PEPFAR

U.S. President's Emergency Plan for AIDS Relief

Namibia
Country Operational Plan (COP) 2020
Strategic Direction Summary
10 March 2020

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Abbreviations and Acronyms

AGYW	Adolescent Girls and Young Women (aged 15-24)
ANC	Antenatal Clinic
APR	Annual Progress Report
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
CAC	Client-led Community Adherence Clubs
CADRE	Cyclical Acquired Drug Resistance Patient Monitoring (CADRE)
CBART	Community Based ART Program
CCBHS	Comprehensive Community Based Health Services
CDC	Centers for Disease Control and Prevention
CMS	Central Medical Stores
CODB	Cost of Doing Business
COP	Country Operational Plan
CSO	Civil Society Organization
DMPPT	Decision Makers Program Planning Tool
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe Women
EDT	Electronic Dispensing Tool
EID	Early Infant Diagnosis
ePMS	electronic Patient Management System
EPOA	Enhanced Peer Outreach Approach
EQA	External Quality Assurance
FAST	Funding Allocation to Strategy Tool
FELTP	Field Epidemiology and Laboratory Training Program (FELTP
FSW	Female Sex Worker
FY	Fiscal Year
GBV	Gender-based Violence
GF	Global Fund
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	Gross National Income
GRN	Government of the Republic of Namibia
HCMS	Human Resources Capacity and Management System
HCW	Health Care Worker
HEI	HIV-exposed Infant
HIVST	HIV Self -Testing
HR	Human Resources
HRH	Human Resources for Health
HTS	HIV Testing Services
HSS	Health Systems Strengthening
IBBS	Integrated Biological and Behavioral Surveillance Survey
ICD	International Classification of Diseases
IEC	Information, Education, and Communication
IHME	Institute of Health Metrics and Evaluation
IMs	Implementing Mechanisms
IPT	Isoniazid Preventative Therapy
ISME	Implementation Subject Matter Experts

KP	Key Populations
LES	Locally employed staff
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDR	Multiple Drug Resistant
MDG	Millennium Development Goals
MER	Monitoring, Evaluation and Reporting
MOHSS	Ministry of Health and Social Services
MSM	Men who have Sex with Men
MTCT	Mother-To-Child Transmission
NAD	Namibian Dollar
NAMPHIA	Namibia Population-Based HIV Impact Assessment
NASA	National AIDS Spending Assessment
NDHS	Namibia Demographic and Health Survey
NEC	New Embassy Compound
NHFA	National Health Force Accounts
NIMART	Nurse-Initiated and Managed ART
NIPH	National Institute of Public Health
NSF	National Strategic Framework
OGAC	Office of the U.S. Global AIDS Coordinator
OPD	Outpatient Departments
OVC	Orphans and Vulnerable Children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counseling
PLACE	Priorities for Local AIDS Control Efforts
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
POC	Place of Care
PrEP	Pre-Exposure Prophylaxis
QA	Quality Assurance
QM	Quality Management
RTK	Rapid Test Kit
SDS	Strategic Direction Summary
SID	Sustainability Index Dashboard
SI	Strategic Information
SIMS	Site Improvement through Monitoring System
SNU	Sub-National Unit
SOP	Standard Operation Procedures
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TA	Targeted Assistance
TB	Tuberculosis
TG	Transgender
TGW	Transgender women
TLD	Tenofivir/Lamivudine/Dolutegravir
TPT	TB Preventative Therapy
TWG	Technical Working Group

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

1.0 Goal Statement

Namibia is estimated to be at 95-95-92 as defined by the UNAIDS 95-95-95 treatment cascade; one of the first high-burden countries to approach epidemic control. COP20 utilizes Namibia's unified PEPFAR program built around structural sustainability to push for success in testing the remaining five percent of people with unknown status, preventing new infections, and retaining more than 175,000 people on treatment.

Primary gaps exist most prominently among those older than 25 being unaware of their HIV-positive status and not on treatment, especially men. The gap of people living with HIV (PLHIV) not on antiretroviral treatment (ART) is concentrated in the larger urban areas in the capital and on the coast. This is probably also influenced by urban migration within Namibia. Prevention measures need to be considered holistically, with particular focus on pregnant and breastfeeding women and their babies, and adolescent girls and young women.

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. This extends to a comprehensive and integrated prevention approach as well, tailored to reach unreached populations or those at highest risk. This structural sustainability model further refined in COP20 is expected to increase domestic ownership, financial responsibility, and quality of care with successful outcomes. This unified program presents Namibia's vision of streamlined, efficient partners, coordinated as one portfolio by the Ministry of Health and Social Services.

Innovative program highlights to address the need in COP20 include:

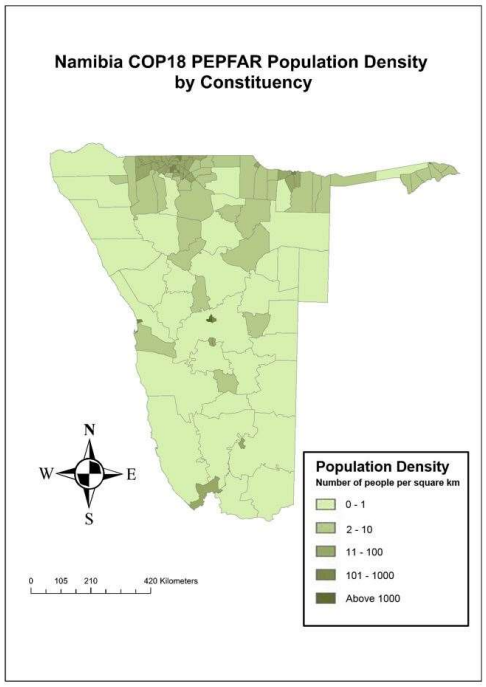
- Applying key retention interventions along the cascade, in those diagnosed, on treatment, who have missed appointments, or are lost to follow up;
- Tracing reasons for missed appointments and ensuring over 98% are re-engaged and confirmed active;
- Improving TLD adherence monitoring through point-of-care urine TDF screening;
- Focusing on pregnant women, a group most at risk of seroconversion;
- Saturate existing five DREAMs districts and expand to four new districts;
- Accelerate and expand community based viral load monitoring interventions under the Differentiated Service Delivery (DSD)
- Scaling community maternal and infant tracing; and
- Using IBBS data to address significant gaps within and improve the KP cascade.

The goal of COP20 is evident: retain PLHIV on treatment and prevent new infections through PEPFAR-Namibia's unified, comprehensive approach using both proven and innovative ways to identify and address populations most at risk. By the end of COP20 PEPFAR Namibia will put an additional 5,290 PLHIV on treatment and ensure 196,784 of the total expected 204,583 PLHIV on treatment will be virally suppressed reaffirming that Namibia is on a truly successful path to sustainability.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Namibia is a sparsely populated desert country of 2.5 million people (Namibia Statistics Agency (NSA), Population Projections 2011-2041) with an area 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 3.63% (CIA Fact Book 2017), and urban population was projected to surpass the rural population for the first time ever in 2019.

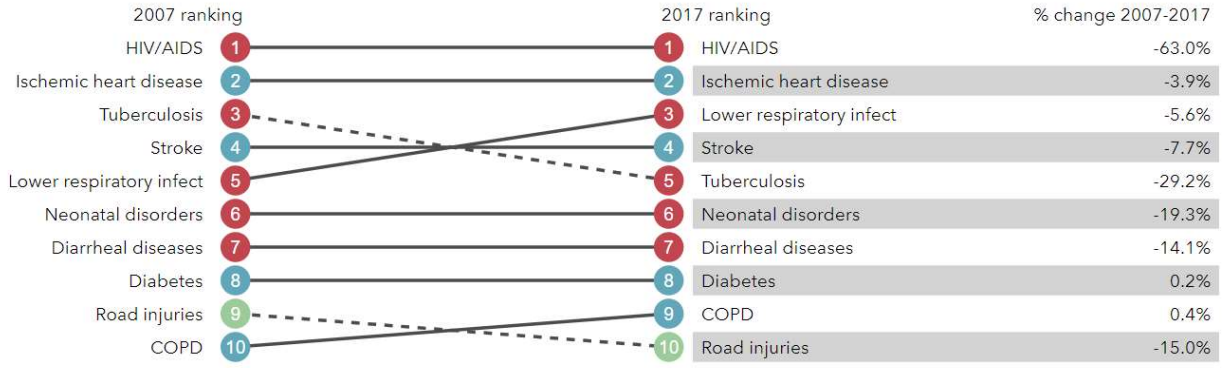


Namibia is an upper-middle income country with a gross national income (GNI) per capita of $ 4,570 (World Bank, 2017), but with starkly unequal income distribution. Namibia's Gini coefficient is 0.61, while its Palma Ratio at 5.8, both near the highest in the world (UNDP HDR statistical update 2018). 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 (MDG) related to access to education, gender parity in education, and health. Impressive results in immunization and nutrition of children have also been achieved, bringing down under-five deaths from 4,200 per year in 1990 to less than 3,000 in 2013: child mortality rates are 45.2 deaths per thousand live births (UN Inter-Agency Group for Child Mortality, 2016). Namibia launched the Sustainable Development Goals agenda in 2016, which build on the MDG and go further in addressing the root causes of poverty and the universal need for development that works for all people.

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

Figure 2.1.2 Top Causes of Death in Namibia (2017)



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

Namibia has been accelerating progress towards HIV epidemic control, and at the end of fiscal year (FY) 19, over 95% of the estimated 208,182 PLHIV in Namibia will be on ART. New HIV infections have halved since 2004, and life expectancy increased by eight years from 56 in 2005 to 64 in 2016 (World Bank). The Government of the Republic of Namibia's (GRN) leadership has also resulted in Namibia achieving high HIV treatment and prevention of mother-to child transmission (PMTCT) coverage levels, and rapidly adopting new international guidelines and best practices. Of note, given the high TB/HIV co-infection rate (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).

HIV Prevalence and Incidence

Namibia has a generalized HIV epidemic, with 8.3% of the general population living with HIV (2020 Spectrum Model). HIV/AIDS will be responsible for an estimated 3,052 deaths in 2020 (see Table 2.1.1), and the disease remains the leading cause of death among adults and the leading cause among 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 19.6% compared to 12.7% for men (see Table 2.1.1). Although limited data are available on sex-specific positivity rates among children, an estimated 0.98% of children under 15 years of age are HIV infected. According to the 2020 Spectrum Model, the highest proportion of estimated new infections is among women older than 25 years, accounting for 36.9% of new infections. Men older than 25 years old are estimated to account for 28.1% of the new infections (2020 Spectrum Model).

The highest estimated incidence is in areas of highest population density, including the Khomas region (where the capital, Windhoek, is situated) and six northern regions. (2020 Spectrum/Naomi Model).

Treatment Coverage

The results from the Namibia Population-Based HIV Impact Assessment (NAMPHIA) survey indicate that most people who test positive for HIV start treatment and generally remain on treatment. 96% of people aware of their HIV-positive status were on ART. That is further supported by NAMPHIA laboratory data that show that 91% of people who report being on ART are confirmed to be virally suppressed. Since the introduction of ART in 2003, the number of PLHIV on ART has increased annually, rising from 75,681 in 2010 to approximately 171,499 in 2019 (see Table 2.1.2). Disaggregated data by age and sex illustrate that the proportional treatment gap is highest among males 15-24 (Figure 2.1.2). The "Treat All" policy, which recommends ART for all PLHIV, was rolled out nationally in 2016 under updated treatment guidelines, and a further update was completed in FY19 to facilitate a full national roll-out of Tenofovir/Lamivudine/Dolutegravir (TLD). Namibia has made incredible strides in its HIV/AIDS response, with a treatment coverage of 95% among PLHIV knowing their status in 2019 (including private sector on treatment).

Prevention of Mother-to-Child Transmission (PMTCT)

PMTCT program data in Namibia shows that almost all (99%) known HIV positive ANC clients are confirmed to be on ART before ANC, and that among newly identified HIV positive clients, all are started on ART in ANC. However, over the course of FY19 a total 1,138 women were newly diagnosed HIV-positive either late in pregnancy or at labor and delivery. This is of major concern, as these mothers are at substantially higher risk of transmitting HIV to their infant. Increased efforts are needed in diagnosing pregnant women earlier in order to start ART with enough time to reach viral suppression before delivery. Namibia is, however, close to achieving a Gold Tier Status by 2023 which translates to <250 cases of MTCT per 100,000 live births. Based on the 2013 Demographic Health Survey, the percentage of pregnant women with four or more antenatal care is just 63%, but delivery in a health center is higher at 87%. PMTCT and early infant diagnosis (EID) services are integrated in all public health sites. In FY19, ART coverage for pregnant women was 93.9%, and antenatal clinic (ANC) coverage (at least one visit) was 101% (see Table 2.1.1).

According to the 2016 HIV sentinel surveillance:

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

Infant HIV case identification through EID is a Namibian policy, but execution remains challenging. The majority of infants (56.5%) had their final HIV status recorded as unknown (APR19). In FY19, PEPFAR Namibia supported 234 sites, addressing >90% of national PMTCT and EID needs.

TB/HIV

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

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

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

HIV Testing Services (HTS)

Namibia has made significant progress in scaling up targeted case finding strategies to all parts of the country and population groups. According to data from NAMPHIA, 86% of adults between the age of 15 and 64 years (79.6% for men and 89.5% for women) who are living with HIV know their status. This shows an improvement from the 75.6% (62.6% for men and 79.6% for women) reported from the 2013 Namibia Demographic and Health Survey (NDHS). Similar to the NDHS 2013, men (age group of 20-29 years) still lag behind in HIV testing uptake. According to Spectrum estimates, 94.5% of PLHIV know their status.

Voluntary Medical Male Circumcision (VMMC)

Modeled national coverage for VMMC among priority age groups of 15-29 years old is 47.7% (Decision Makers Program Planning Tool, DMPPT-2 2019), which is less than the recommended 80% target to achieve a population level impact in epidemic control. The Ministry of Health and Social Services (MOHSS) has scaled up the implementation of an extensive VMMC demand creation campaign. As part of this campaign, PEPFAR Namibia, in collaboration with MOHSS, worked with a popular Namibian musician to promote the benefits of VMMC and increase uptake among young people aged 15-29 years. Promotional concerts were conducted during the high VMMC season from May to September. Due to expansion of service access and demand generation efforts, the PEPFAR VMMC program has seen a 28% increase in VMMC coverage. At the end of FY19, the PEPFAR program reported a record number of circumcisions: 40,465 men (above 10 years of age), (Annual Progress Report [APR] 2019). PEPFAR Namibia's COP20 target will rapidly saturate VMMC services among priority age bands (15-29) in 7 regions (Khomas, Zambezi, Oshana, Ohangwena, Omusati, Erongo and Karas) to 75% VMMC coverage.

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 UNAIDS Spectrum 2020 estimates, Namibia has roughly 11,000 children under the age of 15 living with HIV. Spectrum 2019 estimates the number of orphans who are either single or double orphaned to be 35,029. Among 15-19 year olds, 56.6% of girls and 74.2% boys had never been tested for HIV (NDHS, 2013). With increased ART coverage, children are living longer, requiring sufficient HIV prevention interventions. In FY19 Q4, there were 9,593 children 0-14 years on ART, leaving a treatment gap of roughly 1,500 children in need of identification, linkage and ART care. These children will be targeted for interventions by the OVC program.

