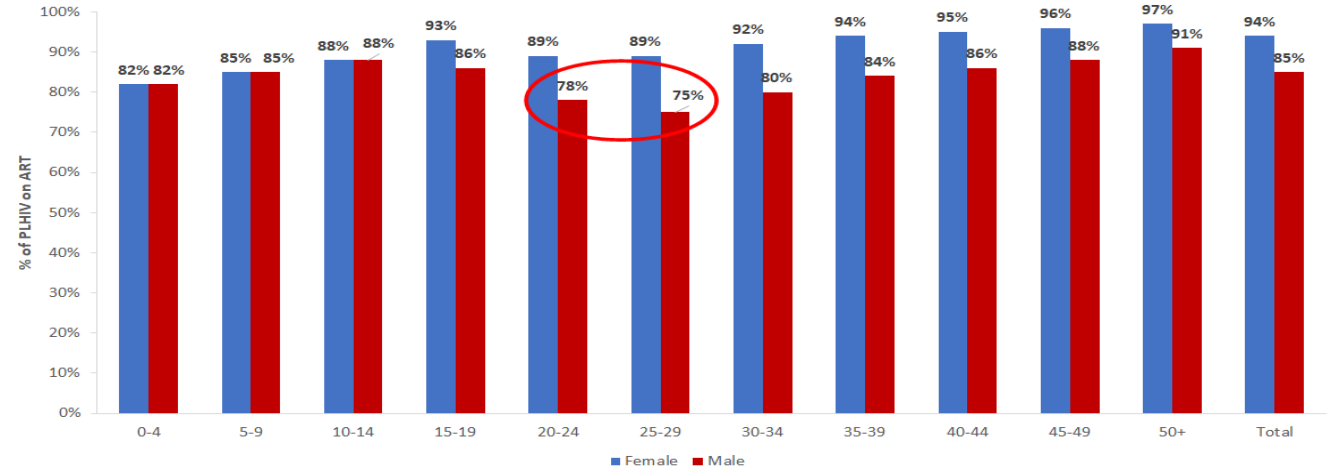
Namibia has made significant progress in scaling up targeted case finding strategies to all parts of the country and population groups. According to data from NAMPHIA (2019), 86% of adults between the age of 15 and 64 years who are living with HIV know their status (79.6% of men and 89.5% of women). This shows an improvement from the 75.6% (62.6% of men and 79.6% of women) reported from the 2013 Namibia Demographic and Health Survey (NDHS). As seen in Figure 2.1.5, the 2022 Spectrum estimates suggest that Namibia's percentage of PLHIV who know their HIV status is even further along at 94% with steady annual increases over time. Figure 2.1.5 below shows the percentage of PLHIV aware of their status as a trend from 2010 to 2021.

Fig 2.1.5. Percentage known status annual trends: 2021 Spectrum estimates



According to the 2022 Spectrum estimates, prominent case finding gaps are among males aged 20-2 years (highlighted with red circle) as well as gaps among younger ages. Female coverage stands at 94% whilst males are lagging standing at 85%, as illustrated below in Figure 2.1.6.

Fig 2.1.6. Percentage of PLHIV aware of status by age and sex.

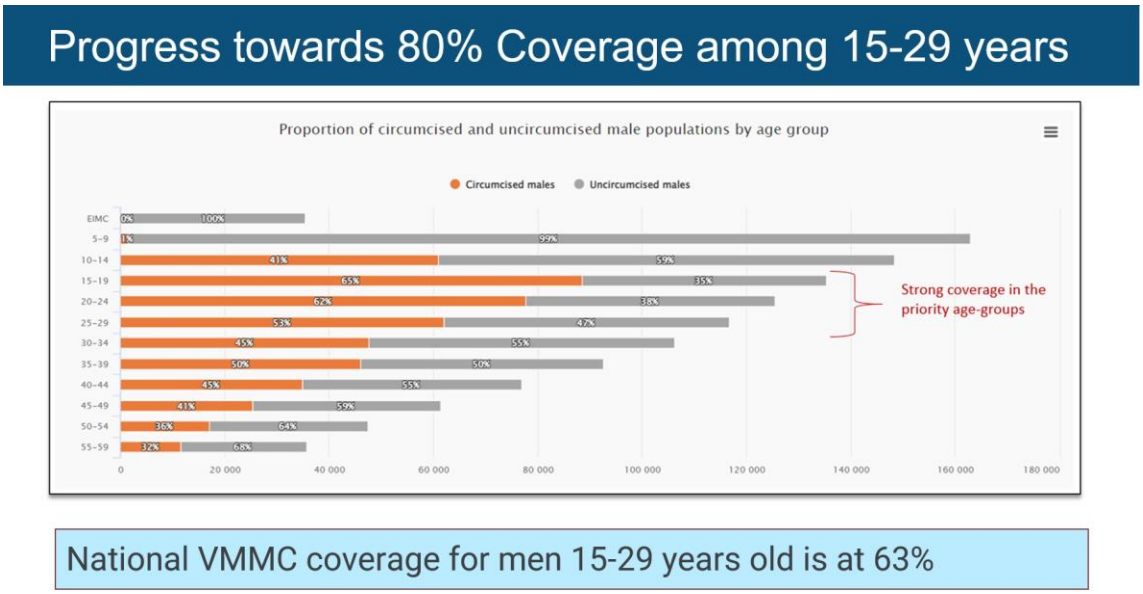


Windhoek and Rosh Pinah Districts have the lowest ART coverage. This could be due to a huge number of PLHIV receiving their ART in the private sector in these urban and mining districts. Private sector data are not accounted for in this analysis as private sector ART data is not disaggregated by district. This underrepresents the true ART coverage in these districts. Although it is very likely that the private sector accounts for much of this gap, PEPFAR Namibia continues to target efforts in these districts as well as other districts where gaps exist.

Voluntary Medical Male Circumcision (VMMC)

Data validation and modeled national coverage for VMMC among priority age groups of 15-29 years old is 63% (Data validation Decision Makers Program Planning Tool, DMPPT-2020/2021), which is less than the recommended 80% target to achieve a population level impact in epidemic control (Figure 2.1.7).

Fig 2.1.7 Progress towards 80% VMMC coverage



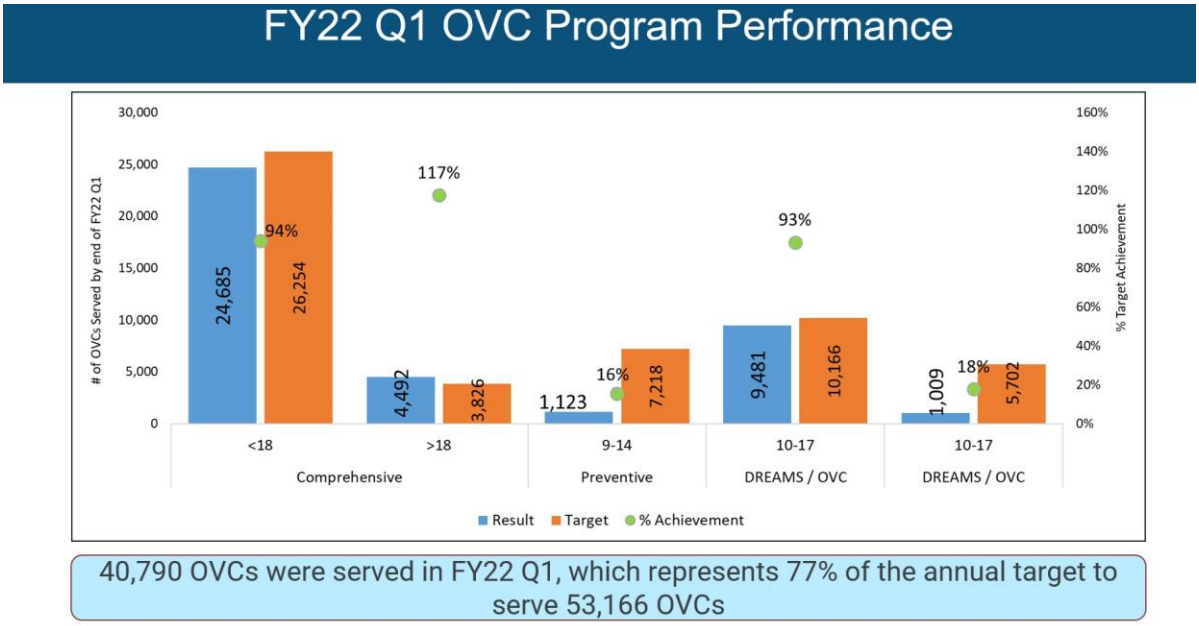
The MOHSS scaled up the VMMC communication and demand creation activities tailored to the priority age band. PEPFAR Namibia collaborated with MOHSS as part of these demand creation activities, working with community mobilizers and government structures to promote the benefits of VMMC and increase uptake among young people aged 15-29 years. The program conducted tailored print and social media demand creation activities during the high VMMC season from May to September. Due to expansion of service access and demand generation efforts, the PEPFAR VMMC program supported MOHSS to achieve saturation (80%) in three regions with an additional six regions near to saturation. At the end of FY21, the PEPFAR Namibia program reported 17,786 (78% of 22,695) achievement, 100% of circumcisions conducted above 15 years of age target population and 82% of these among 15-29 years (Annual Progress Report [APR] 2021). PEPFAR Namibia's COP21 target is 23,000. To achieve this, the program aims to help saturate an additional six regions in COP21 and COP22. PEPFAR Namibia expects to increase the national coverage from 63% to 75% by the end of COP22.

Orphans and Vulnerable Children (OVC)

The HIV epidemic in Namibia has generated a large population of orphans and vulnerable children. Approximately 250,000 children in Namibia are considered vulnerable (NAC 2018-2022). According to the UNAIDS Spectrum 2021 estimates, Namibia has roughly 16,990 children under the age of 20 living with HIV. Spectrum 2022 estimates the number of orphans to be 56,422. Among 15–19-year-olds, 56.6% girls and 74.2% boys had never been tested for HIV (NDHS, 2013). With increased ART coverage, children are living longer and, now require sufficient HIV care and support services, including sexual violence prevention. In Q1 FY22, there were 12,134 children 0-20 years on ART, of which 63% (7,675) were enrolled in the comprehensive OVC program. This leaves an OVC coverage gap of 4,459 HIV-positive children on ART that will be targeted for enrollment in the OVC program in COP21 and COP22. Approximately 40,790

(77% of the FY22 target) were provided with the comprehensive package of OVC services (Figure 2.1.11).

Fig.2.1.8. Number of OVC performance: FY22 Q1 OVC SERVE



In Namibia, children and women are disproportionately disadvantaged by poverty, with up to 56% of children either living in poverty or at risk of becoming poor. Simultaneously, in 2016, 204,162 children were on social grants for vulnerable children and 58% of those eligible were not receiving grants, according to the National Statistical Agency of Namibia. More than half of Namibia's children do not complete primary school. Child grants and universal pensions are important social protection mechanisms in Namibia. Household economic strengthening activities implemented through USG-funded partners are complementary, leveraging government resources with support for money management, additional savings, nutritional information, and food security initiatives.

Gender Inequalities

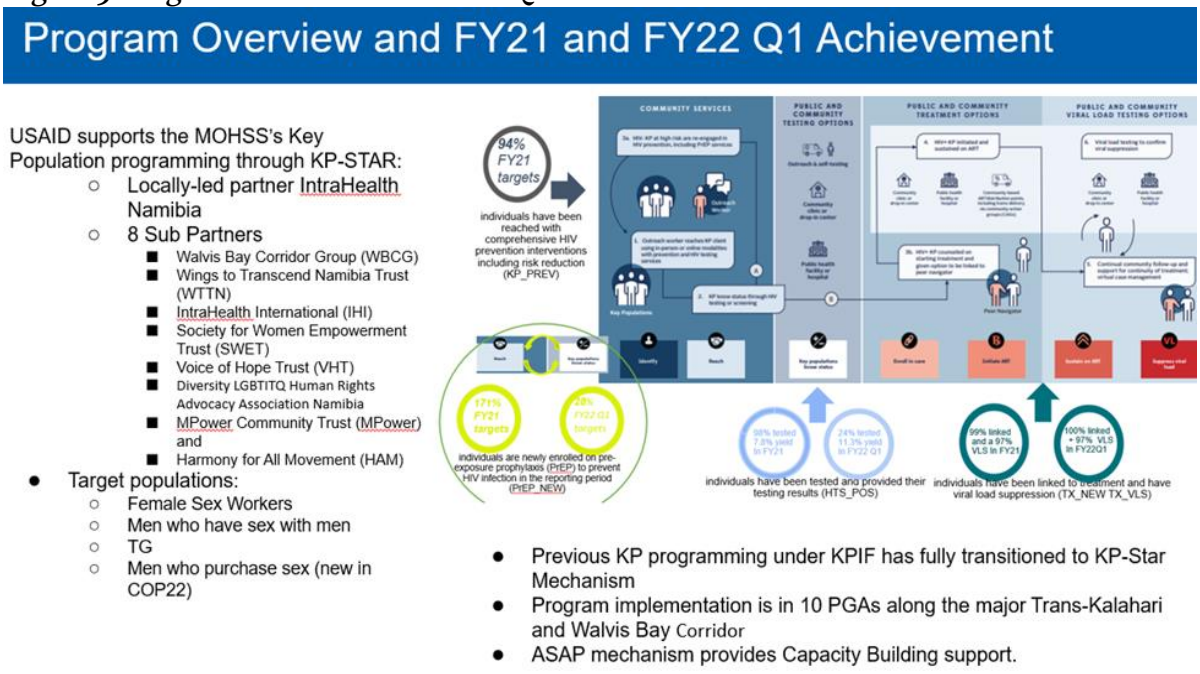
In Namibia, gender norms and gender-specific roles are deeply entrenched. Due to cultural and economic gender inequalities, women and girls are the most affected by the HIV epidemic, with some unable to protect themselves from acquiring HIV. Cultural norms that inhibit health-seeking behaviors in men and boys as well as members of the LGBTQI community also contribute to HIV risk. Both girls and boys face high rates of physical and sexual violence. However, girls experience higher rates of sexual violence than boys while boys experience higher rates of physical violence. According to Namibia's Violence Against Children (VAC) Study published in 2021, 33% of girls and 41% of boys experience physical violence by the age of 18. Further, 12% of girls and 7% of boys experience sexual violence by the age of 18 and, 7% of 13- 24-year-old girls and women experience physically forced or coerced sexual intercourse at their first experience of sexual intercourse.

While the GRN has approved various progressive laws and policies to address inequalities between men and women, limited allocation of financial and human resources makes full implementation difficult. Data is lacking on rates of gender-based violence (GBV) against key populations, including men who have sex with men and transgender women, but GBV is known to impact access to health services both from perceived and actual experiences. A recent study at the global level has shown that criminalization of same-sex behavior is associated with 11 percent lower knowledge of HIV status and eight percent lower viral load suppression, and criminalization of sex work is associated with 10 percent lower knowledge of HIV status and six percent lower viral suppression. This shows the impact of laws and policies that are rooted in gender norms.

Key Populations

Key populations (KP) in Namibia, especially men who have sex with men (MSM), female sex workers (FSW), and transgender women (TGW) are at high risk of HIV. In COP22, PEPFAR Namibia has added men who purchase sex (MWPS) as a priority population to link to FSWs. Based on the Namibia Integrated Biological and Behavioral Survey (NAM-IBBS) conducted in 2019, HIV prevalence was high among FSW: 21.3% in Windhoek, 20.3% in Walvis Bay and 44.2% in Katima Mulilo. Viral load suppression among FSW was 52.0% in Windhoek, 30.1% in Walvis Bay and 75.8% in Katima Mulilo. HIV prevalence among MSM was relatively consistent with that of adult men in the general populations of their respective regions as estimated in NAMPHIA: 8.4% among MSM vs.7.2% among adult men in Khomas (Windhoek) and 9.7% vs. 7.5% in Erongo (Walvis Bay/Swakopmund). Coverage of ART among KPs who had known HIV status was comparable to estimates from NAMPHIA but viral load suppression rates were low: 76.1% in Windhoek and 55.8% in Walvis Bay. Approximately 60% of MSM testing positive for syphilis were also HIV-positive. Figure 2.1.12 describes PEPFAR Namibia's KP program and its achievements.

Fig 2.1.9 Program Overview and FY21 Q1 Achievement



The NAM-IBBS findings help to provide a baseline, but they do differ from programmatic results. PEPFAR-supported programs showed a 99% linkage to treatment in FY21 and 100% in FY22 Q1, an increase from 96% in FY20 among diagnosed KPs. Programs also achieved 97% viral load suppression rate for both the FY21 and FY22 Q1, up from 94% in FY20 (see Figure 2.1.12). In FY23, PEPFAR Namibia will continue to use the findings from the NAM-IBBS, the Small Area Estimation, Preliminary HIV Risk Hotspot Mapping and Key Population Size Estimate in nine PGUs in Namibia (Dec 2021), and PrEP Study Report, as well as findings from the community-led monitoring (CLM) and to inform program design and improve program implementation in COP22.

Pre-Exposure Prophylaxis (PrEP)

Namibia included PrEP in its National Strategic Framework for HIV and AIDS (2017/2018 to 2021/2022) as a prevention strategy for population groups at substantial risk of acquiring HIV infection. In 2021, the MOHSS has included the dapivirine vaginal ring (DVR) and long-acting cabotegravir injection (CAB-LA) in the national HIV clinical guideline as an alternative to oral PrEP to support the implementation of both products when they become available. In FY21, 18,340 clients were newly initiated on oral PrEP, which represents an 86% progress towards annual target, compared to 75% achievement in FY20. The increase is attributed to innovative and targeted demand creation through peer-to-peer engagement and virtual platforms as well as active screening and peer referrals.

In COP22, PEPFAR Namibia will continue to provide technical assistance to the MOHSS in adopting the WHO PrEP guidelines, demand creation with targeted messaging for priority populations, PrEP scale-up and integration in routine maternal care, and introduction of new PrEP biomedical products. The program continues to use data to inform priority prevention interventions targeting people at substantial risk of acquiring HIV, such as adolescent women and young people age 15-24, key populations including MSM, TG, and FSWs, pregnant and breastfeeding women, high-risk negative sexual contacts of index clients, and anyone testing HIV-negative at substantial risk for HIV transmission.

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. The Sustainability Index and Dashboard (2021) highlighted civil society engagement as a primary and critical vulnerability, as civil society play a pivotal role in community-based service delivery models and in facilitating access health services for KPs. Addressing this vulnerability will require the development of a social contracting policy to ensure that the government continues to leverage the considerable technical capacity in these areas in civil society. Policy and operational interventions are also required to bolster other vulnerable elements such as data for decision-making, ranging from HRH data to program quality data.

Table 2.1.1 Host Country Government Results

Table 2.1.1 Host Country Government Results															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	2,554,627	100%	470,882	18.4%	470,822	18.4%	243,428	9.5%	240,274	9.4%	598,601	23.4%	530,619	20.8%	Spectrum/Naomi est. for 12/21
HIV Prevalence (%)		8.45%		0.77%		0.77%		7.21%		3.67%		19.16%		13.46%	Spectrum/Naomi est. for 12/21
AIDS Deaths (per year)	3,165	100%	110	3.5%	111	3.5%	149	4.7%	213	6.7%	1,260	39.8%	1320	41.7%	Spectrum est. mid-2022
# PLHIV	215,888	100%	3,603	1.7%	3,614	1.7%	17,550	8.1%	8,807	4.1%	117,023	54.2%	65,291	30.2%	Spectrum/Naomi est. for 12/21
Incidence Rate (Yr)		0.27%		0.04%		0.04%		0.81%		0.22%		0.34%		0.25%	Spectrum/Naomi est. for 12/21;
New Infections (Yr)	5,940	1.00	193	3.2%	194	3.3%	1,708	28.8%	461	7.8%	1,969	33.1%	1,416	23.8%	Spectrum est. mid-2022
Annual births	87,475	100													Estimated from annual birth rate and population projection
% of Pregnant Women with at least one ANC visit	98,146														Namibia Program Data
Pregnant women needing ARVs	14,072														Namibia Program Data
Orphans (maternal, paternal, double)	56,422														Spectrum est. 2022
Notified TB cases (Yr)	6,537	100%	305	4.7%	330	5.0%	457	7.0%	462	7.1%	1702	26.0%	3281	50.2%	National Tuberculosis and Leprosy Program (NTLP) 2020 Annual Report
% of TB cases that are HIV infected	1,994	30.5%	22	7.2%	25	7.6%	99	21.7%	54	11.7%	720	42.3%	997	30.4%	
% of Males Circumcised	684,584	42.1%			216,476	36.0%			193,194	79.8%			274,914	50.8%	COP22 DataPack and DMPPT
Estimated Population Size of MSM*	2,210 (Windhoek) 670 (Walvis Bay/Swakopmund)														IBBS, 2019
MSM HIV Prevalence		8.4% (Windhoek) 9.7% (Walvis Bay/Swakopmund)													IBBS, 2019
Estimated Population Size of FSW	2,440 (Windhoek) 970 (Walvis Bay/Swakopmund) 890 (Katima Mulilo)														IBBS, 2019
FSW HIV Prevalence		20.9% (Windhoek) 21.2% (Walvis Bay/Swakopmund) 43.6% (Katima Mulilo)													IBBS, 2019
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														
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*														
	Cite sources:														

Table 2.1.2: 95-95-95 cascade: HIV diagnosis, treatment and viral suppression

Table 2.1.2 95-95-95 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*		On ART*	ART Coverage (%), of those aware of their HIV+ status	Viral Suppression (%)***	Tested for HIV***	Diagnosed HIV Positive***	Initiated on ART***
	(#)	(%)	(#)	PLHIV diagnosed* (#)	(#)			(#)	(#)	(#)
Total population	**2,554,627**	8.5%	**215,888**	201,765	195,677	97.0%	92.4%	344,458	12,744	*10,079*
Population <15 years	**941,704**	0.8%	**7,217**	6,590	6,184	93.8%	83.5%	9,233	241	*336*
Men 15-24 years	**240,274**	3.7%	**8,807**	7,767	7,159	92.2%	78.0%	17,993	286	*281*
Men 25+ years	**530,619**	12.3%	**65,291**	60,497	55,781	92.2%	92.3%	72,405	3,983	*3,189*
Women 15-24 years	**243,428**	7.2%	**17,550**	15,923	15,923	100.0%	86.3%	90,268	2,415	*1,782*
Women 25+ years	**598,601**	19.5%	**117,023**	110,988	110,629	99.7%	94.6%	154,559	5,819	*4,491*
MSM	2,210** (Windhoek) 670** (Walvis Bay/Swakopmund)	8.4%** (Windhoek) 9.7%** (Walvis Bay/Swakopmund)	186** (Windhoek) 65** (Walvis Bay/Swakopmund)	119** (Windhoek) 32** (Walvis Bay/Swakopmund)	97** (Windhoek) 27** (Walvis Bay/Swakopmund)	81.9% (Windhoek) 84.0% (Walvis Bay/Swakopmund)	76.1% (Windhoek) 55.8% (Walvis Bay/Swakopmund)	2495	198	*191*
FSW	2,440** (Windhoek) 970** (Walvis Bay/Swakopmund) 890** (Katima Mulilo)	20.9%** (Windhoek) 21.2%** (Walvis Bay/Swakopmund) 43.6%** (Katima Mulilo)	510**(Windhoek) 206** (Walvis Bay/Swakopmund) 388** (Katima Mulilo)	251** (Windhoek) 106** (Walvis Bay/Swakopmund) 100** (Katima Mulilo)	183** (Windhoek) 95** (Walvis Bay/Swakopmund) 97** (Katima Mulilo)	72.9%** (Windhoek) 89.8% (Walvis Bay/Swakopmund) 96.7% (Katima Mulilo)	52.4% (Windhoek) 31.2% (Walvis Bay/Swakopmund) 75.5% (Katima Mulilo)	8502	614	*603*
PWID	N/A									
Priority Pop (specify)	N/A									
* UNAIDS 2022 Naomi District Estimates, February 2022 version for Dec 2021										
**IBBS, 2019										
*** MOHSS Program Data incl NIP										

2.2 New Activities and Areas of Focus for COP22, Including Focus on Client ART Continuity

The Namibia COP22 strategic approach is to sustain the impact of years of PEPFAR investment and partnership with the Namibian people in the response to HIV/AIDS by employing targeted and innovative approaches. The goal of these is to prevent new infections, reduce the mortality rates due to AIDS, and strengthen the systems that underpin a robust public health system that can endure the impact of unexpected external shocks, while providing person-centered health services.

New in COP22 will be PEPFAR's enhanced support to the implementation of the MOHSS Quality Management (QM) Strategy launched in March 2022. The QM collaborative approach will continue with expanded new Continuous Quality Improvement (CQI) initiatives in all program areas across the HIV cascade. For case finding, PEPFAR Namibia will focus on index testing, recency, and linkage to care. The aim is to continue to improve retention to care, VL suppression for patients 0-24 years with intensive focus on disclosure, pediatric- and adolescent-friendly services, and improvement in specimen collection and transportation. For maternal and child health, PEPFAR Namibia will continue to improve maternal retesting, VLS, and EID, as well as improve the number of infants who know their HIV status at 18-24 months or after cessation of breastfeeding (infant final outcome – PMTCT_FO).

The goal for client ART continuity is to achieve durable VL suppression in over 95% of all sub-populations. Interventions that are designed to both prevent loss of patients and be responsive to the needs of patients in the cycle of interruption and return to ART will be implemented. Continuity in care or return to care interventions will include equitable DSD models for all subpopulations, 6MMD, and responsive tracing and post-tracing services. Innovative technologies, such as the PeleBox lockers and SMS reminders, will be maintained to support uninterrupted and on-time pill pickups.

In COP22, PEPFAR Namibia aims to increase TB case finding and decrease TB morbidity and mortality. This will include continued CQI activities, including a death audit, and continued strengthening of the TB/HIV reporting system utilizing the DHIS2 tracker. The main emphasis for the period will be on intensified TB case finding.

With regards to services for children, adolescents, and young people, our goal is to improve data availability and use to understand and address current program gaps and achieve greater than 90%VL suppression among this population. Strategies such as scaling MMD, further expansion of adolescent peer support models, and comprehensive case management will be used to improve adherence and retention. PEPFAR Namibia will expand access to child-friendly services at the facility, provide quality and equitable pediatric care across sites, and support social service provision through the OVC program inclusive of mental health support.

For the PMTCT program, the goal is to improve data availability and use, to understand and address current program gaps and eliminate mother-to-child transmission in Namibia. This is to timely identify new infections and linkage to services among infants, adherence to treatment and VL suppression, ensuring all HEIs access timely scheduled EID services and treatment, and wraparound services for holistic support.

For cervical cancer in COP22, the program plans to scale up CXCA services by introducing a new CQI collaborative to improve implementation of CXCA screening by HCWs; treatment as well as

to improve diagnostic and treatment competence. The national electronic system will be reviewed to incorporate a CXCA cohort tracking to improve re-screening and post-treatment follow-up rates. A phase-based HPV DNA testing & triage to offer alternative CXCA screening methods will be introduced and training of HCW and clients on HPV self-sample will be conducted.

Laboratory priorities in COP22 will maintain those laid out in the previous two COPs. PEPFAR Namibia will continue to focus on diagnostic network optimization to improve access to pediatric VL, EID, and TB diagnostics, specimen transport and results return, CQI, data systems strengthening, and special projects for epidemic control. New to COP22 is the addition of HPV testing to select district-level GeneXpert sites, addition of TB molecular testing to the Abbott m2000 to diversify platforms and assays available for TB testing, and expansion of SMS results return to include direct texts to clinical mentors to alert them to positive EID patients, positive TB patients and high viral loads detected in priority populations to highlight the need for action at the clinical level for these results.

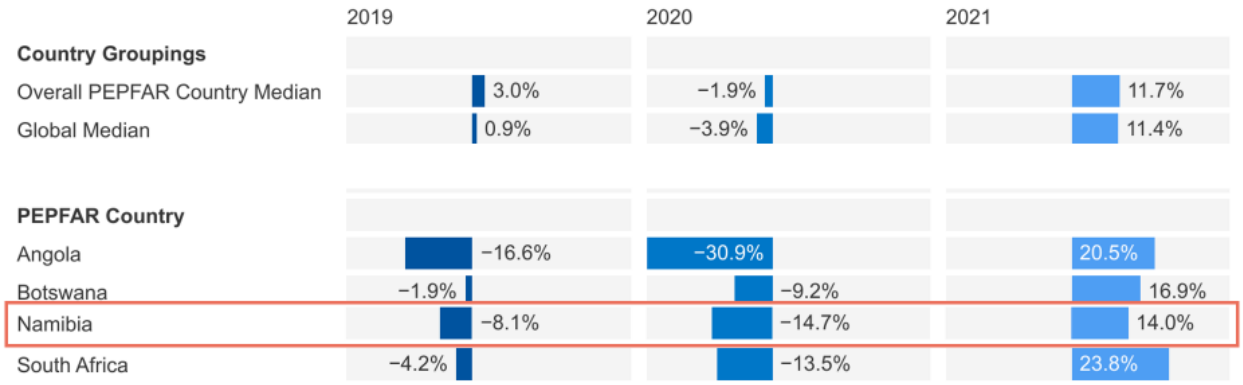
In COP22, the OVC program will support enhanced psychosocial support for families and OVC by government social workers. The DREAMS program will fully transition to local partner implementation through new procurements. Given planned saturation in two DREAMS districts in COP21, a maintenance package will be rolled out in those districts while expanding in two new districts in Kavango West in the second half of the year under the new local partner mechanisms.

PEPFAR Namibia's vision for supply chain and commodities for COP22 is focused both on the present, by providing program critical support to the MOHSS and CMS and the future, catalyzing progress toward the ideal health supply chain for the country. PEPFAR Namibia will continue to work closely with the MOHSS and other stakeholders to enhance and institutionalize data use to mitigate risk, address wastage and other inefficiencies, and establish systems for increased transparency and accountability. Finally, accelerated efforts will be targeted toward a more modernized health supply chain for Namibia, through a network optimization analysis to define the ideal supply chain and collaboration with the MOHSS and the Ministry of Finance.

2.3 Investment Profile

Although the direct health impact of COVID-19 has been severe, the economic impact on the health sector may ultimately prove to be even more consequential. As shown in figure 2.3.1 the global median change in GDP was 0.9% from 2019 to 2020, followed by 3.9% from 2020 to 2021. While it rebounded to 11.4% from 2021 to 2022, overall growth remains below pre-pandemic projections. PEPFAR countries fared better, with a 3.0% increase from 2019 to 2020, followed by a contraction of 1.9% and then an expansion of 11.7% from 2021 to 2022. While almost all PEPFAR countries are estimated to see steady GDP growth in 2022 and beyond, their growth remains below pre-pandemic projections, in contrast to the global economy which is estimated to have almost fully recovered.

Figure 2.3.1 Real GDP Change (Percent change from previous year), country groupings and PEPFAR countries

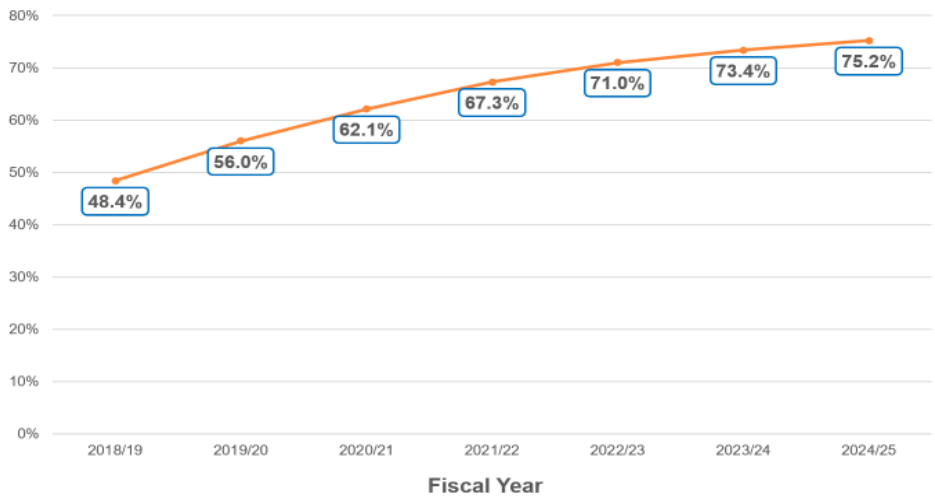


Source: Oum S, Kates J, and Wexler A: "Economic Impact of COVID-19 on PEPFAR Countries." Kaiser Family Foundation Brief (Feb. 2022). https://www.kff.org/report-section/economic-impact-of-covid-19-on-pepfar-countries-issue-brief/

Namibia has been in a recession since 2016, with GDP contracting annually by 0.5% from 2017 to 2019. From 2019 to 2020, it contracted by 8.1%, the worst in the country's history, and then by 14.7% from 2020 to 2021. Like other PEPFAR countries, it also rebounded to 14.0% in 2021, but did not emerge entirely unscathed and faces an uphill battle to return to positive overall growth.

To finance the COVID response and support Namibia's economic recovery, the GRN obtained loans from international lenders, including for the first time from the International Monetary Fund. Namibia is classified as an upper-middle-income country which prevents access to softer borrowing rates that lower income countries can obtain. As shown in figure 2.3.2, the debt-to-GDP ratio in Namibia has climbed steadily from 48.4% in 2018/19 to 67.3% in the FY that ended in March 2022 (i.e., 2021/22). It is projected to continue to increase over the next few years.

Figure 2.3.2 Namibia Debt-to-GDP Ratio, 2018-2025.

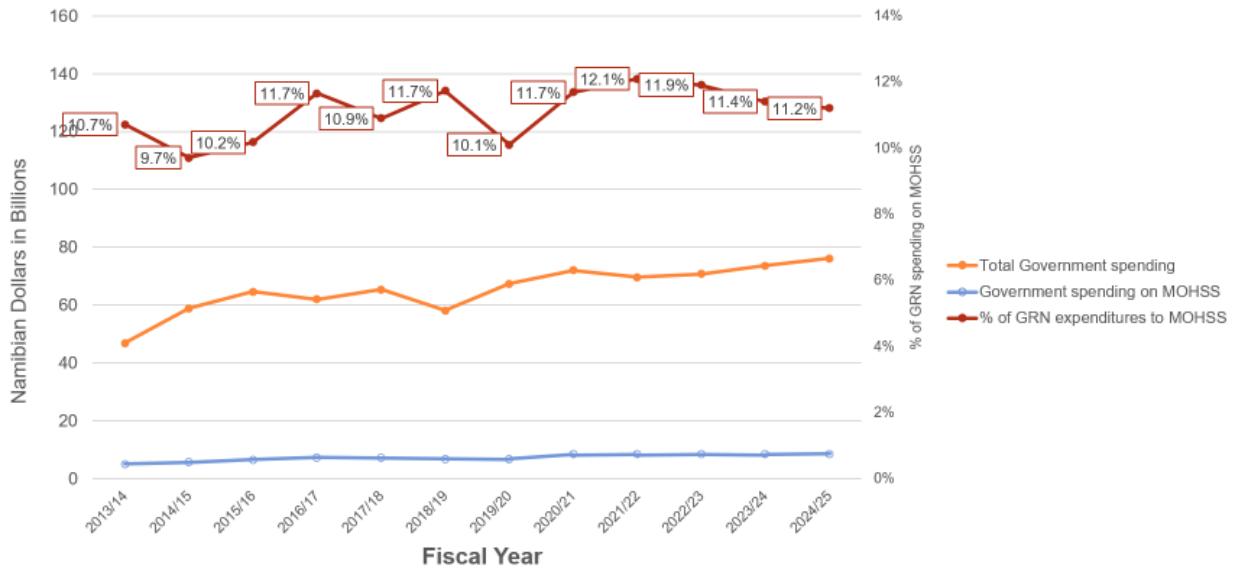


Source: Republic of Namibia, Estimates of Revenue, Income & Expenditure, 2022/23 – 2024/25. Accessed at: https://mof.gov.na/budget

Although the Namibian economy is expected to eventually return to pre-pandemic growth levels, the pace of the economic rebound will determine how quickly loans can be repaid and thus the amount of funding available for economic growth, as well as for public goods such as health.

Despite the economic turbulence wrought by COVID in Namibia, the government has indicated in its current budget and future projections that it intends to prioritize health, likely resulting in relatively stable funding in the coming years. As shown in figure 2.3.3, there has not been a significant decrease in overall government or health spending in Namibia through to FY21/22. Recent MOF projections present a modest increase in the overall government budget to FY24/25, with spending on the MOHSS remaining constant, at around 8.5 billion Namibian dollars per year.

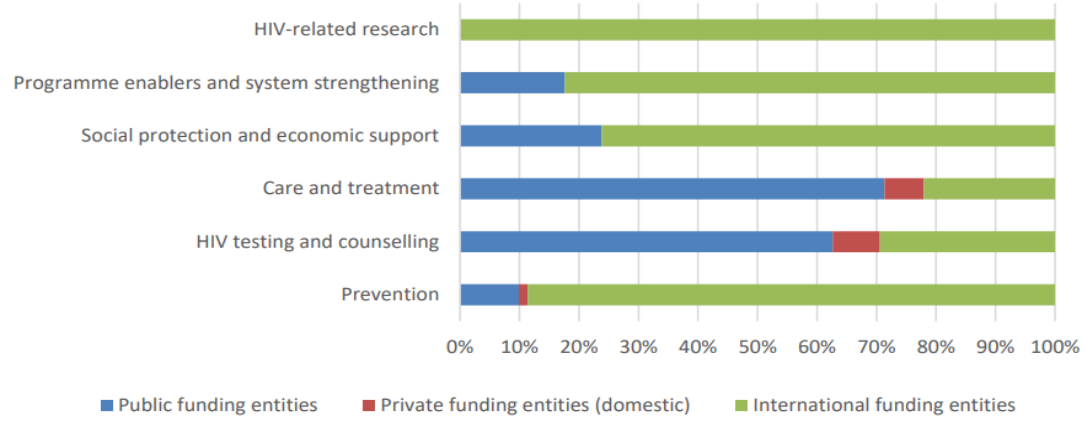
Figure 2.3.3 GRN Spending: Overall and on MOHSS, 2013-2025.



Per the most recent estimate for which data are available, the Namibian government assumes the largest burden of funding the HIV response, accounting for 61% with gradual year-to-year increases. Bilateral donors contributed 23% to the total HIV expenditure, most of which came from the USG. Multilateral donors and development partners' contributions made up 10% of the total HIV spending, of which 90% came from the Global Fund. Domestic corporations and households accounted for the rest.

As shown in figure 2.3.4, the GRN was the largest funder of care and treatment (71%) and HTC (63%) in the most recent estimates. International entities dominated the other categories, accounting for 89% of prevention activities, 76% of social protection, and 82% of program enablers and systems strengthening. The country has remained reliant on donors for funding all HIV-related research.