According to the World Bank, Namibia is one of the most unequal countries in the world and this slows the pace of poverty reduction. Unemployment has remained stubbornly high at 34.0% of the working population in 2016 and is higher among women (38.3%) and the youth (43.4%) (World Bank). 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, according to the National Statistical Agency of Namibia, 204,162 children were on social grants in 2016 and 58% eligible are not receiving grants. 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. Partly due to cultural and economic gender inequalities, women and girls are the most affected by the HIV epidemic, with some unable to protect themselves from HIV. Cultural norms that inhibit health seeking behaviors in men and boys also contribute to HIV risk. According to the 2013 DHS, one in three (32%) women aged 15-49 has experienced physical violence since age 15, and 14% of women in this age group experienced physical violence in the 12 months prior to the survey. Seven percent of women aged 15-49 experienced sexual violence since age 15, and four percent experienced sexual violence in the 12 months prior to the survey. Women who are not employed or are less educated are more likely to have experienced sexual violence. While the GRN has approved a number of progressive laws and policies to address inequalities between men and women, full implementation is difficult due to limited allocation of financial and human resources.

In addition, the Violence against Children Survey (VACS) Final Report will be released by the MGECW in FY20, and will provide recommendations to relevant Namibian ministries, and international and national non-governmental organizations on developing, improving and enhancing prevention and response strategies to address violence against children as part of a larger, comprehensive, multi-sectoral approach.

Key Populations

Key populations (KP) in Namibia, especially men who have sex with men (MSM), female sex workers (FSW), and transgender women (TGW) are at high risk of HIV. Based on the Namibia Integrated Biological and Behavioral Survey (NAM-IBBS) conducted in 2019, HIV prevalence was high among FSW: 20.9% in Windhoek, 21.2% in Walvis Bay and 43.6% 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% vs.7.2% in Khomas (Windhoek) and 9.7% vs. 7.5% in Erongo (Walvis Bay/Swakopmund), respectively. Approximately 60% of MSM testing positive for syphilis were also HIV-positive. Coverage of ART among KPs who had known HIV status was comparable to estimates from NAMPHIA but viral load suppression rates were low; among FSW, viral load suppression was 52.4% in Windhoek, 31.2% in Walvis Bay and 75.5% in Katima Mulilo. Viral load suppression among MSM was 76.1% in Windhoek and 55.8% in Walvis Bay.

The NAM-IBBS findings differ from programmatic results. In FY19 programmatic data showed a strong linkage to treatment and high viral load suppression rates. In FY20, PEPFAR supported programs showed 96% linkage to treatment among diagnosed KPs and 94% viral load suppression rate. The NAM-IBBS provided additional information on population size estimates for all three study sites for FSW, MSM and TG people, meaning we can see that the high rates of successful outcomes for those reached through KP programs are only representing a small portion of those overall populations. In FY21 PEPFAR Namibia will use the findings from the NAM-IBBS to further expand and reach new hidden groups, improve case finding and linkage to treatment strategies for KP in Namibia.

Pre-Exposure Prophylaxis (PrEP)

Namibia included PrEP in its National Strategic Framework for HIV (2017/2018-2021/2022) and granted regulatory approval for tenofovir disoproxil fumarate (Ricovir-M) in May 2017. PEPFAR Namibia provided technical assistance to support the adoption of PrEP in the national guidelines in 2016 and a scale up of coverage in 2017. In FY18 a major PrEP program scale-up focusing on Adolescent Girls and Young Women (AGYW), KPs, and serodiscordant couples resulted in 4,702 people being put on PrEP; and FY19 saw a dramatic increase with 10,583 people accessing PrEP. Namibia now also boasts of a robust National PrEP M&E framework.

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 (2019) highlighted human resources for health (HRH) as a primary vulnerability, and Namibia requires implementation of a human resource staffing structure for the MOHSS that is responsive to the demands of the epidemic. The government is hampered by the fact that there is a hiring freeze meaning that adding positions is not possible. While the overall size of the civil service is bloated, at facility level this is often a problem and the lack of flexibility is a severe challenge to ensure the necessary HRH is available. Policy and operational interventions are required. Other health system components that require strengthening are private sector and civil society engagement, HIV commodity and supply chain systems, and the health information and surveillance system, particularly recent infection surveillance.

Table 2.1.1 Host Country Government Results

	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	2,535,093	100%	466,202	18.4%	466,106	18.4%	243,995	9.6%	240,305	9.5%	592,833	23.4%	525,652	20.7%	Population Projections 2011-2041. Namibia Statistics Agency; Spectrum Naomi Model
HIV Prevalence (%)		8.26%		0.98%		0.98%		4.56%		2.67%		19.59%		12.69%	Spectrum, Jan 30, 2020
AIDS Deaths (per year)	2,535		69		70		170		157		1,189		880		Spectrum, Jan 30, 2020 Spectrum, Jan 30, 2020 Spectrum, Jan 30, 2020
# PLHIV	209,499	100%	4,548	2.2%	4,555	2.2%	11,133	5.3%	6,409	3.1%	116,140	55.4%	66,714	31.8%	Spectrum, Jan 30, 2020
Incidence Rate (Yr)		0.23%						0.46%		0.19%					Spectrum, Jan 30, 2010; NAMPHIA 2017*
New Infections (Yr)	5,331		171		173		1,066		450		1,971		1,500		Spectrum, Jan 30, 2020
Annual births	85,946	100													Estimated from annual birth rate and population projection

% of Pregnant Women with at least one ANC visit	86,624	101%													Namibia Program Data
Pregnant women needing ARVs	12,505	14.4%													Namibia Program Data
Orphans (maternal, paternal, double)	36,174														Spectrum, Jan 30, 2020
Notified TB cases (Yr)	7,770														National Tuberculosis and Leprosy Program (NTLP) 2017 Annual Report
% of TB cases that are HIV infected	2,536	32.64%													
% of Males Circumcised		37%				19%				48%				42%	Namibia Program Data
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**														

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*** (#)	**PLHIV diagnosed**** (#)	**On ART***** (#)	**ART Coverage (%)**	**Viral Suppression (%)*****	**Tested for HIV***** (#)	**Diagnosed HIV Positive***** (#)	**Initiated on ART***** (#)
Total population	**2,535,093**	8.3%	**209,499**	201,941	171,499	84.9%	89.4%	488,963	15,894	*13,598*
Population <15 years	**932,308**	1.0%	**9,103**	8,830	9,593	108.6%	63.2%	38,801	508	*561*
Men 15-24 years	**240,305**	2.7%	**6,409**	6,217	3,448	55.5%	99.5%	35,180	479	*387*
Men 25+ years	**525,652**	12.7%	**66,714**	64,713	49,709	76.8%	88.9%	102,664	4,919	*4,560*
Women 15-24 years	**243,995**	4.6%	**11,133**	10,688	10,047	94.0%	73.8%	98,918	2,367	*2,133*
Women 25+ years	**592,833**	19.6%	**116,140**	111,494	98,702	88.5%	93.3%	213,400	7,621	*5,957*
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)	2189	154	*157*
FSW	2,440** (Windhoek)	20.9%** (Windhoek)	510**(Windhoek) 206**	251** (Windhoek)	183** (Windhoek)	72.9%** (Windhoek)	52.4% (Windhoek)	9349	564	*578*

	970** (Walvis Bay/Swakopmund) 890** (Katima Mulilo)	21.2%** (Walvis Bay/Swakopmund) 43.6%** (Katima Mulilo)	(Walvis Bay/Swakopmund) 388** (Katima Mulilo)	106** (Walvis Bay/Swakopmund) 100** (Katima Mulilo)	95** (Walvis Bay/Swakopmund) 97** (Katima Mulilo)	89.8% (Walvis Bay/Swakopmund) 96.7% (Katima Mulilo)	31.2% (Walvis Bay/Swakopmund) 75.5% (Katima Mulilo)			
PWID	N/A									
Priority Pop (specify)	N/A									

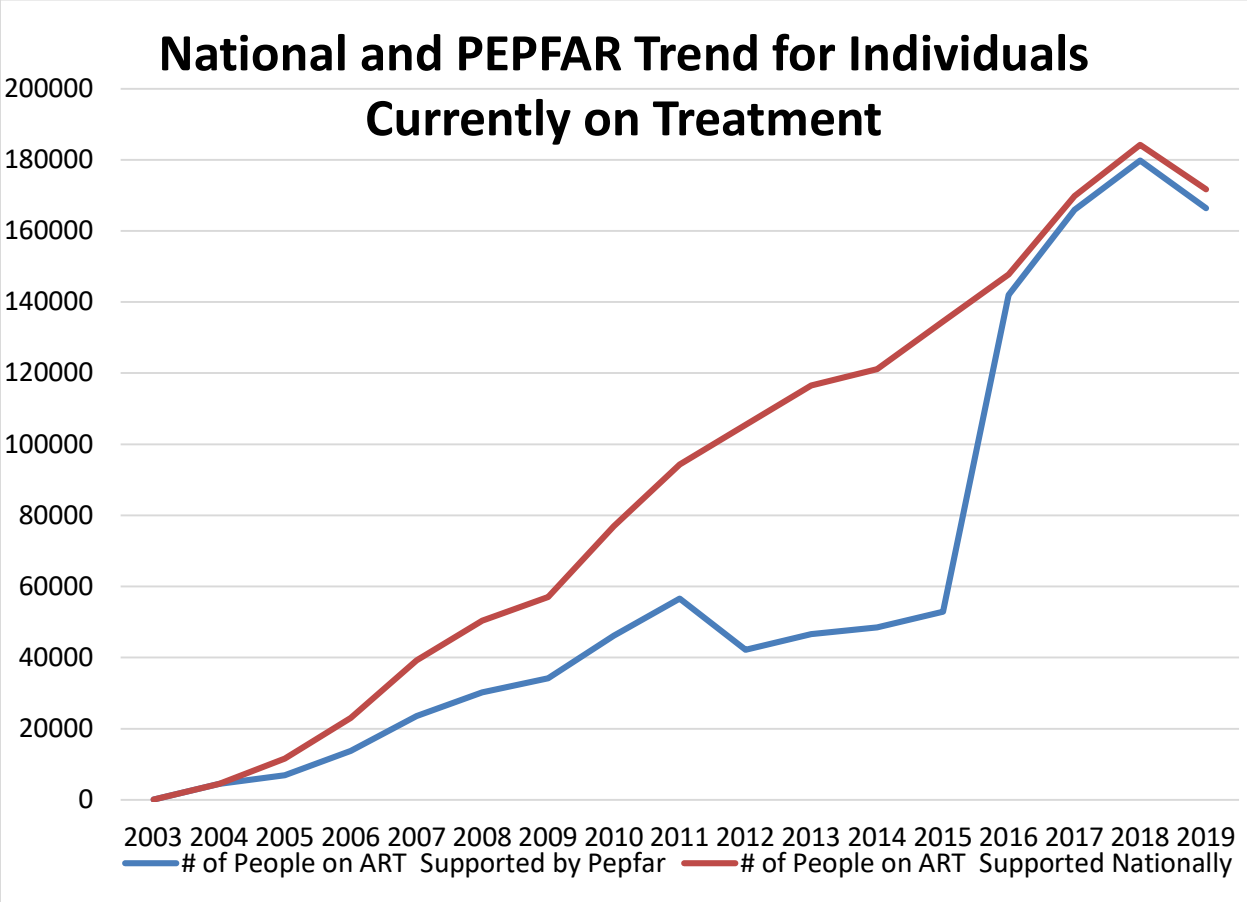
* UNAIDS 2020 Naomi District Estimates, 27Jan2020

**IBBS, 2019
*** MOHSS Program Data incl NIP, not including private sector

****Spectrum Policy Modeling System, Version 5.84 (2020); Namibia model Jan 27 2020

Figure 2.1.1 Updated National and PEPFAR

Trend for Individuals currently on Treatment



2.2 New Activities and Areas of Focus for COP20, Including Focus on Client Retention

PEPFAR Namibia's major drive for COP20 is reaching epidemic control through a unified and integrated clinical cascade primed to identify and address recent infections, ensure that all HIV positive people are put on treatment and remain on treatment, virally suppressed. This is an approach we have termed "structural sustainability", as it entrenches the whole response within the public health approach of the Ministry of Health and Social Services, regardless of whether interventions are at the facility level or community level or whether they are being implemented by the government or private and civil society partners. One of the new interventions for this integrated approach to the clinical cascade is the "Fiver System of Integrated Community Care", where small integrated teams of 5, called "fivers," are embedded in each district. Within the teams, individual field staff manage index partner testing and linkage, while others perform ART and ANC client tracing and managing community adherence groups. Fiver teams will be able to respond nimbly to the particular epidemiology and needs of each area, shifting from case finding to tracing in saturated areas and back to index testing where gaps are found, nationally. Namibia's retention interventions span the clinical cascade from the point that an individual is diagnosed, and are designed to be both preventive of loss, and responsive to times when patients miss their appointments or leave the treatment cascade.

Over the course of FY19 a total 1,138 women were newly diagnosed HIV positive either late in pregnancy, after a previous HIV negative result at their first ANC visit, or newly diagnose at labor and delivery. This contributes to nearly 10% of all PMTCT clients seen in FY19. This is of obvious concern, as these infants are at a substantially higher risk of seroconversion affecting the MTCT rate in Namibia. Additionally, this affects Namibia's ability to achieve Gold Tier Status of eMTCT by 2023. Innovative efforts are needed to decrease the rate of new maternal HIV infections. Namibia has piloted a community-based maternal tracking program that identified pregnant women who had not enrolled into ANC care with unknown HIV status, the program has shown promising results, and with Ambition Funds, this program will be formally implemented nationwide in COP20. Another nascent program address PMTCT shortfalls is the tracking of HIV-positive breastfeeding mother-baby pairs, making sure mothers are retained on ART and virally suppressed. The program with limited geographical scope has achieved 100% maternal retention and 0% of infants positive at 18 months. With COP20, we propose to formalize this tracing program to ensure HIV-positive breastfeeding women are actively tracked at community level.

For COP20 the goal is to eliminate mother-to-child transmission. We will achieve this goal through community tracing of pregnant women, as well as other structural and programmatic quality initiatives. Adjacent to this, Namibia will complete the transition to TLD in COP20, including the complete phasing out of Nevirapine based regimens.

In COP20, Namibia will optimize the laboratory diagnostic network and close the coverage gaps for infant virologic testing and viral load. Firstly, by decentralizing infant testing to molecular laboratories and priority GeneXpert sites will address the poor EID final status documentation seen that has plagued the program. Secondly, by developing an integrated national sample referral system to enhance sample integrity, track turnaround times, and ensure results are returned to the facility and the client. Currently, over 40% of health facilities have viral load suppression of at least 95%, and through site level analysis and an understanding of viral load testing coverage, PEPFAR Namibia has identified a number of high volume sites to target for improvement of viral load coverage and improved viral load suppression outcomes.

In COP20, Namibia will saturate existing DREAMS districts, and deepen the quality of programming, with an increased emphasis on economic strengthening and PrEP provision. Economic strengthening pathways that helm our interventions will include school re-enrollment, employability, and entrepreneurship promotion. Additionally, we will expand to 4 new districts. PEPFAR will also collaborate with the MGECW in a government-to-government agreement to enhance country-level sustainability.

For COP20, Namibia will strengthen community ART monitoring mechanisms through community Adherence Groups (CAGs); providing adherence counseling, community level TB screening and referrals for stable patients differentiated services delivery.

2.3 Investment Profile

The Namibian government is responsible for the majority of health financing, contributing more than 55% of the costs of the multisectoral HIV/AIDS response. The government also procures more than 88% of all HIV/AIDs related commodities. Donors have supported some emergency commodities procurement on request of the government due to protracted government procurement system and owing to the practicality of pooled procurement for some low volume commodities such as pediatric ARVs, with orders not being of sufficient quantity to fill a manufacturing batch. Donors also played an outsized hand in the provision of Human Resources for Health, with more than 1500 health care workers supported across the country, the majority of whom are lay workers (health assistants, data clerks, etc.), but critical clinical staff (doctors and nurses) making up a significant portion (17%) of all HRH supported by donors. Related to HRH, donors fund 76% of HIV/AIDS related training. The HRH investment has been necessitated by the limited quantity and capacity of HRH to deliver comprehensive HIV services in Namibia. Another area favoring donor support is health systems strengthening and program coordination, for which donors provide 73% of the resources, most of it going towards program management of infectious diseases (HIV/AIDS, Malaria, Tuberculosis) and surveillance, research and evaluations.

In recent years, we have executed on a stepwise approach to prepare for eventual sustained epidemic control. In COP18, we supported the Ministry of Health and Social Services to develop the Sustainability Framework for HIV. The now-finalized framework serves as an umbrella document for the response, with key milestones and actions to reach sustainability. PEPFAR also supported the Ministry to develop a minimum package of services for HIV, establishing a list of services essential to sustain epidemic control. We continue to work with our counterparts at the Ministry to advocate for and implement initiatives that address inefficiencies in the HIV response. With health spending near the standard of 15% of government expenditures, the sector needs to achieve better results with the resources it already has. Greater utilization of the private sector and of civil society organizations are options worthy of consideration.

PEPFAR Namibia will support the MOHSS to optimize existing HRH planning to meet the demands of an ever-evolving epidemic. In COP20 PEPFAR will support the development of a Human Resources Information System (HRIS) developing a system that will remove one of the final barriers to efforts at HRH rationalization and sustainability planning for the future of the response. The HRIS will allow for a more strategically deployed and maintained workforce to serve and retain the treatment cohort. This investment is part of a broader sustainability framework, with motivates as a first priority to identify critical functions and HRH gaps to achieve and maintain epidemic control; with the second priority being to support the Ministry of Health and Social Services to make a case for investment in critical HRH to the Ministry of Finance; and the third priority being to engage private sector and civil society organizations to fill critical functions in a public good partnership with the government. PEPFAR's interventions in COP20 will be focused on how to optimize the workforce going forward, ensuring the delivery of client-centered HIV services.

To improve the supply chain management system and reduce the number of emergency procurement request directed at donors, PEPFAR will provide support to the government aimed at strengthening in-country procurement and tender management systems, through framework contracts and pooled procurement. PEPFAR will also support the full roll-out of multi-month dispensing of ARVs to reduce the burden on the supply chain management systems including distribution and storage of commodities, and to declog health facilities, by reducing the number of patients who come in for pill pick-ups.

In 2018/19, donors supported limited procurements upon request from the government, including adult ARVs (by GF), and pediatric ARVs and anti-TB medicines (by PEPFAR). Given the ongoing recession in Namibia and corresponding fiscal constraints, PEPFAR will continue to support emergency procurements on a limited basis. This includes TLD, anti-TB medicines, and small batch items that are difficult to procure, like pediatric ARVs. Additionally, PEPFAR will procure drugs and test kits in COP20 to support PrEP expansion.

Table 2.3.1 Annual Investment Profile by Program Area, in USD, 2017/18

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

Table 2.3.2 Annual Procurement Profile for Key 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 is intentionally left blank, as PEPFAR Namibia does not receive any non-PEPFAR funding or co-funding.

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

2.4 National Sustainability Profile Update

The 2019 Sustainability Index and Dashboard (SID) was completed using a highly participatory approach and in collaboration with the Joint United Nations Program on HIV/AIDS (UNAIDS). PEPFAR held a national stakeholder meeting to validate the SID, where 60 multisectoral stakeholders from government, bilateral and multilateral development partners, civil society and the private sector provided robust feedback on the state of the response's sustainability. Although the SID continues to assess Namibia's HIV/AIDS response as trending towards sustainability, the country has experienced declining growth in recent years, and is operating in a constrained fiscal environment, which can be observed in slightly decreased score for laboratory services and commodity security and supply chain, all related to strained finances. Ten out of the seventeen elements expressed sustainability vulnerabilities, and needing some investment, including: HRH; laboratory; public access to information; civil society engagement; private sector engagement; service delivery; and the whole strategic information domain (see Figure 2.4.1). Of the remaining seven elements, five scored light green and two dark green, indicating that they did not exhibit any significant sustainability vulnerabilities.

While on average the SID showed a slight decline in scores since the 2017 version, most of the declines could be linked to a tougher operating environment due to fiscal constraints and a persistent drought. Namibia has shown great leadership in taking ownership of the integrated multisectoral response to HIV/AIDS, and has been vindicated in recent years with no loss of the gains achieved throughout the years even under tougher operating environments. The government develops and implements a progressive and comprehensive national Strategic Framework for HIV/AIDS (NSF), which is the basis for the response in the country, with development partners (including PEPFAR) and other key stakeholder aligning their own operational plans with this framework. The NSF is being reviewed in 2020 to allow it to respond to new developments in epidemic control, and to reflect the strides Namibia has taken in its response since the current NSF was launched in 2017.

Certain categories and localities of HRH rely heavily on donor funding and expatriates to fill positions. Key HRH weaknesses in the SID 4.0 included: inadequate distribution of health

workers across all facilities and across the public and private sector; the lack of a plan to transition donor-supported HRH to the GRN; and, not fully using HR data for HRH planning and management. A number of health professionals hired by donors as part of PEPFAR's "Treatment Acceleration Plan" remain off the MOHSS' approved staffing structure and a significant number of GF HRH positions ceased to be funded on December 31, 2017, with PEPFAR having filled the gap by supporting a number of critical positions previously funded by GF. Namibia's public health sector operates on outdated Human Resources for Health structure, which is not always responsive to the needs of the country's HIV/AIDS response.

In COP18 PEPFAR had conducted an inventory of all donor supported positions (1533), and in COP19 is supporting the government in scoping optimization options for its HRH, part of this optimization will be support for the development of a HRIS in COP20. The compensation levels of PEPFAR-supported HRH map fairly well to equivalent government cadres, indicating that drastic differences in compensation may not pose as significant an obstacle in Namibia as in many other PEPFAR countries.

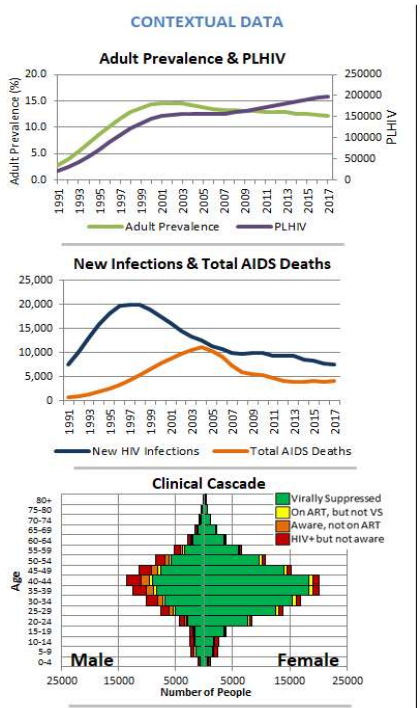
Figure 2.4.1 Sustainability Index Dashboard (SID 2019)

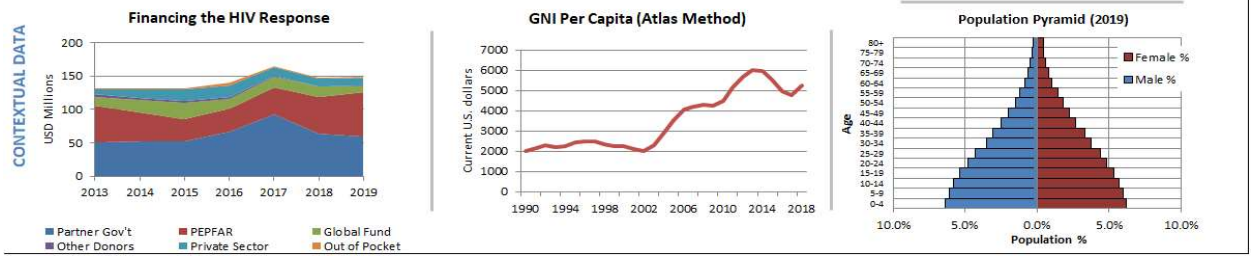
Sustainability Analysis for Epidemic Control: Namibia

Epidemic Type: Generalized
Income Level: Upper middle income
PEPFAR Categorization: Targeted Assistance (Co-finance)
PEPFAR COP 19 Planning Level: $ 81,477,205

SUSTAINABILITY DOMAINS and ELEMENTS

	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	8.20	9.50	8.83	
2. Policies and Governance	6.32	7.55	7.71	
3. Civil Society Engagement	6.83	6.33	5.17	
4. Private Sector Engagement	5.54	4.21	4.32	
5. Public Access to Information	6.00	5.00	6.56	
National Health System and Service Delivery				
6. Service Delivery	5.93	7.31	6.37	
7. Human Resources for Health	5.08	6.88	5.85	
8. Commodity Security and Supply Chain	6.93	8.07	7.14	
9. Quality Management	7.76	7.10	7.10	
10. Laboratory	8.01	8.92	6.78	
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	8.06	7.10	8.13	
12. Technical and Allocative Efficiencies	5.12	7.78	7.00	
13. Market Openness	N/A	N/A	10.00	
Strategic Information				
14. Epidemiological and Health Data	5.62	5.80	5.34	
15. Financial/Expenditure Data	6.67	7.50	6.67	
16. Performance Data	6.78	6.09	5.87	
17. Data for Decision-Making Ecosystem	N/A	N/A	5.17	





A government-wide general hiring freeze remains in place, with special waivers required to fill positions. The MOHSS has sought to manage the hiring freeze by repurposing positions from areas that are sufficiently staffed or over staffed to areas of critical need. Namibia's health training universities and institutions continue to produce medical doctors, nurses, and pharmacists, but they are relatively small in number and graduates do not have specialized or practical experience. In COP19, PEPFAR Namibia successfully realigned some programmatic areas, shifting specific technical areas to the direct management of one agency. This realignment also brought most of PEPFAR's activities under the direct execution of the MOHSS or local partners.

The SID identified several weaknesses in the supply chain, most notably stock outs and low stock for critical commodities and medicines however minimal but including condoms. The Namibian government must be acknowledged for its efforts to ensure HIV commodity security, including procurement of greater than 95% of the ARVs in 2019. Their commitment is evident by the result of no national stockouts of first-line adult ARVs in over 10 years. PEPFAR and Global Fund have played an important role in filling gaps for stockouts of other HIV commodities when needed. With technical assistance from PEPFAR, MOHSS finalized a pooled procurement of vaccines from UNICEF in December at a savings of almost 1 million US dollars. If these mechanisms were fully maximized, the Ministry would stand to achieve significant savings of over US $7 million in the future. In COP20 PEPFAR will support the government in accelerating the implementation of multi-month dispensing of ARVs, characterized by routine 6 months refills of ARVs reducing the burden on the supply chain management systems, particularly regarding the distribution and storage of ARVs at the regional, district and site level; and reducing the frequency of patient visits to clinics for refills.

The SID 4.0 assessment revealed that while the framework exists for the engagement of both civil society and the private sector, there are missed opportunities in actualizing the multisectoral response. Stakeholders voiced concern that civil society coordination was not comprehensive, and that engagement particularly at the subnational level could be improved to be more inclusive of key and vulnerable populations. PEPFAR is working with the UN in supporting the MOHSS in developing a social contracting framework, as in COP20 will be sub-awarding resources from its cooperative agreement to local partners, creating a model for future private sector and civil society engagement and partnership. In COP19 PEPFAR Namibia support GRN to lay the groundwork for sustainable epidemic control, including defining and costing a minimum package of services, and will be undertaking a will be undertaking a broader activity-based costing exercise, that will provide site-level and above-site costs for delivering HIV services.

Access to information remains a weak point in the response. This includes access to information and data within the MOHSS for improved program analysis. Without these data, program managers and implementers are not able to make course adjustments for greater impact and efficiency. Epidemiological data are supported by donors and is considered a sustainability and capacity vulnerability. PEPFAR has partnered with the MOHSS to develop several fact sheets covering a variety of HIV/AIDS programs and activities, including a publicly available summary sheet of the NAMPHIA findings. PEPFAR will work with the government in improving access to information through the development and management of public health information repository.

Through its stakeholder engagement and sustainability interagency technical teams (ITTs), PEPFAR Namibia has held several stakeholder engagements meetings in COP19, including

additional engagements on the portfolio realignment process, and with organizations representing key Populations; the Medical Association of Namibia, representing medical practitioners; and the Namibia Association of Medical Aid Funds (NAMAF), who coordinates medical aid in Namibia. Other activities include working with private health service providers on VMMC and exploring avenues for private pharmacy dispensing of publicly procured ART and PrEP.

PEPFAR Namibia continues to work with the government and other donors to stabilize operations at the Namibia Institute of Pathology (NIP), and will continue to support the operational sustainability of Namibia's public laboratory system, including more the decentralization of EID testing to VL labs. A big focus in COP20 will be a drive for diagnostic network optimization, and the improvement of specimen tracking, transport and results return.

2.5 Alignment of PEPFAR investments geographically to disease burden

For COP20, improved program and national data have further refined the understanding of the epidemic and informed strategies to close the gaps. Figure.2.5.1 shows Namibia's population distribution geographically, which shows that most of the Namibian 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 density of population.

Figure 2.5.3 shows ART Coverage by District and Figure 2.5.4 shows ART Coverage Gap by District. In the highest burden regions along the norther border where PEPFAR has invested the most, indicates a high coverage of ART (Omusati, Oshana, Ohangwena, Oshikoto, Kavango West, Kavango East, Zambezi). However, in the most urbanized and affluent areas, there exists a larger treatment gap than anticipated that is partly filled by the 22,000 ART clients in the private sector (Khomas, Erongo). Finally the regions that are low prevalence and low population but also have the lowest treatment coverage rates, are where there is increased support with more focused technical assistance in COP19 and COP20 (Kunene, Omaheke, Hardap, !Karas). Figures 2.5.5 and Figures 2.5.6 show ART Coverage Gap by sex. These maps show gaps that mirror the overall population maps, with some remaining gaps showing up in the northern border for both males and females. Figure 2.5.7 shows ART Coverage Gap by age, which demonstrates the same potential gaps in the urban areas. Additionally, the younger aged and older aged gaps appear again in areas of the north.

Figure 2.5.8 shows viral load coverage by region. This data demonstrates good viral load coverage rates in most regions with some potential gaps existing in some regions.

Figure 2.5.9 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 (Keetmanshoop, Rehoboth, Gobabis, Khorixas and Otjiwarongo).