Figure 2.3.4. HIV programmatic areas by funding entity, 2017/18



The Namibian government also procures most of all commodities within all categories, including HIV and TB. Over the past few years, donors like PEPFAR and the Global Fund, have assisted with the procurement of some commodities to fill funding gaps, introduce new commodities, or scale up items in line with PEPFAR priorities. Donors support the procurement of commodities that the MOHSS struggles to obtain, such as low consumption ARVs like those for pediatric clients, and for items that the MOHSS has yet to buy or prioritize, like HIV self-test kits.

The role of donors is significant in funding human resources for health, with around 3,800 individual workers supported across the country in 2021. When converted to full time equivalents, PEPFAR supports 2,600 workers, with USAID funding more than 1,200 and CDC approximately 1,360. This amounts to nearly $23 million with CDC support and $18 million with USAID for a total of $41 million for the OU for the year. As a share of the OU's overall spending, $41 million is approximately 60% of the $70 million of programmatic-related outlays.

Table 2.3.1 Investment Profile (funding Landscape) for HIV Programs

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%
Key population prevention	2,724,681	89%	11%	
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 2.3.2 Investment Profile for HIV Commodities, Apr 2019-March 2020

Commodity Category	Total Expenditure (US$)	% PEPFAR	% GF	% Host Country	% Other
ARVs	20,857,110	2%	3%	95%	
Rapid test kits	946,097	4%		96%	
Other drugs	35,589,136			100%	
Lab reagents				100%	
Condoms	560,255	22%		78%	
Viral Load commodities				100%	
VMMC kits	250,300	100%			
MAT					
Other commodities	8,339,404			100%	
Total	66,542,303				

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration					
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	$150,000				
USAID TB	$100,000				
USAID Malaria					
Family Planning					
NIH					
CDC (Global Health Security)					
Peace Corps					
DOD Ebola					
MCC					
COVID	$11,500,000	$3,000,000	6	$21,333,327 (COP21)	Support the COVID response and the repair of PEPFAR programs adversely impacted by COVID.
Total	**$11,750,000**	**$3,000,000**	**6**	**$21,333,327**	

2.4 National Sustainability Profile Update

Namibia has a robust, country-led HIV response that has brought the country to the cusp of epidemic control. It is one of the first high-burden countries to approach this milestone, with progress on the UNAIDS fast track targets currently at 94-97-93 and is on pace to attain the 2030 targets of 95-95-95. Namibia has achieved this progress due to strong political leadership and will, robust institutions, and a dedicated and competent cadre of health workers. This was borne out in the SID 2019 with no areas considered unsustainable and requiring significant investment (i.e., red), ten marked as emerging sustainability and needing some investment (i.e., yellow), and seven as approaching or at sustainability and requiring little or no investment (i.e., green). In general, the SID 2019 suggested that Namibia's HIV response still needed some investments,

particularly in the domains of Governance, Leadership and Accountability, and Strategic Information.

Overall, the 2021 SID reconfirmed Namibia's status as 'emerging sustainability' per the SID classification. This was reflected in the preponderance of yellow for the year, suggesting that investment is still needed to ensure the national response is ultimately sustainable. The biggest sustainability vulnerability at the domain level is Strategic Information. This is an area where development partners shoulder a significant burden for the national data systems, which have been stretched further over the past couple of years due to COVID. The domain with the highest average scores is Strategic Finance and Market Openness, underscoring the longstanding commitment of the GRN as the primary funder of the response. Although sufficient domestic funds are mobilized, efficiency remains an area of significant vulnerability in a landscape with reduced donor funding.

The element 'market openness' is a solid 10 for the second SID in a row, highlighting Namibia's free market economy that allows unfettered participation by non-government entities in various arenas, including in the HIV response. This, however, must be considered alongside 'private sector engagement' which was a 5, indicating that there may be few market-related barriers to private participation, but there is also room for greater public-private engagement. The need for the government to better leverage civil society's unique contributions was similarly evident in Namibia's 'civil society engagement' score, also around 5, and repeatedly brought up by SID workshop participants.

While the overall 2021 SID scores classify the country as emerging sustainability, only 'public access to information' presents a major positive shift from SID 2015 to today. This demonstrates that while Namibia may be emerging per the SID classification, sustainability in the country is still in the early very much in a nascent stage, indicating that a good deal of work needs to be done across nearly all domains for sustainability to be a more realistic and attainable goal. The elements of 'service delivery,' 'human resources for health,' 'laboratory,' and 'technical and allocative efficiencies' round out the yellow elements, all meriting the increased use of a sustainability lens in COP22 and beyond.

Approximately $1 billion dollars is spent annually on health in Namibia, two-thirds of which comes from the GRN. Health spending accounts for approximately 15 percent of overall government expenditures, which meets the Abuja benchmark of government resources to health. It is also likely a sufficient envelope of resources to equitably deliver quality HIV and other services across the country, provided that the health system were reorganized, and resource usage were better maximized through technical and allocative efficiencies. Our COP22 work will build on our COP21 efforts, supporting the MOHSS to use the Namibia Essential Health Services Package (EHSP) and outputs from the activity-based costing and the Human Resource Information System to determine resource needs and spur more efficient utilization. This will also include the development of a resource allocation formula to align resource obligations with the EHSP and epidemiological and other data.

The MOHSS is at an advanced stage in a multi-year restructuring process that will reimagine and, likely, significantly expand the workforce. We will support this effort, in the development of multi-year recruitment and deployment plans to fill priority positions for the delivery of the EHSP. This will involve the use of a workforce optimization tool, leveraging newly available HRIS and costing data to comprehensively plan and manage a more adaptive and diverse workforce.

We will also assist to update the Ministry's retention strategy, with particular attention to cadres with high attrition that are critical for epidemic control, such as pharmacists.

A concerted focus on community and lay cadres is key to sustainability planning both for the Ministry in its shift to a more preventative service model and for ongoing PEPFAR-supported work. If workers in these cadres, that are currently donor-supported, will eventually shift to a domestic funder, the Ministry will need to clearly define their scopes and better understand the costs and expectations for potential social contracting arrangements. To complement these efforts, PEPFAR Namibia will work to support the Ministry's engagement with the private sector and CSOs, given their significant role in the current and future delivery of HIV and other health services. This will involve collaborating with in-country stakeholders to define the future of individual technical areas and the role of non-government actors within them. PEPFAR Namibia will also work to ensure the Ministry is set up to oversee non-government contributors. The establishment of effective contract management systems and processes is imperative for the Ministry to harness the capacity of private and civil society providers while reducing wastage of public sector resources.

PEPFAR Namibia's support to address laboratory-related sustainability vulnerabilities in COP20 and COP21 was significantly affected by the COVID pandemic. The pandemic necessitated a shift to address the immediate need for expanded laboratory scope thereby deprioritizing long-term planning. As a result, PEPFAR Namibia will continue in COP22 with similar priorities to the previous two COP years. Activities in COP22 will include focusing on Diagnostic Network Optimization to improve access to pediatric VL, EID, and TB diagnostics and streamline related workflows. Further optimization will involve assisting with the development of a national specimen transport, tracking, and results return system to address the existing set of ad hoc processes and procedures. This will ensure specimen integrity and thus reliable and timely results, key elements of a sustainable laboratory system.

Access to and use of HIV/TB information remains a weak point in the national response, including the absence of data within the MOHSS for improved program analysis. This impedes program managers and implementers from making evidence-based course corrections for greater impact and efficiency. Donors play a significant role in epidemiological data and systems, creating a sustainability and capacity vulnerability. In COP22, PEPFAR Namibia will build MOHSS capacity to modify existing patient-level systems as M&E needs change. This will increase the resilience of the Ministry's data systems, improve MOHSS ownership of these systems, and ultimately make them more sustainable. PEPFAR has partnered with the MOHSS to develop standard operating procedures and data reviews for patient- and aggregate-level HIV and TB data. PEPFAR Namibia will work with the government to improve access to information through interoperability and data integration. In addition, we will expand MOHSS capacity to use data already collected and monitor programs in a more sustainable manner.

While PEPFAR and the government have maintained their investment in the HIV/AIDS response, the Global Fund has seen a steady decline in its investment, including a Namibia 128% reduction in support towards care and treatment between 2021 and 2022 and a 33% decrease in support for prevention programs during the same period. This is most likely because of the design of the Global Fund grant in Namibia which front loaded spending at the beginning of the grant.

In COP22, PEPFAR Namibia will continue working with host government structures and local civil society organizations to expand the capacity of indigenous partners. Approximately 63% of

PEPFAR Namibia funds in COP20 and COP21 were allocated to Namibian organizations, including government entities, and this trend will continue in COP22. There is potential for this to increase in subsequent years, as PEPFAR Namibia looks to explore more G2G arrangements and transitions from international to local partners.

2.5 Alignment of PEPFAR investments geographically to disease burden

For COP22, improved program and national data have further refined the understanding of the epidemic and informed strategies to close the gaps. Figure 2.5.1 depicts the Namibia's population distribution geographically, which shows that most of the population lives in the far north, with other population centers in Windhoek and the central coast. Figure 2.5.2 shows HIV prevalence by district. Notably, high prevalence occurs in the same districts where there is higher population density.

Figure 2.5.3 shows percentage of ART coverage by district and Figure 2.5.4 shows ART coverage gap by district and by gender. These maps show gaps that mirror the overall population maps, with some remaining gaps in the northern border for both males and females. Data from the highest burden regions along the northern border where PEPFAR has made significant investments indicate high ART coverage (Omusati, Oshana, Ohangwena, Oshikoto, Kavango West, Kavango East, Zambezi). However, in the most urbanized and affluent areas, a large treatment gap exists that is partly filled by an estimated 22,000 ART clients in the private sector (Khomas, Erongo). Finally, there are several regions with low prevalence and low population that also have the lowest treatment coverage rates, which are where there has been increased support with more focused technical assistance and service delivery support since in COP19 that will continue through COP22 (Kunene, Omaheke, Hardap, !Karas). Figure 2.5.5 shows ART coverage gap by age <15 years and 15+ years, which demonstrates the same potential gaps in the urban areas.

Figure 2.5.6 shows viral load suppression for patients on ART by district, which demonstrates excellent on-treatment suppression rates with some room for improvement in districts with lower prevalence (Aranos, Okakarara, Keetmanshoop, Opuwo, Rehoboth, Gobabis, Khorixas and Otjiwarongo).

Figure. 2.5.1. Namibia's Population Distribution

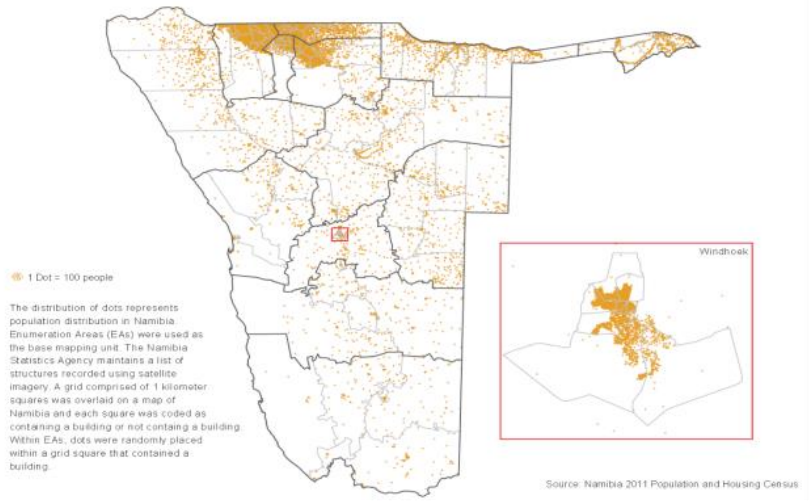


Figure. 2.5.2. HIV Prevalence by District

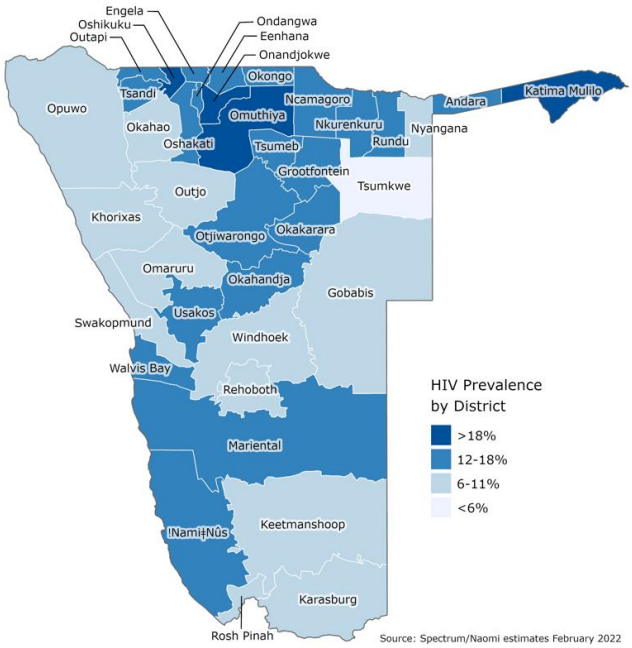
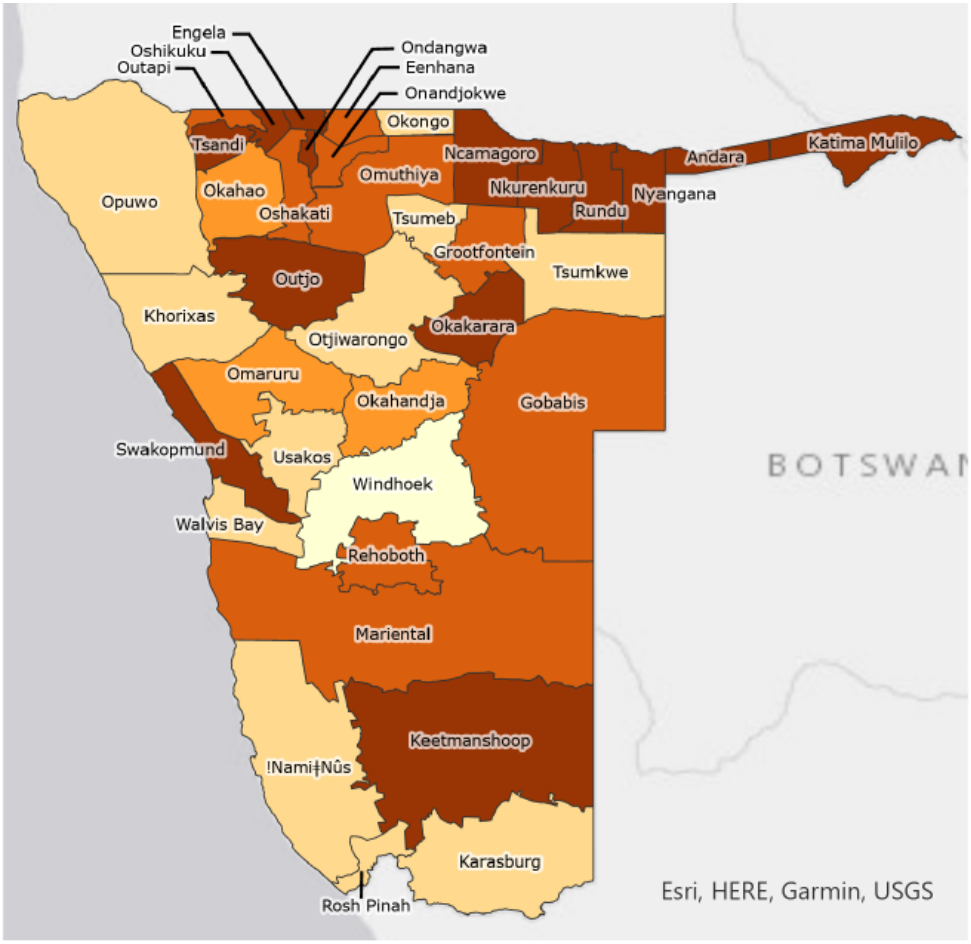


Figure 2.5.3. (%) ART Coverage (All ages) by District

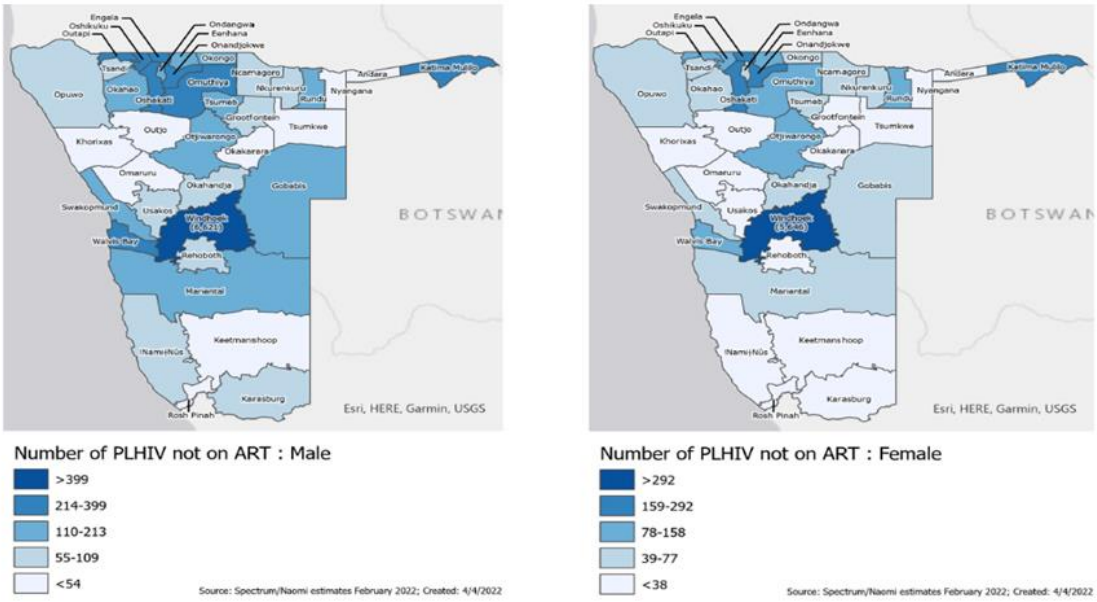


Percent ART Coverage among PLHIV

- >96%
- 95-≤96%
- 94-≤95%
- 56-≤94%
- ≤56%

Source: Spectrum/Naomi estimates February 2022; Created: 4/4/2022

Figure 2.5.4. ART Coverage Gap by District and by Gender (All ages)



The maps above show the PLHIV not on ART by district and sex (females on the left and males on the right). Prominent gaps for both females and males are observed in Windhoek and Walvis Bay districts and smaller gaps in Katima Mulilo, Engela, Onandjokwe, Ondangwa and Oshakati districts. Low prevalence regions continue to show some gaps in ART for both sexes.

Figure 2.5.5. ART Coverage Age Group (<15 and 15+ years)

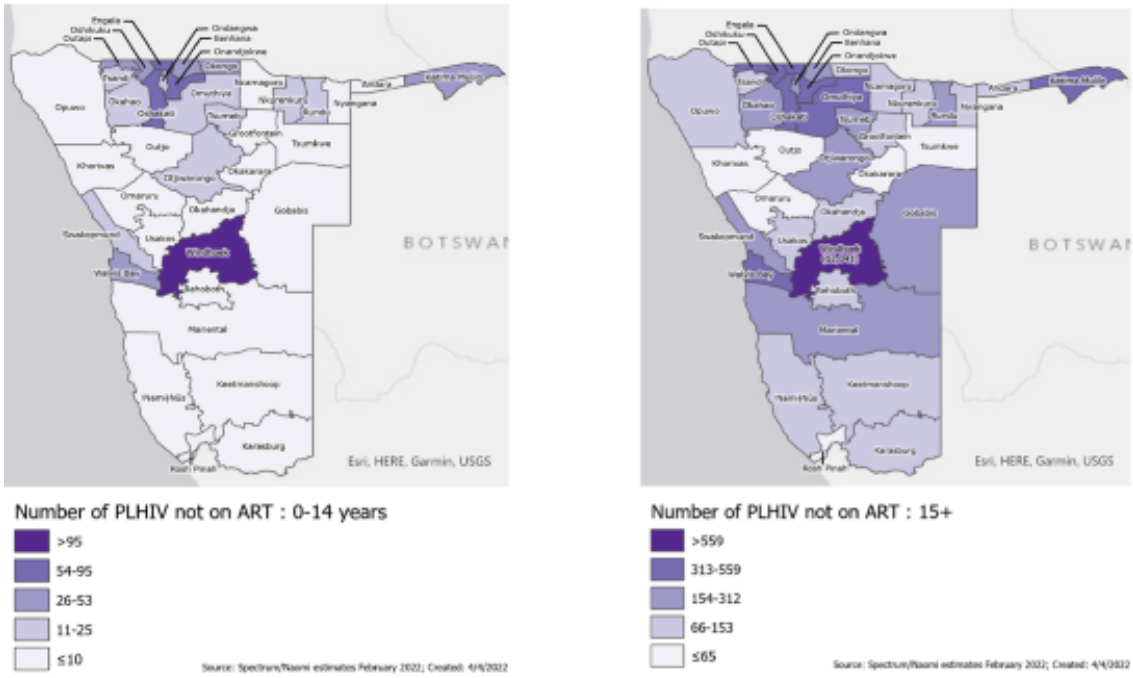
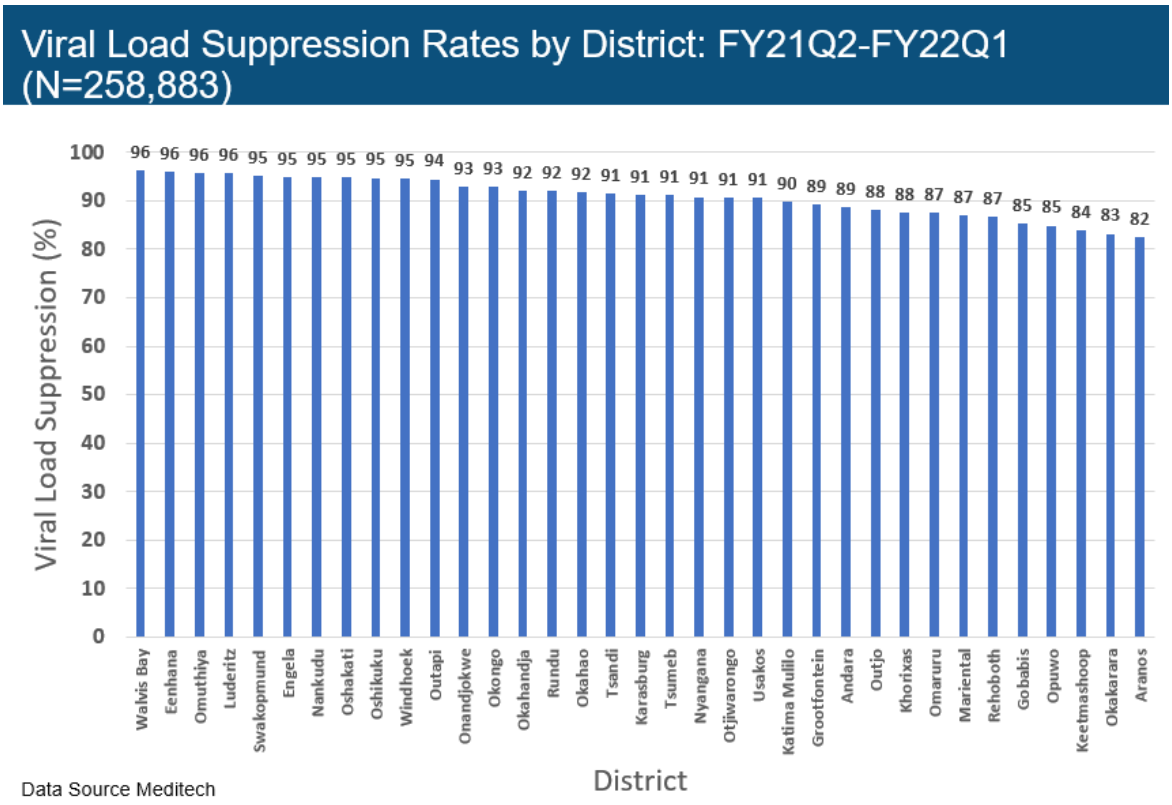


Figure 2.5.5 shows the absolute numbers of children below 15 years of age not on ART. Even though this age group was identified as a coverage gap, the absolute numbers are low across the country.

Figure 2.5.6. Viral load Suppression for patients on ART by District



2.6 Stakeholder Engagement

Host Country Government

The strong working partnership between PEPFAR Namibia and 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 participates in several Technical Working Groups (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 in accordance with the HIV/AIDS National Strategic Framework. Leading up to the COP22 process, PEPFAR Namibia held regular consultative meetings albeit virtually with the Executive Director of the MoHSS and the DSP to provide updates on the latest program performance and the COP22 guidance ahead of drafting the country vision. The MOHSS was a leading partner in the subsequent virtual stakeholders retreat and planning meeting.

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 HIV/AIDS response. The GF

was specifically involved in the initial consultations including the process of developing the COP22 process and participating in the virtual stakeholders retreat as well as the planning meeting. In all engagements, PEPFAR Namibia seeks to address funding gaps and prevent duplication of supported activities among multilateral donors with guidance from the MOHSS. The UN agencies, such as UNAIDS, were engaged in the COP22 process during the virtual stakeholders retreat.

Civil Society/Faith-Based Organizations and Community

PEPFAR Namibia works closely with CSOs, including both implementing partners and organizations, that do not receive PEPFAR funding. These CSOs include key population led and focused organizations, entities that represent PLHIV, Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and other (LGBTIQ+) organizations, sex worker-led organizations, and organizations working with youth and for Orphans and Vulnerable Children (OVC) and adolescent girls and young women (AGYW). In COP 22, PEPFAR Namibia will ensure all people with disabilities will have improved access to stakeholder engagement.

CSOs, community as well as faith-based organizations were invited to participate in the virtual COP22 stakeholder retreat where they provided their input to the vision of Namibia's HIV response. CSOs worked in small, targeted groups to identify gaps, needs and potential challenges that COP22 should address. Following similar practices during previous COP processes, a peer nomination process was undertaken out of which four representatives were selected to attend the virtual planning meeting.

Private Sector

Private sector participants were invited and attended the COP22 virtual stakeholders meeting held on January 27, 2021. It has now become customary to engage the private sector on an ongoing basis on matters of sustainable health financing throughout the year.

2.7 Stigma and Discrimination

Stigma and discrimination impact how Key Populations, men, AGYW and sero-different couples access health services. PEPFAR Namibia will continue to address the impacts of stigma and discrimination through tailored approaches that improve service equity, inclusion, and accessibility by diverse populations.

The Community Led Monitoring (CLM) report found that seven percent of the general population and 18 percent of the key population groups experience stigma and discrimination at health clinics. In COP22, activities will be prioritized to reduce stigma, and discrimination, and encourage uptake and continuation of HIV treatment and prevention services. Activities identified include treatment and viral load literacy, expansion of DSD models (including PeleBox Smartlockers), training of health care workers around stigma and discrimination and targeted demand creation for PrEP, all supported by MOHSS, National AIDS Council and other host country leadership offices.

3.0 Geographic and Population Prioritization

PLHIV burden and the unmet need for ART varies across Namibia, as shown in section 2.4. ART coverage by age and sex is lowest among individuals older than 19 who are unaware of their HIV

positive status and not on treatment, especially men (Figure 3.1). These populations will be a priority for PEPFAR Namibia in COP22 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. Looking by region at the total population with HIV and the number on ART supported by PEPFAR (section 2.4), the highest burden regions are those along the northern border where PEPFAR has invested the most, with high coverage across the cascade. In the most urbanized and affluent areas, there is a larger treatment gap than anticipated, which may be filled by the 22,000 ART clients in the private sector, which is concentrated in those regions. There are regions with low prevalence and low population but also with the lowest coverage rates. Beginning in COP19, PEPFAR Namibia increased support with more focused technical assistance and service delivery support in those regions. This support will be continued and refined in COP22. To increase equity, the current and new DREAMS will strengthen linkages with FSW and LGBTQI focused programs. Additionally, we will review and adapt tools and training materials , where possible, to ensure gender diversity principles and representation in DREAMS programming.

Compared to the high VLS among adult populations in APR21, pediatrics, adolescents and young adults aged 0 to 24 years had comparatively lower VLS rates (Figure 3.2). Limited support for pediatrics disclosure and teen psychosocial support, and suboptimal ARV prescribing have been identified as contributing factors. However, there is improved VLS through the clinical mentor program. The clinical mentors initiate QI activities within their districts to improve key variables like viral load suppression among children and adolescents. In FY21, the Clinical Mentors report shows a VLS range between 79% - 96% with almost half of districts having VLS rates at 90% or greater. This type of facility level support and target setting to improve viral load suppression is having an impact. Additional support for pediatric and adolescent disclosure and teen psychosocial support will be provided nationally in COP22.

The integrated community HIV service model (community index tracing, linkage to care, patient tracing, community adherence groups, mother-baby pair follow-up) will be expanded to include all regions in COP22. Community teams or "Fivers" will be able to respond nimbly to the epidemiology and needs of each area, shifting from case finding to tracing and community adherence group support in saturated areas and back to index testing where gaps are found.

The current cohort of Clinical and Nurse Mentors covering all the 14 Regions of Namibia will be continued with one additional district nurse mentor for Oshana. The 29 District Nurse Mentors are assigned based on the number of sites in each district and the 17 Regional Mentors are assigned one (1) per region (this includes the management structure consisting of a Chief Clinical Mentor and a Deputy Chief Mentor).

The PEPFAR Namibia OVC program is a mature program, implemented in 18 districts with an overlap of OVC implementation in nine Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) districts. These districts were selected based on the high number of PLHIVs, as well as the high prevalence of GBV and violence against children based on the demographic and health survey, VACS, and NAMPHIA data. The OVC program will continue to provide a comprehensive OVC package of services, HIV and sexual violence prevention, and DREAMS like services for girls who are OVCs. The OVC comprehensive package of services is provided based on the needs of a child, including support to CLHIVs to ensure adherence and VLS. The complimentary HIV and sexual violence prevention activities focus on boys and girls 9 -14 years

and provide appropriate interventions. In COP22, the current OVC mechanisms will come to an end mid-year, with new awards to begin in quarter 2 of COP22.

DREAMS is currently operational in 9 Districts and will be expanding to two additional districts (Nankudu and Nkurenkuru) in COP22. Program data on vulnerabilities and risk show that over 98,000 AGYW are vulnerable in the DREAMS districts and DREAMS completion data demonstrate that the DREAMS program will reach saturation in 2 districts in COP22. Based on the analysis, vulnerability risk rates for AGYW currently range from 43% - 60% depending on the district and age group. Given the expected saturation, national data in HIV incidence and prevalence, teen pregnancy and school dropout data, and other vulnerability data to identify the 2 districts in the Kavango West Region which have high vulnerabilities were used. Careful consideration was also given to Global Fund implementation when selecting the DREAMS expansion sites. In COP22, the two existing DREAMS mechanisms will come to an end mid-year, the DREAMS program will fully transition to local partner implementation under the new awards. A new integrated child and youth program which will include OVC comprehensive, OVC Prevention and DREAMS will begin and overlap with the current DREAMS and OVC program in mid COP22.

There are three key priorities in COP22 for the Key Population program, (1) Programmatic efficiency through reviewing the epi data/understanding context and ensuring programming is being responsive to the data, to focus on certain locations and to maintain progress overall (2) implement programming that focuses on KP program sustainability and (3) Service Delivery including KP competent and KP sensitive services to allow for more person-centered services. PEPFAR Namibia will focus on adjusting programming based on studies such as the NAM IBBSS data, the small area estimates and focusing on approaches and modalities identified to be effective and to implement existing studies results and allow for the program to be more person-centered and ensuring equitable access to services. On program sustainability, support will focus on the identification of social enterprise opportunities, explore social contracting options, and on the continued capacity expansion for KP-CSOs and to continue to strengthen program efficiencies. Adjustments around KP service delivery will focus on addressing service delivery at clinics and on an improved enabling environment and expanding on activities to address these program gaps.

The COP22 VMMC Strategic direction focuses on 4 areas which include (1) Accelerating VMMC service delivery by increasing providers, and expanding availability of outreach and private sector services to increase the VMMC uptake in "higher-risk" men for HIV infection, (2) Targeted context specific demand creation through dedicated community mobilizers, leveraging existing community / DREAMS champions and maximize social and print media for demand creation with tailored approach, (3) Quality improvement activities such as proficiency training, mentorship and coaching programs, coupled with routine supporting supervision and CQI activities, and (4) Enhanced MOHSS's Capacity and strengthen collaboration with GF/WHO to fast track VMMC coverage. These will help the government of Namibia to increase VMMC coverage, strengthened national capacity to plan, implement and monitor VMMC service delivery, and sustain the impact.

Figure 3.1. Namibia Population Pyramid (PLHIV Only)

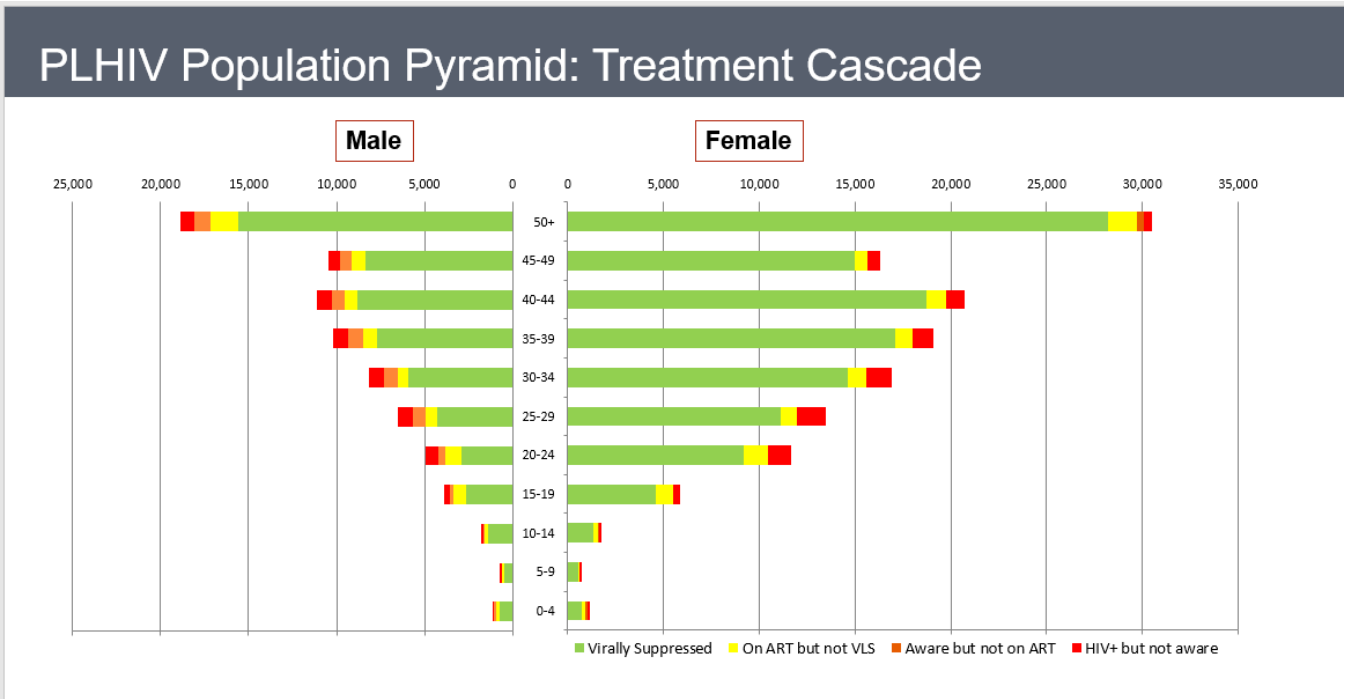


Figure 3.2. Viral Load Suppression Rates by Age/Sex, Namibia FY21Q2-FY22Q1: (N=253,427)