Figure. 2.5.1 Namibia's Population Distribution

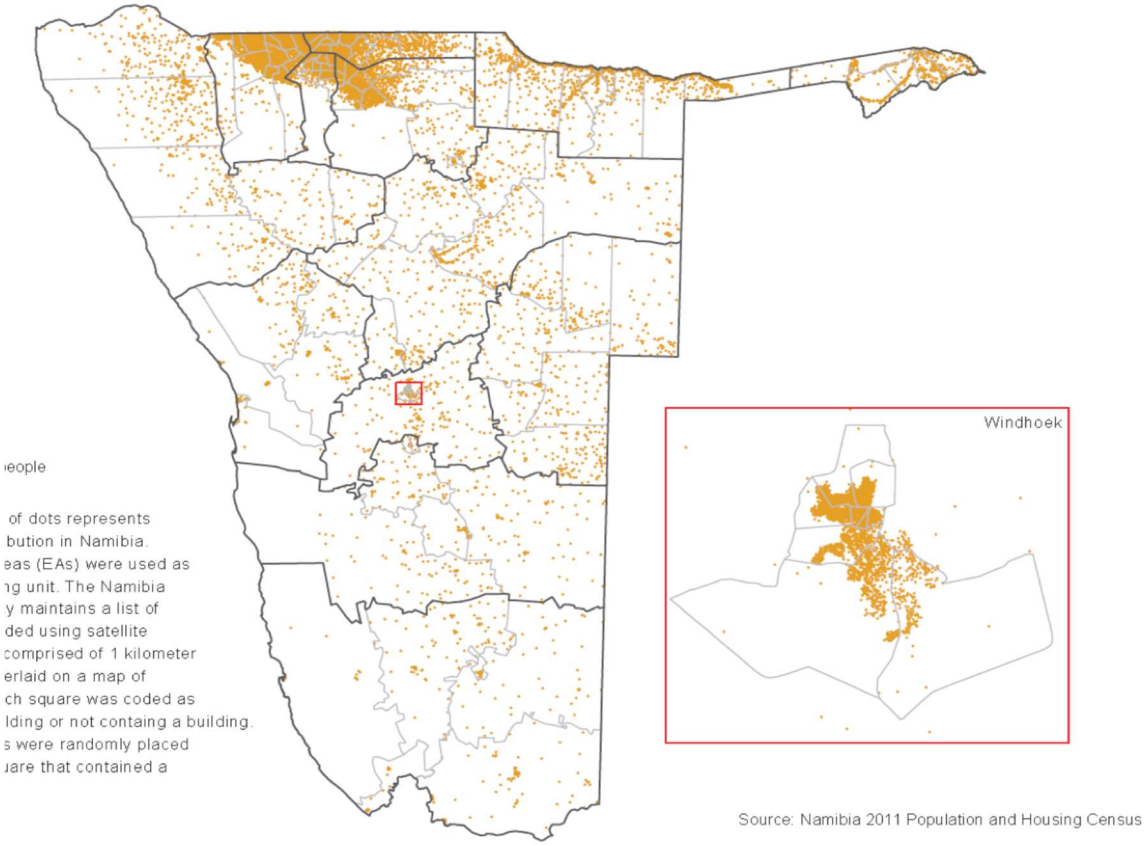


Figure. 2.5.2 HIV Prevalence by District

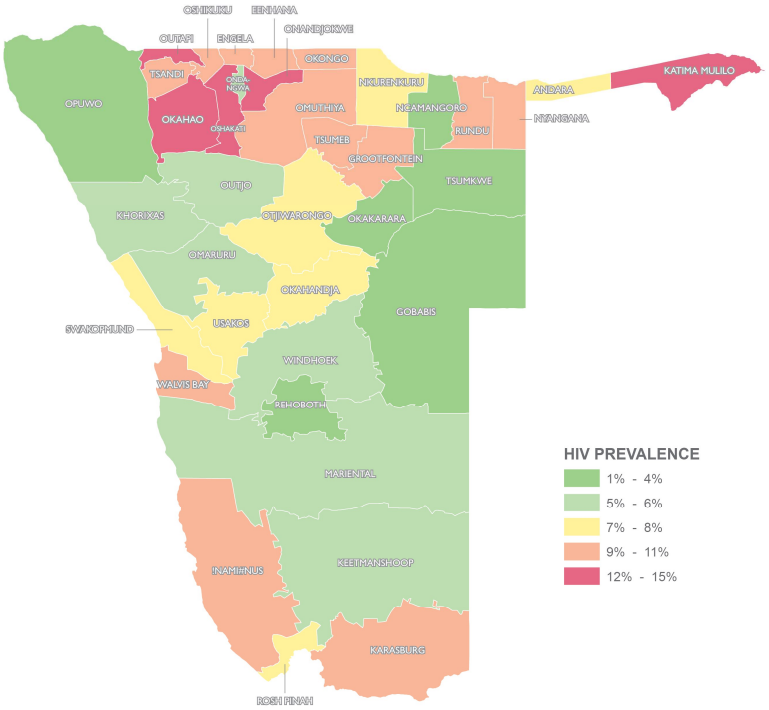


Figure 2.5.3 ART Coverage by District

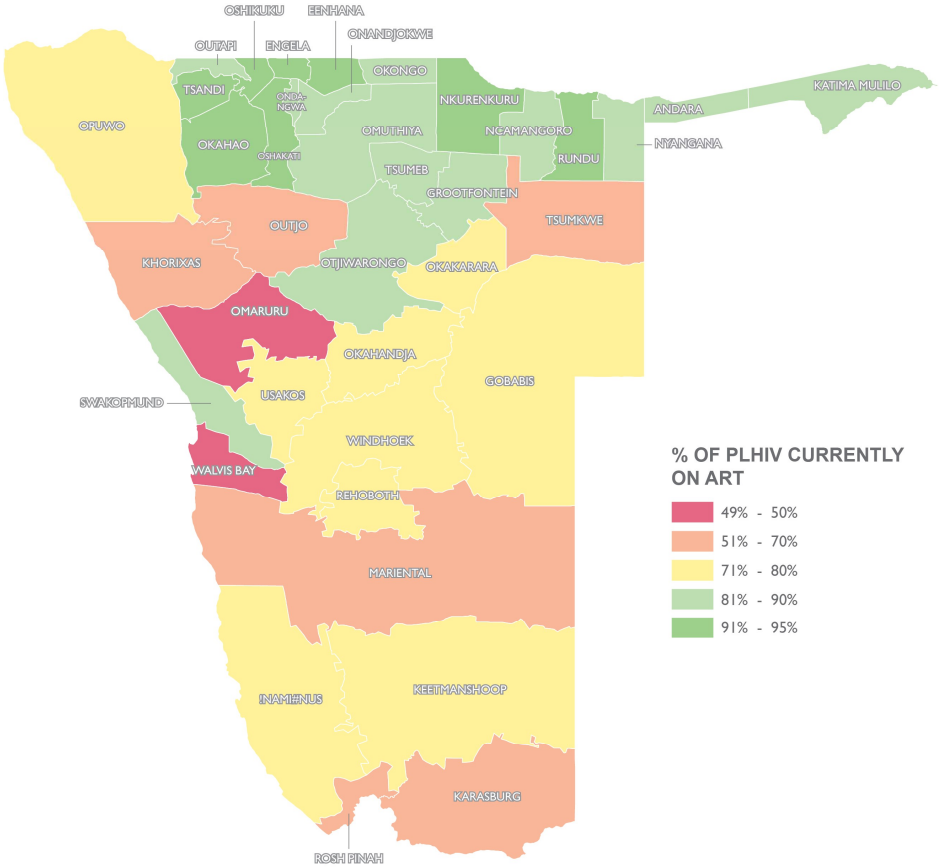


Figure 2.5.4 ART Coverage Gap by District

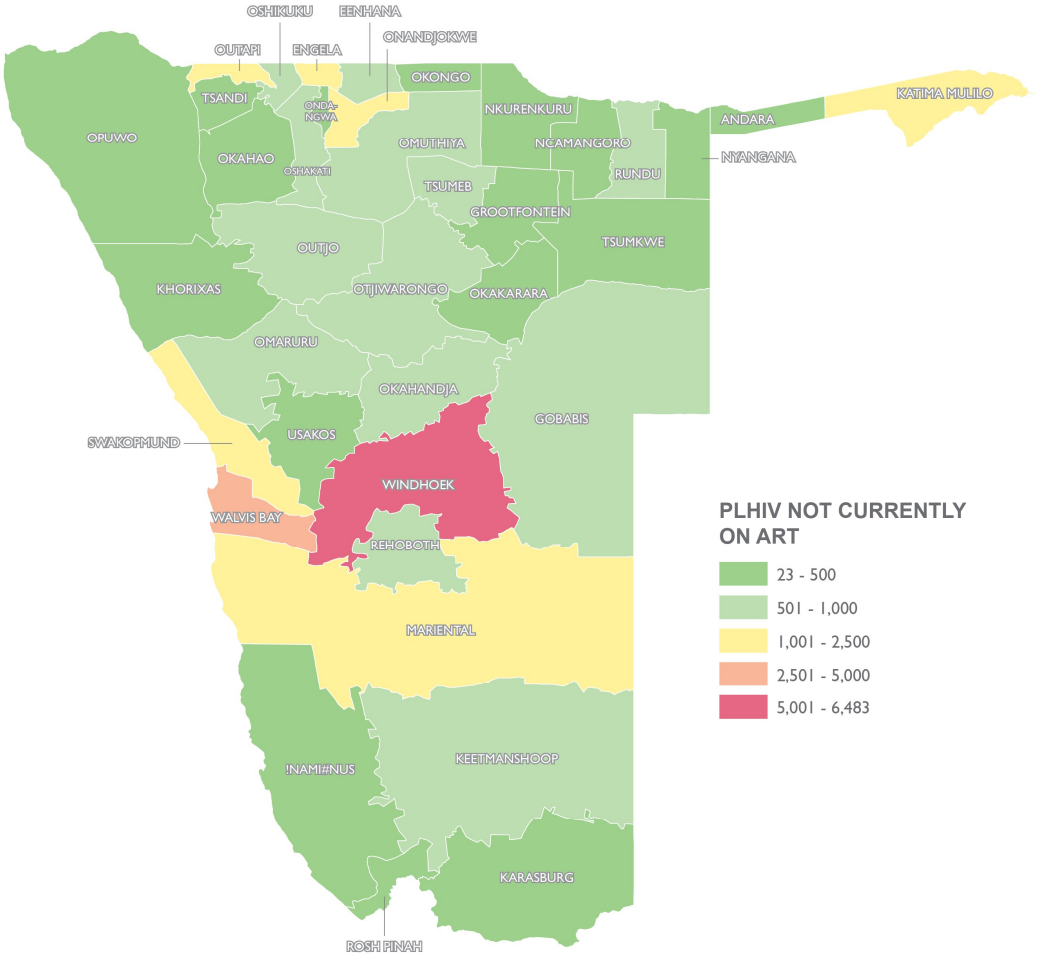


Figure 2.5.5 ART Coverage Gap by Sex (females)

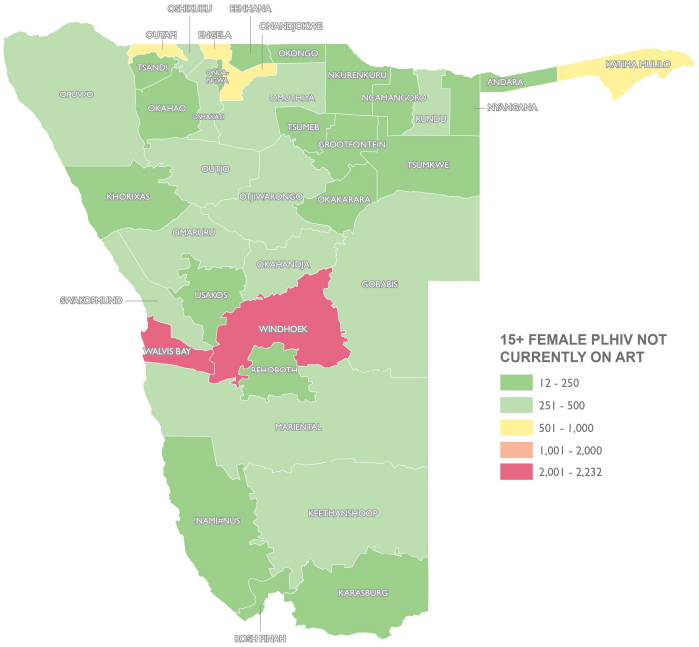


Figure 2.5.6 ART Coverage Gap by Sex (males)