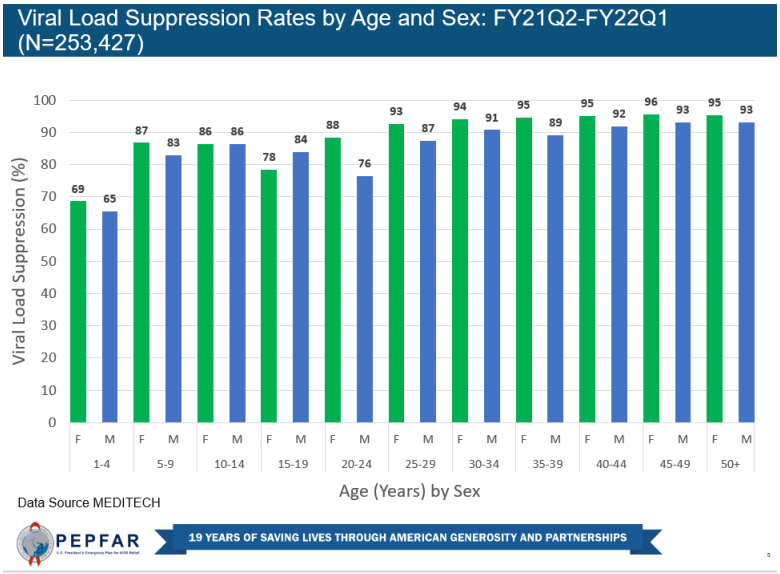


Figure 3.4. Clinical Mentorship Network Geographic Coverage COP22

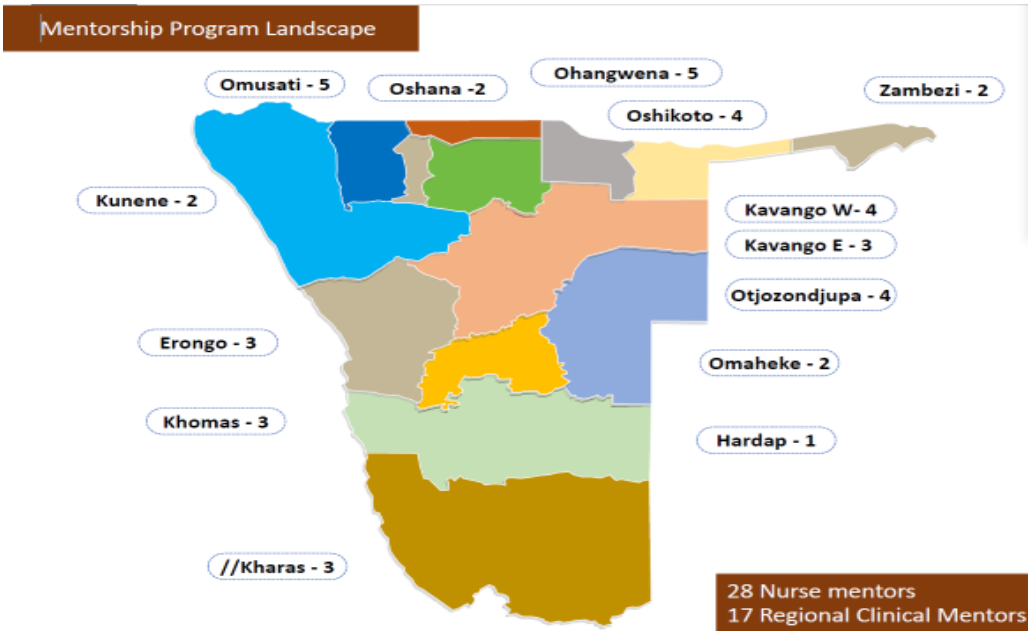


Figure 3.5. Clinical Mentorship Network Structure COP22 and beyond

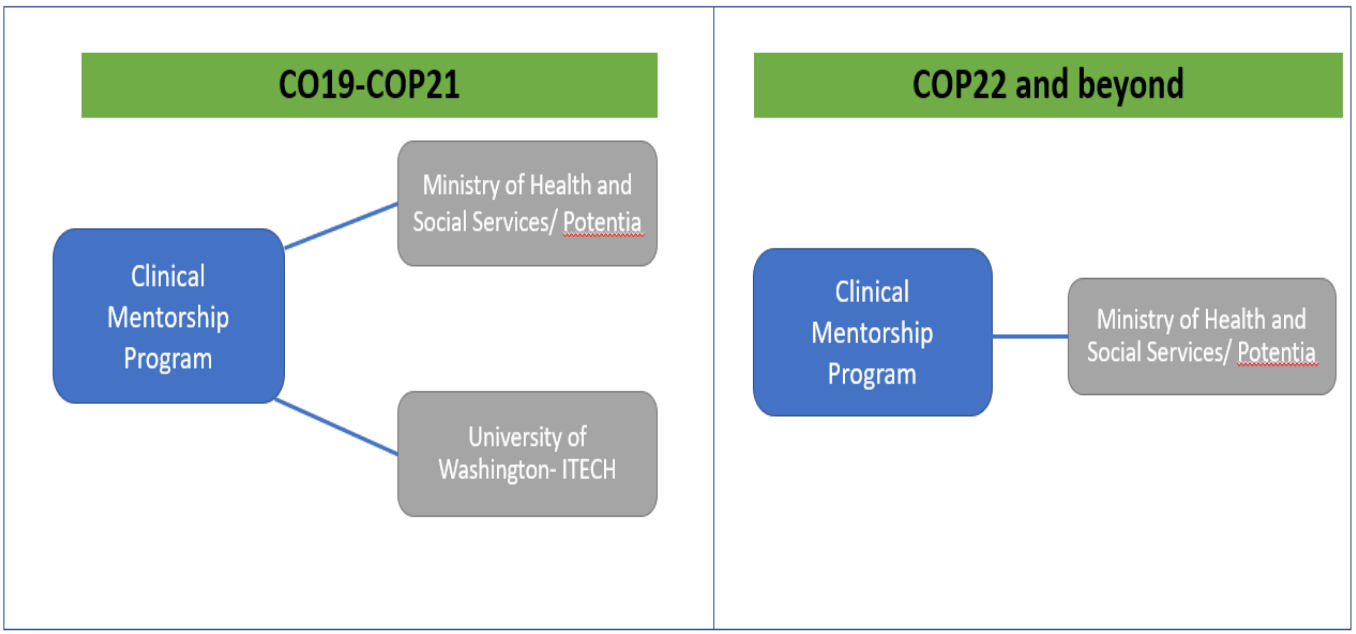


Figure 3.6. DREAMS and OVC Program Supported Health Districts and Regions

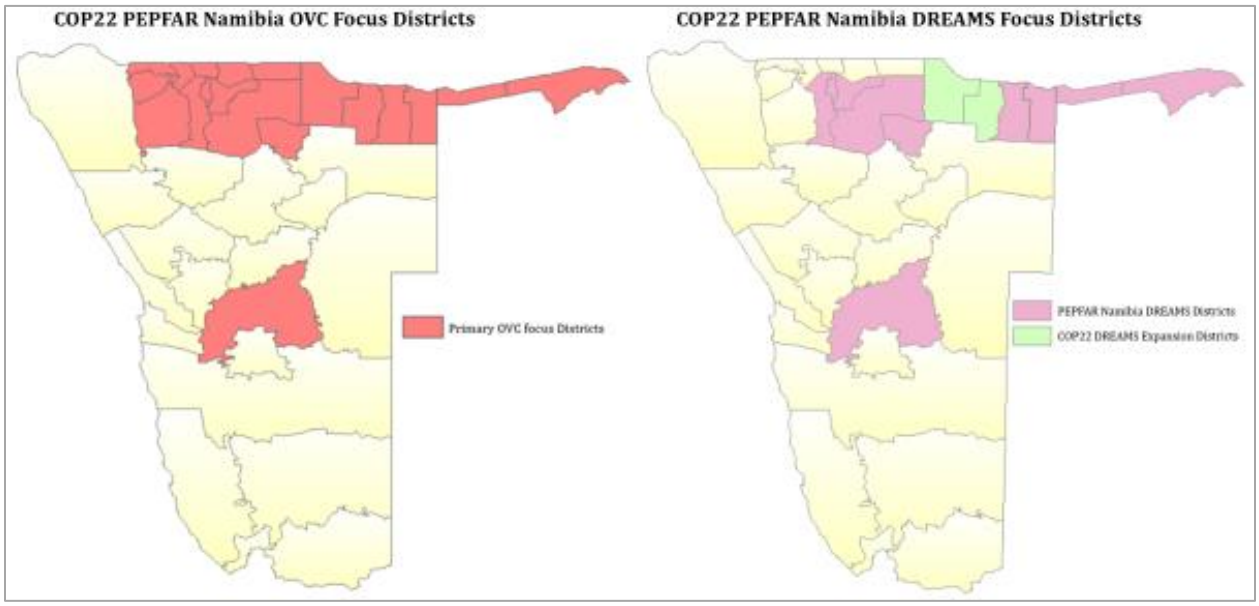
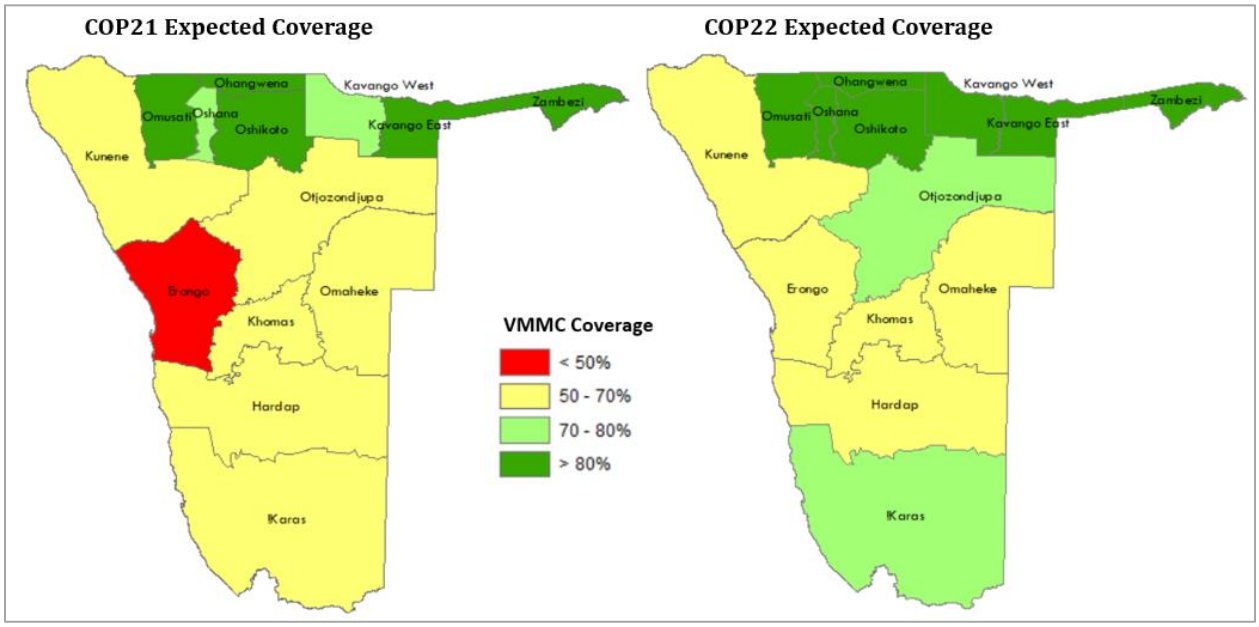


Figure 3.7. VMMC Coverage from FY21 expected Coverage and Targets for FY 2021



Rebuilding our core Health program with normal 2-year Peace Corps Volunteers entering service early in the COP22 year. Peace Corps is also establishing several other alternative service models that we believe will be able to make more meaningful contributions to the overall inter-agency

PEPFAR effort. These include (1) Peace Corps Response: Specialized skill volunteers who serve one-year assignments to address specific skill needs in partner organizations, (2) Virtual Service: Remote support for specialized skill needs of partners. We believe that these alternative service options will enable Peace Corps to support other agencies and their partner organizations beyond the scope of our two-year program which focuses primarily on activities targeting AGYW and OVC. We see this as potentially supporting the evolution and sustainability of the program by addressing skill gaps in implementing organizations. We will also be leveraging our Economic Empowerment Program, (which has not previously been aligned with PEPFAR) to support the economic strengthening objectives for PEPFAR target populations.

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)	COP19 (FY20)	COP21 (FY21)	COP22 (FY23)
Attained	10,444	2 Districts	12 Districts	All 14 Regions	35 Districts	35 Districts
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			

*UNAIDS 2021 Naomi District Estimates, 08 Feb 2022

4.0 Client-Centered Program Activities for Epidemic Control

4.1 Finding the missing and offering treatment initiation

Figure 4.1.1 shows the percentage known status trends since 2010 based on the latest Spectrum/Naomi modeling. These data show an annual steady increase in percentage known status among PLHIV with coverage standing at 94% in 2021. As shown in Figure 4.1.2, data suggest that the percentage of PLHIV aware of their HIV status on treatment by age and sex with female coverage standing at 94% whilst males are lagging at 85%. These data show prominent case finding gaps (highlighted with red circles) among males aged 20-29 years. Gaps are also observed for younger ages as well.

PEPFAR Namibia implements a strategic mix of HTS modalities to optimize our case finding across different populations. HTS POS trends as shown in Figure 4.1.3 across financial years from FY 17- 21 show a general decline in the number of HIV positives identified over time with 12,744 HIV positive identified in Fy21. Given our epidemic status, further declines are expected as the country continues to close the gap and reach sustainable epidemic control. Overall testing numbers by quarter show that HTS volumes, positives identified, and percentage yields remained relatively stable despite the COVID epidemic as shown in Figure 4.1.4.

Case finding results by age, sex and geography for FY21 continue to show that the program is finding priority populations. Figure 4.1.5 shows a higher positivity yield for men older than 30 years and with a higher positivity yield among young females aged 15-29 years. Figure 4.1.6 shows the absolute numbers tested positive by age and sex and shows similar trends with high numbers identified for females aged 15-39 years and for males 25 years and older.

Programing data for FY21 show that the Index Testing modality (Facility and Community Index Testing) continues to be the most effective case finding strategy with 19% positivity yield for Community Index Testing and 16 % for Facility Index Testing as seen in Figure 4.1.7. However, due to COVID19 epidemic restrictions, this modality was negatively impacted. Other PITC continue to show the highest number of tests done and number positives identified with an average yield of 3%. To optimize this modality, HIV Self Testing will be added to outpatient department (OPD) screening, especially for men and children to ensure no opportunities are missed for these priority populations. A validation study of the adult screening tool is currently underway, once completed findings could support MOHSS to further optimize this modality. The TB modality circled in red in Figure 4.1.7 include known positives as well. The TB program is addressing this and will soon be able to disaggregate known POS from new positives. Post ANC volumes remain suboptimal whilst percentage yield is high at 11.5%. Data quality and programmatic interventions will be addressed for this modality moving forward. MOHSS intends to intensify testing rates in the Index Testing program in COP22 and beyond.

Figure 4.1.1: PLHIV Known HIV Positive Status Trends

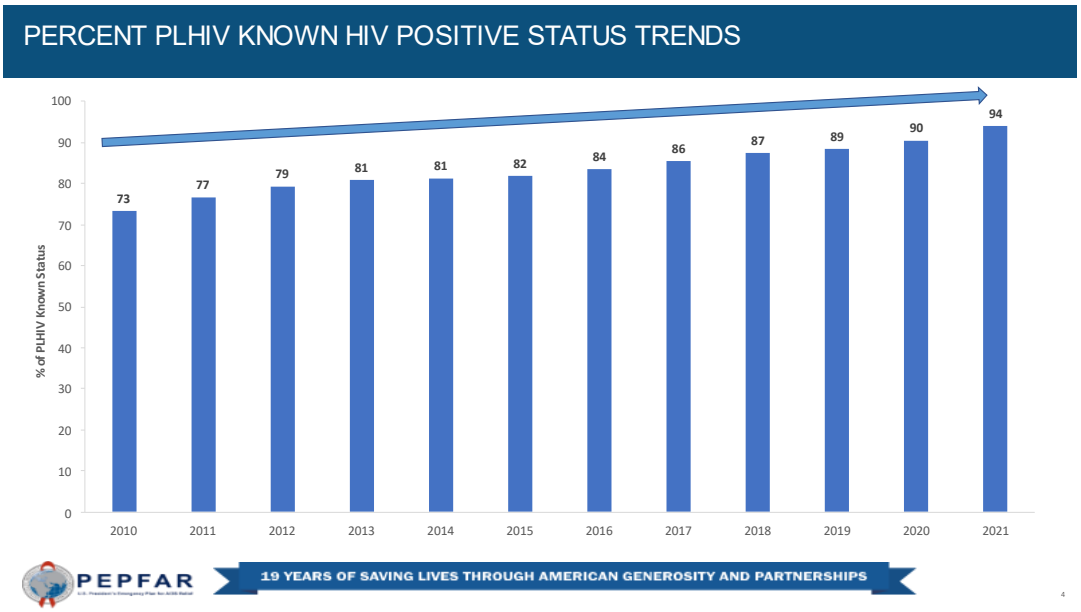


Figure 4.1.2 Percent PLHIV on ART by Age and Sex

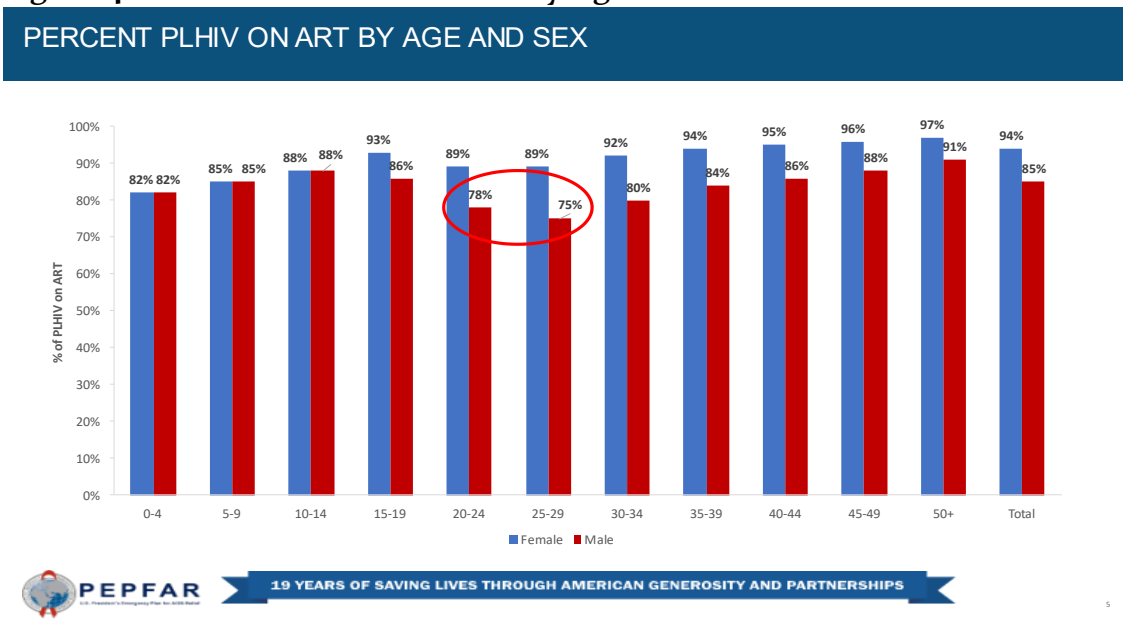


Figure 4.1.3 Namibia's HTS POS Performance from FY 17 - FY 21

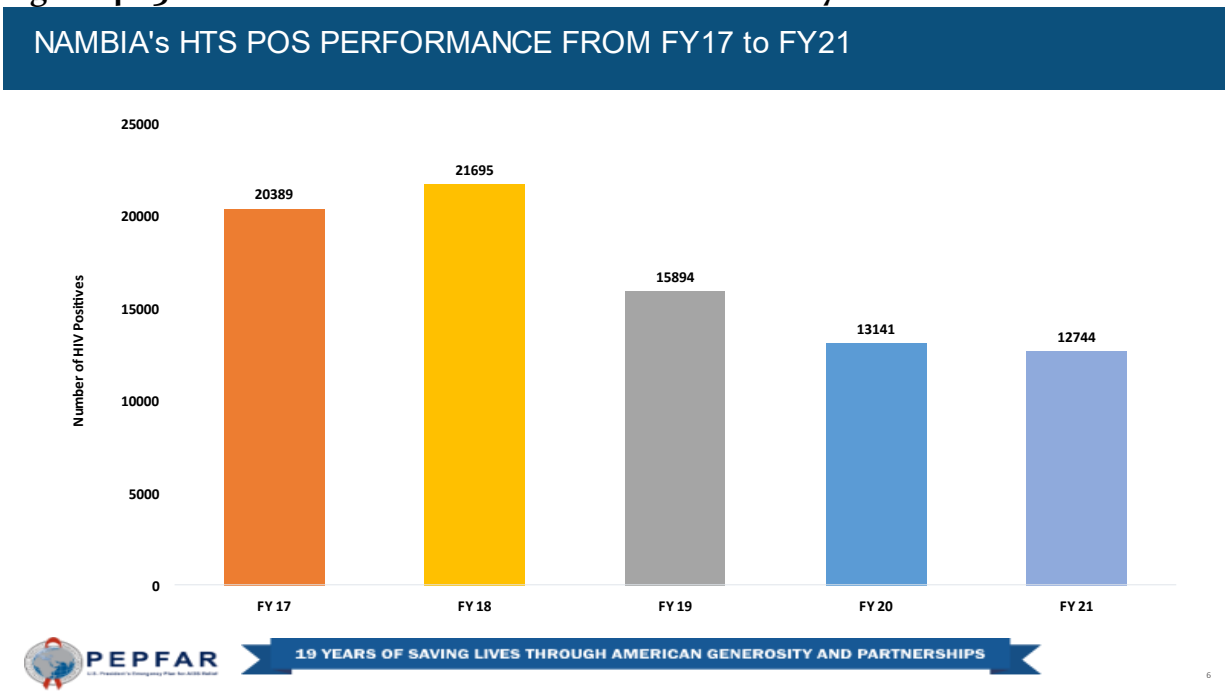


Figure 4.1.4 Namibia's TST, TST POS and % Yield, FY20 Q1 - FY22 Q1

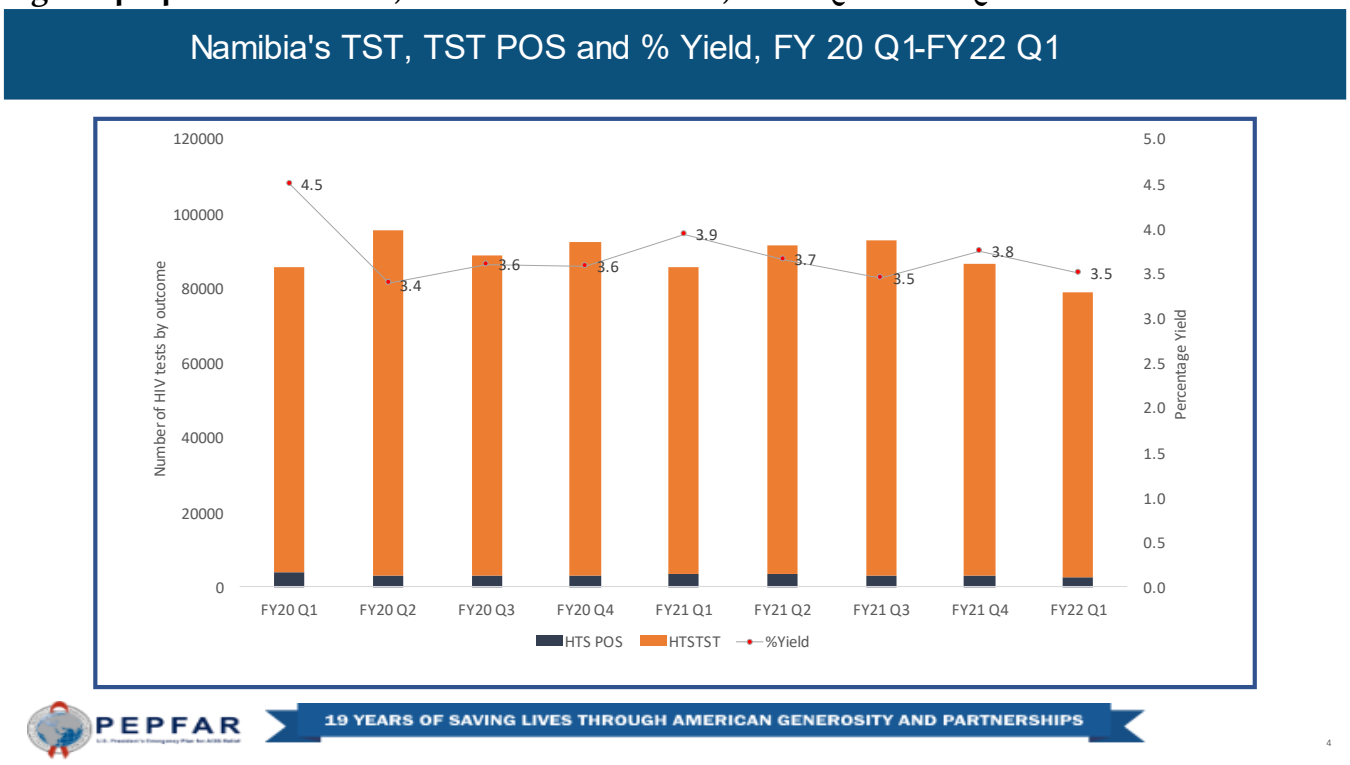


Figure 4.1.5. HTS Yield by Age and Sex FY 20

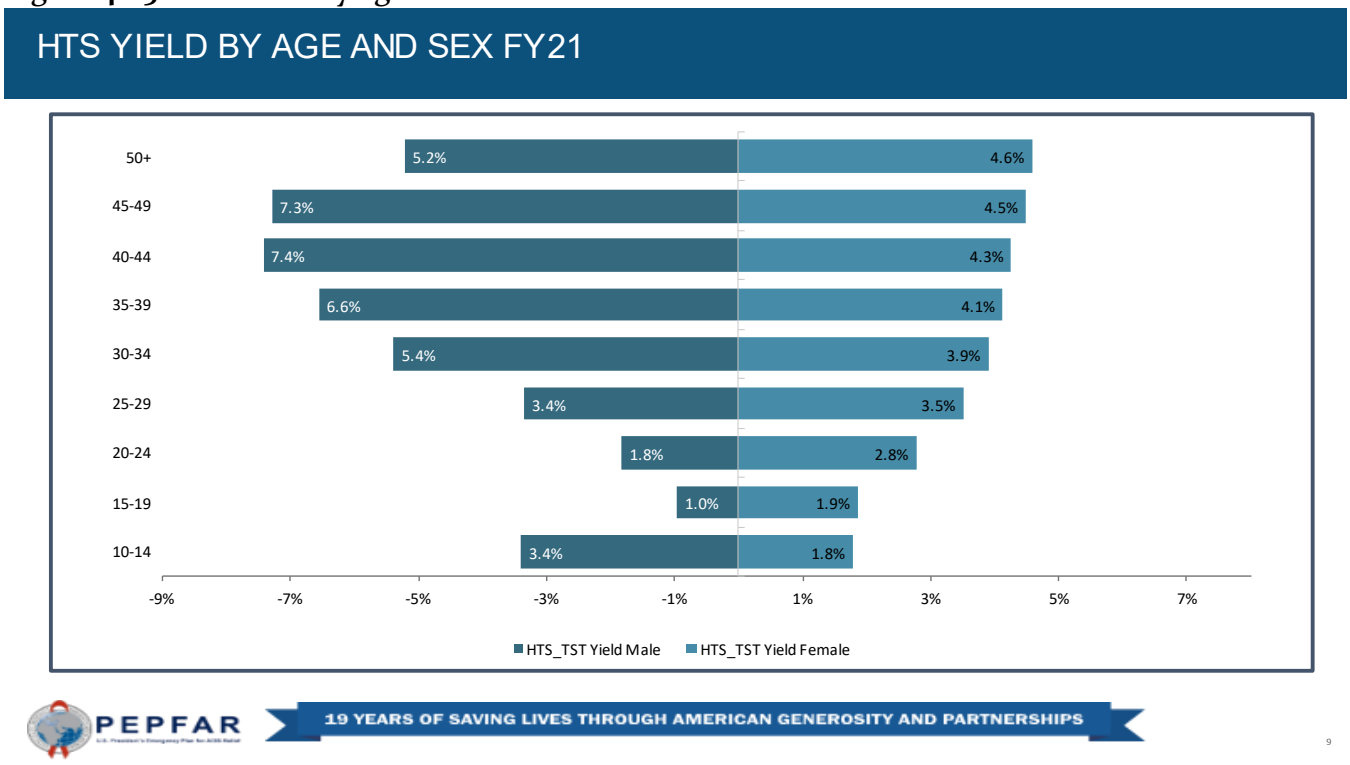


Figure 4.1.6. HTS POS Results by Age and Sex FY 21

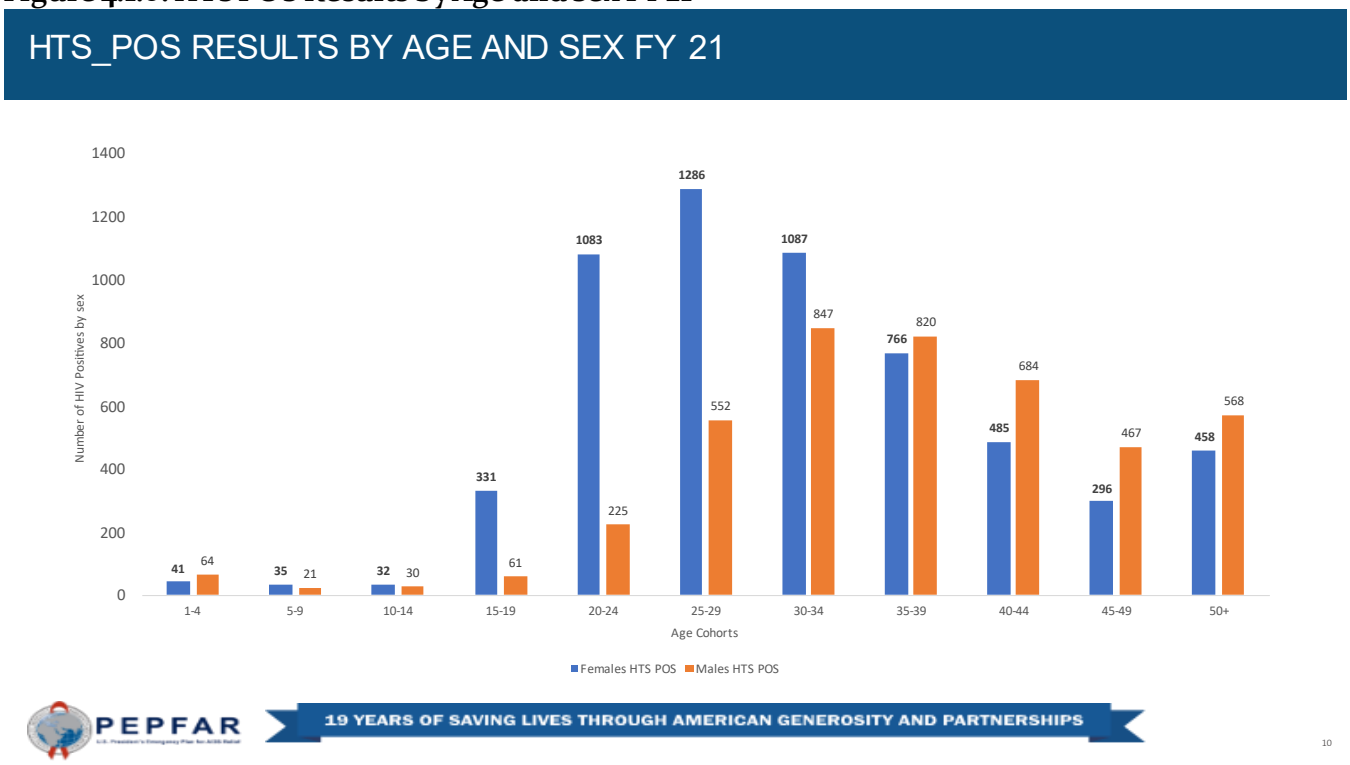
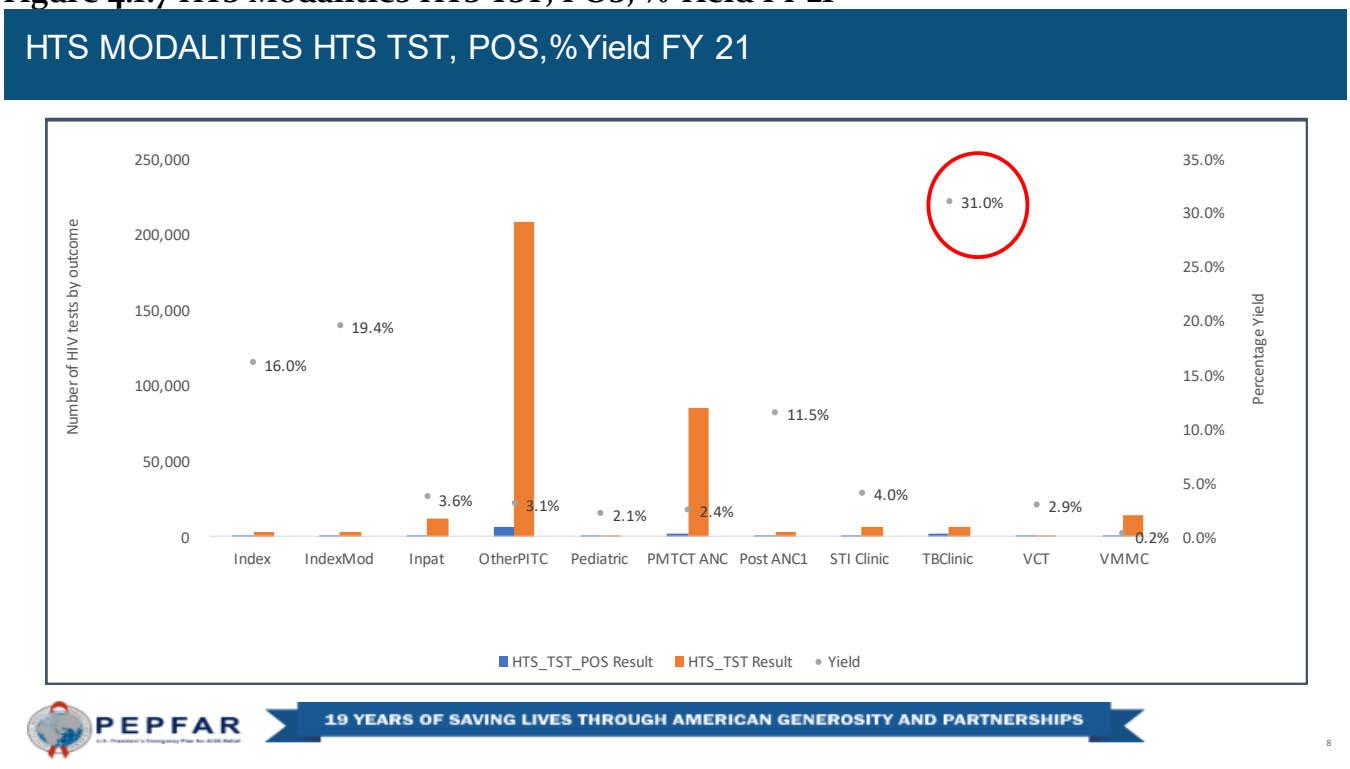


Figure 4.1.7 HTS Modalities HTS TST, POS, % Yield FY 21



Provision of Comprehensive Index Partner Testing

MOHSS committed to implement Index Partner Testing at scale in *Circular 12 of 2019*. Public Health facility staff were trained during FY20 and 21 to deliver safe and ethical Index Testing services. Although the program observed efficiencies from FY19 to FY20, the COVID19 restrictions in Namibia negatively impacted this modality with reductions in testing volumes, positives identified and percentage yields in FY21 as seen in Figure 4.1.8. Despite these challenges, the program continues to identify priority populations. Figure 4.1.9 show the number of Index contacts tested and percentage yield disaggregated by sex for FY20 – FY22 Q1. These data show that generally more men are tested in the Index program (as illustrated in the blue bars) with testing yields ranging between 14-25%. Fewer females are tested, however their percentage yields are higher than their male counterparts with yields ranging between 12-32% across the financial quarters. Looking at age breakdowns by sex in Figure 4.1.10, higher percentage yields for females aged 15-24 years and males aged 35-49 years are observed. The volume of tests is high for females aged 20-34 years and males aged 25-49 years of age. Elicitation rates for children of Index mothers continue to improve over time but remain suboptimal as seen in Figure 4.1.11. The MOHSS issued circular no 49 of 2021 directing Index testing providers to routinely offer Index testing services to Index clients for their children contacts. Additionally, the Circular also approved the use of HIV self-testing kits for children above the age of 2 years, to be offered to Index clients to enable them to test their children at home. As seen in Figure 4.1.12, testing rates stand at 55% of all contacts elicited as illustrated in the Index Testing quality cascade for FY21, which is a direct result of negative impact of COVID19 on this program. The implementing partners resultantly developed a database to keep track of the backlog of contacts by site. This database enabled the team to ensure that they follow up on all contacts. Additionally, ARPA funding is currently being utilized to address this backlog.

PEPFAR Namibia continues to support the implementation of PEPFAR's minimum requirements for Index testing. All sites have been assessed in FY20 and results show compliance to most of the minimum standards, however a few standards were identified which needed remedial actions. Nationwide trainings were conducted on the adapted safe and ethical training as well as on the LIVES training. The worst performing sites were visited and provided with onsite support and mentoring using the MOHSS standard site supervision tool. These issues will continue to be addressed. Continuous collaboration and oversight with in-country CSOs will be supported to ensure that Index testing remains confidential, voluntary, and consented. To further strengthening Index testing programming in Namibia, MOHSS with support from PEPFAR Namibia finalized the development of an electronic Index testing database and new data collection tools. This revised system will improve reporting. The quality of data is expected to improve with better coordination between what facility partners reports and community partners reports.

For COP22, PEPFAR Namibia will continue to support the MOHSS and other implementing partners to scale up and refine their Index testing and targeted testing approaches through intensified site level support as permitted by COVID 19 conditions. Additionally, PEPFAR Namibia will continue to provide comprehensive Index testing countrywide as seen in Figure 4.1.13, including low burden regions in identified hotspot towns. Direct service delivery provision is well-aligned to where the HIV burden and rapid test for recent infection (RTRI) recent results is highest, as well as population dense areas. Ensuring the safety of patients through intimate partner violence (IPV) screening and adverse events monitoring remain a critical part of the Index

testing program, through ongoing site support and LIVES support for those clients who screen positive for IPV.

Figure 4.1.8. Index TST, POS< % Yield By Quarterly Trends

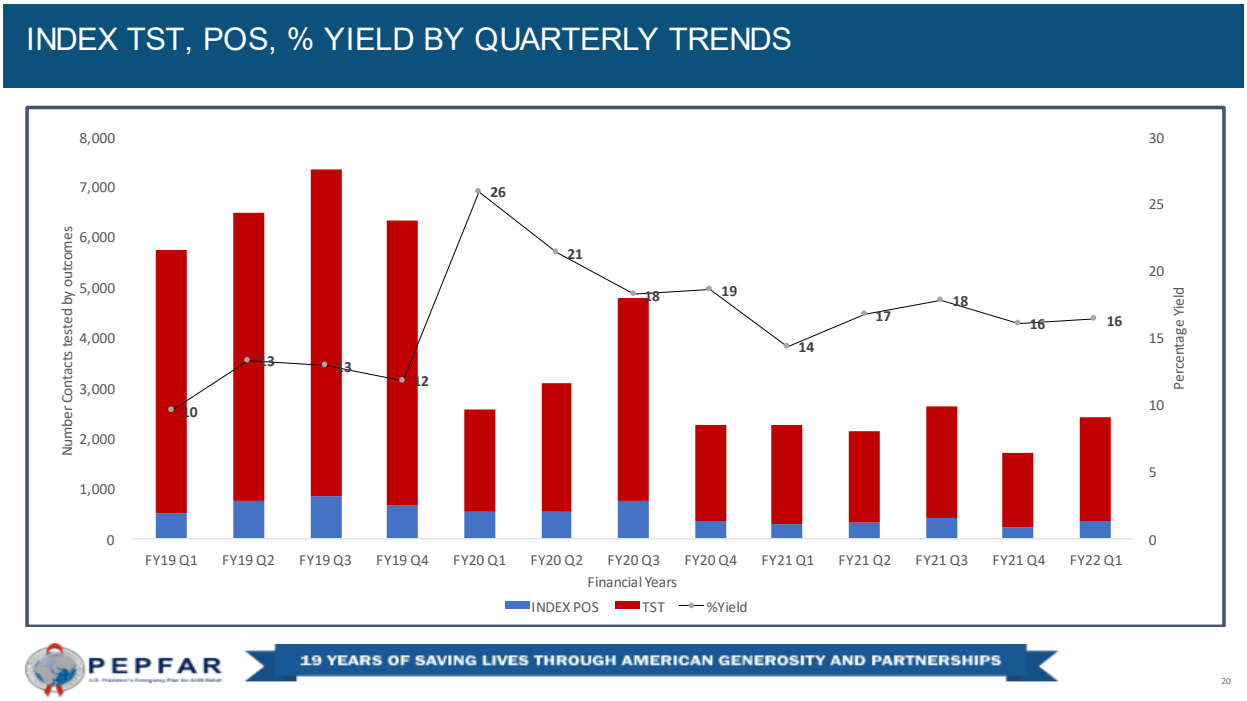


Figure 4.1.9. Index Testing Contacts Tested % Yield by Sex FY20 Q1 - FY22 Q1

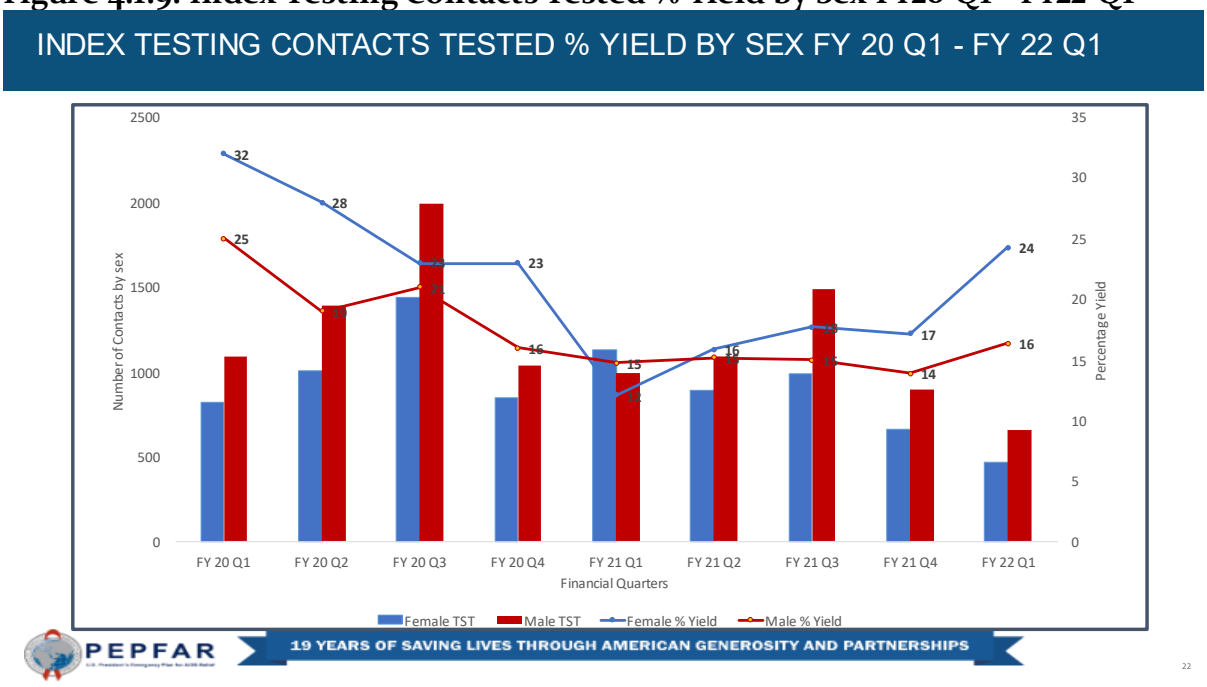


Figure 4.1.10 Index Testing Age and Sex Disaggregation FY21

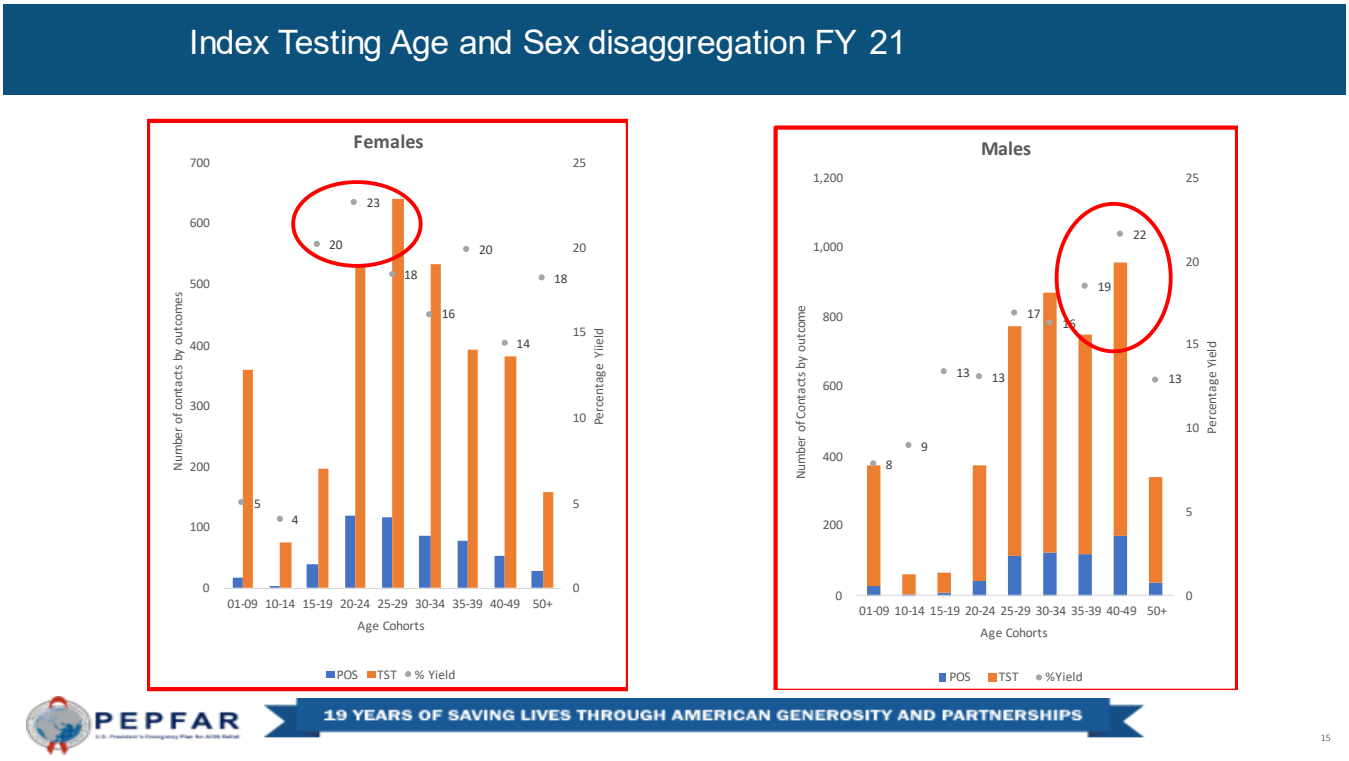


Figure 4.1.11 Proxy Index Quality Cascade: Peds Elicited by Quarter FY21 Q1 - FY22 Q1

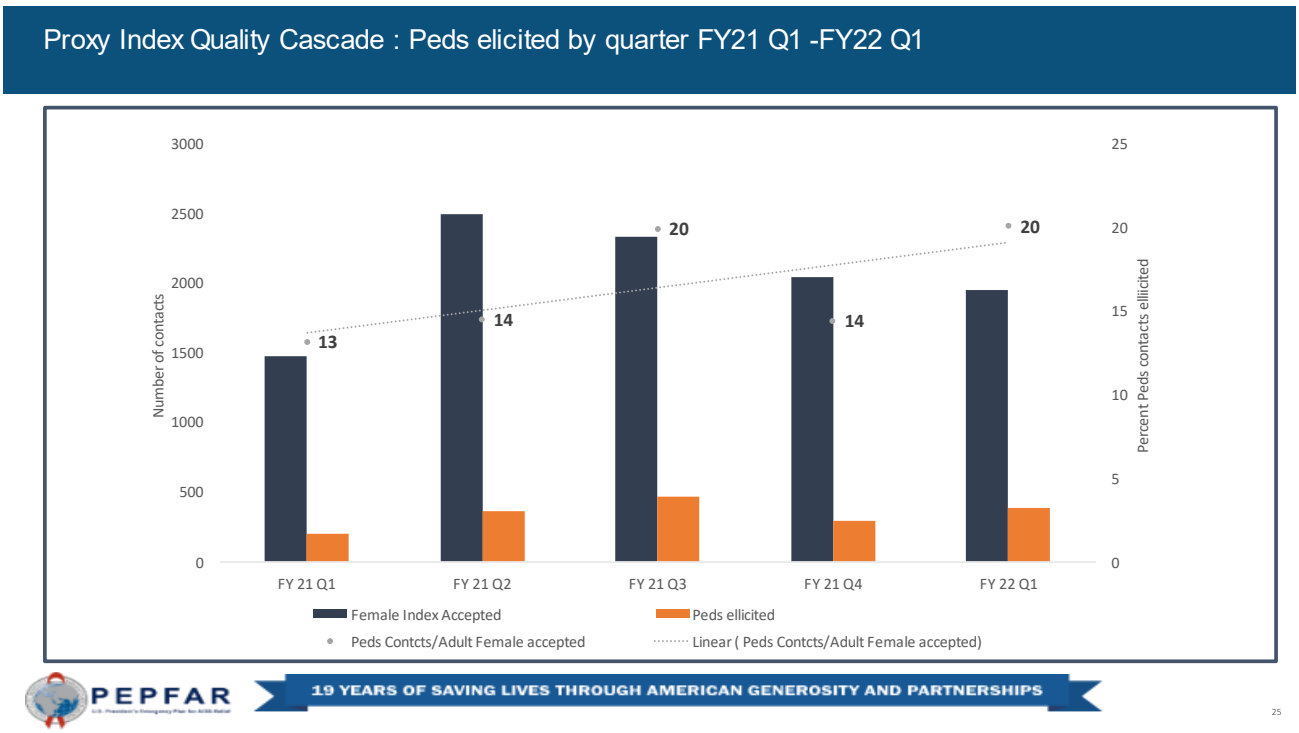


Figure 4.1.12 FY21 Index Testing Quality Cascade

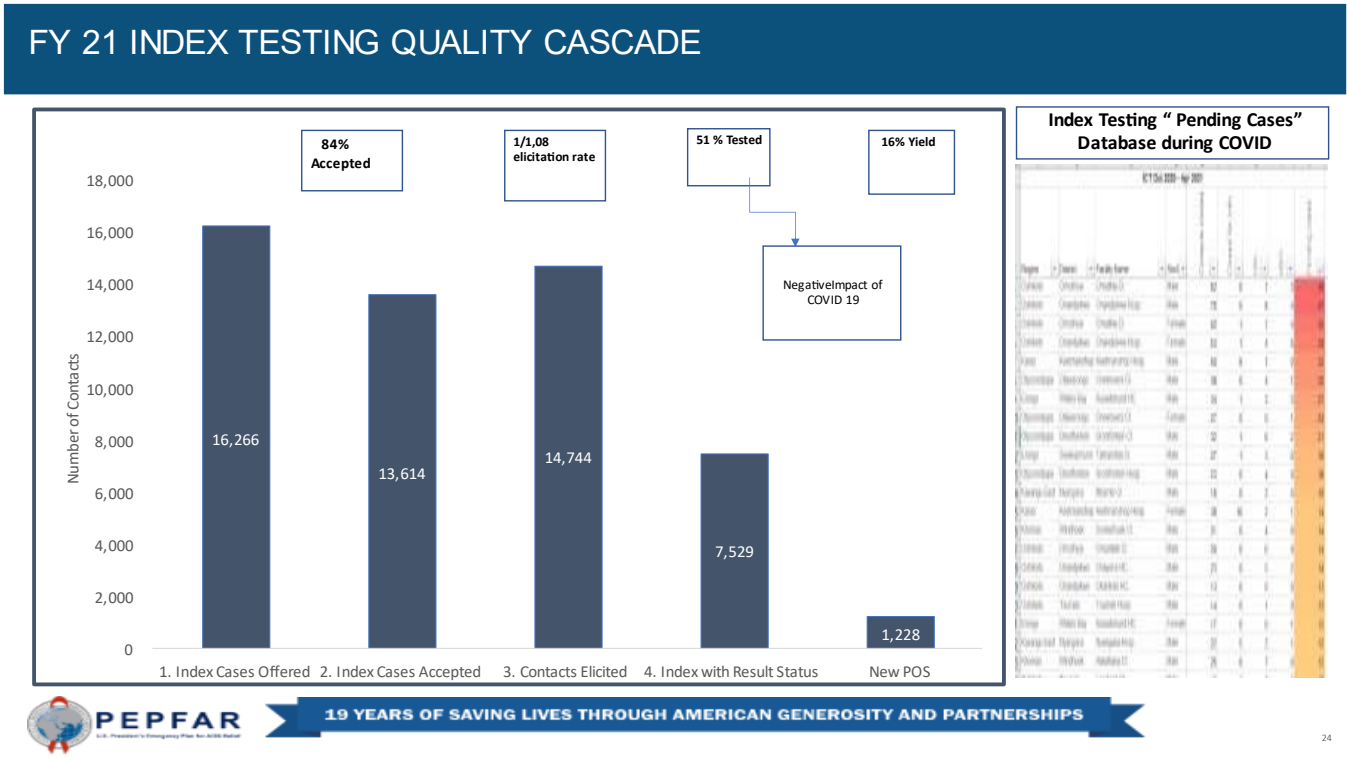
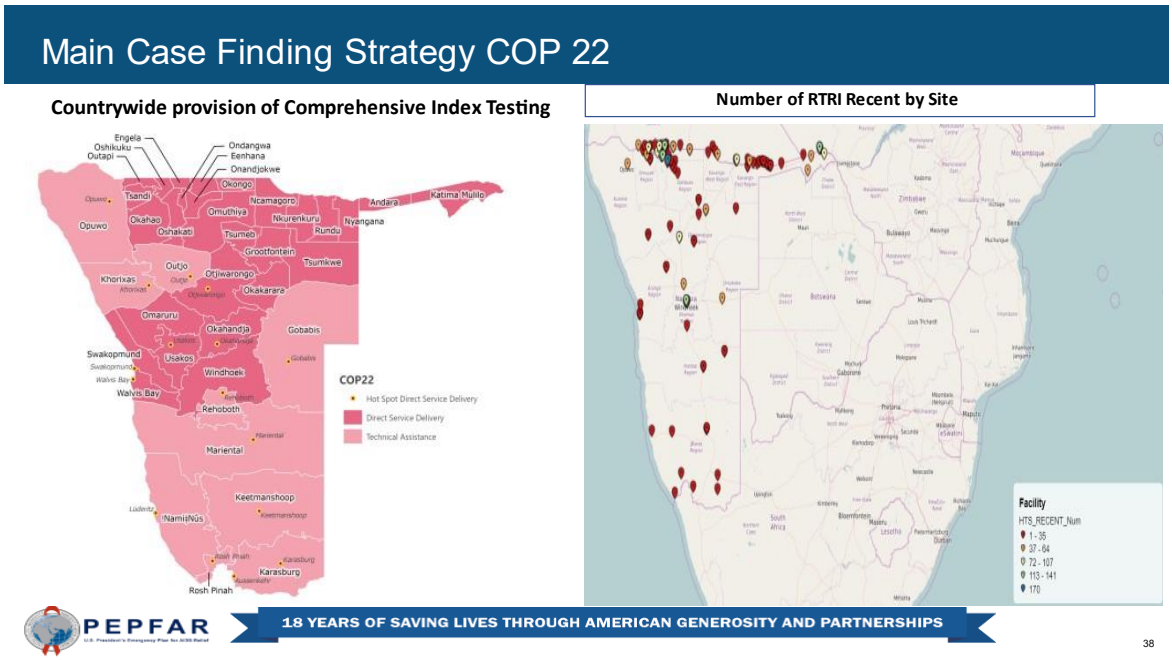


Figure 4.1.13. Main Case Finding Strategy COP 22



Recency Testing

Recency site coverage trends reported for the past five quarters in Figure 4.1.14 show improved coverage overtime standing at 52% in FY22 Q1. (Denominator is the number of ART sites not HTS Testing sites). Namibia retests all HIV positives at ART clinics before treatment initiation hence Recency is only rolled in ART clinics. Recency coverage among HTS positives newly identified improved overtime, however it remains sub-optimal standing at 35% for FY22 Q1. To improve HTS POS coverage, the program is working on expanding Recency to additional public health facilities as well as train additional Recency testers for the high-volume facilities.

In terms of Recency results, Figure 4.1.15 and 4.1.16 shows that recent infection testing algorithm (RITA) and recent range between 1-4% by age and sex show higher proportion of recent among females aged 15-24 years at 4% and among men aged 25-29 at 3%. In terms of the percent recent from total positives tested with Recency testing in each modality, the highest observed is the PMTCT ANC modality at 7%, with Index Testing at 6% and Other PITC at 4% as shown in Figure 4.1.17. RTRI recent on the map shows the distribution of Recent infections across the geography of Namibia and shows a higher concentration in the North, North-eastern, central and coastal regions. Case finding efforts especially the provision of comprehensive Index testing will geographically be aligned.

Recency data use and public health response remains a key priority in COP22. The public health response using recency assays, summarized in Figure 4.1.18 provide a strategic framework to inform a timely and targeted public health response to recent and long-term infections, including examination of potential transmission hot spots at local, sub-national and national levels to identify and respond to gaps in HIV prevention programming. The program is working on revising the public health response national standard operating procedures to guide providers on the procedures to conduct outbreak investigations. Namibia will be conducting a quality improvement collaborative with the Quality Improvement/Quality Management teams to systematically implement the Recency public health response in COP22. The recency response will pivot around ensuring those newly diagnosed receive a package of services including recency and Index Partner Testing (IPT) services as well as PrEP and ART provision.

PEPFAR Namibia intends to increase coverage to 100% by end of COP22 by rolling out the lab-based Recency model in the remaining 120 low volume facilities as seen in Figure 4.1.19. Due to COVID19 restrictions, scale up of Recency has been slowed significantly. As a result, the program is currently also utilizing ARPA funds requested to accelerate scale up efforts in line with the planned expansion. This rollout will ensure that all newly diagnosed and eligible persons who present for ART initiation will have a known recency status. Additionally, urine tenofovir point-of-care testing will be implemented to determine the percentage of known positives among the newly diagnosed.

Figure 4.1.14. Recency Coverage: Sites and HTS POS FY 21 Q1 - FY22 Q1

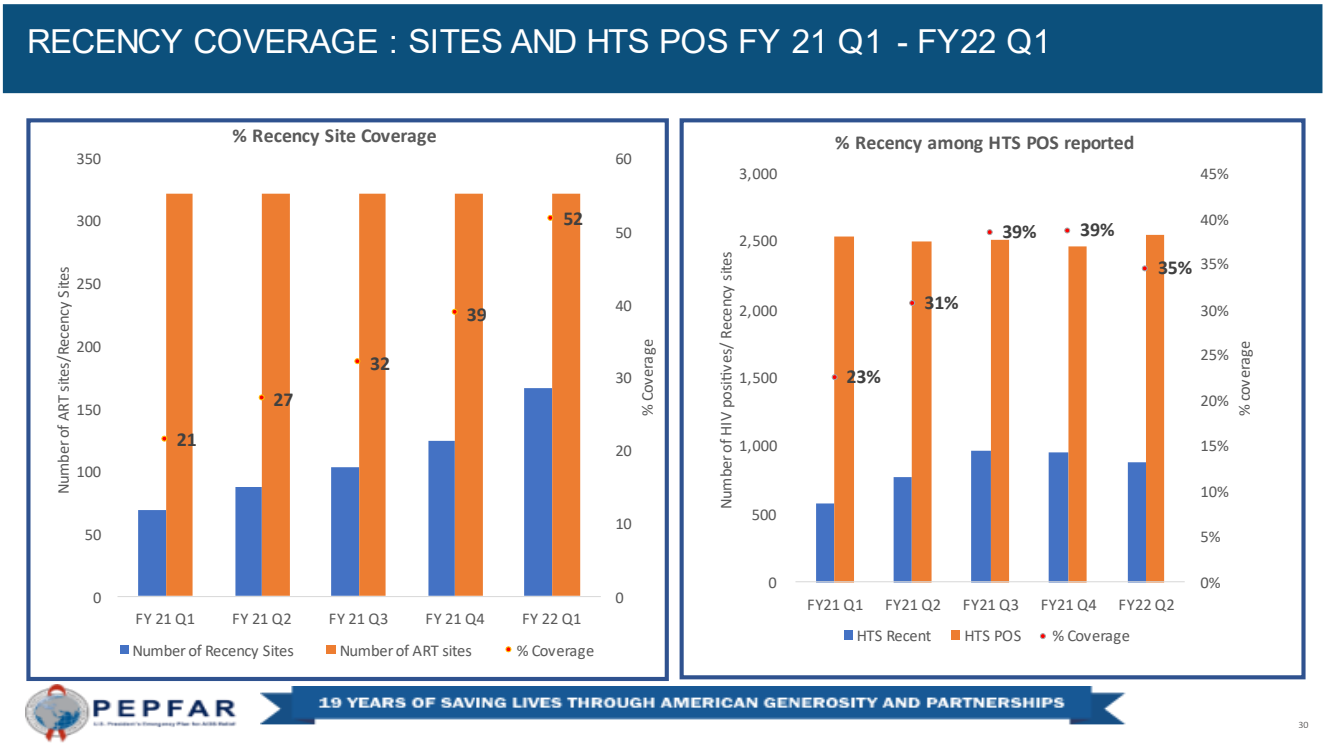


Figure 4.1.15 RITA Long Term and Recent, % Recent FY21 Q1 - FY22 Q1

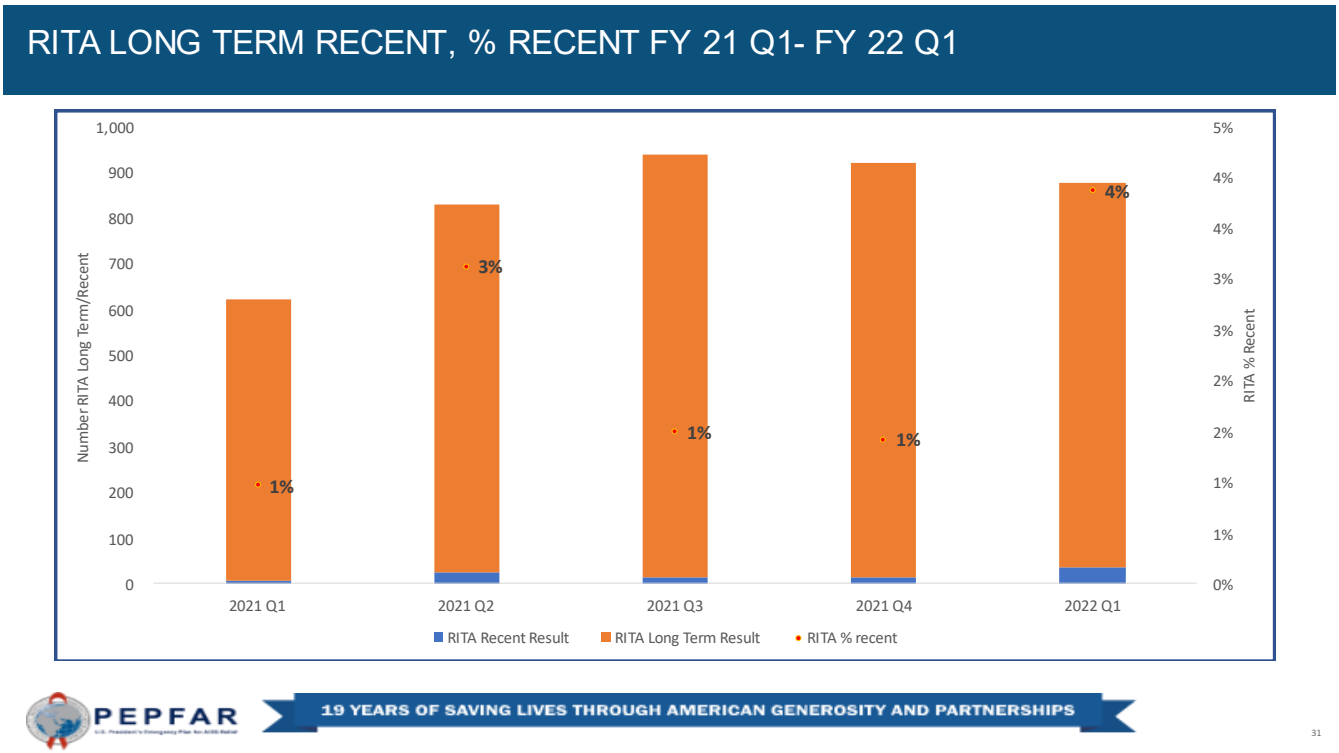


Figure 4.1.16 Number Long Term and Recent, % Recent by Age and Sex FY21 Q1 - FY22 Q1

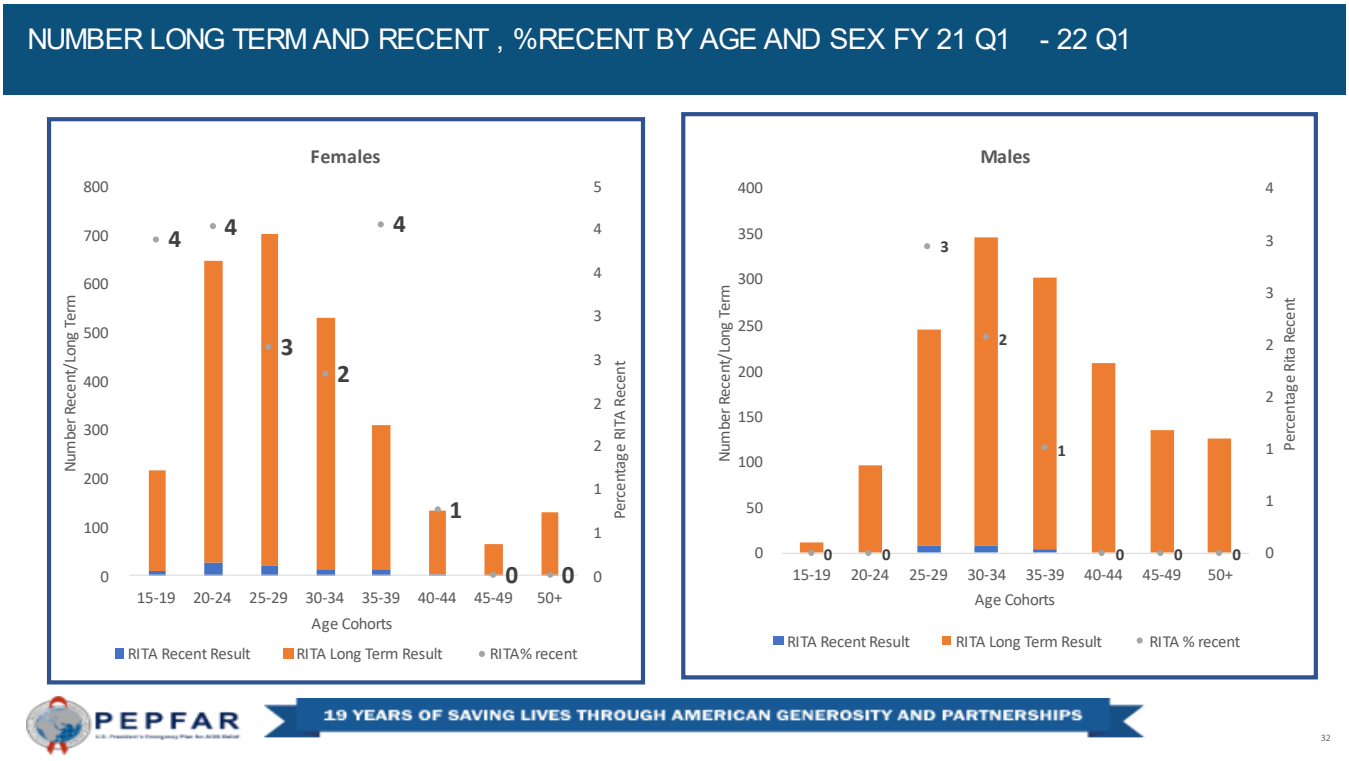


Figure 4.1.17 Number of Recent Infections By Site and Modality

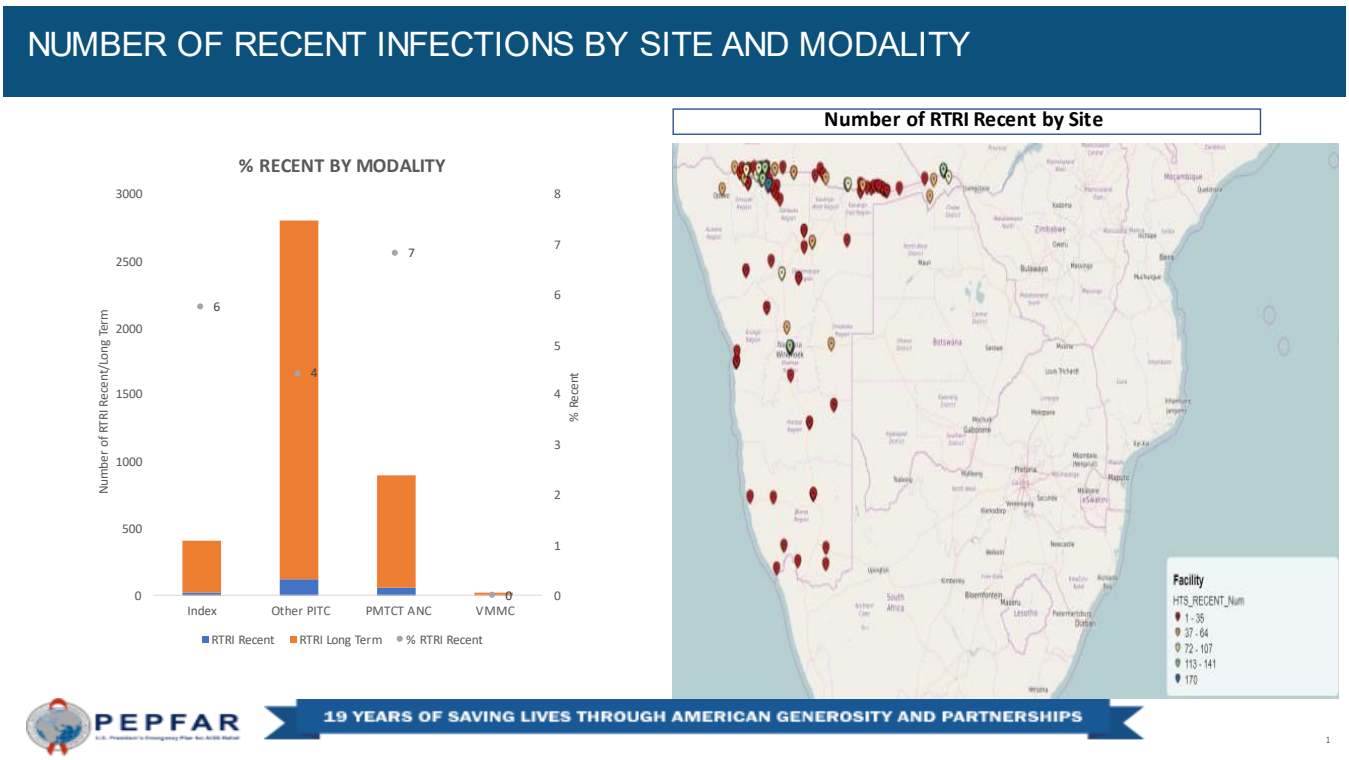


Figure 4.1.18 Recency Public Health Response Plan

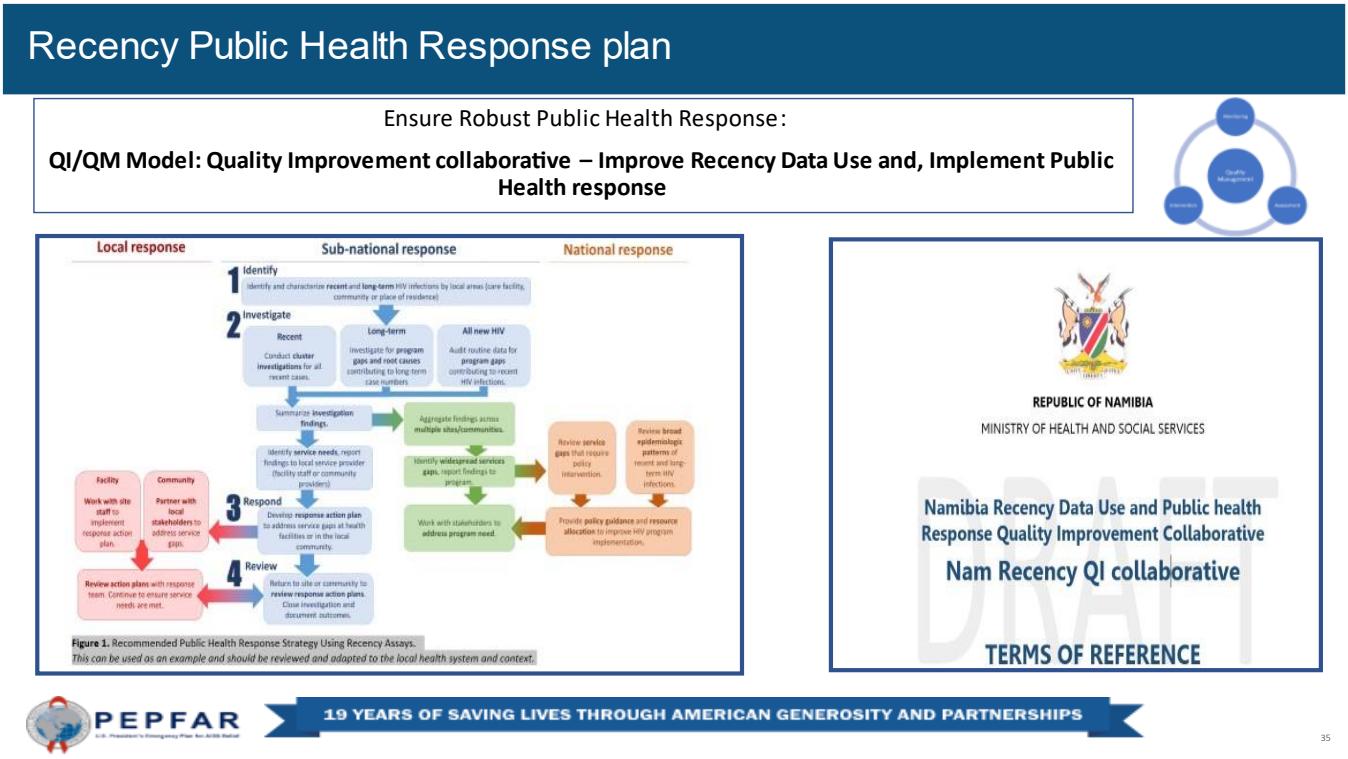
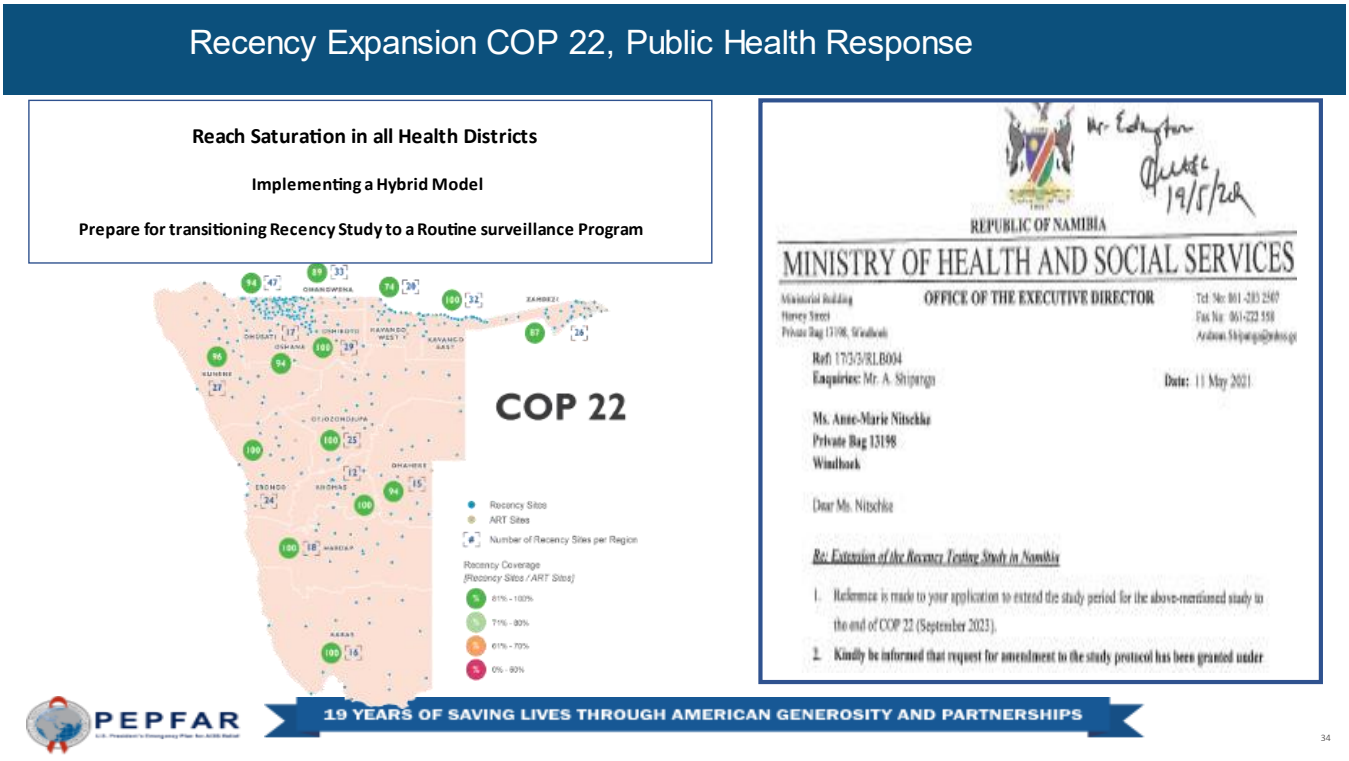


Figure 4.1.19 Recency Expansion COP22, Public Health Response



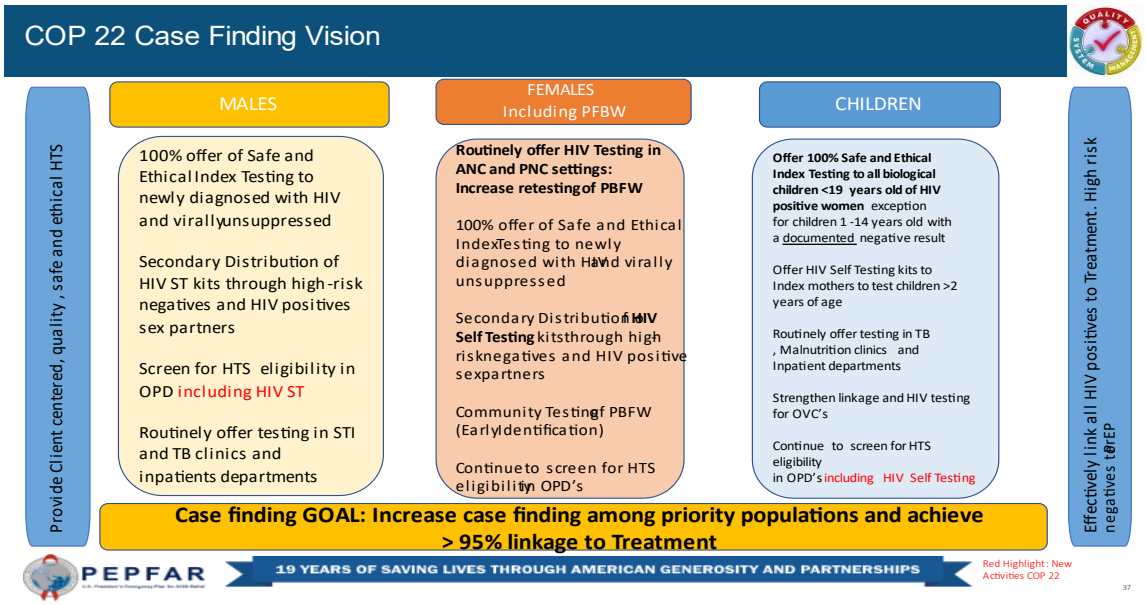
Targeted Facility Based Testing

Routine testing will continue for pregnant and breastfeeding women, STI and TB patients and children of women living with HIV. HIV self-testing will be integrated in services delivered to high risk negative pregnant and breastfeeding women, STI, family planning and TB clients through secondary distribution to their sexual partners. Given the low volumes for the post-ANC modality, efforts to support the implementation of the re-testing policy will be intensified to ensure as many negative pregnant and breastfeeding women are re-tested. In COP22, the program will continue technically supporting MOHSS to optimize their screening program in out-patient departments. HIV self-testing will be added to the screening algorithm in OPD to ensure priority populations (men and children) are screened and opportunities to test them are not missed. Additionally, PEPFAR Namibia received ethical approval to validate the adult screening tool and is currently working on a final amendment. The results regarding sensitivity and specificity of the tool will enable MOHSS to further optimize their screening program. The mentoring program will continue to support optimization efforts.