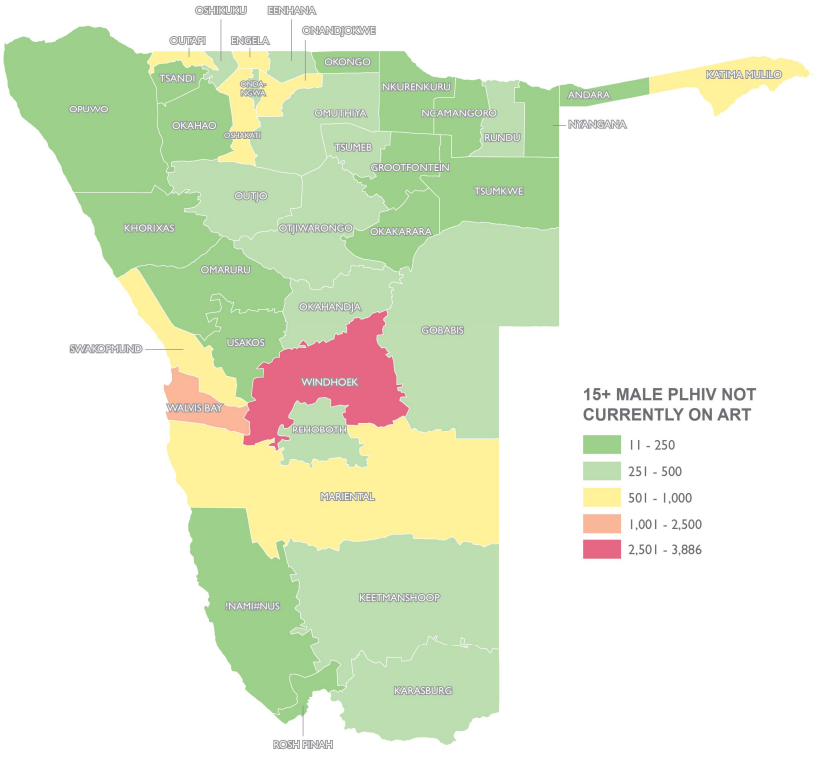


Figure 2.5.7 ART Coverage Gap by Age

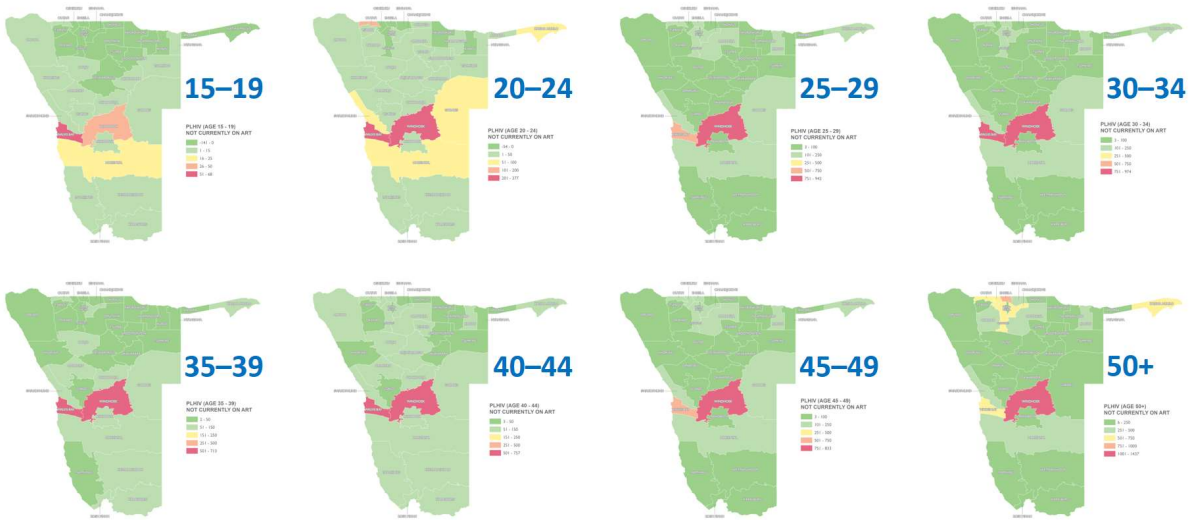


Figure 2.5.8 Viral load coverage for patients on ART by Region

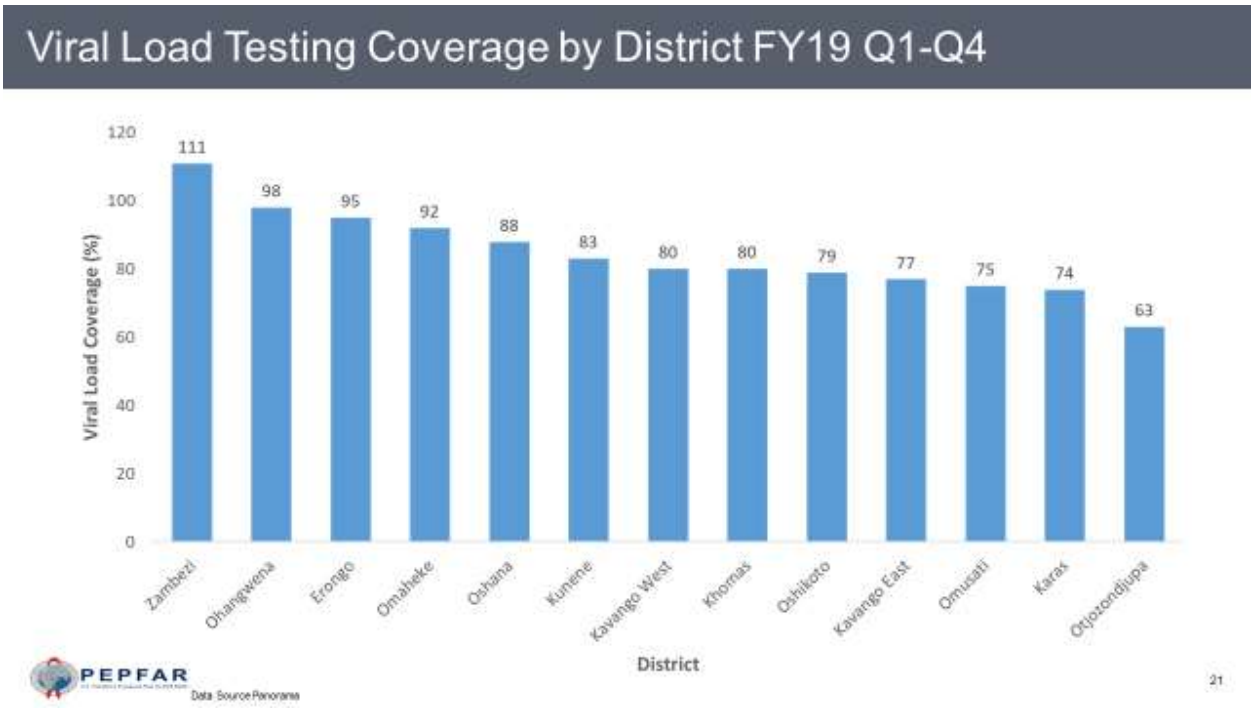
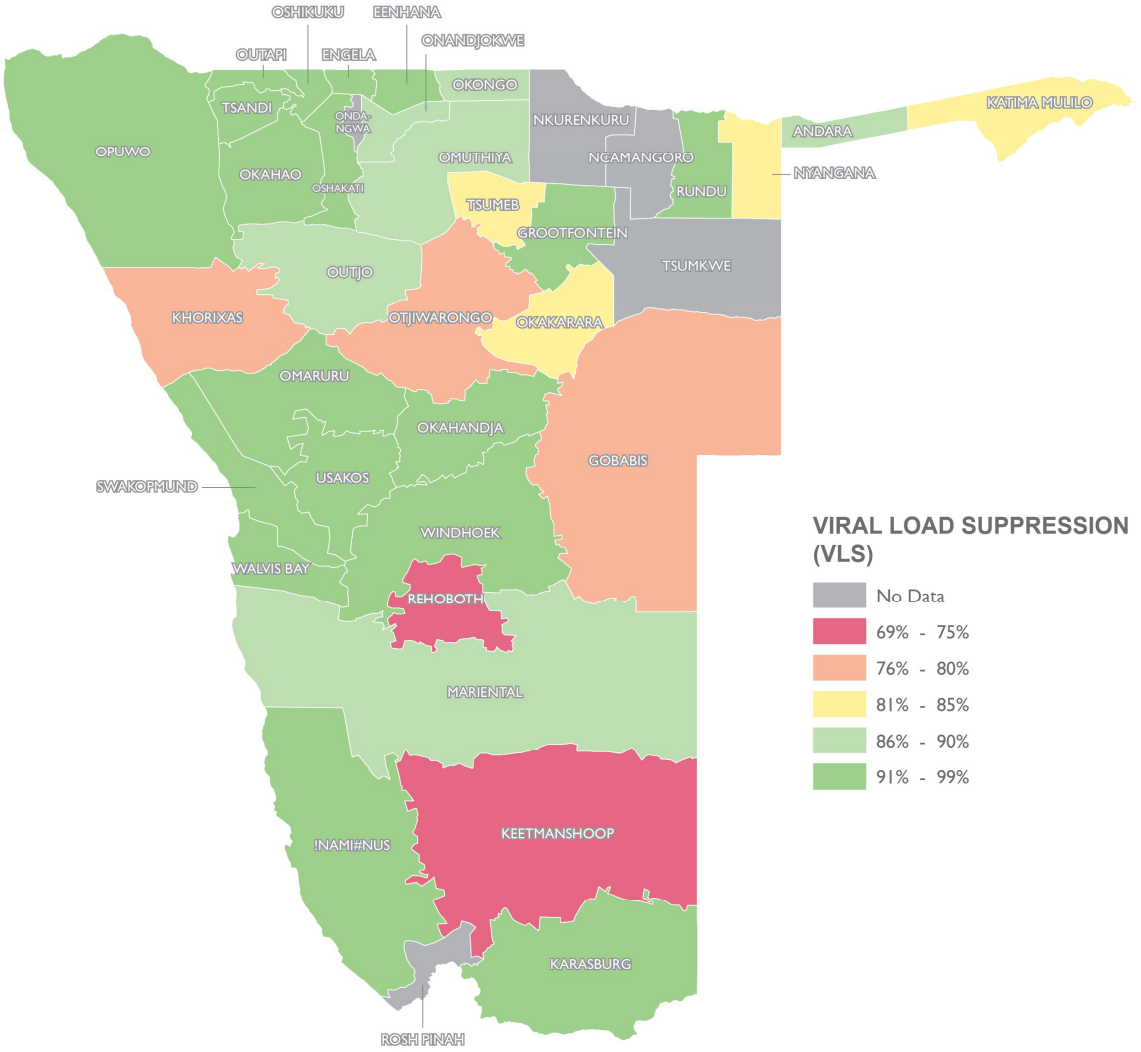


Figure 2.5.9 Viral load suppression for patients on ART by District



2.6 Stakeholder Engagement

Host Country Government

The strong working partnership between PEPFAR 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 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. Leading up to the COP20 process, PEPFAR Namibia held regular consultative meetings with the Executive Director of the MOHSS and the DSP to update them on the latest program performance and the COP20 guidance ahead of drafting the country vision. The MOHSS was a leading partner in the subsequent planning meetings and the in-person meeting held in Johannesburg.

Global Fund and Other External Donors

PEPFAR Namibia prioritizes efforts directed at mobilizing the contribution of multilateral partners in the development and implementation of the national response. The GF was specifically involved in the initial consultations including the process of developing the COP20 process and participating in in-country meetings and attending the PEPFAR in-person meeting in Johannesburg. Working with the MOHSS, PEPFAR Namibia was also involved in the ongoing GF grant application process. In all engagements, PEFAR Namibia seeks to address funding gaps and duplication among multilateral donors with guidance from the MOHSS. The UN agencies were engaged in the COP20 process in country and the UNAIDS team was present at the in-person meeting in Johannesburg.

Civil Society/Faith-Based Organizations and Community

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

CSOs and community and faith based organizations participated in the in-country COP20 stakeholder meeting 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 COP20 should address. During stakeholder consultations, a peer nomination process was undertaken in which four representatives were selected to attend the in-person meeting in Johannesburg. The CSO representatives engaged with broader stakeholder groups in order to gauge their perspectives and priorities to ensure they represented the collective voice of civil society appropriately.

Private Sector

Private sector participants were invited and attended the COP20 stakeholder meeting held on January 28-29, 2020. There are ongoing plans for additional engagements throughout the year, particularly relating to sustainable health financing.

3.0 Geographic and Population Prioritization

PLHIV burden and the unmet need for ART vary across Namibia as shown in section 2.4. ART coverage by age and sex is lowest among individuals older than 25 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 COP20 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 through PEPFAR support (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 exists a larger treatment gap than anticipated which may be filled by the 22,000 ART clients in the private sector, mostly concentrated in those regions. There are regions that are low prevalence and low population but also have the lowest coverage rates. PEPFAR Namibia has already started to increase support with more focused technical assistance in COP19. This support will be continued and refined in COP20.

Compared to the high VLS among adult populations in APR19, pediatrics, adolescents and young adults age 0 to 24 years had comparatively lower VLS rates (Figure 3.2). Slow rates of decentralization for pediatrics and adolescents, limited support for pediatrics disclosure and teen psychosocial support, and suboptimal ARV prescribing have been identified as contributing factors. Additional support for pediatric and adolescent viral load suppression will be provided nationally in COP20.

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 COP19 through a mixed direct service delivery and technical assistance model. In COP20, PEPFAR Namibia will expand this integrated community HIV service model to include direct service delivery to important hot spot towns, to ensure that this integrated community model may achieve maximum reach. Community teams or "Fivers" will be able to respond nimbly to the epidemiology and needs of each area, shifting from case finding to tracing in saturated areas and back to index testing where gaps are found.

The current cohort of Clinical and Nurse Mentors cover all the 14 Regions of Namibia. The 28 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). This is a pivotal example of Namibia's structural sustainability efforts.

The geographic focus in the areas with highest burden and unmet need will align all PEPFAR activities for OVC, AGYW, PLHIV, key populations, and other priority populations to create a synergistic impact. OVC activities will be implemented in 33 districts with an overlap of OVC implementation in nine Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe Women (DREAMS) districts. OVC activities are aligned to geographic areas of the highest HIV burden and greatest unmet ART needs for children and adult populations. DREAMS interventions will be implemented in nine districts with high HIV prevalence rates, high prevalence of GBV rates and high teen pregnancy rates: Katima Mulilo, Omuthiya, Onandjokwe, Tsumeb, Windhoek, Oshakati, Rundu, Nyangana and Andara. The latter four districts are expansion districts that will begin implementation in COP20. DREAMS activities will target AGYW ages 10-24 in an effort to decrease the HIV incidence and ultimately keep them HIV-negative. In these districts, PEPFAR Namibia will ensure layered age-appropriate programming up to age 24 (Figure 3.6) with a strong emphasis on economic strengthening and PrEP provision for older AGYW. Interventions for HIV prevention, care and treatment targeting KPs will be implemented in ten districts across nine regions. In four of these districts (Katima Mulilo, Windhoek, Walvis Bay and Swakopmund), results from the NAM-IBBS 2019 show high HIV prevalence among FSW and MSM. ART coverage for KPs living with HIV who know their status was comparable to estimates for the adult general population,

however viral load suppression rate was low. KPs in these districts also had limited engagement with peer educators and despite its national rollout since 2016, uptake of PrEP among eligible KPs is low. Programmatic interventions in the priority districts will address key barriers to access and use of KP competent prevention, care and treatment services including violence response.

As a result of PEPFAR support to the MOHSS, national VMMC coverage among young men aged 15-29 years old has increased from 35% in 2017 to 47.7% by the end of calendar year 2019. Regions with direct PEPFAR support recorded some of the highest coverage: Windhoek (Khomas region 62.2%), Katima Mulilo (Zambezi Region 70%), Oshakati (Oshana region 61%), Swakopmund and Walvis Bay (Erongo region 52%) (DMPPT, Version 2.0, 2019). Newly supported regions had low VMMC coverage; Rosh Pinah and Luderitz (!Karas region 37.6%) and Oshikuku, Onandjokwe and Tsumeb (Oshikoto region 34.9%). In FY20, PEPFAR Namibia expanded support for VMMC programs in areas where GF services have decreased. FY20 activities will focus on the provision of direct service delivery support, demand creation and quality management and quality improvement for a rapid VMMC scale up in all priority regions. It is expected that the COP20 OU target will rapidly saturate seven priority regions (Khomas, Erongo, Zambezi, Ohagwena, Omusati Oshana, and Karas) to 78% VMMC coverage by the end of FY21. (Figure 3.7).

Figure 3.1. Namibia Population Pyramid (PLHIV Only)

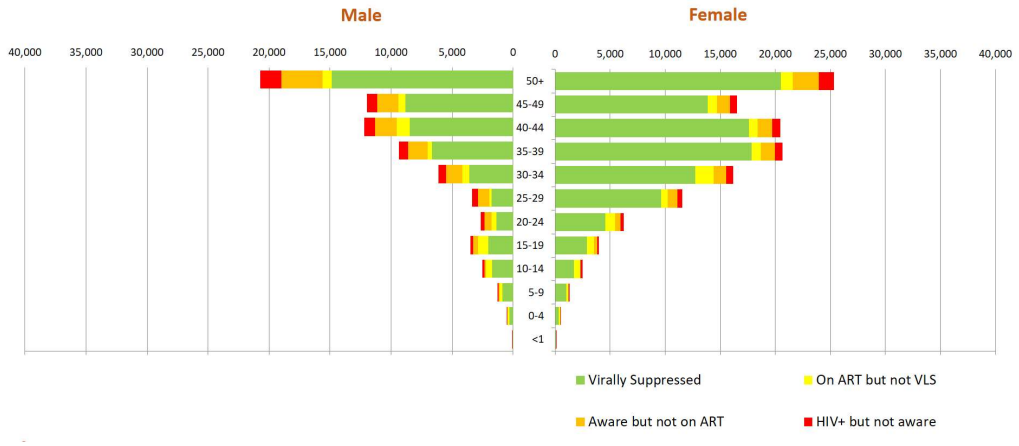


Figure 3.2. Viral Load Suppression Rates by Age/Sex, Namibia APR19: (N=167,204)