Overall Case finding Strategy for COP22

The case finding strategic vision for COP22 is essentially a continuation of COP21 with adjustments to address gaps as shown in Figure 4.1.20. Priority populations include males, children and females especially pregnant and breastfeeding women. The goal is to increase case finding among priority populations and achieve >95% linkage to treatment. The main case finding strategy is to provide safe and ethical comprehensive index testing both at community and facility levels. HIV self-testing will continue to be utilized for secondary distribution to hard-to-reach sex partners and biological children >2 years of Index clients. To optimize PITC, additional HIV self-testing will be offered in OPD, especially to males and children attending OPD. HIV self- testing will be utilized to test more biological children of Index clients and sexual partners of high-risk negatives and HIV positive clients.

Figure 4.1.20. COP22 Case Finding Vision



Immediate ART initiation

Namibia has been implementing a test and treat policy since 2016. Given the latest Spectrum estimates of Namibia's progress towards meeting the UN Fast track targets, it is an indication that Namibia is successfully in linking those who test HIV positive to treatment, with 94% of PLHIV diagnosed with HIV and 98% on treatment.

Figure 4.1.21 shows Namibia's trends in overall linkage proxy over the last 13 quarters ending FY22 Q1. Consistent linkage proxy rates are observed over time at about 80% by quarter. The same-day ART initiation data in Figure 4.1. 22 shows individuals newly started on treatment within 7 days and % coverage over the last 8 quarters ending FY 22 Q1. We observe more than 90% initiated on treatment within 7 days across all quarters.

Though linkage has been consistently high, Namibia aims to achieve greater than 95% linkage to care in all districts. Site level linkage proxy analysis show higher linkage rates for lower volume sites with lower linkage rates for volume facilities as seen in Figure 4.1.23. This data is consistent with known data about the mobility of the population that while individuals may get tested positive in the urban high-volume sites, a significant number may prefer to go and start their ART at low volume ART sites, closer to their homes in smaller towns. COVID19 may have also impacted the program as movement restrictions resulted in fewer people physically visiting health facilities (4.1.23).

Further disaggregation by quarter and sex show that the proxy linkage rate among females is slightly lower compared to males (Figure 4.1.24). It is also worth noting that the number of females identified is twice as high as their male counterparts. Figure 4.1.25 show linkage proxy rates for FY 21 by age and sex and which shows lower linkage rates among men 30 and older as well as younger females aged 1-4 years and 15-24 years.

Patients who opt out from immediate linkage are recorded into the national database and referred to the districts where they would prefer to continue their ART. However, Namibia does not routinely trace these patients and confirm that they made it to the next facility. PEPFAR Namibia will expand tracing activities to all regions in COP22 to ensure that lists of patients referred to other facilities for continuing ART elsewhere are shared with implementing partners in the community to assist in tracing patients to confirm that they made it to the next facility. Additionally, patients newly initiating ART will be offered support at community level through linkage to the MenStar program for males and teen clubs for young people, and case management tools for individuals not otherwise reached, until they achieve stability and are enrolled in a DSD model.

PEPFAR Namibia can achieve consistently high linkage rates through active linkage mechanisms as well as understanding systemic challenges which may inflate the number of positives noted. MOHSS established a National Taskforce to conduct a root cause analysis into the linkage proxy challenges to carry out a data validation exercise to interrogate reporting of HTS POS data, which will be implemented in a sample of sites in the coming months. It is anticipated that with these results data reporting systems can be streamlined to ensure better alignment with TX New data.

In addition, linkage challenges will be strengthened as seen on Figure 4.1.26, MOHSS issued the circular in April 2022. The circular provides directives to site level staff to strengthen their existing linkage strategies by implementing a case management approach and ensure close monitoring through quality improvement initiatives with support from the Quality Monitoring and improvement program.

Figure 4.1.21. Linkage Proxy Trends FY 19 Q1 - FY22 Q1

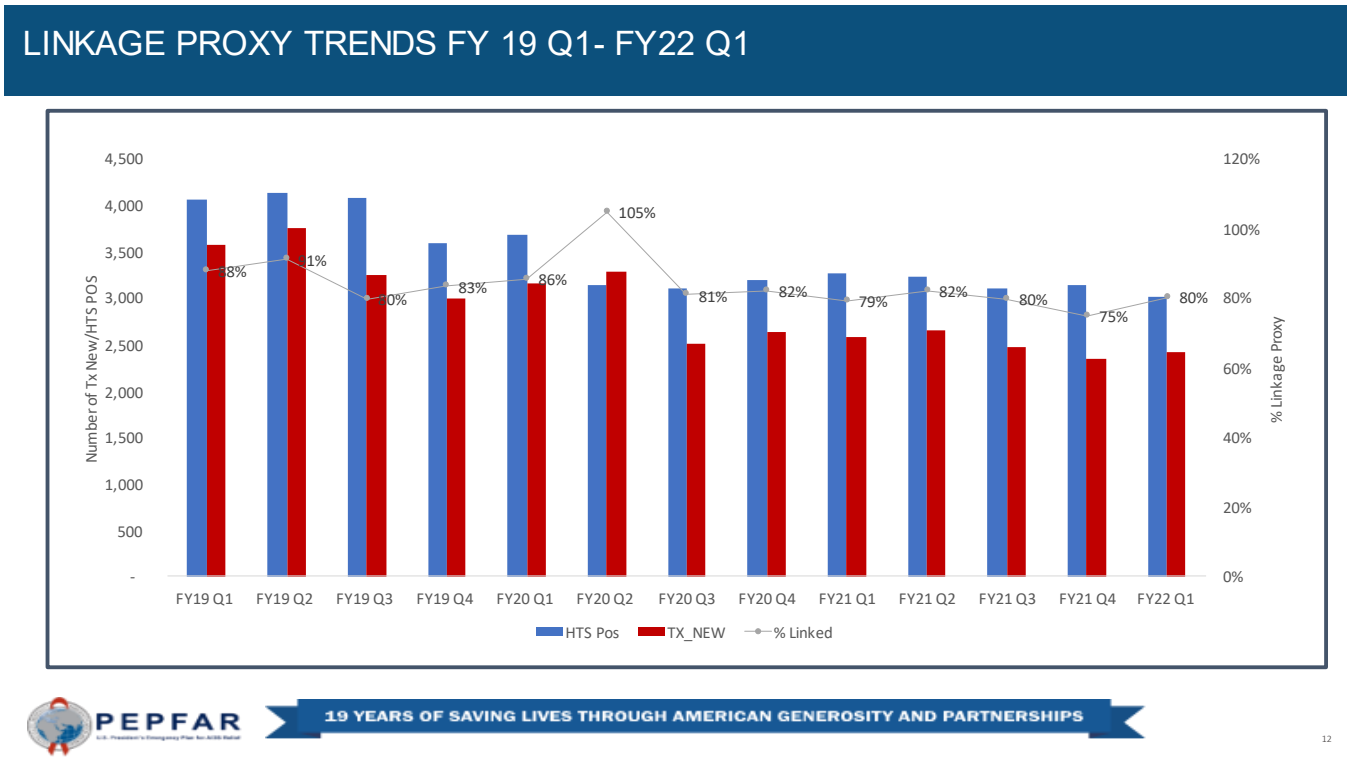


Figure 4.1.22. TX NEW by Time Period and Quarters FY 20 Q1- FY22 Q1

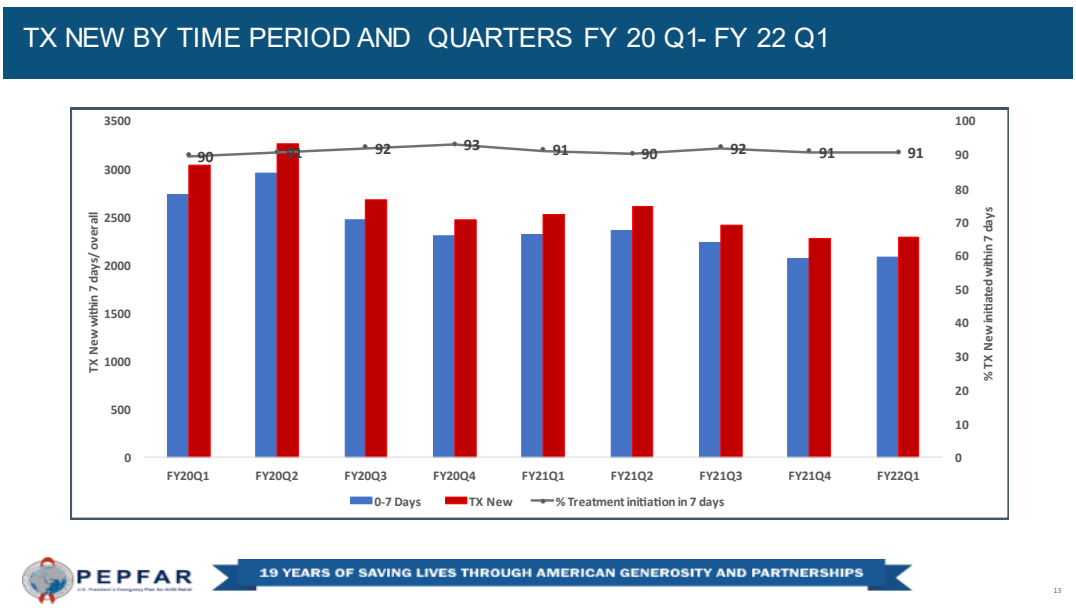


Figure 4.1.23. Linkage Proxy by Site FY21

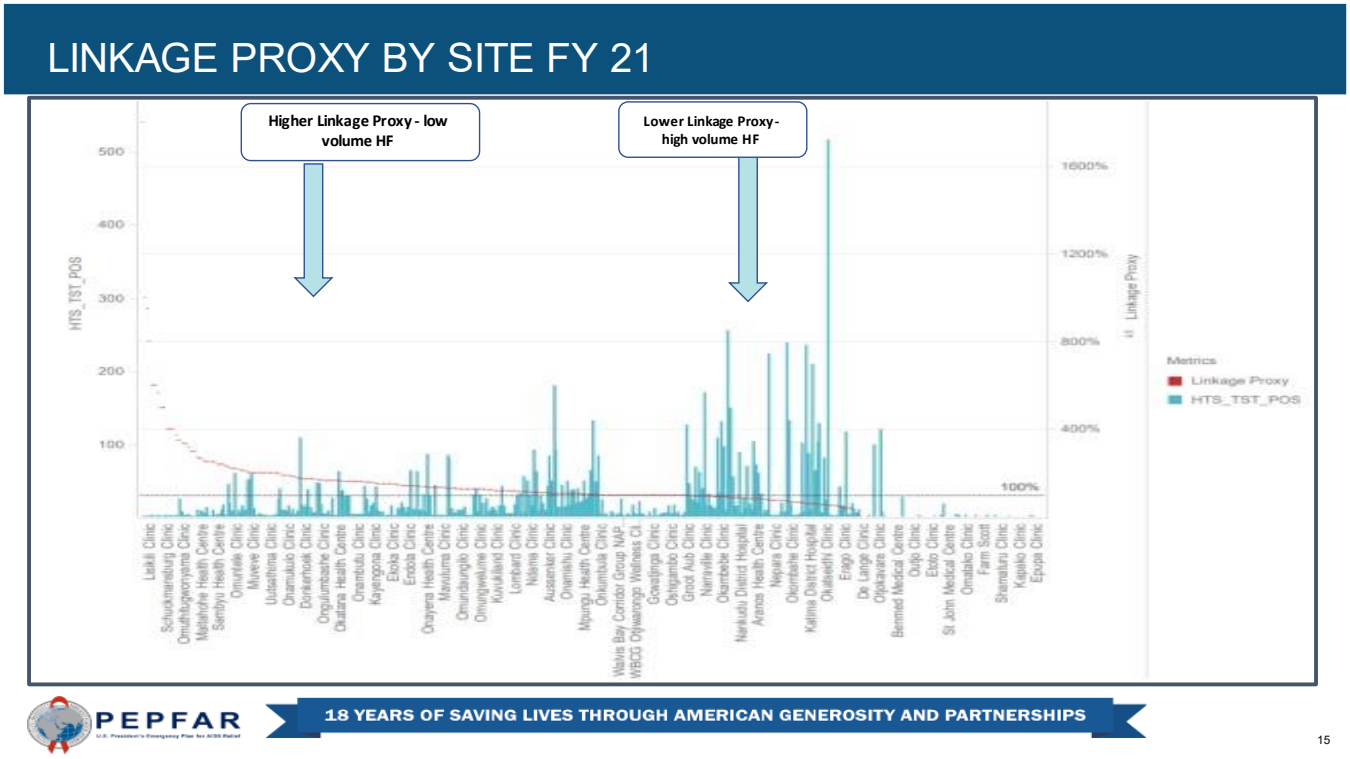


Figure 4.1.24. HTS POS and % Linkage Proxy By Sex FY21 Q1-FY22 Q1

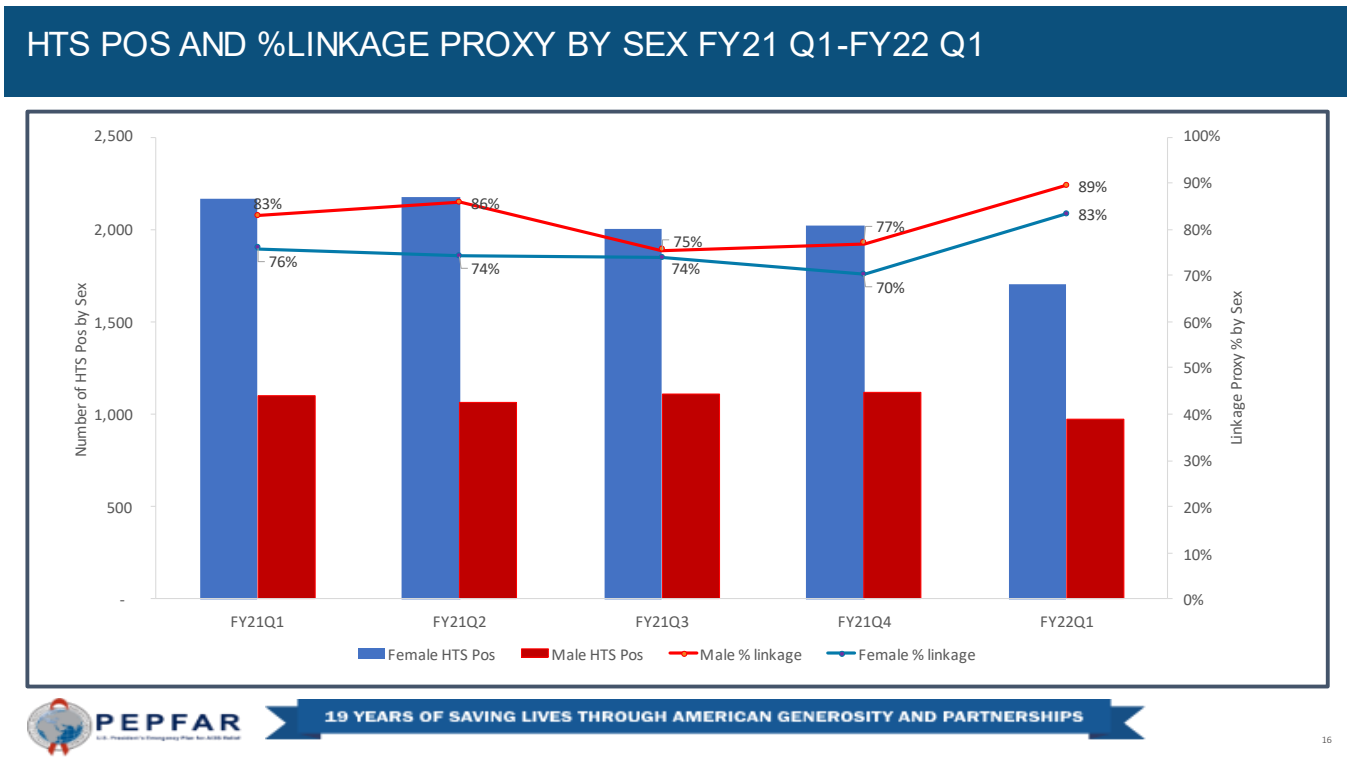


Figure 4.1.25. FY21 Proxy Linkage by Age and Sex

FY 21 PROXY LINKAGE BY AGE AND SEX

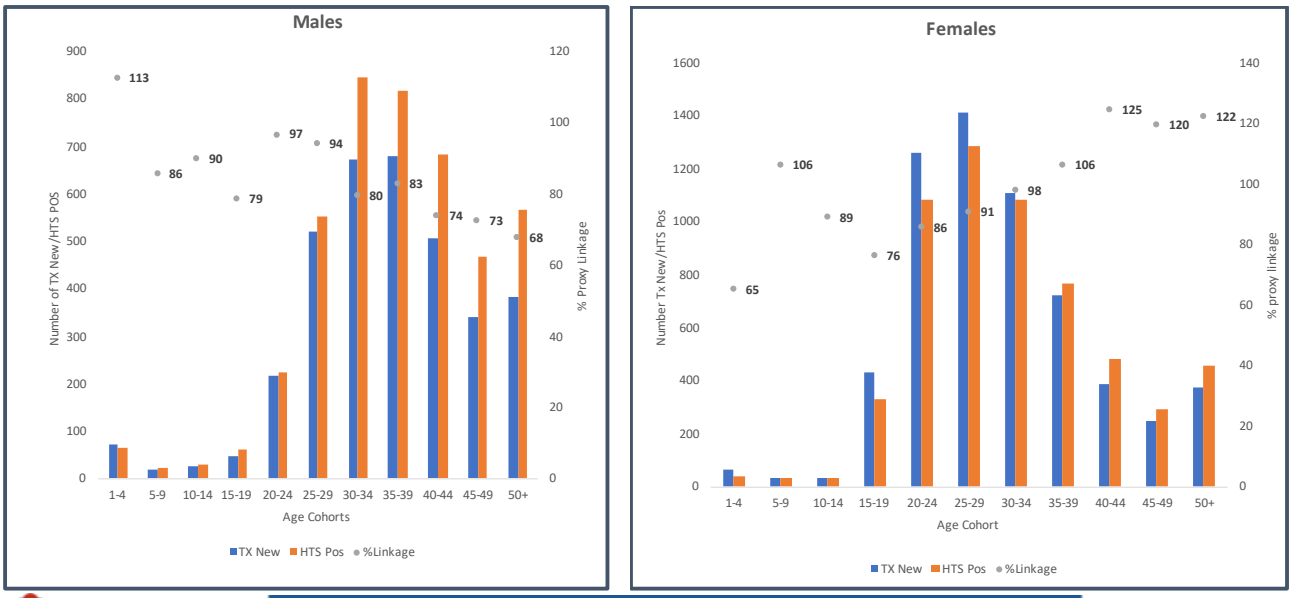


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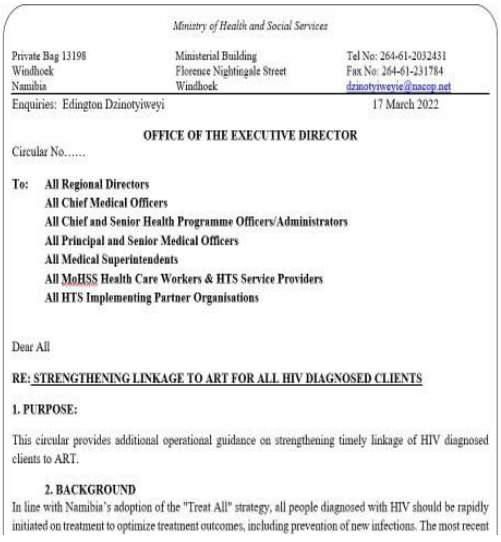
Figure 4.1.26. Strategies to Address Linkage Rates

STRATEGIES TO ADRESS LINKAGE RATES

National MOHSS taskforce- Next Steps

Strategies	Objectives
Identify and Address Systemic Challenges	Conduct a data validation exercise in a sample of Health Facilities
Address the programmatic gaps in linking clients from HTS to Treatment	MoHSS circular to provide directives on strengthening linkage strategies: • Implement a case management approach. • Track progress through Quality Improvement/Quality management teams • Enlist community- based organizations to track and link HIV positive clients.

MoHSS Circular : Strengthening Linkage



Ministry of Health and Social Services

Private Bag 13198 Windhoek Namibia
Ministerial Building Florence Nightingale Street Windhoek
Tel No: 264-61-2032431 Fax No: 264-61-231784 dzinotyiweyie@nacop.net

Enquiries: Edington Dzinotyiweyi 17 March 2022

OFFICE OF THE EXECUTIVE DIRECTOR

Circular No.....

To: **All Regional Directors**
All Chief Medical Officers
All Chief and Senior Health Programme Officers/Administrators
All Principal and Senior Medical Officers
All Medical Superintendents
All MoHSS Health Care Workers & HTS Service Providers
All HTS Implementing Partner Organisations

Dear All

RE: STRENGTHENING LINKAGE TO ART FOR ALL HIV DIAGNOSED CLIENTS

1. PURPOSE:

This circular provides additional operational guidance on strengthening timely linkage of HIV diagnosed clients to ART.

2. BACKGROUND

In line with Namibia's adoption of the "Treat All" strategy, all people diagnosed with HIV should be rapidly initiated on treatment to optimize treatment outcomes, including prevention of new infections. The most recent

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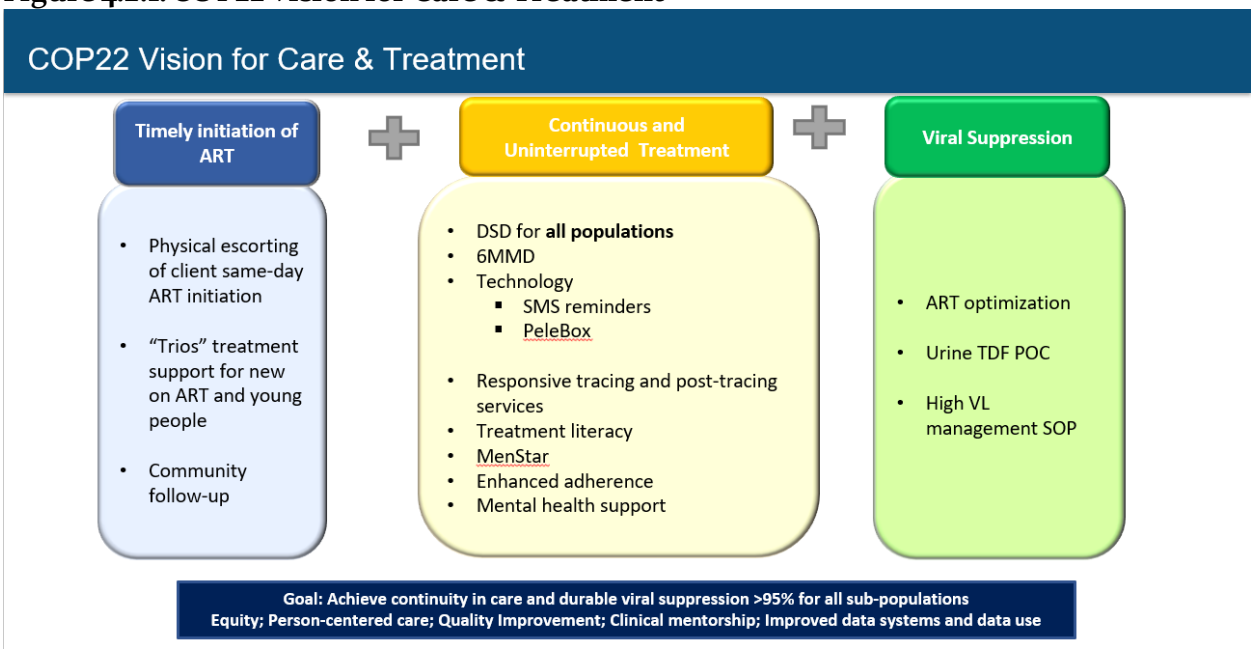
4.2 Continuity of treatment and ensuring viral suppression

PEPFAR Namibia's COP22 strategy is to continue the COP21 trajectory with some additions to fill in gaps. The goal of this strategy is to improve continuity of care and viral load suppression to achieve >95% for all sub-populations. The interventions that Namibia will implement in COP22 are designed to be both preventive of loss, and responsive to those in the cycle of interruption and return to ART (Figure 4.2.1). PEPFAR Namibia will continue to ensure that an individual is immediately linked to ART on the same day or within seven days of HIV diagnosis in line with national guidelines. This will be achieved through continued physical patient escorting, and community-level support for Test and Treat through community index testing, immediate linkage to ART and treatment supporters for those new on ART. Once patients are enrolled into ART, there are several interventions which are designed to ensure that patients stay in ART. These include ART optimization, which includes full scale implementation of TLD use among adults and DTG- based regimens among pediatrics, multi-month dispensing (MMD) of ARVs, differentiated service delivery (DSD) models.

Figure 4.2.1. COP22 Vision for Care & Treatment



Continuity in treatment and return to care interventions will include the enhancement of equitable DSD models for all sub-populations, scale-up of 6 month dispensing and responsive tracing services. The key concept is providing person-centered services throughout the cascade to be maximally responsive to patients needs and ensure uninterrupted services and durable viral load suppression. The implementation of the High Viral Load Management SOP will continue in COP22 to further strengthen viral load suppression interventions at site level. Innovative technologies such as SMS reminders and the PeleBox lockers will used at priority high volume sites to ensure uninterrupted and on-time pill pickups. PEPFAR Namibia will also maintain Urine tenofovir testing for TLD adherence. New to COP22 will be an addition of post-tracing services to an already robust patient tracing program to ensure patients who are successfully traced are

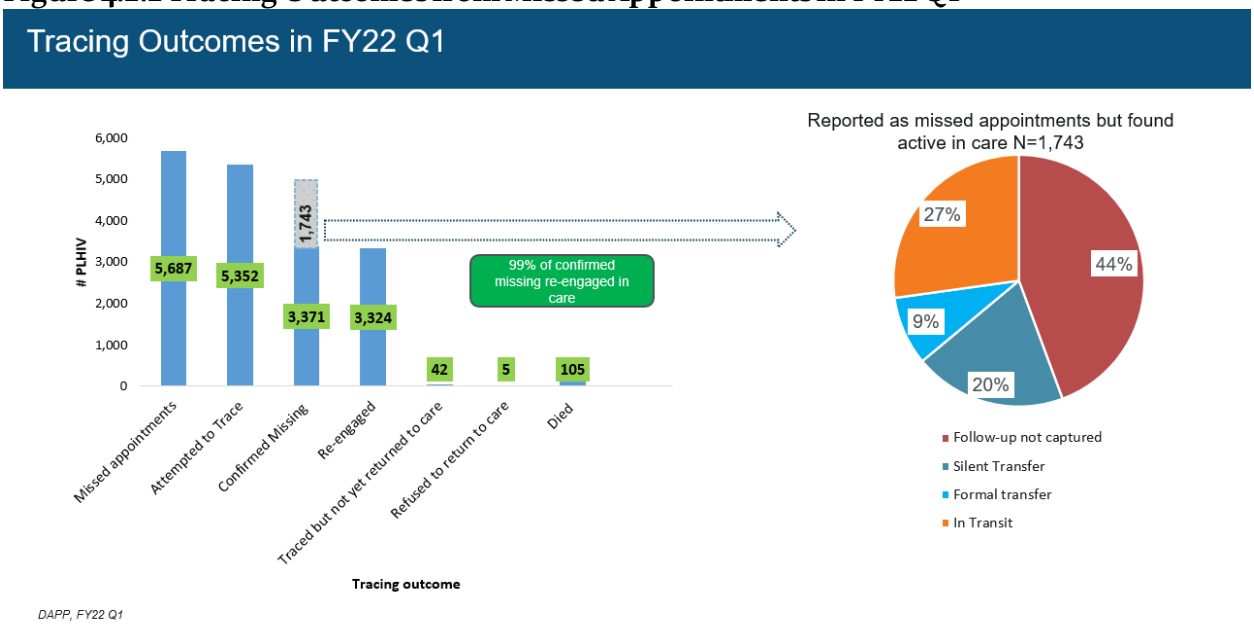
respectfully received back into care and immediately linked to services to prevent future interruptions in treatment. The post-tracing algorithm aims to address the barriers to continuity in treatment and link patients to supportive interventions.

PEPFAR Namibia began the SMS reminder system in COP20 to cover 73 sites which have EDT systems installed. SMS reminders help patients to remember their pill pick-up appointments and to adhere to their medication. In COP22, PEPFAR Namibia will maintain this system at selected high-volume sites. These dispensing points enable people, particularly those who may have trouble visiting the clinic in regular working hours, to collect their repeat chronic medication including other non-HIV medications such as diabetes and hypertensive medicines in under two minutes, 24 hours a day, seven days a week. In districts where PEPFAR Namibia supports KP interventions, individuals who are clinically stable on treatment will be linked to pick their medication from the PeleBox lockers. This programmatic strategy will further strengthen adherence, minimize stigma, and support continuity in treatment for KPs.

PEPFAR Namibia will continue implementing the urine tenofovir point-of-care testing at 50 ART sites, which began in COP20, to monitor TLD adherence among patients who are not suppressed. This is an inexpensive test that will be used to objectively measure recent adherence in patients failing TLD after a period of adherence counseling. This will avoid unnecessary costly repeat viral load testing or unnecessary switching to more expensive protease inhibitor (PI) regimens. In late COP21 and COP22, HIV drug resistance sequencing will be conducted on patients with persistent virological failure at 9 and 12 months after enrollment to determine the optimal time for switching from TLD after virologic failure.

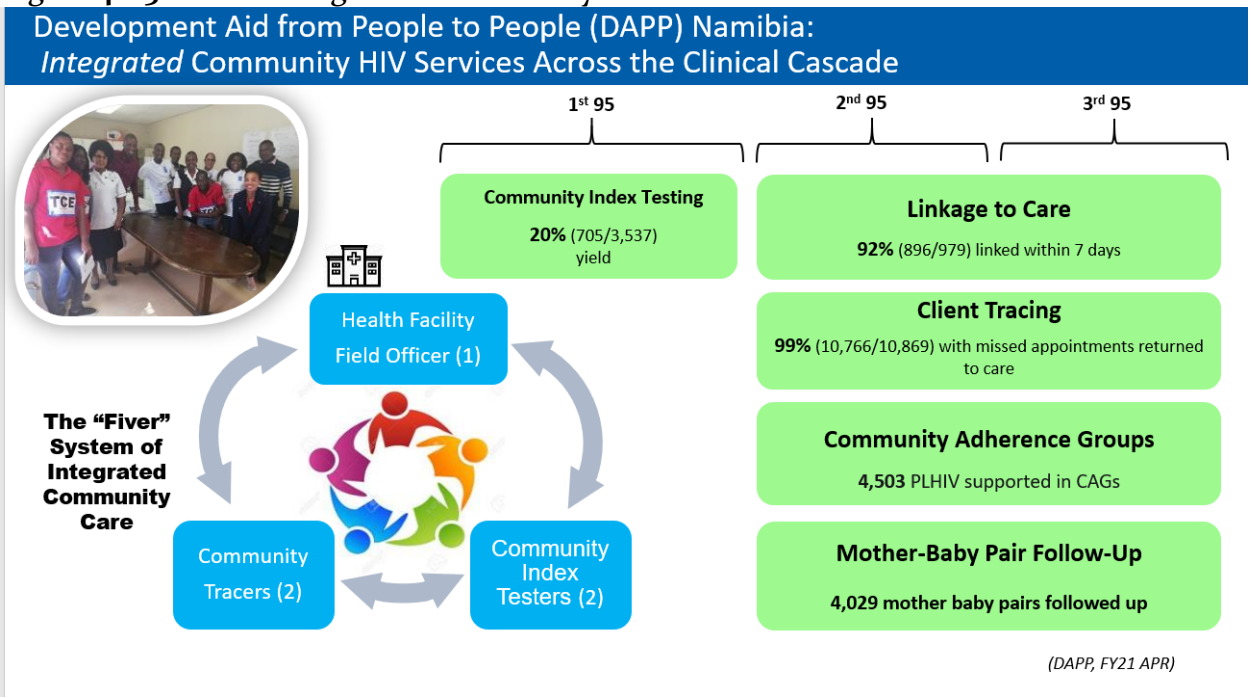
Namibia has a comprehensive SOP for identifying and tracing patients with missed appointment or interruption in treatment. Patients who meet these criteria are identified using an electronic medical record-generated list, and facilities in partnership with community healthcare providers trace patients using telephone call, SMS, or home visit. Tracing interventions are initiated as soon as possible to minimize treatment interruption. In FY22 Q1, the tracing program, which is being implemented in all 14 regions of Namibia was able to bring 99% of the patients confirmed to be missing back into care (Figure 4.2.2). In COP22, tracing interventions will be maintained with strategic focus on districts with high interruption in treatment numbers. The tracing SOP includes a post-tracing services algorithm; once a patient has been traced and returned to care, they will receive adherence counseling which will include an assessment of the factors that contributed to interruption in treatment, restart on ART and support to prevent further recurrences of treatment interruption.

Figure 4.2.2 Tracing Outcomes from Missed Appointments in FY22 Q1



With COP22, the integrated "fiver" system will continue scaling to bring tracing efforts nationwide. Fiver teams will be able to respond nimbly to the HIV disease epidemiology and needs of each area, shifting from case finding to tracing in saturated areas and back to index testing where gaps are found (Figure 4.2.3). Retention and tracing of individuals who are lost to follow up among key and priority populations will be supported through a network of peer navigations. Peer navigators from KP-led CSOs will be trained and equipped to implement MOHSS standards and SOPs for adherence counseling as well as tracing and returning individuals lost to follow up from within their social networks into care and treatment. All peer navigators will be attached to KP-competent health facility to support routine linkage to clinical services including ART.

Figure 4.2.3 COP 20 Integrated Community HIV Services Across the Clinical Cascade



Integrating mental health screening into HIV care and treatment services has several benefits, including improved adherence and continuity in care, and reduced high risk behavior, all of which ultimately lead to improved viral load suppression and reduction in HIV transmission. PEPFAR Namibia began implementing the Common Elements Treatment Approach (CETA) in COP20, and in COP21 it is being implemented in selected sites to support mental health screening and therapy for adolescents and adults with interruption in treatment and high viral load. In COP22, PEPFAR Namibia will continue to support mental health screening and therapy for PLHIV.

In COP21, PEPFAR Namibia is supporting MOHSS to finalize a comprehensive treatment literacy curriculum and will train PLHIV, community and facility healthcare providers. In COP22 PEPFAR Namibia will continue to implement treatment literacy activities at facility and community level.

In COP21 PEPFAR Namibia is supporting MOHSS to implement the MenStar model with the development of a men-oriented services curriculum and conducting a Men's Health campaign to improve treatment continuity and viral suppression. Based on lessons learned from the MenStar approach, PEPFAR Namibia will continue to work with MOHSS in COP22 to enhance person-centered services for men and train HCWs in new approaches for service delivery (male-friendly services, family clinics and improved customer care by HCWs). The positive approach from MenStar will be used to develop positive messaging to improve enrollment, retention, and viral load suppression especially in specific population groups like adolescent and young men.

All continuity in treatment interventions across the cascade will continue to be implemented guided by the principles of equity, person-centered care, continuous quality improvement, clinical mentoring, improved data systems and data use.

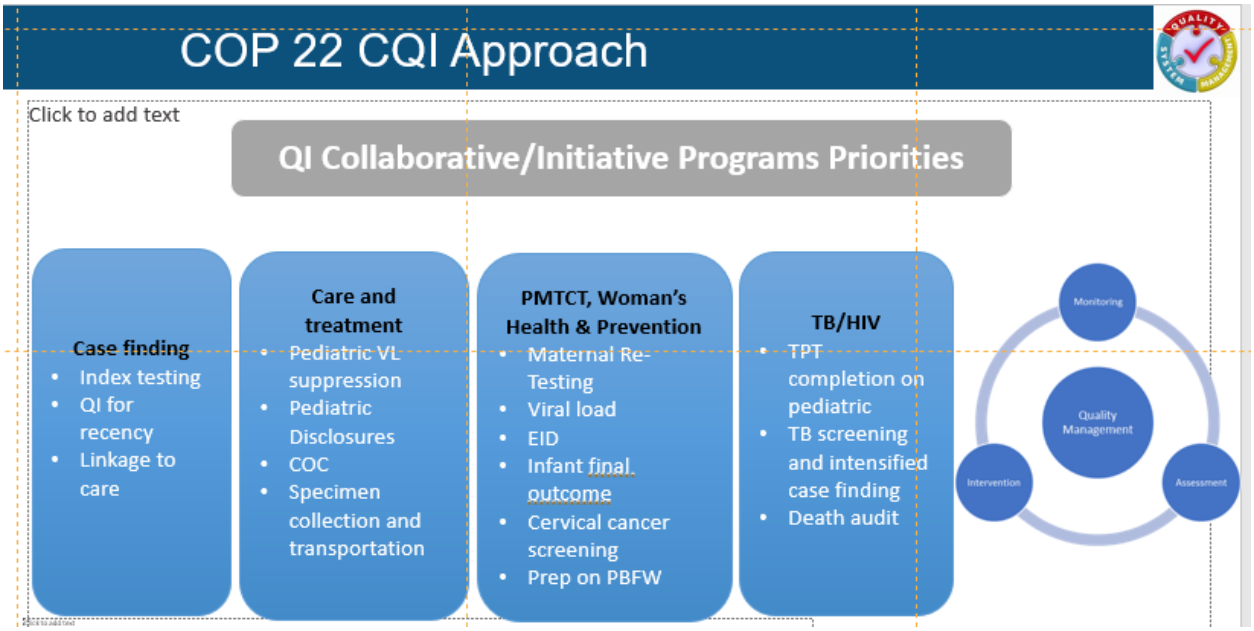
The current cohort of Physician and Nurse Mentors covers all the 14 Regions of Namibia. In COP22, a new Clinical Mentorship oversight structure brings PEPFAR Namibia partners under the leadership of the MOHSS for a unified clinical mentoring program with full national reach. During FY21 mentors supported more than 300 sites in Namibia, largely targeting nurses who form the bedrock of the Namibia HIV program through Nurse Initiated and Managed ART (NIMART). More than 2,400 nurses were mentored at site level during this period. This type of site level mentoring ensures rapid translation of national policies such as TLD transition, MMD, and differentiated service delivery into practice at the clinic level.

QM Model

Following the successful implementation of NAMLIVE Quality Improvement (QI) Collaborative (2018-2020), Namibia has adopted collaboratives approach for implementing continuous quality improvement initiatives. In COP21, PEPFAR Namibia has four collaborative QI initiatives running in 157 sites across four program areas in all 14 regions in the country.

In COP22, the collaborative approach will continue with expanded new collaborative QI initiatives in all program area across HIV cascade of case finding, care and treatment, PMTCT, women's health and prevention, and TB/HIV as indicated in Figure 4.2.4.

Figure 4.2.4 COP 22 CQI Approach

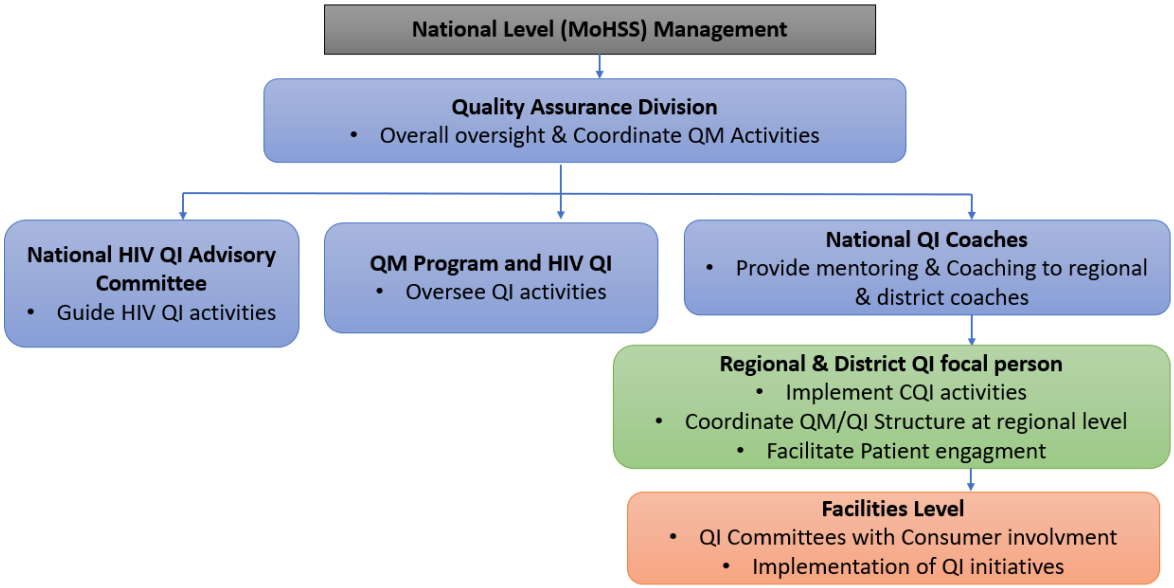


In March 2022, the MOHSS launched the National Quality Management Policy and Strategic Plan that aims to guide the implementation of Quality Management/Quality Improvement in the Ministry between 2022-2026. The policy and the implementation framework of QI objectives is to improve the MOHSS quality management systems, ensure patient–centered care and empowerment of consumers, improve patient and health-care worker safety and improve clinical practice. With this strategic plan and strengthening of the quality management division, in COP22 PEPFAR Namibia will support the acceleration phase of implementing the MOHSS quality

management model across all the care and treatment cascade with a view of sustaining impact in the coming several years in line with the PEPFAR technical guidance provided in the Namibia Planning Level letter.

In COP22, PEPFAR Namibia will support the planned MOHSS Quality Management System by strengthening the leadership and organizational infrastructure for the quality management division at all levels of health care, as well as capacity building for continuous quality improvement. This structure comprises of technical staff at the national level supporting new dedicated quality management focal persons at regional, district and high burden facilities. These focal persons will be engaged with planning and coordinating quality management activities in the Ministry, facilitating leadership engagement, roll out of MOHSS policy, strategy, and standards, capacity building in QI methodology, implementing QI collaboratives and other QI activities, and improve quality of care and actively engage patients in planning and health care delivery at all health care level as shown in Figure 4.2.5.

Figure 4.2.5 Governance & Organizational Structure Framework of Quality Management in the MOHSS



Interventions to Ensure Viral Load Suppression

PEPFAR Namibia continues to be successful in achieving excellent VLS results across most districts and record high VLS in individuals older than 25 years, but still have significant gaps in younger ages. However, some districts with lower suppression rates have room for improvement (Khorixas, Gobabis, Mariental, Opuwo, Keetmanshoop, Okakarara, and Aranos). To close the remaining gap to reaching full epidemic control, an intensified focus will need to be implemented to achieve targets in COP22. PEPFAR Namibia will be targeting high volume sites with lower VLS performance for additional support. The PEPFAR Namibia COP22 vision for maintaining and improving viral load suppression includes: 1) ART optimization through TLD adherence with assessment of urine TDF point of care testing; 2) Improving adherence and retention through person-centered models (MMD, CAG, CCBHS, PeleBox lockers, SMS reminders); 3) Expanded patient tracing; 4) Improving viral load monitoring (Clinical Mentorship Model, QI

Collaboratives); 5) Person-centered experience (mental health, positive messaging, healthcare worker trainings in customer service through MenStar methodology); and 6) Investigating use of true point of care (POC) at priority locations (border sites, hard to reach populations, etc).

Optimizing ARV regimens will be a critical component to achieving durable viral load suppression. Namibia fully transitioned to TLD in COP20, as per the updated national ART guidelines which include TLD as the first-line regimen for all eligible populations, and NVP-based regimens have been phased out. Viral load monitoring will be improved by providing near point of care and some point of care VL testing for pregnant and breastfeeding women and patients failing treatment with GeneXpert and mPIMA platforms. With the proposed targeted interventions to improve those few regions that are lagging, the aim is to achieve at least 85% VLS across all districts in Namibia by the end of COP22.

4.3 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, Poverty Eradication and Social Welfare (MGEPESW), MOHSS, Ministry of Sport, Youth and National Service (MSYNS) the Ministry of Education, Arts and Culture (MOEAC) and Ministry of Home Affairs, Immigration, Safety and Security. Activities align with geographic areas of the highest HIV burden, highest HIV incidence in AGYW and greatest unmet ART needs for children. The activities ensure that AGYW, OVC, and their caregivers receive PEPFAR assistance, and are linked to national social grants and other social safety nets and health strategies for support.

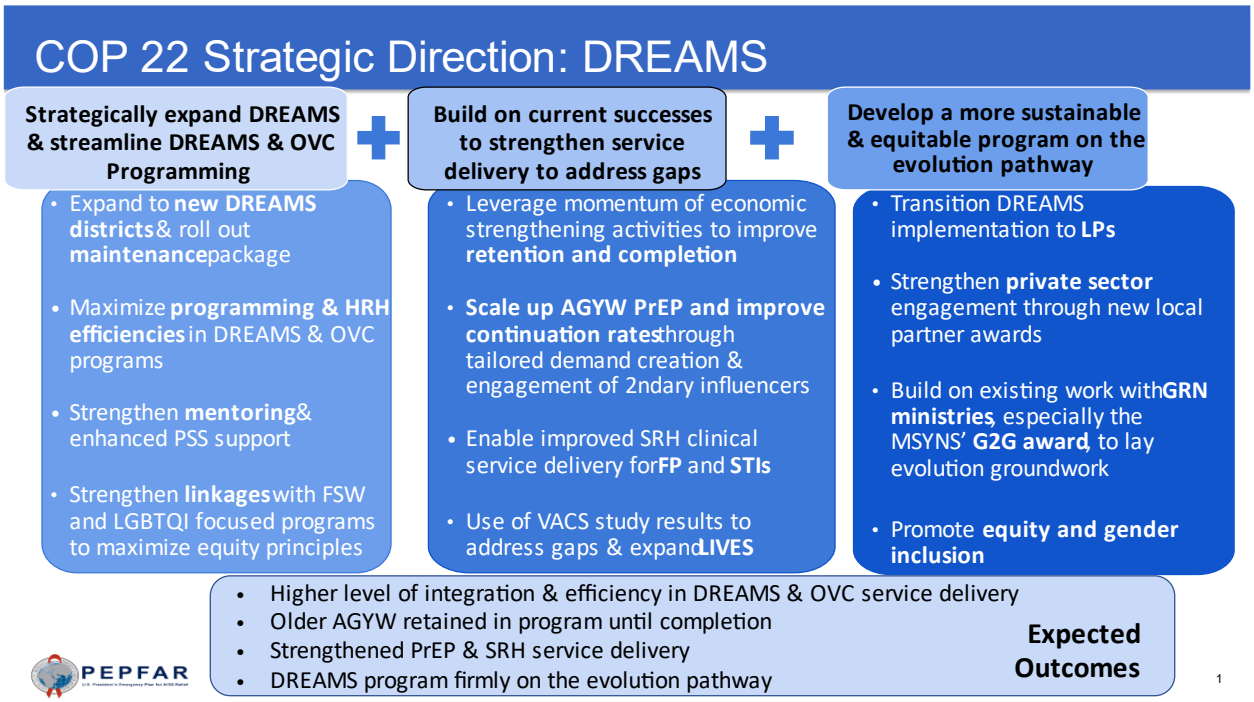
In COP22, PEPFAR Namibia will continue to implement the approved DREAMS package and work towards 75% saturation in all PEPFAR-supported districts and age bands. In COP21, the 15-19 vulnerable population was saturated in two districts (Omuthiya and Tsumeb), with the 10-14 and 20-24 age groups in Tsumeb and the 20-24 age group in Omuthiya expected to reach saturation in FY22. Therefore, these 2 districts will shift to maintenance implementation in COP22.

Therefore, PEPFAR Namibia will expand to two new districts in the Kavango West Region in COP22. PEPFAR Namibia used vulnerability data to identify the most vulnerable districts for DREAMS expansion, namely national data on HIV incidence and prevalence, teen pregnancy and school dropout data, and male viral load suppression data from Ministry data sets and Spectrum. Other considerations, such as current DREAMS and Global Fund AGYW implementation sites and alignment to current OVC programming sites, were also used.

PEPFAR Namibia supports rapid implementation of a layered DREAMS package of services as shown in Figure 4.3.1. Interventions include HIV and violence prevention, adolescent-friendly sexual and reproductive health (SRH) services, contextual intervention on gender norms, and referral of AGYW sexual partners to HIV prevention, testing and treatment services. COP22 will feature enhanced psychosocial support training for DREAMS mentors and a significant scale up of AGYW PrEP. The DREAMS program will increase PrEP AGYW targets, increase the enabling environment for PrEP uptake, ensure a continuous supply of PrEP commodities, and improve PrEP continuation rates. There will be an increased focus on self-identifying high-risk groups, such as those AGYW found at ANC, FP and STI clinics. DREAMS Ambassadors and mentors will

roll out IEC materials targeting secondary influencers, especially sexual partners, peers, and parents.

Figure 4.3.1. COP22 Strategic Direction: DREAMS



Given the chronic shortage of family planning (FP) commodities in Namibia, PEPFAR Namibia will add a modest FP-focused scope to the program in COP22. Under the Procurement and Supply Management (PSM) mechanism, PEPFAR Namibia will provide TA to the Central Medical Stores and the Ministry's Family Planning Unit to monitor FP commodities stock, increase visibility of FP commodity gaps, and advocate for additional resources for Family Planning commodities. Additionally, PEPFAR Namibia will work with the MOHSS to move beyond syndromic STI management by supporting the Ministry to update their STI guidelines. These FP and STI activities will assist to strengthen SRH programming for AGYW in Namibia.

In terms of non-clinical interventions, AGYW and OVC are linked to economic strengthening, social grants, and education support. Economic strengthening interventions for older AGYW in all DREAMS SNUs will utilize two pathways: employability and entrepreneurship. In COP22, PEPFAR Namibia will strengthen private sector engagement to support more AGYW to transition to paid employment and self-employment opportunities.

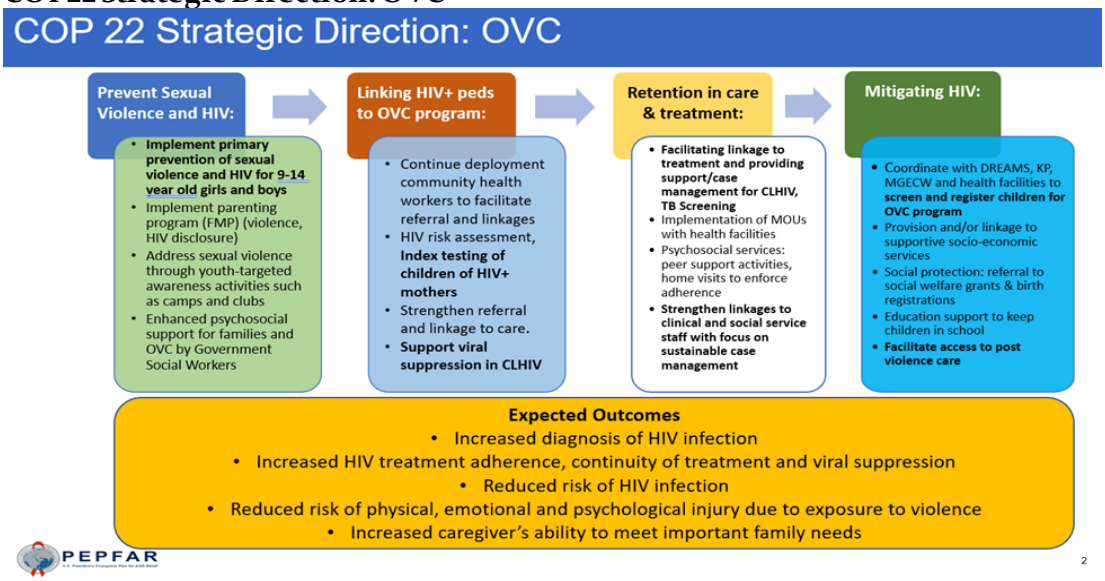
All partners use a unified DREAMS layering, tracking, and reporting system. Consolidated data is reported to USG by one partner. At the end of Q1 FY22, the DREAMS project had 30,840 active beneficiaries and 24,984 AGYW had completed at least the primary package of services. At the end of FY21, 9,935 AGYW were enrolled on PrEP and 5,517 AGYW received post-GBV care.

In COP22, PEPFAR Namibia will work towards developing a more sustainable and streamlined DREAMS and OVC program. Given that the two existing DREAMS mechanisms and the OVC mechanism will come to an end mid-year, the DREAMS program will fully transition to local

partner implementation under the new awards. Further, the already geographically aligned AGYW and OVC programs will become streamlined into the new child and youth program, which will create programming efficiencies. PEPFAR Namibia will draw on an HQ field mechanism to strengthen local partner capacity. To strengthen GRN's capacity to implement high quality AGYW/youth programming, PEPFAR Namibia will continue its partnership with MSYNS through the G2G agreement. The G2G agreement will help build the capacity of the MSYNS to implement youth services and drive the institutionalization of AGYW interventions within government systems. Similarly, PEPFAR Namibia will continue to engage the GRN in the provision of services to OVC/children. The program will engage MGEPESW to strengthen and harmonize its case management system, support the enrolment of children on the government social welfare programs and strengthen the GBV services.

In COP22, PEPFAR Namibia's OVC program will continue to provide a comprehensive family-centered and case management approach using CHWs deployed in high volume clinics and communities, use tools and training to strengthen layering and to address comprehensive needs of children, caregivers, and families. The Namibia OVC program will support sustained HIV epidemic control through linking at least 90% of HIV positive children to the comprehensive OVC program. The OVC program will work collaboratively with clinics to identify HIV-infected children and caregivers using the electronic dispensing tool list and then offer family enrollment into the OVC program. This process provides psychosocial and family support to children, coupled with clinical care provided by health facilities to ensure that CLHIV in the OVC program are retained in care and treatment. The OVC program will also increase HIV case finding among OVCs and will implement and strengthen the Index (HIV-infected) client-based household recruitment process. These approaches and others as shown in Figure 4.3.2 below.

The OVC program will also leverage collaboration with pediatric, PMTCT, and treatment programs to ensure caregivers are trained on ART regimens and adherence support for CLHIV. For example, CHWs identify children with adherence or viral load suppression issues and refer them to the nurses for house visits and follow-up interventions, including regimen education, enrollment in caregiver groups, disclosure support, registering families on social grants, referring CLHIV to teen clubs, and provide parenting sessions for parents and caregivers. **Figure 4.3.2. COP22 Strategic Direction: OVC**



The Peace Corps Making a Difference Counterparts Initiative (MAD) counterparts and volunteers will also play a critical role in enrolling OVC to the program and linking beneficiaries to other services. At household level, the OVC program will promote and strengthen family resilience through household economic strengthening for caregivers and older OVC and increase caregiver ability and resilience to take care of OVCs. The OVC preventive approach will focus on sexual violence and HIV prevention interventions, while the OVC DREAMS approach will provide OVC services to vulnerable AGYW who are enrolled in the DREAMS program.

The program will work closely with schools and the MOEAC to implement Coaching Boys into Men and Windows of Hope, both GRN-developed curricula, as a sustainable approach to OVC programming. HIV and sexual violence prevention activities will focus on boys and girls 9-14 years with an emphasis on reaching boys using specific curricula for youth camps and clubs. Some examples of these curricula delivered by Peace Corps volunteers include Peace Corps Boys Respecting Others (BRO); and Grassroots Soccer (GRS); Youth Exploring and Achieving in Health (YEAH); and Girls and Guys Leading Our World (GLOW).

In Q1 FY22 the OVC program reached 40,790 beneficiaries, compared to its target of 53,166. At the end of FY21, 100% of OVC under 18 enrolled in the OVC program had a known HIV status. All children reported as HIV positive were on treatment with 97% of the eligible having valid VL documentation and, of those, 91% were virally suppressed, demonstrating that these approaches are working.

Key Populations

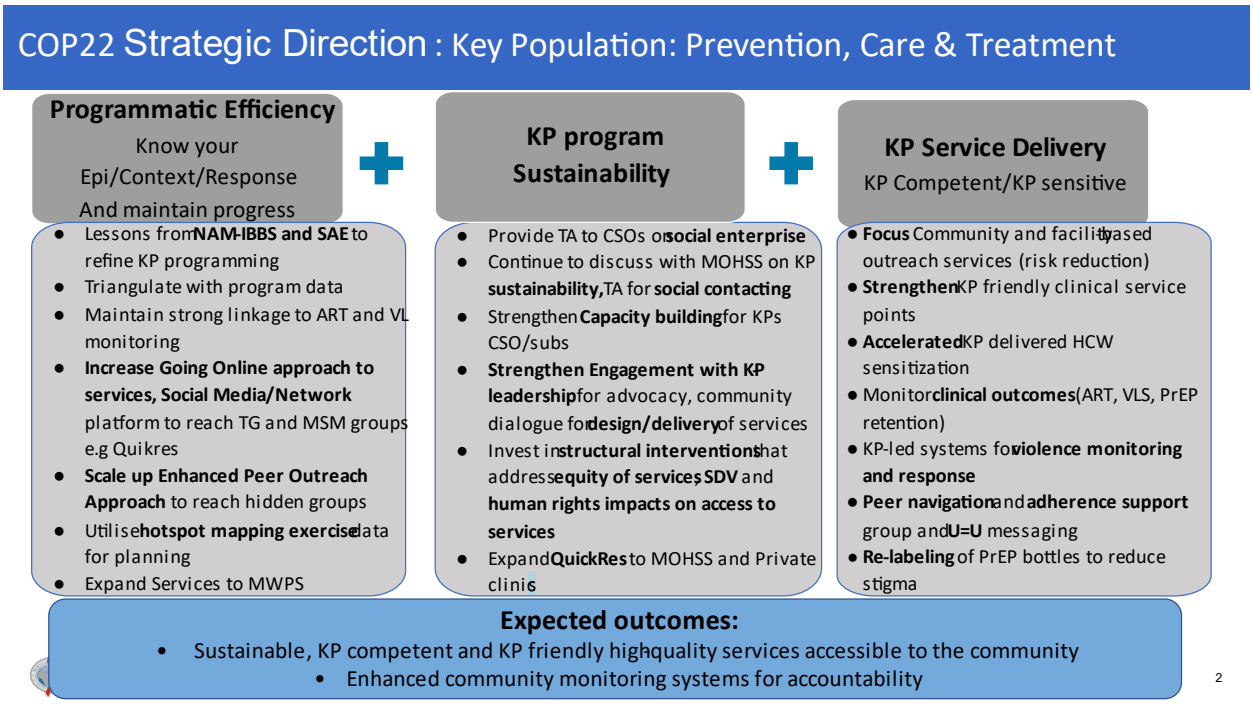
The key population program has a continued upward trajectory of case finding, while maintaining absolute positives combined with the strong PrEP results. The combined FY21 case finding rate was 7.8% and for FY22 Q1 we are at 11.3%. The introduction of the enhanced peer outreach approach (EPOA) in FY21 shows an improvement, as well as the utilization of HIV ST. Additional highlights include: strong linkage to treatment in FY21 at 102% among FSW and MSM; however, only 57% for TGWs and 100% in FY22Q1 for all populations; 19% of all PrEP_NEW are KPs; strong uptake of PrEP for those that are eligible including 74% for FY21 and 51% for FY22; and a low viral load coverage in FY22 Q1 of FSWs with a low VLC of 54%; MSM at 52% and TGW at 64% but a high VLS of over 95%.
Relevant data points from the NAM-Integrated Biological and Behavioral Survey (IBBSS), small area estimates, and programmatic data will be used in FY23, priority areas were identified allowing for adapted programming to speak to the specifics on the ground and allowing for adaptations for person centered services.

The COP22 KP strategic direction is summarized in Figure 4.3.3. The program will continue to strengthen community HTS services, continue identification of new KPs including those most vulnerable and adapt programming to ensure it is more person-centered, using target population specific strategies. For VL coverage PEPFAR Namibia will work to ensure that continued messaging on viral load testing, and support U=U messaging. Person-centered adaptions include ensuring services can adapt to the hotspot mapping report and more tailored needs such as a review of current hours/days for services, expanding to the harder to reach sub-KP populations, adding services to men who purchase sex and looking to ensure that HIV ST access is expanded.

Structural interventions

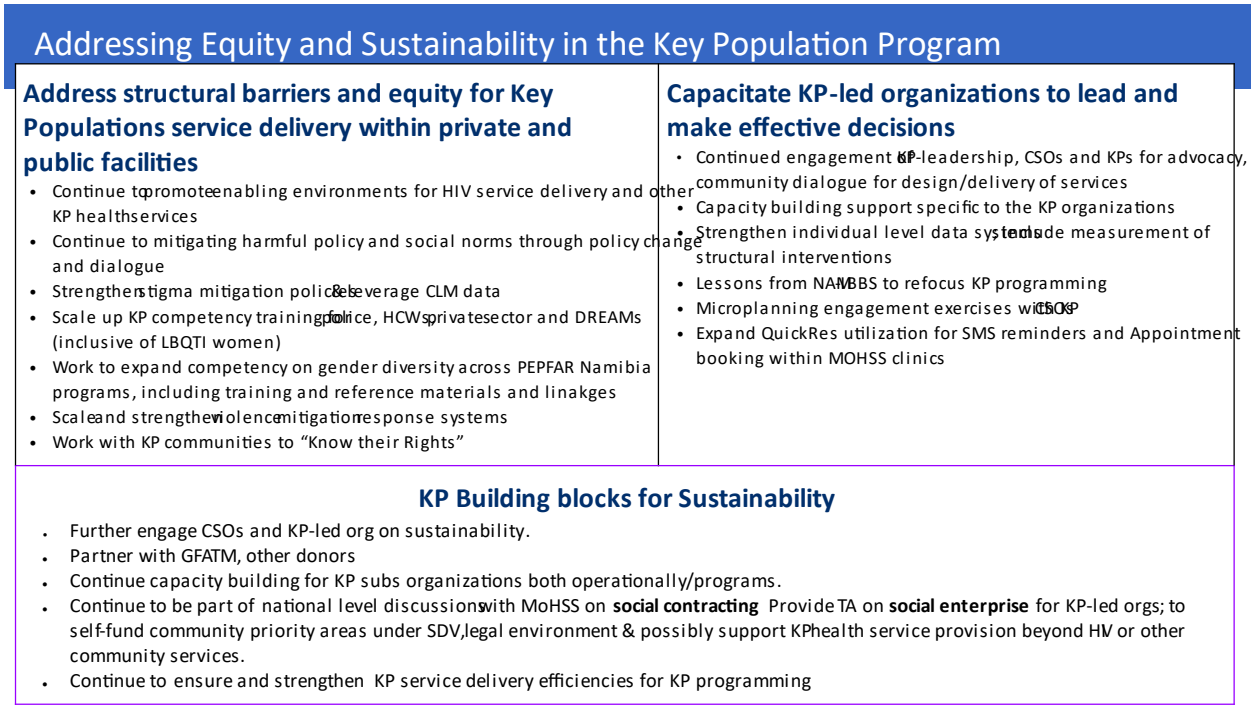
A core shift in FY23 is a focus on addressing structural interventions as part of ensuring person-centered services as well as sustainability. Core activities include promoting an enabling environment for HIV service delivery and other KP health services, mitigating harmful policy and social norms through policy review, change and dialogue, strengthening stigma mitigation policies & leverage CLM data, scaling up KP competency training for police, HCWs, private sector and DREAMs (inclusive of LBQT women), scale and strengthen violence mitigation response systems, working with KP communities to know their rights, leverage existing programs such as OVC and DREAMs programming for the LGBTQI populations and partnering with other USG agencies to promote the importance of human rights.

Figure. 4.3.3. COP22 Strategic Direction: Key Population: Prevention, Care & Treatment



Programmatic approaches to improve HTS yield and increase case finding in COP22 will build on current activities supported in COP21. These include case risk screening and optimized HTS among social networks and assisted/unassisted HIVST programming to complement prevention services. Unassisted HIVST programing will be linked through social media platforms and private sector clinics targeting MSM and TGW. PEPFAR Namibia will support the full implementation of PEPFAR Minimum Program Requirements for index testing and site certification procedures. Continuous dialogue with community members and oversight will ensure sites remain in compliance with all minimum requirements throughout implementation. The COP22 Sustainability Vision for Key Populations is summarized in Figure 4.3.4.

Figure 4.3.4 COP22 Equity and Sustainability Vision for Key Populations



VMMC

The modeled national coverage for VMMC among priority age groups (15-29) in FY22Q1 is 63% (DMPPT-2 2021). PEPFAR Namibia's primary objective is to support MOHSS to increase coverage of VMMC services among priority age groups in regions and districts with high unmet need to achieve saturation (80%). As a result of PEPFAR Namibia's support to the MOHSS in FY21, national VMMC coverage among young men aged 15-29 years old increased to 63% by the end of calendar year 2021. Regions with direct PEPFAR support recorded some of the highest coverage: Kavango East (100%), Zambezi (83%), and Omusati (76%). The coverage in the other regions ranges as low as 27% in Hardap and as high as 72% in Oshana (Program report, FY22Q1).

In FY21, PEPFAR Namibia continued saturation of VMMC programming and successful adaptations amidst COVID19, implemented age-pivot, prioritized staff, and client safety, promoted an effective and safe VMMC methods in 12 regions of Namibia. In FY21, PEPFAR Namibia supported circumcision for 17,778 men; (78%) of the overall for FY21 OU target of 22,695, 100% of which are in priority age group 15+ yrs. COP21(FY22), the target is to circumcise 23,000 clients.

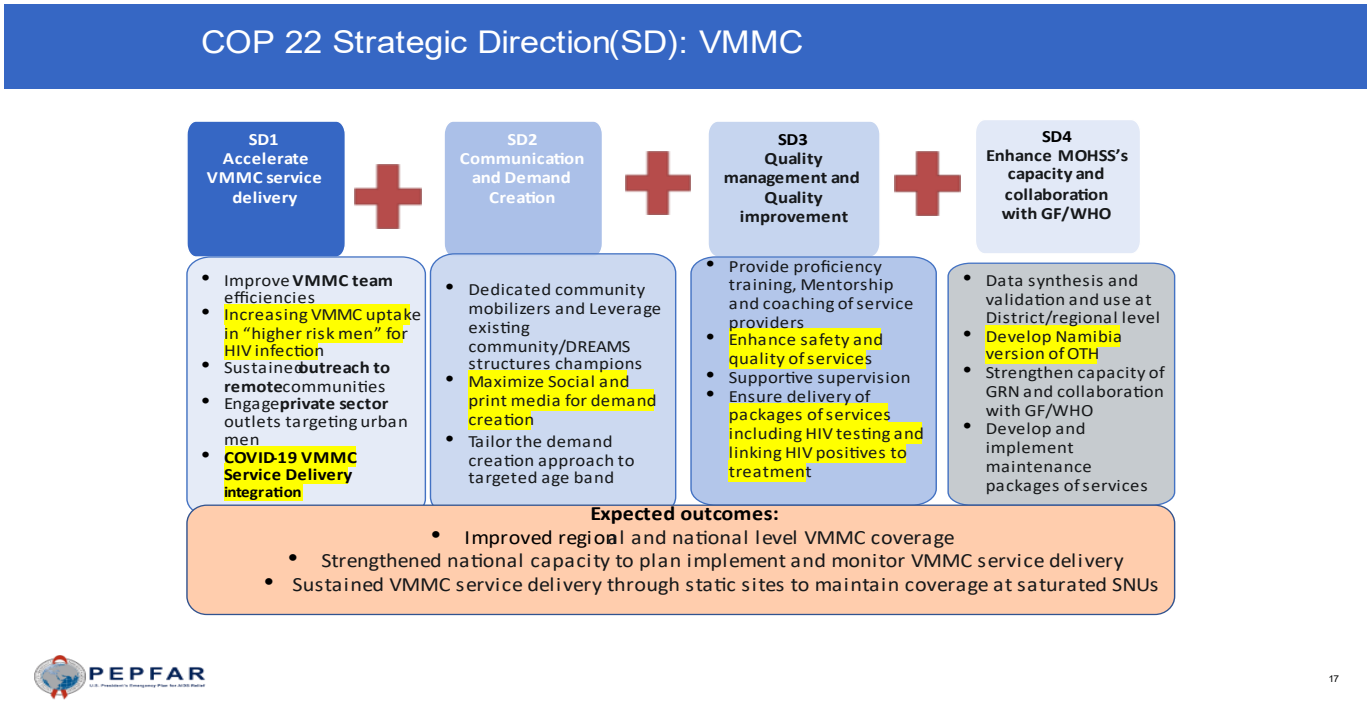
PEPFAR Namibia's COP22 target will continue to recover from COVID19 control measures and safely scale to saturate in six priority regions (Khomas, Kavango West, Ohangwena, Oshana, Oshikoto, Erongo) to increase the national coverage to 84%. The delivery of VMMC services in eight regions will overlap and complement with PEPFAR Namibia's DREAMS/OVC program. In COP22, target population remains 15+ and will achieve the overall OU target of 23,500.

In COP22, PEPFAR Namibia will continue to support age-specific, scientifically proven, and human-centered communication and demand creation strategies through community mobilizers, maximizing social and print media and tailored demand creation approach to target the 15+age

band. In addition, PEPFAR Namibia will increase efficiencies of the clinical team at fixed and outreach sites, enhance site optimization, provide direct service delivery to high volume sites, increase VMMC uptake in "higher risk men" for HIV infection, engage private sector outlets targeting urban men and work on COVID19 vaccination and VMMC service delivery integration. The demand creation strategy will also utilize existing institutions, religious and traditional leaders, peer promotion by recently circumcised men, and enhance community mobilization by engaging female partners. Client safety and quality services will be given due emphasis through mentorship, supportive supervision and coaching of service providers to ensure clients get packages of services including HIV testing and linking HIV positives to treatment. The COP22 vision for VMMC is summarized in Figure 4.3.5.

PEPFAR Namibia will also support the MOHSS to plan, implement and monitor the VMMC program, including sustainability planning for the regions that have reached saturation (Zambezi, Kavango East and Omusati) and other regions. The support will focus on proficiency assessment and training for clinicians, use of hybrid models for quality improvement, training, and supportive supervision (i.e., scale-up hybrid external QA/collaborative QI), avail the equipment needed at the sites, and strategies to integrate VMMC services into combined prevention programming (KP, DREAMS, PrEP, condoms). In addition, support will be provided to implement WHO/PEPFAR adverse event management protocols and establish a system to improve adverse events prevention, management, reporting, and referrals using the revised and Namibian version of online training hub. Furthermore, the support will help MOHSS to use the reusable dorsal slit technique in line with SGAC guidance and change the needle/suture used for VMMC to a 4.0 suture on a 19mm, 3/8 circle, reverse-cutting needle in COP22. All new VMMC services providers will be trained on the dorsal slit method and refresher training will continue in FY22/FY23.

Figure 4.3.5. COP22 Strategic Direction/Vision and Priority Interventions to Achieve COP Target



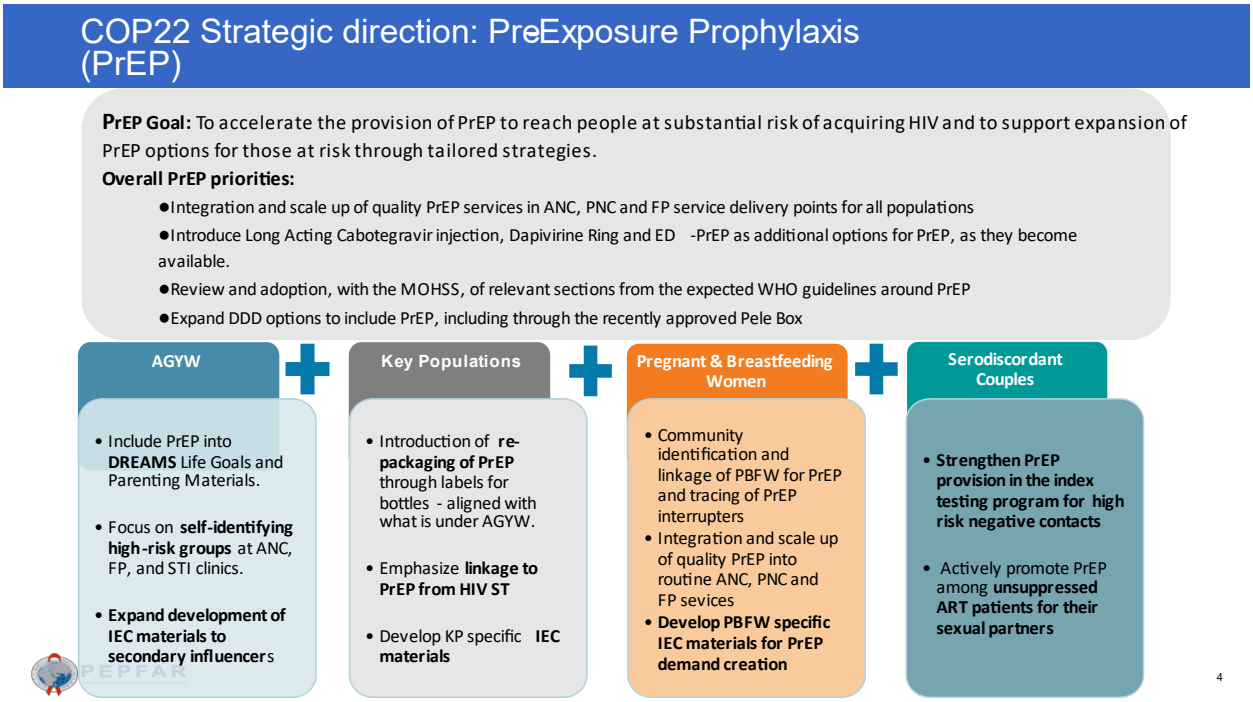
Pre-Exposure Prophylaxis

PEPFAR support for PrEP programs in Namibia continues to show high performance. In FY20 the program reached 15,589 people (75% of the target) newly initiated on PrEP and in FY21 reached 18,340 people (86% of the target). Namibia is succeeding in reaching targeted populations such as KPs, sero-different couples, PBFW, AGYW, and all people testing HIV negative at risk through the different prevention programs. By the end of FY21 more then 2/3 of all people initiated on PrEP were AGYWs and KPs. One of the key challenges has been lack of reporting on PrEP data in public facilities due the MOHSS nonfunctional M&E. In COP21, PEFPAR Namibia supported MOHSS to incorporate new MER 2.6. indicator (PREP_CT) in paper-based tools and electronic system (DHIS2) and MOHSS is expected to start reporting in Q3 FY22. The country has also recently completed the Namibia PrEP use and discontinuation study and will leverage lessons to better improve the program.