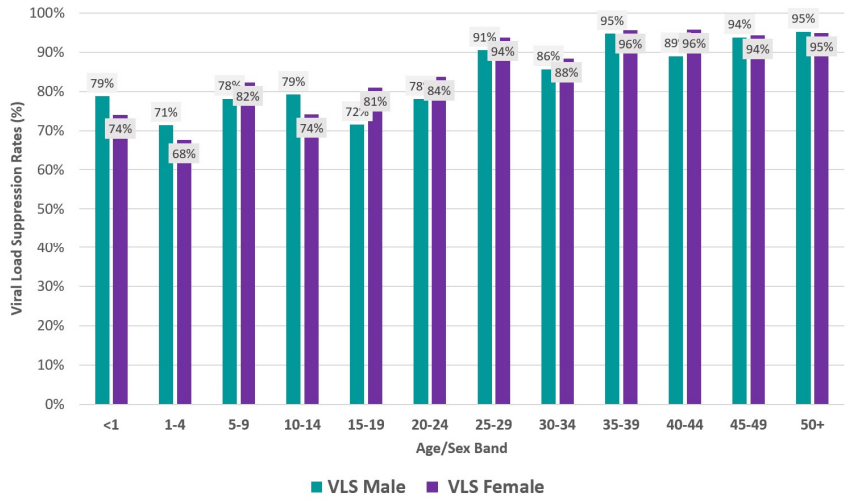


Figure 3.3 Community Model of Index Testing and Tracing COP20

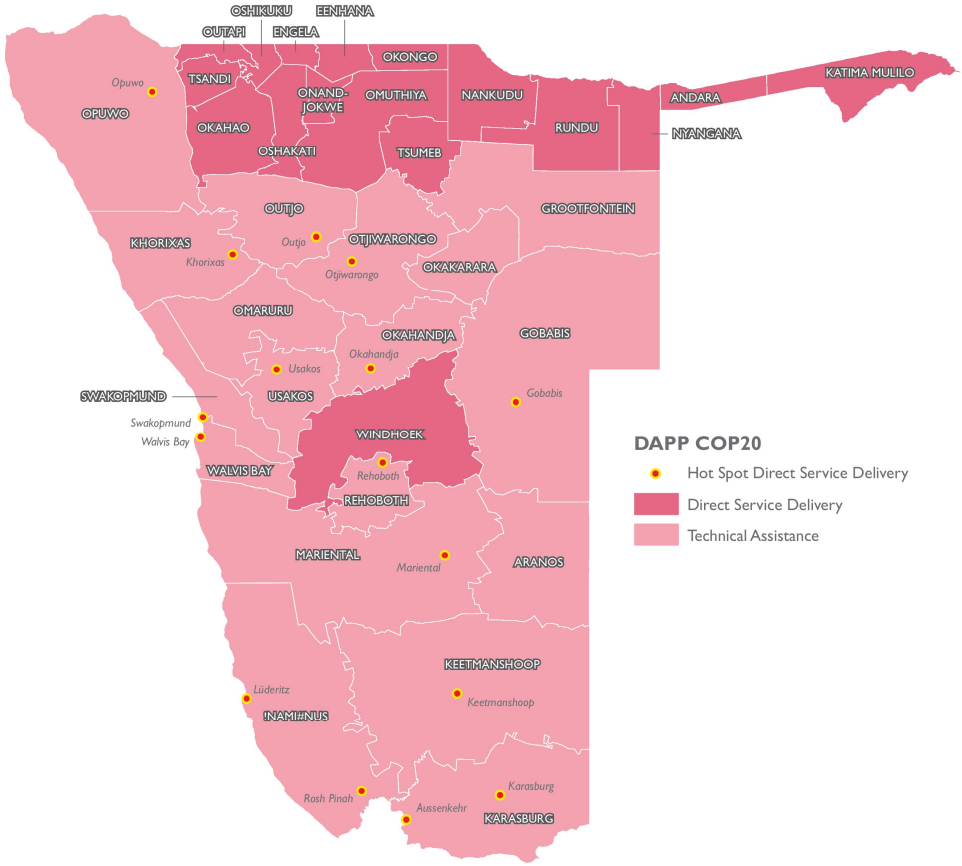


Figure 3.4 Clinical Mentorship Network Geographic Coverage COP20

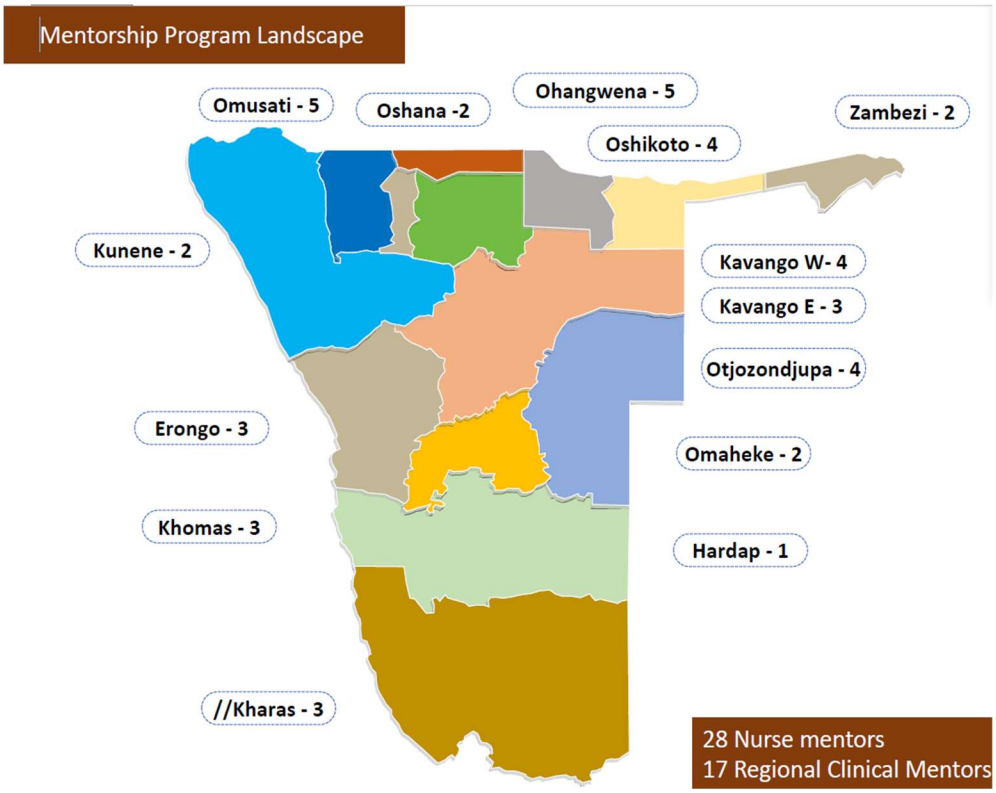


Figure 3.5 Clinical Mentorship Network Structure COP20

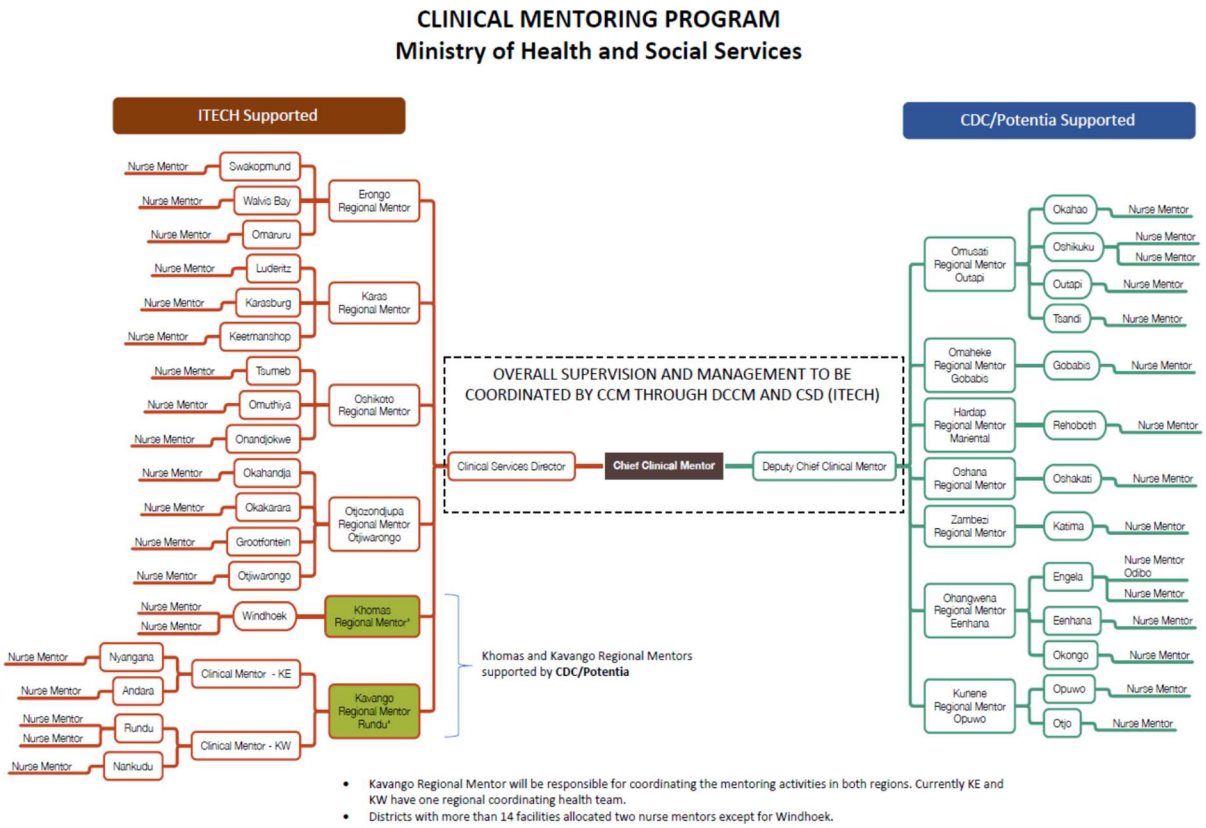


Figure 3.6 DREAMS and OVC Program Supported Health Districts

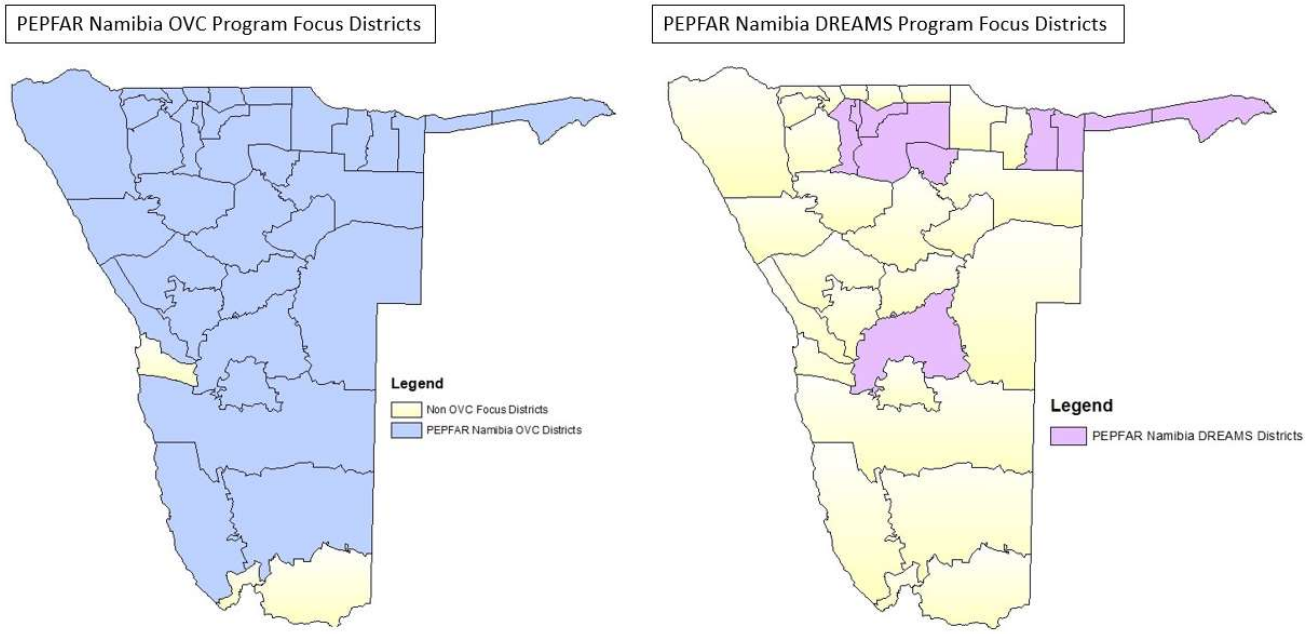
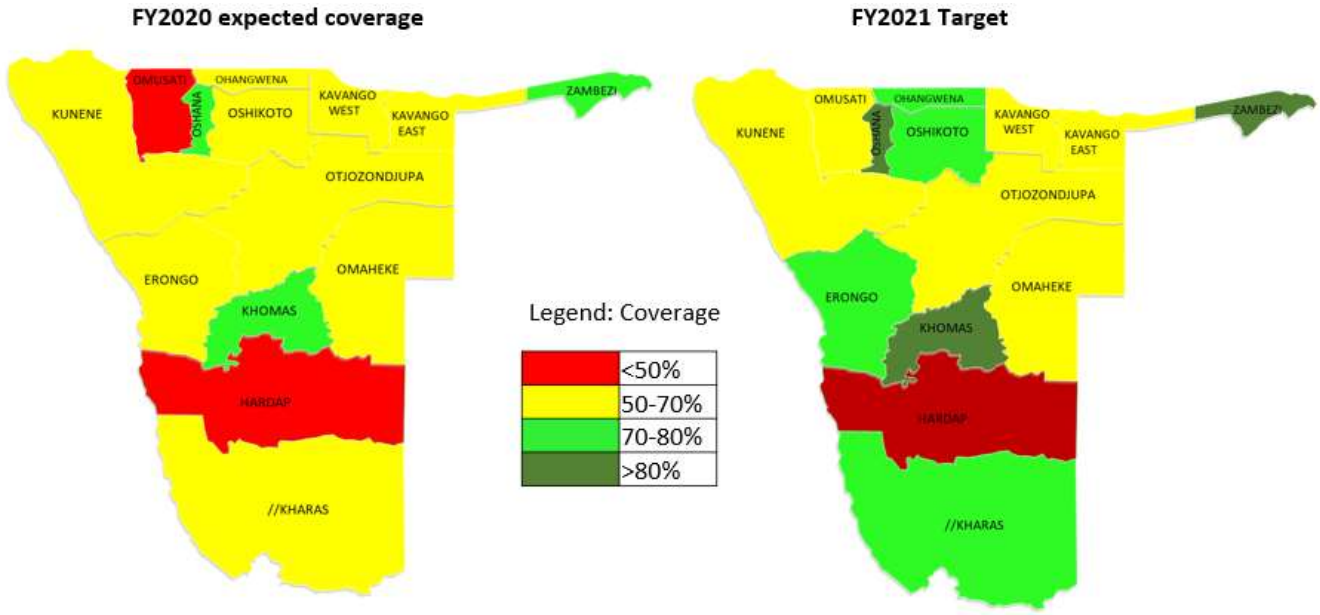


Figure 3.7 VMMC Coverage from FY20 expected Coverage and Targets for FY 2021



In FY20, Peace Corps Namibia will increase the number of Volunteers in the health program to support primary prevention, DREAMS and OVC activities. Peace Corps Volunteers will be added to new districts where such services are currently not available. It is anticipated that Peace Corps reach will grow and expand in the upcoming implementation phase and Volunteers will be placed with the MOHSS and the Ministry of Education, Arts and Culture and local and international NGOs to increase outreach. All activities involving volunteers will aim to accelerate access to evidence based prevention care, support and treatment for OVCs and their caregivers, AGYW, boys and young men.

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)	COP20 (FY21)
Attained	10,444	2 Districts	12 Districts	All 14 Regions	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 2020 Naomi District Estimates, 27 Jan2020

4.0 Client Centered Program Activities for Epidemic Control

4.1 Finding the missing and offering treatment initiation

In FY19, PEPFAR Namibia identified 15,894 HIV positive persons. After a record number of HIV positives were identified in FY18, a downward trend in positives identified was noted in FY 19 (Graph 4.1.1). This trend is expected to continue as the country continues to close the gap and reach epidemic control.