In COP22, PEPFAR Namibia will continue to expand PrEP services and will focus on the scale up of PrEP in four key priority service areas. PrEP will be scaled up through: 1) Integrating quality PrEP services in ANC, PNC, clinics to expand PrEP 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 targeting high risk men and AGYW; 3) PrEP services will also be expanded as an integral part of Index Partner Testing ensuring that high risk HIV- negative sexual contacts are offered PrEP; and 4) PEPFAR will continue to prioritize KPs and AGYW for PrEP expansion through both community and facility-based service delivery approaches.

Routine Intimate Partner Violence (IPV) screening will continue to be an integral part of PrEP provision. New biomedical PrEP options such as Dipivefrine Vaginal Ring (DVR) and long-acting injectable Cabotegravir Long-Acting (CAB-LA) injectables will be explored in COP22, which will improve retention, as well as utilizing Pelebox lockers for medicine pickup to make PrEP more accessible. The COP22 vision for PrEP is summarized in Figure 4.3.6.

Figure 4.3.6 COP Strategic Direction: Pre-Exposure Prophylaxis (PrEP)



In COP 22, PEPFAR Namibia will continue expand PrEP services to reach populations at substantial risk of HIV infections. Services will be tailored to the following priority populations such as pregnant and breastfeeding women, sero-different couples, AGYW, key populations, and all people testing HIV negative at identified substantial risk. In COP22, PEPFAR Namibia will continue to expand the community based active screening for PrEP eligibility and linkage to PrEP among AGYW and KPs. These interventions will be delivered through a coordinated approach within the community during outreach, safe spaces for AGYW, DREAMS Ambassadors, trained peer educators and in collaboration with HCW at health facilities. The clinical mentor program will support the integration of PrEP within the PMTCT program and maternal healthcare settings and assist sites to increase retesting of PBFW.

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

The MOHSS successfully transitioned PLHIV to TLD by the target date of December 2020, and the MOHSS is now continuing to ensure that all new patients are initiated on TLD from the start. There is an ongoing review of regional level TLD performance against regional targets. The Clinical Mentorship program works with the regions to ensure that clients who are eligible for TLD are promptly identified and transitioned to TLD. The COP22 procurement of about 11,000 packs of 180-day bottles of TLD, is designed to accelerate 6-month multi-month dispensing.

PEPFAR Namibia will continue to support MOHSS in rapidly phasing out the use of NVP-based first line ART regimens among both adults and children. PEPFAR Namibia and MOHSS have undertaken to no longer procure nevirapine-based and efavirenz-based ARVs for treatment since COP19. MOHSS is also discontinuing procuring LPV/r granules for children as the National program moves towards DTG optimization.

Differentiated Service Delivery, Multi-Month Scripting and Dispensing

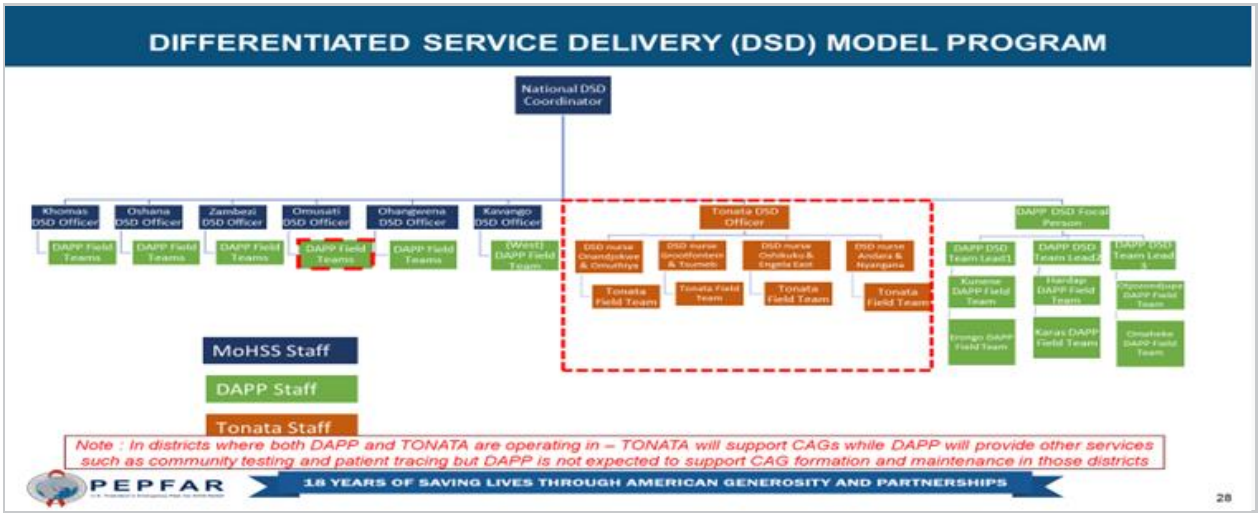
Differentiated Service Delivery (DSD) continues being scaled up in many regions and by the end of FY22 Q1, Namibia had over 2000 Community Adherence Groups (CAGs); over 100 206 Comprehensive Community-Based Health Services (CCBHS); and over 100 teen clubs across the country. The number of patients enrolled in community-based models continued to increase steadily through FY22 Q1 ending the quarter with close to 23,000 PLHIV enrolled in the community-based models. In COP22, DSD models will be offered to all sub populations established on ART including children, adolescents, pregnant and breastfeeding women and men.

The MOHSS is committed to MMD scale up from 3 months MMD up to 6 MMD, and PEPFAR Namibia continues to support the GRN in this endeavor. In the past year, MMD was relatively stable despite global supply chain challenges. Approximately 70% of clients received a 3–6-month supply of ARVs between February to December 2021. The proportion of clients receiving 6 MMD during the same period remained stable at an average of 25%. These results are a direct result of the ART/TB Supply Chain TWG that convened at the beginning of the COVID-19 pandemic in 2020 and continued to meet regularly to ensure MMD was being rolled amidst external challenges. In COP22, PEPFAR Namibia will continue to collaborate with MOHSS to responsively identify and address barriers to scaling up 6 MMD and implement facility level systems to strengthen the management of MMD as a key component of DSD.

The challenges of costs and transport for clients are common reasons for missed pill pickups. Namibia is well poised for further expansion and nuancing of CAGs and CCHBS, platforms that help reduce cost and transport burdens.

Figure 4.4.1. below illustrates the framework showing the geographic, staffing matrix and service package allocation between the MOHSS, and supporting partners DAPP and TONATA. This framework will ensure efficiency and standardized implementation of all MOHSS-led PEPFAR supported DSD services across the country. DSD remains a critical component of ensuring continuity in treatment, and in COP22, PEPFAR Namibia will enhance the quality of services and implement equitable DSD models for those new on ART, sub-populations (children, adolescents, PBFW) and PLHIV with an unsuppressed viral load.

Figure 4.4.1. Differentiated Service Delivery (DSD) Model Program



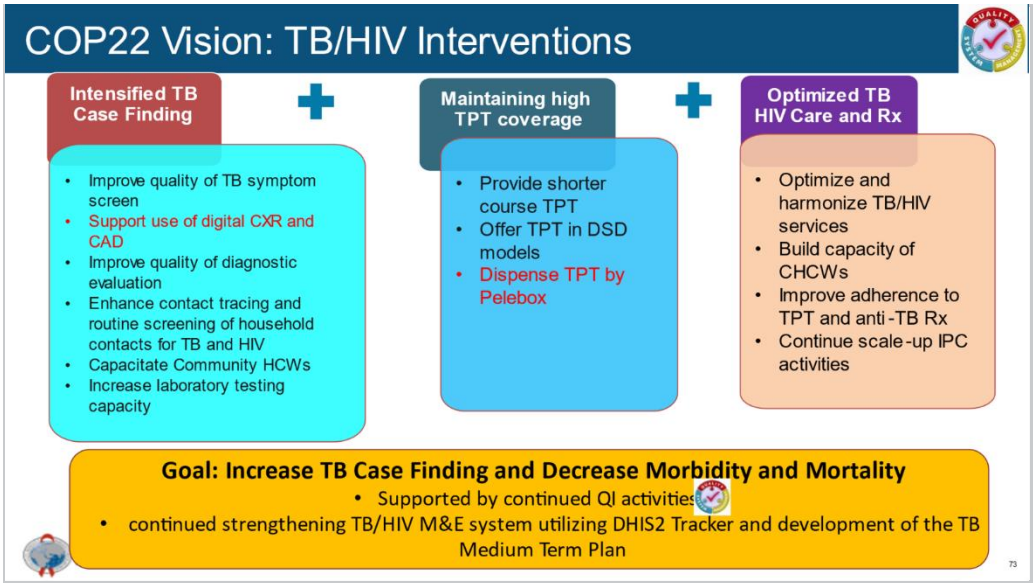
Addressing Low ART and VL Coverage in Four Low Burden Regions

Although most regions have been performing very well with ART coverage and viral suppression, there are four regions (!Karas, Hardap, Kunene, and Omaheke) that have been underperforming due to a lack of support as efforts in previous years focused on high-burden regions. In COP22, PEPFAR Namibia will continue strengthening support to these regions through targeted HR support, clinical mentoring, quality improvement infrastructural modifications to ensure quality person-centered care, as well as diagnostic network optimization and improving specimen transport activities to increase access.

Intensified TB Case-Finding, maintaining high TB Preventive Therapy coverage and optimized TB/HIV Care

The main goal for the TB/HIV Program in COP22 will be to increase TB case finding and decrease TB morbidity and mortality. The overarching strategies to support the goal include: enhanced QI activities, continued strengthening of the TB HIV reporting system utilizing the DHIS2 tracker, and development of the next medium-term plan for TB. Starting in COP21 and moving into COP22, the low positive TB screening yields will be addressed as well as ensure that the whole TB diagnostic cascade including return of results is improved. PEPFAR Namibia will also strive to maintain high TPT coverage as well as optimize TB HIV care and treatment.

Figure 4.4.2. COP22 Vision: TB/HIV Interventions



Globally, WHO has reported a decrease in the number of reported TB cases and increased deaths because of the COVID19 pandemic. When compared to FY2019, Namibia reported a 16% and 14% decrease in numbers of notified cases in FY2020 and FY2021 respectively. This decline recorded in Namibia is consistent with the global trends in reported TB cases observed over the same period indicating a worrying gap in TB case finding during the last 2 years due to COVID19 restrictions.

In FY21 and Q1 of FY22, 99% of TB patients had a documented HIV status. The percentage of TB HIV co-infected patients initiated on ART in FY21 has also remained high at 97%. There has been a steady rise in the percentage of ART patients screened for TB, reaching a peak at 95% in Q2 2020. It was at 89% in Q4 of FY21, which is just below the target of 90%. However, the overall positivity yield of the screening remains low at 0.2%. The yield is at 0.1% for those already on ART and higher at 4% for the patients newly enrolled on ART. These yields for both old and new PLHIV on ART is lower than the expected thresholds set at 5% for patients already on ART and 15% for patients newly initiating ART. In addition, there has been poor reporting on the diagnostic cascade following a positive TB screen.

To address the challenges in TB screening and case finding, the Patient Care booklet (which is the primary data source) will be revised and the electronic patient monitoring system, to adequately capture the whole TB screening cascade. PEPFAR Namibia will also utilize the national mentoring system and QI approaches to improve TB screening while ensuring regular monthly reporting on screening indicators (this will be one of the key areas of the National QI model). The TB contact tracing covering all household contacts will be intensified and community HCWs will be capacitated by expanding the scope of work of community partners as well as train MOHSS health extension workers on TB case finding and management. A long-term solution will include working on establishing a unique patient identifier which will allow data sharing and tracking of patients and results across different reporting systems.

In COP22, PEPFAR Namibia will introduce the digital chest x-rays with computer-aided detection software as part of the TB screening for PLHIV in specific sites. This is anticipated to increase the screening yield. Continuous laboratory support will be provided to increase testing capacity and continue supporting TB LAM implementation to ensure early TB treatment.

The QI collaborative remains the main vehicle to improve TPT completion. Data from the sites shows an overall 92% TPT completion rate by January 2022. This is supported by a national data extraction from Quantum ePMS in December 2022 which showed that 93% of active clients had documentation of completing a course of TPT. In COP22, the program will continue with QI activities, using the shorter course TPT regimen as well as intensifying TB contact tracing including offering TPT to adult and children who are close contacts as well as dispensing TPT through the Pelebox lockers.

In order to optimize TB HIV Care, in COP22 PEPFAR Namibia will continue to promote the one-stop approach to HIV care including using optimized regimens. This will integrate the work of community HCWs into TB management as well as continue with infection and prevention control activities. As TB deaths have remained high among all categories of patients but disproportionally higher in PLHIV, PEPFAR Namibia will also conduct regular death audits. In COP22, PEPFAR Namibia will continue to work with MOHSS to review the TB medium-term plan and continue supporting the implementation of the DHIS2 TB tracker as part of improvement of the data reporting system.

Border Epidemic

Namibia has a growing population of non-Namibians accessing health services along its borders. PEPFAR Namibia is supporting the optimization of services alongside the Namibian border with the goal to improve health outcomes for non-Namibians seeking and accessing services at service delivery points alongside the border, and to decrease HIV incidence in Namibia.

From April 2020 until December 2021, close to 3000 pill pickups occurred at border sites, and the majority (68%) received three months or more MMD. Under the system, Namibian healthcare workers staff at border sites, with the help of immigration officials, provide comprehensive HIV services by conducting clinical consultation, blood monitoring, ART refill and other essential primary health care services.

In COP 22, PEPFAR Namibia will continue to strengthen border services by providing sites that turned in to permanent outreach points with prefabricated structures where integrated Primary Health Care and ART services can be provided. With these structures in place, cervical cancer screening, VMMC, PMTCT services, lab optimization, case finding and prevention services by offering PREP to pregnant and breastfeeding mothers and strengthening data capturing and reporting of all services delivered can be offered. Prefabricated structures will be provided working in collaboration with the GF.

Improve Access to HIV Services in Prisons

With PEPFAR Namibia support, Correctional Facilities and police holding cells are now able to provide services such as HIV testing and prevention services, optimized case finding support, direct linkage to care, VMMC referrals, cervical cancer screening and HIV prevention support upon release. Care and treatment are the major services which are focused on and include ART

directly observed therapy (DOT) optimization, VL monitoring and suppression, PMTCT services, mentoring and support for HCWs, improving TB screening and uptake of TPT, and implementation of collaborative QI activities. There is also strong support for strategic information by scaling up data systems, data quality management and M&E support.

In COP22 the focus is on strengthening the provision of quality HIV and TB services in Namibia Correctional Services and through the police by ensuring service availability and accessibility across all correctional facilities and police stations. PEPFAR Namibia will support the implementation of a standardized M&E system aligned to the MOHSS HIV M&E in Correctional Facilities. With the recently finalized minimum package of TB and HIV services document which was developed with the support of PEPFAR and officially approved and signed off by the Minister of Home Affairs, Immigration, Safety and Security, one of the major focus areas will be the implementation of this document. A key priority of the package is linkage to comprehensive HIV care for inmates after their release to ensure continuation of care in the general population.

Mental Health

In COP19, PEPFAR Namibia began supporting MOHSS to introduce mental health care into HIV services. The Common Elements Treatment Approach (CETA) continues to be used, which is an integrated mental health program fully delivered by lay providers and designed for low-resource settings. In COP22, PEPFAR Namibia will continue to support mental health services for PLHIV with focus on those in the cycle of interruption and return to ART and those with high viral load.

4.5 Additional Program Priorities

Policy updates

In March 2022, the MOHSS launched the National Quality Management Policy and Strategic Plan that aims to guide the implementation of quality management/quality improvement in the Ministry between 2022-2026. With this strategic plan and strengthening of the quality management division, in COP22, PEPFAR Namibia will support the acceleration phase of implementing the MOHSS quality management model across all the care and treatment cascade with a view of sustaining impact in the coming several years in line with the PEPFAR technical guidance provided in the Namibia Planning Level letter.

Index testing scale up in the context of safe and ethical testing

PEPFAR Namibia conducted safe and ethical assessments in FY21 and showed that the majority of Index testing sites are in compliance with PEPFAR's minimum requirements, however some gaps were noted. Subsequently, MOHSS trained all index testing service providers on the safe and ethical training curriculum as well as on the LIVES training. Ongoing site support is done (MOHSS standardized supervision tool for Index Testing) as well as refresher training to ensure standards are maintained.

COP22 decision-making based on POART discussions and performance reviews

The COP22 planning process fully integrated assessments from the POART discussions and other performance reviews. PEPFAR Namibia has had meetings at an individual, group and stakeholder

level to discuss progress to date and needs in the future. Namibia's COP22 plan is a clear reflection of these discussions.

As part of COP22 planning, the OU reviewed COP20 Q1 – Q4 performance and COP21 performance to date, looking at performance by priority populations, where data was available and focused program adjustments accordingly. For example, COP22 priority focuses on addressing barriers to uptake, and continuation of PrEP, based on the need for improved integration of PrEP in routine maternal health services for PBFW and actively promoting PrEP among unsuppressed ART patients for their sexual partners, adjustments of existing PrEP guidelines following WHO PrEP guidance, increased access to PrEP services and overall improved population-specific demand creation strategies and IEC materials. Programming also looked at the upcoming biomedical prevention pipeline and ensured the integration of these potential products into COP22 planning.

Partner management to align with PEPFAR program strategy

CDC and USAID perform regular monitoring activities of all implementing partners, meeting monthly at a minimum. These monitoring activities include regular review of progress against the established targets in relation to the approved budget and work plan. It also includes annual site visit meetings to evaluate performance at the site-level and ensure resources are accounted for. While these are standard measures put in place to monitor our PEPFAR implementing partners, engagement with Implementing Partners goes beyond these routine monitoring activities to provide ongoing technical assistance and convene all relevant stakeholders for strategic meetings, when necessary.

CLM plans for program improvement and involvement of key populations

In COP22, PEPFAR Namibia will continue to prioritize CLM, in this year expanding to two partners to lead on implementation. The information collected will continue to inform program activities. CLM activities are implemented under the guidance of a multi-partner steering committee, and this oversight and guidance ensures the direction and responsiveness of the activity. In COP22, specific interventions will be applied to gain feedback from key populations.

4.6 Commodities

PEPFAR Namibia provides program-critical support to the MOHSS and Central Medical Stores to prevent stockouts, maldistribution, and wastage of HIV and TB related and other essential commodities. This will continue in COP22. The program will also focus on improved supply chain strategy and planning, supporting efforts to transition to and scale up optimal product options and expand MMD, and strengthening in-country systems and capacity to undertake timely and best value procurement. The Namibian Government has procured the majority of all commodities within every category for many years running, and despite the economic downturn, that is expected to continue.

The GRN has carried out successful tenders for ARVs, resulting in long-term supplier contracts and stable ARV supply. It has not had similar success with essential medicines and other commodities, reflected in stock variability throughout the country, such as for family planning items. Stock of condoms and lubricants have been affected by the COVID-19 pandemic, and PEPFAR and the Global Fund are providing stopgap support. PEPFAR will also continue to

advocate for procurement efficiencies, such as pooling, and will assist with systems for contract and supplier management to ensure limited resources are used as efficiently as possible.

PEPFAR Namibia will continue to support the institutionalization of analysis and use of distribution, dispensing, and deidentified patient data for process improvements, and increased transparency and accountability. Key to this work is scaling up efforts to establish GS1 standards for traceability of commodities from manufacturer to patient. Additionally, the program will accelerate efforts toward a more modernized, country-led supply chain, working closely with the MOHSS to ensure stable commodities funding, stable staffing within CMS, and a clear path forward for the health supply chain. This will include a network optimization analysis, to build evidence on the ideal supply chain for the country, balancing resource investments and operational expenses to achieve desired service levels.

With PEPFAR support, Namibia began transitioning to dolutegravir-based regimens in October 2019. This effort commenced with the arrival of TLD as the primary first-line offering for adults, a regimen that Namibia fully transitioned to in COP20. In June 2021, PEPFAR supported the arrival and rollout of the first stock of DTG10 for use as the preferred first-line for pediatric patients and the country is approaching full transition. In COP22, PEPFAR Namibia will procure $250,000 of pediatric ARVs, the majority of which will support scale-up of DTG10 among CLHIV. The remainder will procure nevirapine and zidovudine suspensions for infant prophylaxis.

For COP22, $100,000 has been allocated for VMMC commodities for 17,000 diathermy electrodes, 250 reusable VMMC kits, and 4,600 single-use kits of essential consumables. In addition, the OU received $400,000 from the Central Condom Fund for 7.8 million condoms and 2 million lubricant sachets, primarily to support specific populations, particularly KPs, as well as other priority populations, such as AGYW.

PEPFAR Namibia continues to prioritize PrEP expansion. In COP22, the program will spend more than $700,000 on Emtricitabine/Tenofovir 200/300 mg and an additional $23,000 on the dapivirine ring to expand the availability of PrEP options in the country. In addition, PEPFAR Namibia will procure $334,000 of OraQuick HIVSTs and $145,000 of HIV recency tests. Laboratory support will also include the procurement of $380,000 worth of TB LAM tests, Urine TDF tests, HPV reagents, and EID, VL, and TB reagents and consumables.

4.7 Collaboration, Integration and Monitoring

PEPFAR Namibia interagency coordination is strong. Program areas form an integrated cascade across the three 95s, with the community, facility, and health system partners successfully providing comprehensive services. This model represents Namibia's vision of streamlined, efficient partners, coordinated as one portfolio by the MOHSS and includes PEPFAR, MOHSS and other stakeholder-funded services. This extends to a comprehensive and integrated prevention approach, with a focus on highest risk or unreached populations. This model in Namibia is designed to increase domestic ownership and quality of care with successful outcomes.

Working with host government structures and international implementing partners to increase the capacity of indigenous partners is a continued key focus for COP22 collaboration, integration and monitoring. Approximately 70% of PEPFAR Namibia COP20 funds were allocated to indigenous organizations in COP21 and the same will be allocated in COP22.

In coordination with the GRN, civil society organizations, private sector, and other key donors/agencies (i.e., Global Fund and UNAIDS), PEPFAR Namibia is supporting 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. Furthermore, PEPFAR Namibia will continue to support development of a national specimen transport and results return system that builds on existing NIP transport but expands to include innovative and new to Namibia concepts for improving access equality.

PEPFAR Namibia and agencies are represented in the Health Development Partners group, a coordinating body led by WHO and composed of MOHSS representatives, and multilateral and bilateral partners. Collaboration is also strengthened through a strong presence by all agencies on technical working groups within the MOHSS. PEPFAR Namibia holds a seat on the GFATM Country Coordination Mechanism and directly collaborates and coordinates with the GFATM Portfolio Manager and Namibia Team in Geneva to assure alignment of priorities and activities, particularly to avoid duplication on HRH deployment and ARV procurement.

CDC and USAID conduct active management of implementing mechanisms via in-person and virtual 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 is conducted. Reviews also focus on quarterly disbursements, accruals and upcoming expenditures, and SIMS findings. Feedback and technical direction are provided during these meetings.

Interagency implementing partner feedback meetings improve site-level knowledge and share performance progress. Site-level monitoring is achieved through SIMS and site visits. Written plans address weaknesses and follow up visits with all partners are conducted.

The interagency team will also improve service delivery quality and efficiency by supporting the strengthening of the quality management program organizational infrastructure at all levels of health care and implementing a quality management model which will address gaps in all program area across the cascade. The use of the Funding Allocation to Strategy Tool (FAST) ensures that targeted site level and above site activities are mapped to optimize country systems to govern and manage the HIV response by focusing on key programmatic barriers and geographic priorities.

4.8 Targets by population

PEPFAR Namibia does not have any scale up locations.

Table 4.8.1. VMMC Coverage and Targets by Regional SNU for 15-29 year old

Target Populations [Specify age bands for focus]	FY21 Population Size Estimate	Current Coverage (Expected) FY22	VMMC_CIRC Target FY23
Erongo	34,104	49%	3,895
Hardap	12,972	59%	1,246
Karas!	11,851	57%	2,128
Kavango East	26,666	121%	1,772
Kavango West	5,475	75%	307
Khomas	76,585	58%	5,973
Kunene	13,537	59%	0
Ohangwena	34,035	89%	1,800
Omaheke	10,766	54%	0
Omusati	33,442	97%	1,739
Oshana	28,928	77%	1,126
Oshikoto	29,055	90%	1,495
Otjozondjupa	22,508	63%	1,580
Zambezia	15,229	86%	439
Total COP21 Target	355,153	72%	23,500

*COP22 Datapack
**VMMC Decision-Makers' Program Planning Toolkit (DMPPT)

Target Populations for Prevention Interventions

PEPFAR Namibia has made concerted efforts to improve available information regarding key populations, as reaching KP is critical for sustainable HIV epidemic control. In 2019, PEPFAR Namibia completed an Integrated Biological and Behavioral Survey (IBBSS), which provided updated information on population size estimates for FSW, MSM and TG people in three priority districts. COP22 program prioritization looked at multiple relevant data sources developed and funded under our program including the NAM-IBBSS, the recently completed Small Area Estimates report, PrEP study report and a draft report of hotspot mapping. The data was used to feedback programming and targeting settings for areas requiring increased focus.

Overall, the COP22 targets align with the goal of reaching 90% of estimated KPs through peer-driven interventions, enhanced peer outreach approaches (EPOA), hotspot mapping and linkage to clinical services that include HTS, PrEP and ART. As the COVID19 restrictions are relaxed and opportunities reach hotspot areas increases, other high-risk groups who form important bridge populations, will be reached alongside reaching key populations with HIV prevention interventions such as the quickres online reservation tool and HIV self-testing kits. Referrals to other HIV prevention interventions as relevant will be intensified such as children living with key populations in hot spots and vulnerable AGYWs who are KPs will be referred to OVC and DREAMS program respectively. In COP22, there will be a focus on building on activities that promote an enabling environment for KP service delivery through structural interventions and gender inclusivity of the LGBTQI community.

Table 4.8.2. Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY22)	FY22 Target
FSW (KP_PREV)	*8,082, 2,196↑ 1,057↑↑, 674↑↑↑	90%	15,234
MSM (KP_PREV)	2,210↑, 670↑↑	90%	4,727
TG Women (KP_PREV)	N/A	90%	1,406
PP_PREV (General Pop)	N/A	46% (Eligible high risk)	94,625
PP_PREV (AGYW 10-24)	***98,176 (Vulnerable Pop)	83%	85,965
AGYW (AGYW_PREV)	**98,176 (Vulnerable Pop)	75% (Eligible high risk)	28,801 (N), 49,441 (D)
PrEP_NEW (General Pop)	N/A	N/A	34,495
PrEP_NEW (KP)	14,889	85% (100% of HIV neg eligible high risk)	4,402
PrEP_NEW (AGYW 15-24)	**199,227	50%	19,235

*IBBS 2013
**2022 Projected Population for girls 10-24 years old (Kavango East, Kavango West, Khomas, Oshana, Oshikoto, Zambezi and Khomas), source: DataPack
***2022 Projected Vulnerable AGYWs using saturation analysis data for Kavango East, Kavango West, Khomas, Oshana, Oshikoto, Zambezi and Khomas
Population size estimates, NAM-IBBS 2019: ↑Windhoek, ↑↑Walvis Bay/Swakopmund, ↑↑↑Katima Mulilo

OVC and Pediatric - Entry Stream Target Setting Process and Assumptions

The OVC target setting process started with an analysis of the current cohort of OVC beneficiaries supported in FY22. The number of HIV positive OVCs in FY22 was also compared to the number of actively enrolled pediatric ART patients, the goal is to enroll 90% of CLHIV on ART in the comprehensive OVC program. The COP22 OVC targets include children living with HIV ages 0-17 and HIV-affected children (e.g., children of HIV+ caregivers, HIV exposed infants, children of key populations, children at risk or who have experienced violence, at risk AGYW ages 10-17). The target for OVC_SERV is also based on the estimated number of orphans and vulnerable children from the 2021 Spectrum and 2021 population projections. Furthermore, for DREAMS OVC related targets, consideration was given to the current epidemiological context of the AGYW population in the DREAMS SNUs and vulnerability based on program screening, VACS data, and eligibility criteria. An anticipated 80% of all HIV infected and affected OVCs in all implementation sites will need specific HIV-related services within facilities and communities. These services include linkage to HTS, violence and HIV prevention, psychosocial counseling, referrals to care and treatment, support for ART adherence and retention, and HIV disclosure.

In COP22, PEPFAR Namibia will reach a total of 52,561 OVCs in all implementation SNUs. 32,878 (63%) of the total targets will be attributed to OVC comprehensive, 14,834 (28%) to DREAMS, and 7,257 (14%) are for OVC Preventive. Of the 32,878 OVC comprehensive approach, 27,342 represent active OVC beneficiaries and 5,536 beneficiaries are expected to graduate, translating to

a graduation rate of 17%. OVC comprehensive targets for children under 18 have increased to reflect the CLHIV enrollment goals to be in line with the program direction. HIV risk assessments will be conducted to ensure that of the 29,358 OVC under age 18 in the OVC comprehensive approach, 100% have a known HIV status. 100% of HIV-positive OVC in PEPFAR Namibia supported sites will be linked to treatment and have their viral load monitored.

Table 4.8.3. Targets for OVC and Linkages to HIV Services

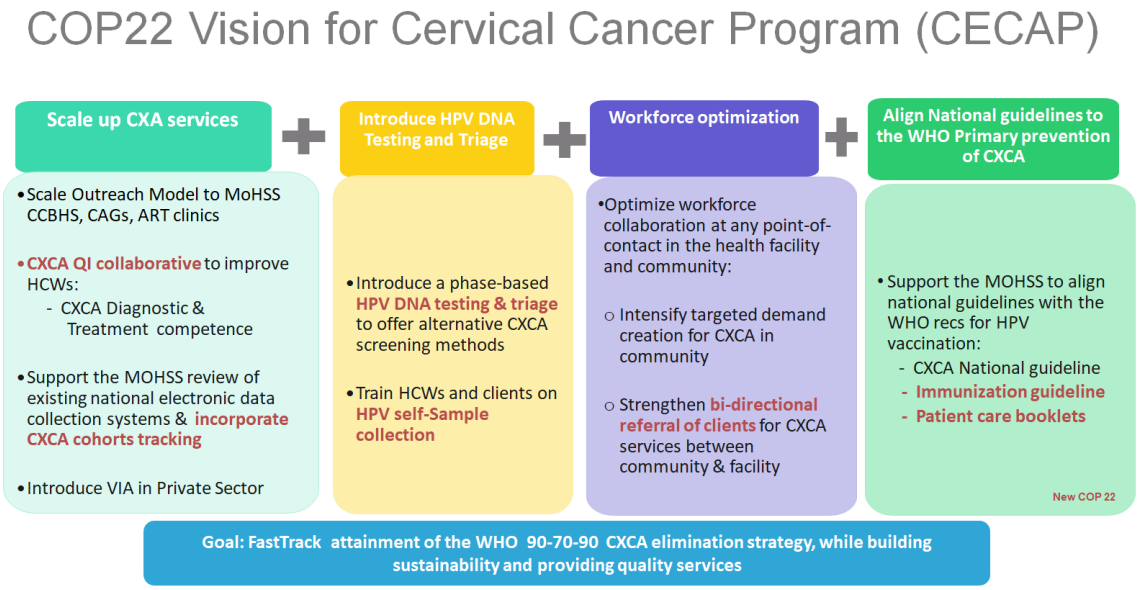
SNU	Target # of active OVC (FY21 Target) OVC_SERV*	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target) OVC*	OVC_SERV Preventive*
Andara	1,442	649	155
Eenhana	3,236	2,327	586
Engela	7,038	5,249	1,310
Grootfontein	50	0	50
Katima Mulilo	7,780	3,954	767
Keetmanshop	75	0	75
Nankudu	886	578	213
Nkurenkuru	849	546	177
Nyangana	1,565	737	177
Okahandja	50	0	50
Okahao	657	420	78
Okongo	429	301	69
Omuthiya	3,229	2,274	431
Onandjokwe	4,943	2,930	354
Oshakati	5,710	2,625	818
Oshikuku	1,265	941	179
Otjiwarongo	60	0	60
Outapi	1,245	857	278
Rundu	3,903	1,978	472
Swakopmund	52	0	52
Tsandi	791	491	143
Tsumeb	2,022	1,721	342
Walvis Bay	126	0	126
Windhoek	5,158	780	295
Total	**52,561**	**29,358**	**7,257**

*COP22 Datapack

4.9 Cervical Cancer (CXCA) Program Plans

Namibia formally started providing CXCA screen and treat services in February 2019, and at the end of COP20 established 178 sites in all 14 regions in the country, of which 61 are static sites and 117 outreach sites, providing Visual Inspection with Acetic acid (VIA), ablation therapy and loop electrosurgical excision procedure (LEEP) services. The fully integrated prefabricated PEPFAR supported units are in Khomas, Zambezi, Ohangwena, Omusati, Erongo, Kavango and Oshikoto regions. These units offer screen and treat services in one location, allowing more women immediate access to treatment. Namibia has been improving on the treatment rate from 70% in FY19 to 95% in FY21 despite COVID-19 related challenges.

Figure 4.8.1 COP22 Vision for Cervical Cancer Program (CECAP)



As illustrated in Figure 4.8.1 above, by the end of COP22, the country is planning to expand access of cervical cancer screening services and to increase targeted screening from 42% at the end of FY21 to 70% in line with the WHO CXCA elimination strategy and maintain the treatment rates for WLHIV between 95% -100%. The program plans to introduce a QI Collaborative to improve CXCA diagnostic and treatment competencies among HCWs and will optimize cervical cancer screening services by introducing VIA in the private sector. Treatment competencies will also include providing services to lesbian, bisexual, queer women and transgender men. Introducing a phase-based human papillomavirus (HPV) DNA testing and triage will offer alternative CXCA screening methods and training of HCWs and clients on HPV DNA testing and self-sample collection.

A CXCA cohort tracker will be incorporated in the national electronic data collection system to flag clients who are due for follow-up services, and this will be complemented with an automated text or WhatsApp message to remind clients of their next CXCA appointment. The program will continue to use the CXCA register to track clients. To enable a holistic approach to healthcare service delivery and to establish a linkage to care pathway through a booking system that will serve to remind WLHIV during pill pickups and ART services of their next appointment, the program will strengthen collaboration between HCWs at ART, CECAP sites and pharmacies. The program will also track eligible clients for cervical cancer screening and treatment within the well-established community tracing program to scale up cervical cancer screening and close treatment gaps. At facility level, a fast-track escort system will be implemented. Intensified targeted demand creation activities in the community will be conducted through targeted training of community-based partners to establish a bidirectional referral system. The country will continue to implement the Mixed Model Approach to provide cervical cancer screening at

fixed and mobile outreach services with emphasis on the outreach model to CCBHSs, CAGs, and rural ART clinics by using mobile vans for outreach services. Monthly outreach services in each region will occur, targeting specifically WLHIV and optimizing ART/PMTCT visits to increase same day screening of WLHIV as standard of care.

Other priority areas for the program will include strengthening the well-established MOHSS referral system for treatment of invasive cervical cancer. Thermal coagulation will continue to be scaled up to increase the rate of same day treatment of eligible pre-cancerous cells to 100%. Increased public-private partnerships and stakeholder involvement is needed to create a sustainable national program, and the program will commence negotiation with local medical aid funds to incorporate see and treat in benefit packages. There is a need to standardize data collection tools and implement M&E into national reporting framework to improve data quality and timeliness of reporting.

A target of 46,887 WLHIV will be screened in COP22. To address specific policy related activities that will increase access and scale up of cervical cancer screening, the country will utilize a national 5-year CXCA elimination strategic plan to expand national programing of the CECAP program outside of PEPFAR. The program further plans to institutionalize cervical cancer trainings through local tertiary institutions to standardize training. Medical doctors and nurses will thus be able to conduct the CXCA see and treat screening approach, ablative therapy and LEEP treatment upon completion of their basic training. The aim is to increase the number of HCWs to scale up CXCA services while improving the quality of trainings to pave the path towards sustainability of CXCA services.

4.10 Viral Load and Early Infant Diagnosis Optimization

At national level, Namibia is well poised to meet the testing needs of patients for VL, EID and TB testing using molecular platforms. To work towards further optimizing the system, in COP22, the program will continue with the analysis of the current utilization and workflow at all molecular sites (high throughput and GeneXpert). Currently, there are eight regional high VL laboratories with 15 total instruments. These instruments at 250 working days, with a single 8-hour shift per day, have a capacity of 533,000 tests per year.

EID and TB testing each use a single molecular testing platform and assay to conduct testing nationwide. To further complicate EID, testing is centralized to a single laboratory with two CAP/CTM 96 instruments and a capacity of approximately 63,000 tests per year. Although this capacity exceeds the needs of the country, the centralization of testing has led to longer than optimal turnaround times, loss of samples during transit from other regions, stoppage of testing due to equipment failure, and stockout issues during supply chain shortages.

In COP22, PEPFAR Namibia will continue to expand EID testing to all capable VL laboratories to address low coverage issues and longer than optimal turnaround times. In COP21, this work began with capacitating the four Abbott m2000 instruments in country (two in Oshakati and two in Windhoek Central). In late COP21 and into COP22, three laboratories in Outapi, Rundu and Katima, with Hologic Panther systems, will be capacitated with EID testing as well as Walvis Bay which has two GX16 GeneXpert machines. Once that is complete, further expansion of access to EID will be done by adding multiplexing of existing GeneXperts currently used for TB in sites with high need and low coverage for EID. PEPFAR Namibia continues to explore the possibility of

addition of true POC testing (mPIMAs) and this will be expanded for selected sites at the borders as well as hard to reach areas.

To address issues related to TB testing, in COP22 the addition of Abbott RealTime MTB and RealTime MTB RIF/INH Resistance assays will be added to assist in ensuring continued identification and resistance detection when Xpert tests are in limited supply. This will add high throughput platform capacity to accommodate larger numbers when needed. In COP22, significant investments to procure additional TB Xpert Ultra tests will be made.

Further optimization activities involve assisting the country develop a national specimen transport, tracking, and results return system. Currently, there is no tracking of specimens or results, and movement of specimens and results to and from facilities is largely done in an ad hoc manner. NIP currently manages specimen transport between laboratories and from facilities to laboratories in a few designated clinical settings. In COP22, PEPFAR support will also move Namibia closer to a national system by continuing to support personnel and developing a team that involves both MOHSS and NIP to investigate best practices and develop a framework for a national system.