Spectrum estimates for 2019 and the latest program data indicate that 95% of PLHIV know their status. Data suggest that the remaining gap in testing may be highest among men 20 to 34 years of age. The geographical gaps for case finding were identified in some of the high burden districts such as Engela and Katima Mulilo while gaps persisted in the low prevalence regions with lower volumes of cases in Kunene, Hardap, !Karas and Omaheke and Otjozondjupa regions. These low volume regions also proportionally have more males in their population distribution.

Case finding results by sex, age, geography and modality show that for FY19, index partner testing in both the community and facilities as well as provider-initiated testing and counseling (PITC) modalities were successful in finding HIV positive men in PEPFAR-supported regions. The number of HIV positives and yield by modality for FY20 Q1, show that Facility Index Testing yields increased sharply to 33% from an average yield of 5.8% in FY19 (Graph 4.1.2). This increased yield reflects the optimization of this modality. Community Index Testing continues to produce high yields with 26% for FY20 Q1 and the other PITC modality shows a reduction in volumes tested and an increase in yield to 4.3% from an average yield of 3% in FY 19. These changes are as a result of data cleaning processes and the implementation of the PITC screening tool. It is expected that this trajectory will continue given the constant refinement of both the index testing and PITC modalities in FY19. The HIV testing yield for FY20 Q1 is higher among men older than 30 years, than women and younger men. PEPFAR Namibia continues to find men with the current implementation modalities.

In COP20, PEPFAR Namibia's overarching goal for case finding is to implement a national case-based surveillance system with integrated public health response at individual and community levels. This goal will be achieved through the provision of recency testing in all regions. The response will directly link into Namibia's comprehensive index partner testing program as well as provision of HIV self-testing, targeting hard to reach partners of HIV positive Index Cases and partners of high-risk negatives.

Provision of Comprehensive Index Partner Testing

In COP18, the GRN committed to implement Index Partner Testing at scale in Circular 12 of 2019 in all districts and with all facility and community partners. Subsequently, the MOHSS trained all 14 regions on the Index Testing approach as well as PITC Optimization and HIV self-testing. Results from the Q1 FY20 are reporting a shift in programming. For the remainder of FY20, PEPFAR Namibia continues to support the MOHSS and other implementing partners to refine their Index Testing and targeted testing approaches through intensified site level support. Additionally, PEPFAR Namibia is currently providing technical assistance through a community partner to the low burden regions to improve their community index testing programs with efficiency and fidelity. Ensuring the safety of patients through intimate partner violence (IPV) screening remains a critical component to index testing and will be tracked pre- and post- index testing services. The program will conduct an IPV evaluation in FY20 to determine incidence of IPV and assess sensitivity and specificity of the IPV screening tool in the context of Index Testing and Recency testing services. In COP20, PEPFAR Namibia will continue to support case finding in high burden regions/districts with the provision of community index testing Direct Service Delivery (DSD). Outside of the DSD districts, PEPFAR Namibia IPs will continue to provide TA support to the

MOHSS. DSD support for community index testing will also be provided at hot spot towns within low burden regions/districts. HIV self-testing will be integrated into the Index Testing program to reach those "hard to reach sexual partners" through secondary distribution.

Programmatic index testing activities are currently suspended among KPs. This is in response to concerns raised by global civil society groups about index testing procedures which have not followed WHO guidance that ensures everyone is offered index testing in a confidential, voluntary and consented manner. PEPFAR Namibia will support the implementation of PEPFAR's minimum requirements for index testing. All sites will be assessed to ensure they meet minimum program quality for index testing and are certified. Continuous collaboration and oversight with in-country CSOs will be supported in order to ensure that index testing remains confidential, voluntary and consented. Other modalities for HIV testing services will continue to be support such as; peer driven social network testing and outreach-based testing with integrated HIV self-testing programs among KPs.

Recency Testing

Recency testing was started in July 2018 and delivered in five high burden districts in 42 health facilities. As of February 2020, 1,708 new diagnoses were reported in the Recency districts of which 96% consented to recency testing. The final Recent Infection Testing Algorithm (RITA) available results were 1,463 with 51 recent cases (3.5%). These data indicate that there are significant higher recent infections among women, younger age individuals, and sex workers. A higher number of recent cases were found in Onandjokwe, Oshakati and Windhoek Districts. Recency testing will be scaled to all 14 regions in FY20 and complete saturation will be accomplished in FY21. 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. The recency response will pivot around ensuring those newly diagnosed receive a package of services including recency and index partner testing services as well as PrEP and ART provision. Enhanced IPT, PrEP and ART services will be offered to those who test recent and their partners. Additionally, these data will assist the program to identify potential hotspots of transmission, which will prompt some limited mobile outreach activities to those locations.

Targeted Facility Based Testing

In COP18, the MOHSS trained all providers on the approved PITC screening tool and began rolling it out to all regions. In COP19, the immediate action for Q2 is to conduct regional meetings to discuss the implementation of the tools, especially for high volume sites (Outpatients Departments) to strengthen the systematic use of the tool. The mentoring program will continue to monitor and evaluate the program implementation and trouble shoot at site level throughout COP19. Routine testing will continue for pregnant and breast-feeding 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 breast-feeding women, STI, family planning and TB clients through secondary distribution to their sexual partners. In COP20, it is anticipated that targeted testing will be routinely offered at all Public Health Facilities and this program will be fully transitioned to the Namibian government with no funding support from PEPFAR Namibia.

Immediate ART initiation

Namibia has successfully implemented test and treat at health facilities in all districts since 2016. Given the latest estimates (Spectrum combined with Program Data) of Namibia's progress towards meeting the UN Fast track targets, of the 95% of PLHIV diagnosed with HIV, 95% were on treatment, which is an indication that Namibia is successful in linking those who test HIV positive to treatment. In FY20 Q1,

PEPFAR Namibia achieved 88% linkage of newly identified positives to treatment within the quarter, which is consistent with linkage rates previously achieved for FY19 (Graph 4.1.3). PEPFAR Namibia can achieve consistently high linkage rates through active linkage mechanisms, with healthcare providers physically escorting patients for ART initiation, and following up to ensure that positives are started on ART. The community index testing program equally achieves high linkage rates with a 97% linkage rate in FY20 Q1. The same-day ART initiation data for FY19 showed significant improvements in policy implementation, which shows that for Q1 FY20, same-day linkage for the community index program stood at 91%. Though linkage has been consistently high, Namibia aims to achieve greater than 95% linkage to care in all districts. An analysis of district linkage proxies for FY20 Q1 shows that the high-volume sites had a proxy linkage between 73% and 91%, such as Windhoek and Zambezi regions. Additionally, there were several smaller sites whose proxy linkage exceeded 100% with rates as high as 375% (Graph 4.1.4). This 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 numbers of them may prefer to go and start their ART at low volume ART sites, closer to their homes in smaller towns.

The current test-and-treat SOP recommends offering ART on the same day that an HIV diagnosis is made. Patients who opt to Patients would also be 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.

With PEPFAR Namibia expanding tracing activities to all regions in COP19 and beyond, it will ensure that the lists of patients who are referred to other facilities for continuing ART elsewhere, are shared with implementing partner who then assist in tracing patients to confirm that they made it to the next facility.

Children and Adolescents

In August 2019, the new Namibia National ART guidelines were launched. These guidelines are progressive when considering pediatric populations and have already endorsed DTG as the preferred first line regimen across all age bands starting at 4 weeks old. This is in anticipation of DTG 10 becoming available within the next two years and will be able to be rapidly implemented without having to undergo an additional guideline revision. Of note is the optimization of the use of protease inhibitor (PI) formulations. The MOHSS is committed to no longer procuring LPV/r syrup and transitioning all eligible children to LPV/r granules due to the increased tolerability. There are also plans to procure the 4-in-1 granules to aid caregivers in administration of ART to young children in COP20. Namibia is progressive in its policy to support the best ART regimens possible for children. By eliminating the use of NNRTIs in children, PEPFAR Namibia hopes to see improvement in overall viral suppression.

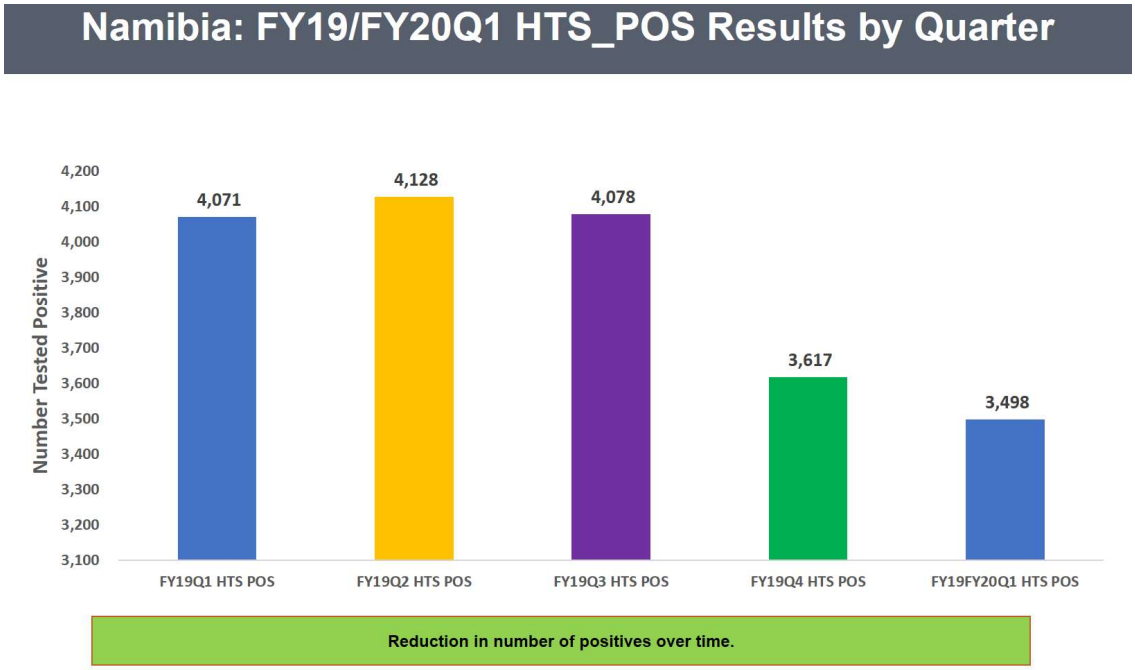
Namibia has been successful in implementing and rolling out differentiated service delivery models, including teen club support groups. In COP18 Q4, over 4,000 young people were receiving support through the teen club model. Teen clubs have rapidly expanded in Namibia over the past three years, with many regions now offering teen clubs at the clinical level. However, of the 11,057 adolescents living with HIV, only 4,056 are supported through a teen club model, translating to only 36.6% of eligible adolescents living with HIV. It is evident that children who are engaged in the teen club have good clinical attendance and undetectable viral loads. Of those individuals who did not have undetectable viral loads at entry, 20% have had an improvement in suppression since joining a teen club.

Nevertheless, the teen club model faces challenges. Currently, teen clubs are only offered at the facility level, which means they are dependent on available, private space that a facility can offer. It is also dependent on an HCW from that facility to organize and implement. Some facilities are not willing to add burdens for already overworked staff. Additionally, there is currently no standardized curriculum or guidance for HCWs on appropriate teaching topics, so teen clubs vary greatly from facility to facility.

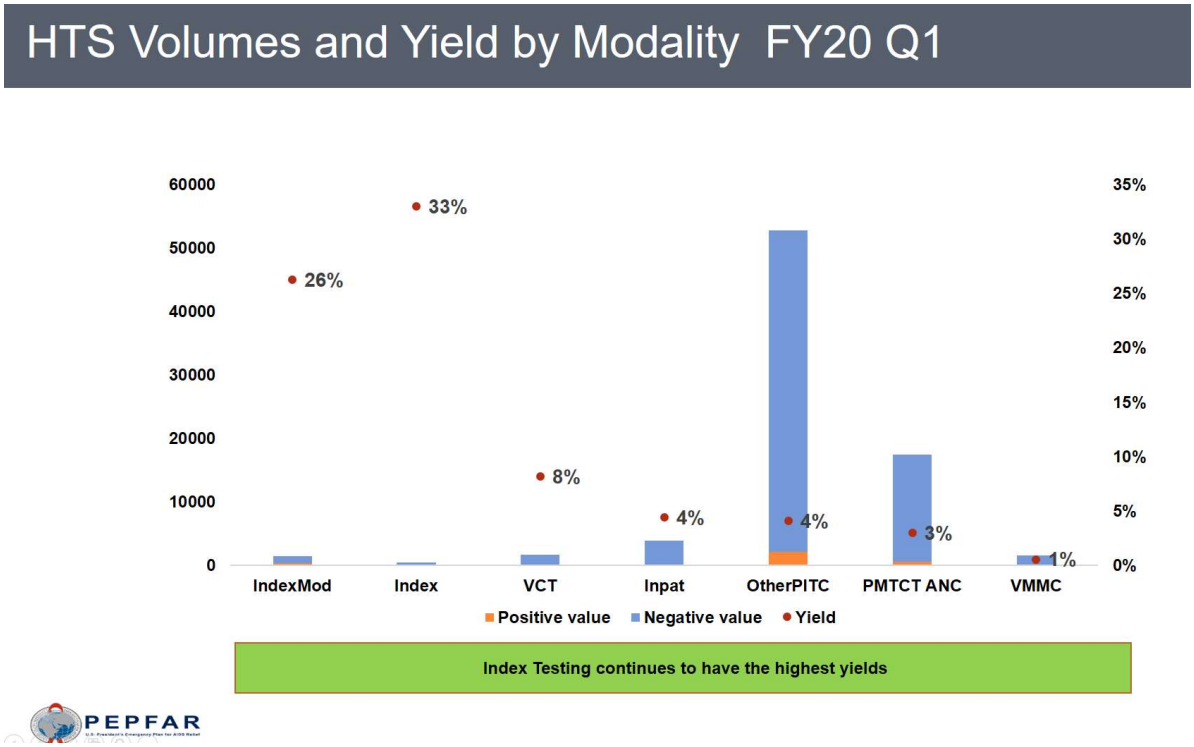
Some of these issues are being addressed in COP19. Planning for COP20 will continue to work on standardization of teen clubs, expanding options for teen clubs to meet in community settings or at school, increase support from peer mentors to decrease burden on HCWs, and increase reporting on the clinical outcomes of children enrolled in the teen club model.

The Zvandiri model of care through Community Adolescents Treatment Supporters (CATS) has begun implementation in COP19 through a Memorandum of Agreement with MoHSS and an implementing partner. It has started with two (2) regions. Through COP20 ambition funding, this model will expand to two additional regions, covering four of the highest burden regions in the country. In January 2020, CATS phase one (1) training occurred in Oshana and Khomas. 37 young people were successfully trained to become peer supporters and CATS to work across the clinical cascade to help mobilize young people, children and infants for testing. CATS also assist by linking newly identified children, families and young people to care, assisting in counseling and adherence support, and working towards complete viral suppression for each of their clients.