Continuous quality improvement will continue in COP22 by supporting virtual Strengthening Laboratory Management Toward Accreditation (SLMTA) training for laboratory technicians and supporting the gradual transition of accreditation activities for the regional laboratories to NIP. As of COP21 six VL molecular laboratories have been accredited leaving only two in the country lacking accreditation. PEPFAR will further support CQI activities by continuing with the HIV rapid testing proficiency testing (PT) production, recency, and addition of PT production for TB-LAM

In COP22, PEPFAR Namibia will continue to support recency with VL testing for completion of the RITA algorithm as the percent reclassification that occurs after VL testing continues to be high. PEPFAR Namibia will also continue with PT, CQI and purchasing of tests. However, new to COP22, will be the introduction of a hybrid model of site and laboratory-based testing as expansion to the remaining 120 low volume sites is completed. The plan is to collect samples from the 120 low volume sites and transport them to the Windhoek central laboratory for testing. This hybrid model will help reduce costs needed for training of staff and CQI visits at these low volume sites and test wastage for tests that might otherwise go unused at these sites. Laboratory based staff will be added in COP22 to assist with this activity to ensure timely result turnaround time.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Namibia's SID 2021 process commenced with the constitution of a core team, comprised of representatives from the PEPFAR country team and UNAIDS. The core team engaged health sector technical working groups and key informants from 7 of the 14 regions of Namibia to prepopulate the SID tools, before convening a broader stakeholder validation workshop with more than 60 multisectoral stakeholders in attendance.

Namibia's 2019 SID classified the country as 'emerging sustainability,' noting that targeted investments were still needed to ensure epidemic control was ultimately sustainable. The 2021 SID

confirmed the country's 'emerging sustainability' status, as demonstrated by zero reds (i.e. unsustainable and requires significant investment), ten yellows (i.e. emerging sustainability and needs some investment), and seven greens (i.e. at or approaching sustainability and requiring little or no investment). Both the 2019 and 2021 SIDs highlighted the need for targeted above site investments, notably in the domains of Governance, Leadership and Accountability, and Strategic Information. The specific elements characterized as requiring targeted attention via the 2021 SID were civil society engagement, private sector engagement, service delivery, HRH, laboratory, technical and allocative efficiencies, and all elements within the strategic information domain.

The results of the SID 2021 fed directly into the development of the Table 6 investment strategy, which endeavored to ensure that above-site activities were designed to address elements scored as 'emerging sustainability'. Key programmatic barriers were developed by reviewing the SID and other data sources and consulting with the OU's interagency technical teams. The vast majority of systems in Namibia are GRN-owned and -operated, with some support from PEPFAR and the Global Fund. PEPFAR Namibia will not deviate from that paradigm and will continue to build on existing systems and consolidate them to maximize efficiencies where feasible.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

PEPFAR Namibia's COP22 vision for sustaining epidemic control employs an agile and adaptive approach to management, operations and staffing that is aligned with PEPFAR Namibia's focus on preventing new infections and maintaining the treatment cohort. We do this while at the same time being thoughtful about laying the foundation for a sustainable transition post epidemic control by strengthening critical health system capacities.

Each year, PEPFAR Namibia's USG agencies conduct a review during COP planning to examine staffing footprints and associated technical and operational functions. Analysis indicated a need to review and update position descriptions, renew effort to fill all vacant positions and ensure we are investing adequately in the human resources necessary to sustain gains.

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

- The USAID Donor Coordination and Community Care Advisor LES position is currently vacant and will be repurposed to LES Deputy Health Office Director. This new repurposed position will serve as the point person for in the absence of Office Director and coordinating and tracking emerging risks to the health system (drought, COVID-19, etc.
- One of the existing USAID's Regional QA Advisors, LES position is currently vacant and will be repurposed to a USAID Program Management Specialist (Local Partner/Organizational Development). The new repurposed position will provide leadership and expertise level support to enhance local partner transition of PEPFAR program focusing on OVC/DREAMS, and Key Population programs. These new repurposed positions are expected to be filled by the end of FY22 Q4.

There are six positions the team is working to fill:

- CDC's Associate Director for Programs (ADP), formerly titled Clinical Services Branch Chief, was vacated in January 2022. Interviews are ongoing with plans to have the position filled by FY22-end.
- CDC's Associate Director for Science (ADS) remains vacant after the candidate declined the post during our deadly 4th wave of COVID. Interviews are ongoing with plans to have the position filled by FY22-end.
- CDC's Extramural Lead position was vacated in March 2022. Recruitment is ongoing with plans to have the position filled by FY22-end.
- CDC's Epidemiologist position for Pink Ribbon Red Ribbon is being repurposed to support increased needs within our office for surveillance, monitoring and evaluation support. Recruitment will begin in May 2022.
- USAID's Supervisory Health Development Officer (FSO) was vacated in September 2020. Currently on a bidding list to have the position filled by FY22-end.
- USAID's Strategic Information Senior Technical Advisor was vacated in December 2021; identified candidate accepted the offer, to have the position filled by August 2022.

There are two new positions being requested:

- In COP22, with the additional funding from SGAC to strengthen local partner transition, we will be hiring two additional positions in COP22 to facilitate the local partner capacity and local partner transition activity that eventually led to sustainability

COP22 will see a 4% decrease in CODB from $15.4 million in COP21 to $14.7 million in COP22. CODB remained streamlined and flat for State and CDC and decreases for Peace Corps and USAID due to changes to USAID's CODB with the shift of ~$400K to USAID's SA Regional office.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1: Continuous Nature of SNU Prioritization to Reach Epidemic Control

COP15 SNU	SNU Priority COP15	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	COP20 SNU	SNU Priority COP20-COP22
!Karas	2 Hot spots	55%	Andara	ScaleUp Agg	63%	Nyangana	Attained	100%	Namibia Cluster 1	ScaleUp Sat	90%	!Karas	Attained	Andara	Attained
Erongo	2 Hot spots	59%	Eenhana	ScaleUp Agg	72%	Outapi	Attained	100%	Kavango East-West Cluster	ScaleUp Agg	90%	Erongo	Attained	Eenhana	Attained
Hardap	Non-PEPFAR	47%	Engela	ScaleUp Agg	72%	Okahao-Tsandi Cluster	ScaleUp Sat	81%	Tsumeb	ScaleUp Sat	90%	Hardap	Attained	Engela	Attained
Kavango	Priority	84%	Katima Mulilo	ScaleUp Agg	62%	Oshakati-Ondangwa Cluster	ScaleUp Sat	81%	Windhoek	ScaleUp Sat	90%	Kavango	Attained	Katima Mulilo	Attained
Khomas	Priority	61%	Ncamangoro	ScaleUp Agg	92%	Oshikuku	ScaleUp Sat	100%	Katima Mulilo	ScaleUp Agg	90%	Khomas	Attained	Ncamangoro	Attained
Kunene	Non-PEPFAR	48%	Nkurenkuru	ScaleUp Agg	92%	Tsumeb	ScaleUp Sat	90%	Walvisbay	Sustained	90%	Kunene	Attained	Nkurenkuru	Attained
Ohangwena	Priority	64%	Nyangana	ScaleUp Agg	161%	Windhoek	ScaleUp Sat	80%	!Nami#nus-Rosh Pinah Cluster	Sustained	90%	Ohangwena	Attained	Nyangana	Attained
Omaheke	Hot spot	56%	Omuthiya	ScaleUp Agg	105%	Andara	ScaleUp Agg	90%	Gobabis	Sustained	90%	Omaheke	Attained	Omuthiya	Attained
Omusati	Priority	91%	Ondangwa	ScaleUp Agg	76%	Engela-Eenhana-Okongo Cluster	ScaleUp Agg	82%	Grootfontein	Sustained	99%	Omusati	Attained	Ondangwa	Attained
Oshana	Priority	80%	Tsandi	ScaleUp Agg	62%	Katima Mulilo	ScaleUp Agg	73%	Keetmanshoop	Sustained	92%	Oshana	Attained	Tsandi	Attained
Oshikoto	Priority	110%	Okahao	ScaleUp Sat	62%	Ncamangoro-Nkurenkuru-Rundu Cluster	ScaleUp Agg	97%	Okahandja	Sustained	100%	Oshikoto	Attained	Okahao	Attained
Otjozondjupa	3 Hot spots	56%	Onandjokwe	ScaleUp Sat	105%	Omuthiya-Onandjokwe Cluster	ScaleUp Agg	109%	Opuwo	Sustained	90%	Otjozondjupa	Attained	Onandjokwe	Attained
Zambezi	Priority	53%	Oshakati	ScaleUp Sat	76%	!Nami#nus-Rosh Pinah Cluster	Sustained	45%	Otjiwarongo	Sustained	90%	Zambezi	Attained	Oshakati	Attained
			Oshikuku	ScaleUp Sat	90%	Gobabis	Sustained	50%	Swakopmund	Sustained	90%			Oshikuku	Attained
			Outapi	ScaleUp Sat	181%	Grootfontein	Sustained	65%	Karasburg	Ctrl Supported	0%			Outapi	Attained
			Rundu	ScaleUp Sat	92%	Keetmanshoop	Sustained	83%	Khorixas	Ctrl Supported	0%			Rundu	Attained
			Tsumeb	ScaleUp Sat	166%	Okahandja	Sustained	90%	Mariental	Ctrl Supported	0%			Tsumeb	Attained
			Windhoek	ScaleUp Sat	76%	Opuwo	Sustained	48%	Okakarara	Ctrl Supported	0%			Windhoek	Attained
			!Nami#nus	Sustained	41%	Otjiwarongo	Sustained	50%	Omaruru	Ctrl Supported	0%			!Nami#nus	Attained
			Gobabis	Sustained	60%	Rehoboth	Sustained	50%	Outjo	Ctrl Supported	0%			Gobabis	Attained
			Grootfontein	Sustained	59%	Walvis Bay-Swakopmund Cluster	Sustained	77%	Rehoboth	Ctrl Supported	0%			Grootfontein	Attained
			Keetmanshoop	Sustained	81%	Karasburg	Ctrl Supported	0%	Tsumkwe	Ctrl Supported	0%			Keetmanshoop	Attained
			Okahandja	Sustained	89%	Khorixas	Ctrl Supported	0%	Usakos	Ctrl Supported	0%			Okahandja	Attained
			Okongo	Sustained	72%	Mariental	Ctrl Supported	0%						Okongo	Attained
			Otjiwarongo	Sustained	53%	Okakarara	Ctrl Supported	0%						Otjiwarongo	Attained
			Rehoboth	Sustained	58%	Omaruru	Ctrl Supported	0%						Rehoboth	Attained
			Swakopmund	Sustained	79%	Outjo	Ctrl Supported	0%						Swakopmund	Attained
			Walvis Bay	Sustained	79%	Usakos	Ctrl Supported	0%						Walvis Bay	Attained
			Karasburg	Ctrl Supported	0%									Karasburg	Attained
			Khorixas	Ctrl Supported	0%									Khorixas	Attained
			Mariental	Ctrl Supported	0%									Mariental	Attained
			Okakarara	Ctrl Supported	0%									Okakarara	Attained
			Omaruru	Ctrl Supported	0%									Omaruru	Attained
			Opuwo	Ctrl Supported	44%									Opuwo	Attained
			Outjo	Ctrl Supported	0%									Outjo	Attained
			Rosh Pinah	Ctrl Supported	41%									Rosh Pinah	Attained
			Tsumkwe	Ctrl Supported	0%									Tsumkwe	Attained
			Usakos	Ctrl Supported	0%									Usakos	Attained

COP15 SNU	SNU Priority COP15	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	COP20 SNU	SNU Priority COP20-COP22
!Karas	2 Hot spots	55%	Andara	ScaleUp Agg	63%	Nyangana	Attained	100%	Namibia Cluster 1	ScaleUp Sat	90%	!Karas	Attained	Andara	Attained
Erongo	2 Hot spots	59%	Eenhana	ScaleUp Agg	72%	Outapi	Attained	100%	Kavango East-West Cluster	ScaleUp Agg	90%	Erongo	Attained	Eenhana	Attained
Hardap	Non-PEPFAR	47%	Engela	ScaleUp Agg	72%	Okahao-Tsandi Cluster	ScaleUp Sat	81%	Tsumeb	ScaleUp Sat	90%	Hardap	Attained	Engela	Attained
Kavango	Priority	84%	Katima Mulilo	ScaleUp Agg	62%	Oshakati-Ondangwa Cluster	ScaleUp Sat	81%	Windhoek	ScaleUp Sat	90%	Kavango	Attained	Katima Mulilo	Attained
Khomas	Priority	61%	Ncamangoro	ScaleUp Agg	92%	Oshikuku	ScaleUp Sat	100%	Katima Mulilo	ScaleUp Agg	90%	Khomas	Attained	Ncamangoro	Attained
Kunene	Non-PEPFAR	48%	Nkurenkuru	ScaleUp Agg	92%	Tsumeb	ScaleUp Sat	90%	Walvisbay	Sustained	90%	Kunene	Attained	Nkurenkuru	Attained
Ohangwena	Priority	64%	Nyangana	ScaleUp Agg	161%	Windhoek	ScaleUp Sat	80%	!Nami#nus-Rosh Pinah Cluster	Sustained	90%	Ohangwena	Attained	Nyangana	Attained
Omaheke	Hot spot	56%	Omuthiya	ScaleUp Agg	105%	Andara	ScaleUp Agg	90%	Gobabis	Sustained	90%	Omaheke	Attained	Omuthiya	Attained
Omusati	Priority	91%	Ondangwa	ScaleUp Agg	76%	Engela-Eenhana-Okongo Cluster	ScaleUp Agg	82%	Grootfontein	Sustained	99%	Omusati	Attained	Ondangwa	Attained
Oshana	Priority	80%	Tsandi	ScaleUp Agg	62%	Katima Mulilo	ScaleUp Agg	73%	Keetmanshoop	Sustained	92%	Oshana	Attained	Tsandi	Attained
Oshikoto	Priority	110%	Okahao	ScaleUp Sat	62%	Ncamangoro-Nkurenkuru-Rundu Cluster	ScaleUp Agg	97%	Okahandja	Sustained	100%	Oshikoto	Attained	Okahao	Attained
Otjozondjupa	3 Hot spots	56%	Onandjokwe	ScaleUp Sat	105%	Omuthiya-Onandjokwe Cluster	ScaleUp Agg	109%	Opuwo	Sustained	90%	Otjozondjupa	Attained	Onandjokwe	Attained
Zambezi	Priority	53%	Oshakati	ScaleUp Sat	76%	!Nami#nus-Rosh Pinah Cluster	Sustained	45%	Otjiwarongo	Sustained	90%	Zambezi	Attained	Oshakati	Attained
			Oshikuku	ScaleUp Sat	90%	Gobabis	Sustained	50%	Swakopmund	Sustained	90%			Oshikuku	Attained
			Outapi	ScaleUp Sat	181%	Grootfontein	Sustained	65%	Karasburg	Ctrl Supported	0%			Outapi	Attained
			Rundu	ScaleUp Sat	92%	Keetmanshoop	Sustained	83%	Khorixas	Ctrl Supported	0%			Rundu	Attained
			Tsumeb	ScaleUp Sat	166%	Okahandja	Sustained	90%	Mariental	Ctrl Supported	0%			Tsumeb	Attained
			Windhoek	ScaleUp Sat	76%	Opuwo	Sustained	48%	Okakarara	Ctrl Supported	0%			Windhoek	Attained
			!Nami#nus	Sustained	41%	Otjiwarongo	Sustained	50%	Omaruru	Ctrl Supported	0%			!Nami#nus	Attained
			Gobabis	Sustained	60%	Rehoboth	Sustained	50%	Outjo	Ctrl Supported	0%			Gobabis	Attained
			Grootfontein	Sustained	59%	Walvis Bay-Swakopmund Cluster	Sustained	77%	Rehoboth	Ctrl Supported	0%			Grootfontein	Attained
			Keetmanshoop	Sustained	81%	Karasburg	Ctrl Supported	0%	Tsumkwe	Ctrl Supported	0%			Keetmanshoop	Attained
			Okahandja	Sustained	89%	Khorixas	Ctrl Supported	0%	Usakos	Ctrl Supported	0%			Okahandja	Attained
			Okongo	Sustained	72%	Mariental	Ctrl Supported	0%						Okongo	Attained
			Otjiwarongo	Sustained	53%	Okakarara	Ctrl Supported	0%						Otjiwarongo	Attained
			Rehoboth	Sustained	58%	Omaruru	Ctrl Supported	0%						Rehoboth	Attained
			Swakopmund	Sustained	79%	Outjo	Ctrl Supported	0%						Swakopmund	Attained
			Walvis Bay	Sustained	79%	Usakos	Ctrl Supported	0%						Walvis Bay	Attained
			Karasburg	Ctrl Supported	0%									Karasburg	Attained
			Khorixas	Ctrl Supported	0%									Khorixas	Attained
			Mariental	Ctrl Supported	0%									Mariental	Attained
			Okakarara	Ctrl Supported	0%									Okakarara	Attained
			Omaruru	Ctrl Supported	0%									Omaruru	Attained
			Opuwo	Ctrl Supported	44%									Opuwo	Attained
			Outjo	Ctrl Supported	0%									Outjo	Attained
			Rosh Pinah	Ctrl Supported	41%									Rosh Pinah	Attained
			Tsumkwe	Ctrl Supported	0%									Tsumkwe	Attained
			Usakos	Ctrl Supported	0%									Usakos	Attained

APPENDIX B – Budget Profile and Resource Projections

B1. COP22 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP22 Budget by Program Area

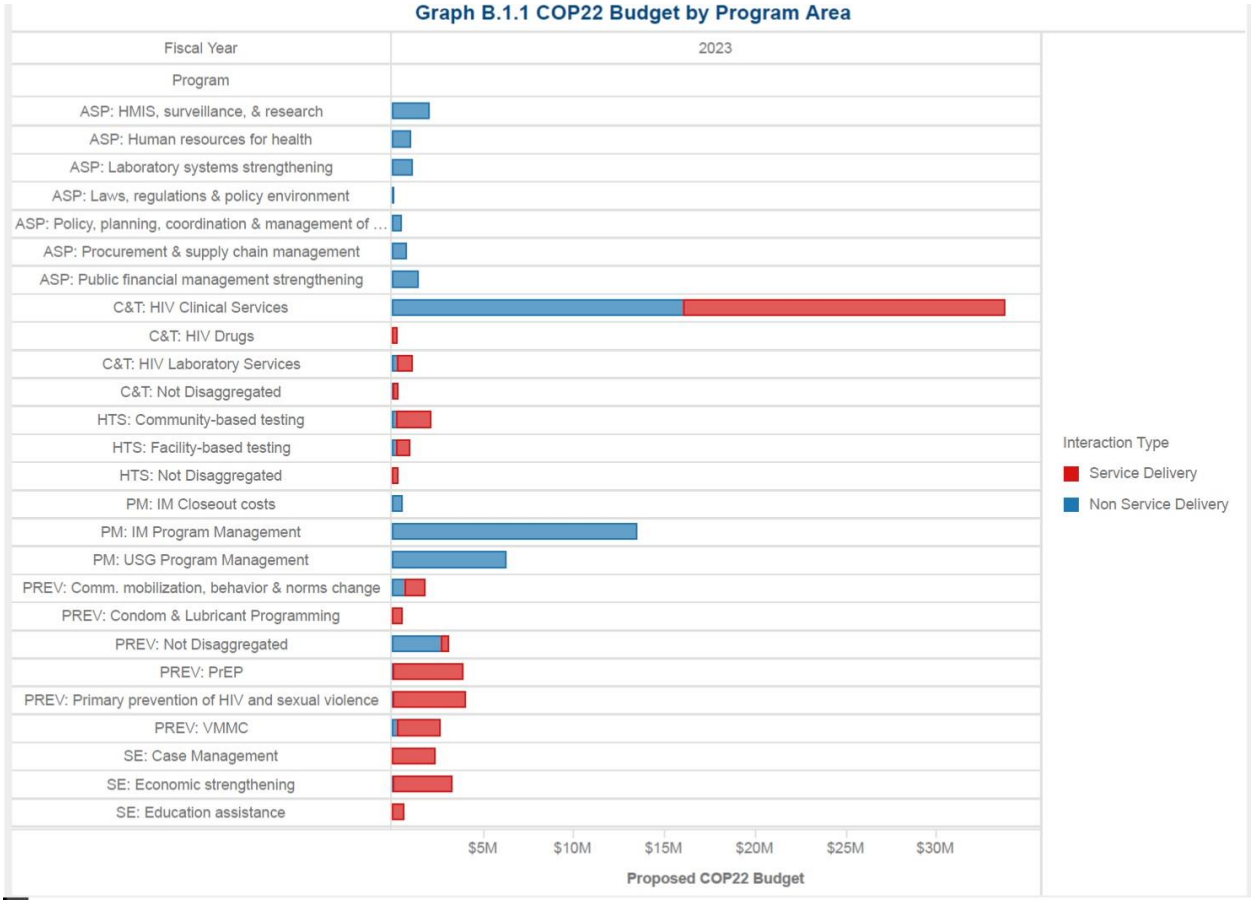


Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		**$48,222,674**	**$42,027,326**	**$90,250,000**	**53%**	**47%**	**100%**
C&T	**Total**	**$16,426,256**	**$18,961,180**	**$35,387,436**	**46%**	**54%**	**100%**
	HIV Clinical Services	$16,033,288	$17,745,873	**$33,779,161**	47%	53%	**100%**
	HIV Drugs		$250,000	**$250,000**		100%	**100%**
	HIV Laboratory Services	$340,424	$735,425	**$1,075,849**	32%	68%	**100%**
	Not Disaggregated	$52,544	$229,882	**$282,426**	19%	81%	**100%**
HTS	**Total**	**$450,000**	**$2,929,999**	**$3,379,999**	**13%**	**87%**	**100%**
	Community-based testing	$200,000	$1,890,262	**$2,090,262**	10%	90%	**100%**
	Facility-based testing	$250,000	$705,737	**$955,737**	26%	74%	**100%**
	Not Disaggregated		$334,000	**$334,000**		100%	**100%**
PREV	**Total**	**$3,796,303**	**$12,143,132**	**$15,939,435**	**24%**	**76%**	**100%**
	Comm. mobilization, behavior & norms change	$666,800	$1,147,815	**$1,814,615**	37%	63%	**100%**
	Condom & Lubricant Programming		$557,633	**$557,633**		100%	**100%**
	Not Disaggregated	$2,670,943	$386,030	**$3,056,973**	87%	13%	**100%**
	PrEP	$81,060	$3,780,990	**$3,862,050**	2%	98%	**100%**
	Primary prevention of HIV and sexual violence	$80,000	$3,912,464	**$3,992,464**	2%	98%	**100%**
	VMMC	$297,500	$2,358,200	**$2,655,700**	11%	89%	**100%**
SE	**Total**	**$537,335**	**$7,993,015**	**$8,530,350**	**6%**	**94%**	**100%**
	Case Management		$2,293,152	**$2,293,152**		100%	**100%**
	Economic strengthening	$55,000	$3,217,240	**$3,272,240**	2%	98%	**100%**
	Education assistance		$615,527	**$615,527**		100%	**100%**
	Legal, human rights & protection	$124,771		**$124,771**	100%		**100%**
	Not Disaggregated	$357,564	$1,361,918	**$1,719,482**	21%	79%	**100%**
	Psychosocial support		$505,178	**$505,178**		100%	**100%**
ASP	**Total**	**$6,703,910**		**$6,703,910**	**100%**		**100%**
	HMIS, surveillance, & research	$2,040,041		**$2,040,041**	100%		**100%**
	Human resources for health	$1,017,500		**$1,017,500**	100%		**100%**
	Laboratory systems strengthening	$1,063,219		**$1,063,219**	100%		**100%**
	Laws, regulations & policy environment	$20,392		**$20,392**	100%		**100%**
	Policy, planning, coordination & management of disease control programs	$433,986		**$433,986**	100%		**100%**
	Procurement & supply chain management	$755,000		**$755,000**	100%		**100%**
	Public financial management strengthening	$1,373,772		**$1,373,772**	100%		**100%**
PM	**Total**	**$20,308,870**		**$20,308,870**	**100%**		**100%**
	IM Closeout costs	$566,960		**$566,960**	100%		**100%**
	IM Program Management	$13,466,936		**$13,466,936**	100%		**100%**
	USG Program Management	$6,274,974		**$6,274,974**	100%		**100%**

Table B.1.3 COP22 Total Planning Level

Table B.1.3 COP22 Total Planning Level

Metrics	Proposed COP22 Budget		
Operating Unit	Applied Pipeline	New	Total
Total	**$9,369,702**	**$80,880,298**	**$90,250,000**
Namibia	$9,369,702	$80,880,298	**$90,250,000**

*Data included in Table B.1.3 should match FACTS Info records and total applied pipeline amount required in PLL guidance.

Table B.1.4 COP22 Resource Allocation by Program and Beneficiary

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary

Operating Unit	Metrics	Proposed COP22 Budget							
	Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total	C&T
Namibia	**Total**	**$35,387,436**	**$3,379,999**	**$15,939,435**	**$8,530,350**	**$6,703,910**	**$20,308,870**	**$90,250,000**	**100%**
	Females	$2,482,655		$10,967,952	$5,038,237	$238,357	$3,895,654	**$22,622,855**	7%
	Key Pops	$774,841	$551,717	$727,816	$170,061	$97,164		**$2,321,599**	2%
	Males			$2,755,700		$50,000	$540,000	**$3,345,700**	
	Non-Targeted Pop	$31,574,124	$2,158,376	$606,060		$6,103,889	$15,873,216	**$56,315,665**	89%
	OVC			$450,000	$3,322,052			**$3,772,052**	
	Pregnant & Breastfeeding Women	$555,816	$669,906	$405,635		$214,500		**$1,845,857**	2%
	Priority Pops			$26,272				**$26,272**	

B.2 Resource Projections

PEPFAR Namibia went through an extensive review of program data and expenditure review data to seek efficiencies towards our stated goal for COP22, which is to sustain the impact of gains in the response to HIV/AIDS in Namibia over the years. Teams were tasked with reviewing their programs with an eye on identifying opportunities for efficiency. The planning process also included reviewing programmatic gaps, taking into consideration government, Global Fund and multilateral partner budgets and interventions. One of the major sources of efficiencies was the consolidation of most HRH into one mechanism to benefit from economies of scales and the local partner's considerable experience and capacity for HRH management.

APPENDIX C – Tables and Systems Investments for Section 6.0

The Key Systems Barriers-E, Table 6-E tab, and SRE Tool-E tab of the Table 6 and SRE Excel workbook should be saved as a PDF and attached here in Appendix C.

The final Excel workbook should be considered a part of the SDS and submitted at the same time.


1 Key System Barriers-E.pdf


2 Table 6-E.pdf


3a SRE Tool-SaSR.pdf


3b SRE Tool - Eval.pdf

APPENDIX D– Minimum Program Requirements

The minimum requirements for continued PEPFAR support include:

Care and Treatment	
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	Status: In Process Issues or Barriers: While significant progress has been made, same day initiation on treatment for newly identified HIV positive patients is 84% and within 7 days it is 90%. Linkage proxy rates remain consistent over several quarters around 80%.
2) Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	Status: In Process Issues or Barriers: Pediatric optimization is near complete with 87% of 0-19 transitioned to a DTG-based regimen.
3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	Status: In Process Issues or Barriers: The majority of patients are on 3+MMD, while 6MMD continues to increase dependent on stock availability.
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	Status: In process Issues or Barriers: There is high TPT coverage; however, a significant number of historic TPT completions have not yet been updated in DATIM resulting in unrealistically high TPT targets for COP21. There is still a need to improve TB case finding through improved screening AND diagnostic testing.
5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results	Status: In process Issues or Barriers: Progress has been delayed by disruptions due to COVID-19, including limited ability to conduct site visits, and to on-board trained staff for coordinator positions.

delivered to caregiver within 4 weeks.	
Case Finding	
6) Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	Status: In process Issues or Barriers: Offer rates for children of index cases continues to be suboptimal, though the release of the MOH circular on testing HIV-exposed children in 2020 has increased pediatric trends. All Index Testing providers trained on safe and ethical Index Testing as well as on LIVES adapted training. Ongoing site support is done to ensure standards are maintained. Although COVID made it difficult to provide adequate support. Issue hindering implementation: COVID 19 Regulations: especially stopping community activities including community Index Testing during periods of community spread. As a result, Index Testing volumes, positives identified dropped and resulting in %yield drops.
Prevention and OVC	
7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)	Status: In process Issues or Barriers: Relatively strong performance given COVID-19 disruptions, but need to continue to scale PrEP for AGYW, KPs, PBFW and partners of index clients. Issue hindering implementation: The current National HIV Clinical guideline is not updated per WHO guideline to start PrEP at 7 days. The National Technical Working group will discuss the WHO recommendations to be included in National guidelines. The Ministry of Health is currently finalizing and implementing a National data base for PrEP data reporting
8) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2)	Status: Completed Issue hindering implementation: None

facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	
Policy & Public Health Systems Support	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	Status: Completed Issue hindering implementation: None
10) Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.	Status: Completed Issue hindering implementation: None
11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	Status: Completed Issue hindering implementation: None
12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Status: Completed Issue hindering implementation: None
13) Clear evidence of agency progress toward local partner direct funding, including increased	Status: Completed. Issue hindering implementation:

funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	None
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	Status: In Process Issues or Barriers: While the Government of Namibia leads and funds the majority of the National Response, economic growth has been weaker than expected and further compounded by COVID-19. This limits the Government's ability to continue to increase its funding toward public health and HIV.
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Status: In process Issues or Barriers: Patient mortality is captured in ePMS as a date of death when it is updated properly; however, the cause of death is not captured. PEPFAR has supported ICD-11 mortality coding to standardize cause of death reporting, to be incorporated in the national e-Death registration system. The goal is to link the national eDeath registration system to ePMS, to improve mortality reporting in HIV data systems.
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	Status: In process Issues or Barriers: Legal, governance, and data security guidelines need to be drafted and approved before the unique health identifier can be linked to national IDs; these have been slow to develop. Within the HIV data systems, a Master Patient Index is being piloted to duplicate patient systems, and in the process create an HIV-specific unique identifier to link to the unique ART number and track patients across systems and facilities.

APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

The government of Namibia funds the bulk of the HIV/AIDS response, and provides strong political leadership in policy formulation, strategy development and oversight as well as service delivery. This has propelled Namibia to near total HIV/AIDS epidemic control, with a tripartite partnership consisting mostly of the government, development partners and civil society actors. In recent years, and awakened by the outbreak of COVID-19, the private sector has emerged as a potential game changer for the sustained impact of the decades long HIV/AIDS response in Namibia.

Namibia has a robust country led HIV/AIDS response based on the best available data and clinical practice guidelines, which has the country on the cusp of epidemic control, one of the first high burden countries to approach epidemic control, with the response having achieved 94-97-93 on the UNAIDS 95-95-95 FAST-TRACK 2030 targets.

Namibia has been able to achieve these goals on a foundation of strong political leadership, robust institutions, consistent investments in the public health system, and a dedicated and competent cadre of health care workers. This is evidenced in the scoring of the SID 2021 for Namibia, with no red scores, and eight out of the fifteen scores being some type of green hue. In general, the SID 2021 suggests that Namibia's HIV/AIDS response still needs some investments, particularly in Governance, Leadership and Accountability, National Health System and Service Delivery, as well as the Strategic Information domains. These are areas except for National Health System and Service Delivery, that PEPFAR Namibia has not previously invested significantly or consistently in, leading to public health support systems that have not kept pace with investments in prevention, and care and treatment programs, which have expanded and innovated to an extent that demands more of the data systems, laboratory systems and supply chain management systems as well as the human resources for health.

Namibia's strategy to sustain the impact of the HIV/AIDS response is premised on two pillars, the first being systems, which include the development, optimization and futureproofing of health support systems such as the supply chain, laboratory, HRH management systems, data management systems. Secondly, to truly sustain the impact of our interventions, there is a need to ensure that the programs supported are scaled-up, optimized or rightsized for a maintenance phase of the response, and that quality management systems, which are the hallmark of the response, are institutionalized and integrated across the public health system, and that a responsible and mindful transition to absolute local ownership of the entire response is orchestrated.

PEPFAR Namibia intends to engage the government of Namibia on this evolution of the HIV/AIDS response through existing technical structures and platforms, such as the Universal Health Coverage Steering Committee and the HIV Sustainability Technical Working Group, while opening a political and diplomatic dialogue on mindful transition to total local ownership.

Misalignments between Investments and Outcomes

PEPFAR Namibia has worked to reduce the misalignment between its investments and public health outcomes, by using the results of the biennial SID process to identify gaps in public health outcomes, particularly for HIV/AIDS as well as the sustainability of service delivery platforms and health system components.

From the last SID, declines in scores for sustainability for planning and coordination, public access to information, technical and allocative efficiencies, financial and expenditure data, and service delivery are a testament of how elements that previously showed robust sustainability can

be vulnerable to external shocks such as new global pandemics putting a strain on the public health system.

The country's key public health management systems such as laboratories, supply chain, surveillance and information management systems were put under immense pressure, although some were considerably compromised, they generally fared better than expected, a testament to the years of investments by government and development partners to ensure a public health system that is able to support sustainable HIV/AIDS epidemic control. These areas received significant investment of ARPA funds to repair damages to the program and to the systems, but will require significantly more investment to ensure that they support and sustain the impact of the response.

There are some gaps in terms of government investment towards the response with donors having primary responsibility for:

- Key Populations;
- Self-testing kits and supplies;
- Male circumcision kits and supplies; and
- Health Workforce training and supervision for HIV/AIDS.
- Some Non-Service Delivery Assistance;
- CSO community health workforce; and
- Strategic Information.

These are also areas that support the first and the last 90s (94 and 93 respectively for Namibia) of the FAST-TRACK goals, with prevention programs linked to testing and health-seeking behavior, and HRH and community health force playing a key role in ensuring continuity of care and improved viral load outcomes.

Program Expenditures vs. SID Score Trends and Responsibility Ratings:

Investments in systems-related (above site programs) intervention initiatives have not been consistent over the years and have often been reactive. Where there has been consistent investment in systems the SID scores have shown an improvement or there has been an arrest of declining scores, accounting for lags in investments in the impact thereof.

Figure E.1.1. Trends in Investments and SID Scores for System-Related Elements

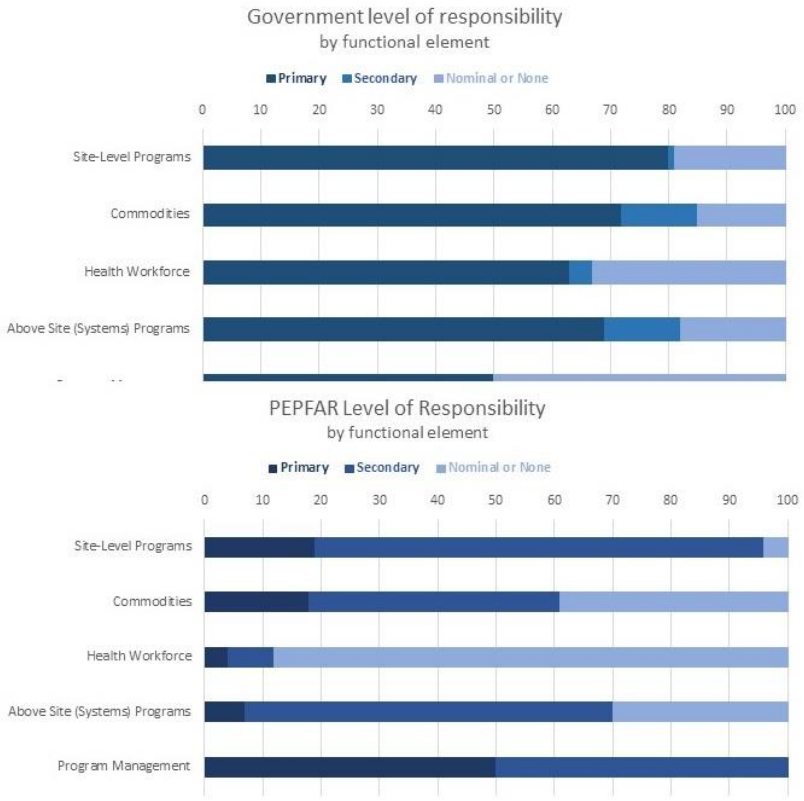
Above Site Investments and Activities Reported in COP Table 6 & SID Trends

Above Site Activities and Budget Reported in Table 6

	COP18	COP19		COP20		Score Over Time
SID Budget Domain	Activities	Activities	Budget	Activities	Budget	
Planning and Coordination				3	$914,250	
Policies and Governance	1					
Public Access to Information		7	$947,500			
Service Delivery	10			5	$450,586	
Human Resources for Health	2	9	$1,219,135	3	$500,000	
Commodity Security and Supply Chain	3	4	$700,000	2	$280,000	
Laboratory	3	1	$700,000	4	$1,700,000	
Technical and Allocative Efficiencies	1					
Epidemiological and Health Data	10			18	$4,328,000	
Financial/Expenditure Data		1	$672,500	1	$100,000	
Performance Data		14	$2,397,643	1	$60,000	
Domestic Resource Mobilization		2	$244,000			

The government of Namibia bears primary responsibility for the majority of the response, but PEPFAR provides significant technical capacity in above-site program, including a role in program quality management.

Figure E.1.2. Primary Responsibility Ratings from Responsibility Matrix



Areas for Transition

As Namibia gets even closer to total epidemic control, the is a need to align programming with the demands of the new reality, by finding efficiencies within existing activities, institutionalizing unique program quality management and improvement approaches, to allow for eventual transitioning of the program to local management, by using data to home in on effective models and enhanced local capacity. Key to this will be reducing HRH footprint without compromising the impact of the response, strategically supporting the government to optimize its workforce.

Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

PEPFAR Namibia has a 19-year-old collaborative relationship with the Government of Namibia, premised on joint annual planning and program implementation using enhanced public health systems and in partnership with community partners where appropriate. An HIV Sustainability framework was jointly developed. The key elements will be the basis of a sustainability roadmap, defining how health system vulnerabilities will be addressed, and how the government will gradually assume more responsibility for those elements of the program primarily supported by development partners. Part of the engagement is around Universal Health Coverage, a model of inclusive and equitable access to quality health care that will ensure that the impact of PEPFAR supported interventions is sustained.

PEPFAR country team members are both members of an HIV/AIDS sustainability TWG and the UHC Steering Committee, two platforms providing the foundation of our sustainability engagements. These engagements ensure that the Government of Namibia can continue to assume greater ownership of the HIV response, while not sacrificing critical health and other program areas to do so.

Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting)

PEPFAR has been engaging with the government on a data sharing agreement to support access to and integrate all public health data systems. By supporting data system integration including a data warehousing architecture, program and service level datasets will be used to tell a story, de-duplicate records and identify patients who were erroneously labelled as “lost to follow-up”, build interactive dashboards on key indicators, offer multi-layer data analysis and triangulation, monitor and evaluate the impact of programmatic changes in a timely manner, and offer the government real-time data dashboards on fixed and mobile devices for timely decision making at all levels from the community level, through the clinical cascade to the national policy level.