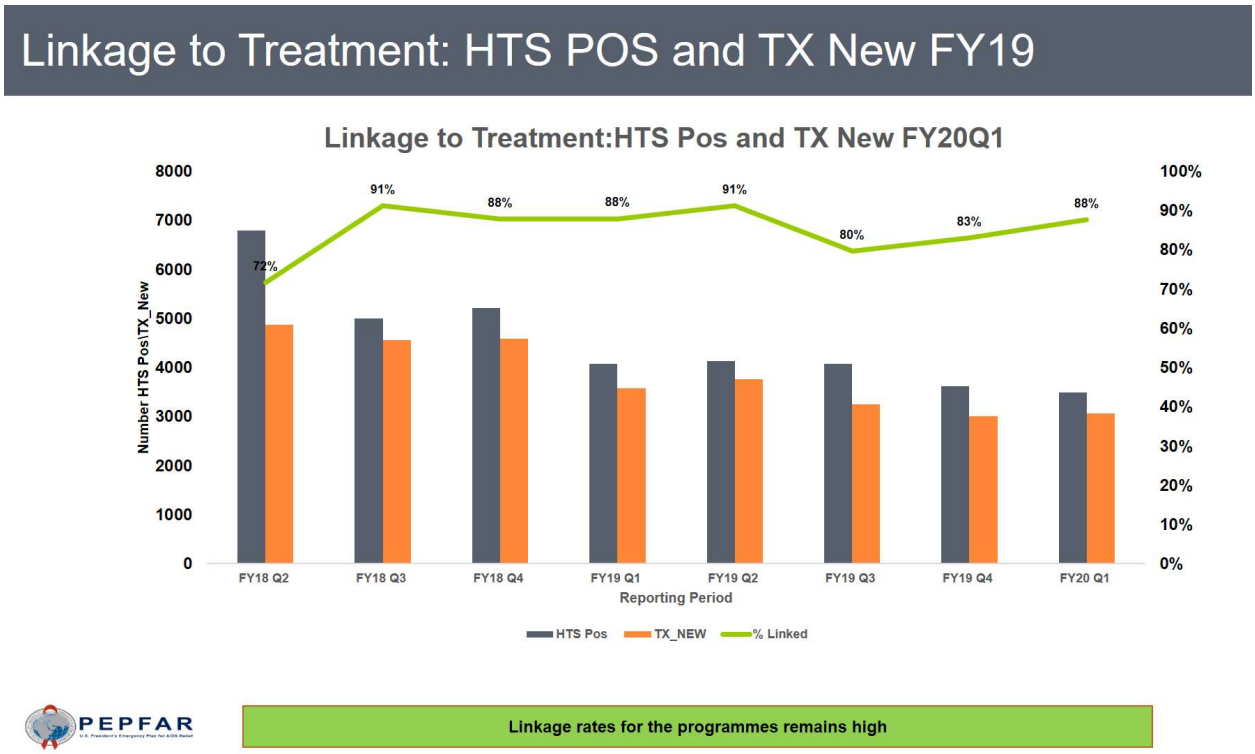
Graph 4.1.1 HTS Positive Results by Quarter



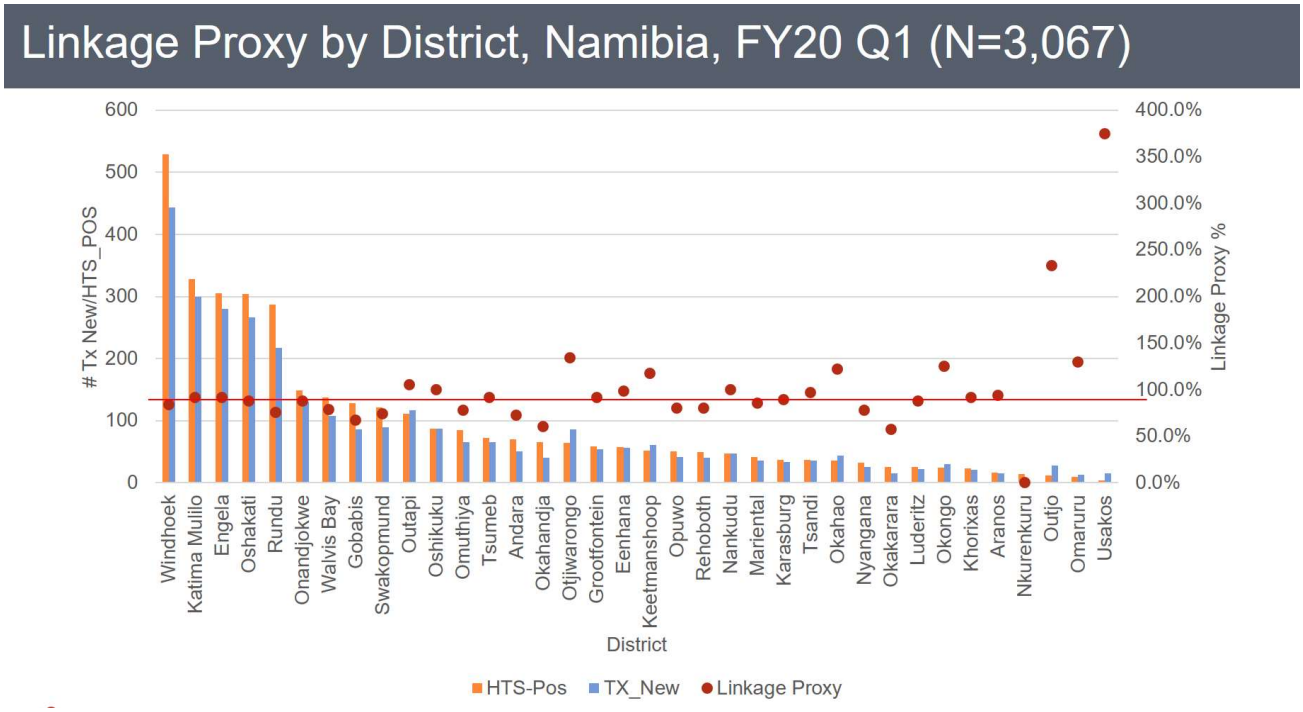
Graph 4.1.2 HTS Volumes and Yield by Modality FY20 Q1



Graph 4.1.3 Linkage to Treatment: HTS POS and TX NEW FY19



Graph 4.1.4 Linkage Proxy by District, Namibia, FY20 Q1 (N=3,067)



4.2 Retaining clients on treatment and ensuring viral suppression

In COP20, PEPFAR Namibia will implement a broad range of retention interventions across the cascade from the point that in individual is HIV-diagnosed. These interventions are designed to be both preventative of loss to follow-up (LTFU) and responsive to times when patients miss their appointments or are LTFU. (Figure 4.2.1)

Namibia will ensure that an individual is immediately linked to ART on the same day or within seven days of HIV diagnosis. Immediate linkage will be accomplished through physical patient escorting, a national same-day-ART start policy, and a Community Test and Treat SOP which includes ART starter packs.

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 TLD transition to be completed by June of 2020, multi-month dispensing (MMD) of ARVs, differentiated service delivery (DSD) models (Community Adherence Groups (CAGs) and Community Based ART (CBART)), and TRIOs (treatment supporters for patients initiating ART). In COP20, PEPFAR Namibia will implement additional interventions which include Common Elements Treatment Approach (CETA) to address mental health issues in patients on ART, SMS Reminders, PeleBox Smartlocker System, Urine TDF testing for TLD adherence and CADRE TLD HIV drug resistance (HIVDR) monitoring.

PEFPAR Namibia plans to deploy the SMS reminder system in COP20 to cover 73 sites which currently have EDT systems installed. SMS reminders will help patients to remember their pill pick-up appointments and to adhere to their medication. With Ambition Funds, PEPFAR Namibia will deploy the PeleBox Smartlocker system in five high volume urban sites in COP20. These dispensing points

enable working men and women to collect their repeat chronic medication in under two minutes, 24 hours a day, seven days a week. In districts where PEPFAR supports KP interventions, individuals who are clinically stable on treatment will be linked to pick their medication from the PeleBox Smartlocker. This programmatic strategy will further strengthen adherence, minimize stigma and support retention for KPs.

PEPFAR Namibia will also implement urine TDF point-of-care testing 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 PI regimens.

Namibia has an SOP for tracing and begins tracing patients who missed clinical appointments by more than seven days using an EMR-generated list, to ensure clients are retained and remain in care prior to becoming lost to follow-up. In FY20 Q1, among patients who were confirmed to be missing, the tracing program was able to bring 98% back into care (Figure 4.2.2). This model will be scaled up to cover all ART clinics in Namibia starting in COP20. Using these national standards, PEPFAR Namibia community based partners can provide direct service delivery in high burden regions, technical assistance to the MOHSS in low burden regions, and will provide direct service delivery in hot spot towns (Figure 4.2.3). With COP20 Ambition Funds, the integrated "fiver" system will also 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 4.2.4). 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 in order to support routine linkage to clinical services including ART.

All retention interventions across the cascade, will implement interventions such as Improved Data Use, Clinical Mentoring and Continuous Quality Improvement, Positive Messaging (U=U) and Client-Centered Care. The current cohort of Physician and Nurse Mentors cover all the 14 Regions of Namibia. The 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. This is a pivotal example of Namibia's structural sustainability efforts. During FY19, 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 in the same 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. Through the QI Collaborative known as NAMLIVE , there was a rapid improvement in the areas of focus, including escalation of TPT coverage. In COP20, PEPFAR Namibia will continue utilizing the QI Collaborative approaches such as NAMLIVE to accelerate improvements in new and ongoing quality gaps impacting retention such as Early Infant Diagnosis (EID), Maternal Neonatal and Child Health (MNCH), ART optimization among children, Viral Load Suppression among youth, and further TPT scale up.

Based on lessons learned from the MenStar approach, PEPFAR Namibia will be developing the client-centered services and train HCWs in new approaches for service delivery, which enhance the client experience (e.g. Male Friendly Services, family clinics and improved customer care by HCWs). The positive approach from MenStar will be used to develop positive messaging particularly targeting newly initiated ART patients, youth, and men. Additional positive messaging material will be developed to improve enrollment, retention and viral load suppression especially among men, adolescents and the youth.

Figure 4.2.1 Retention Interventions

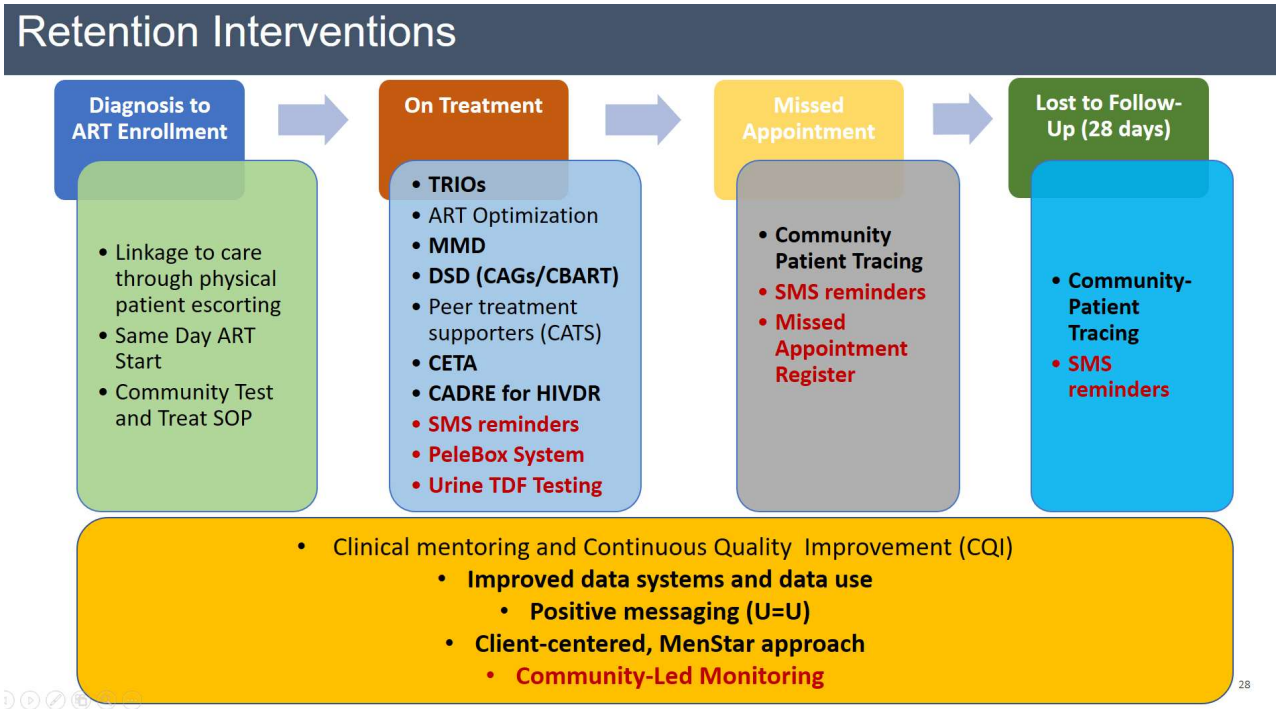


Figure 4.2.2 Patient Tracking Outcomes from Missed Appointments, FY19

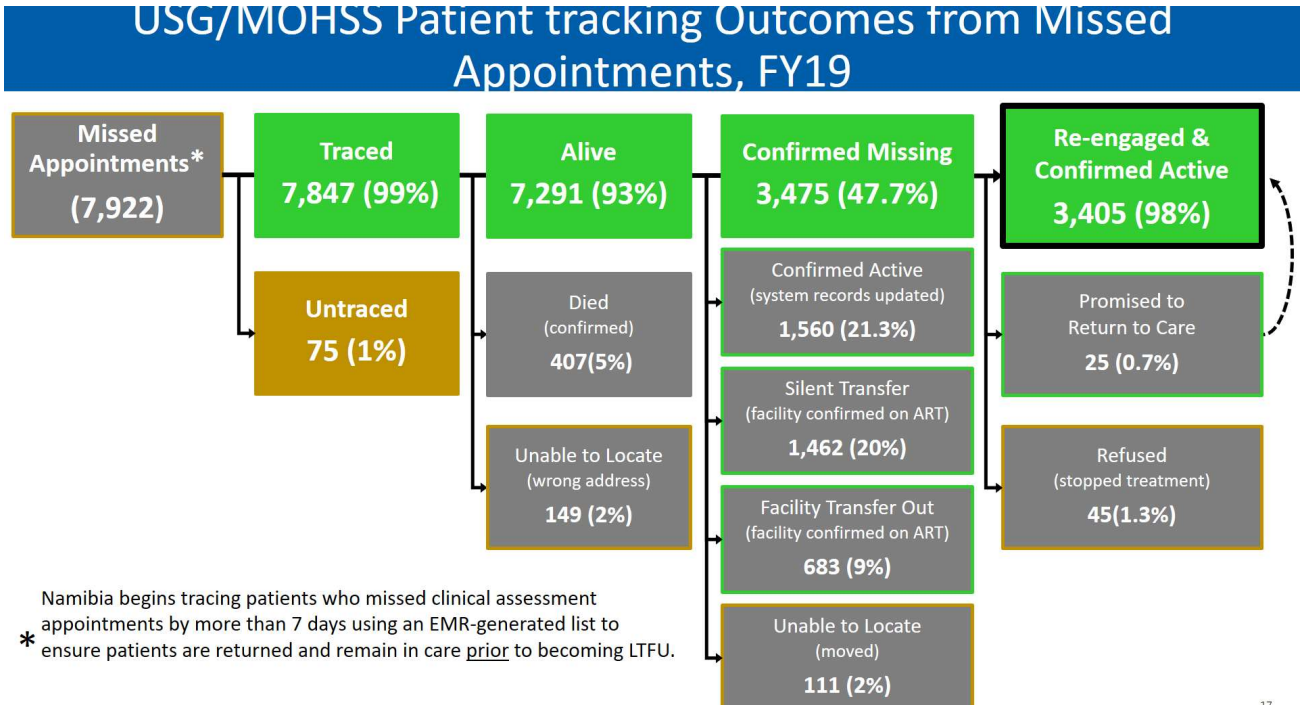


Figure 4.2.3 Geographic Coverage of Integrated Community Model (TRACING) COP20

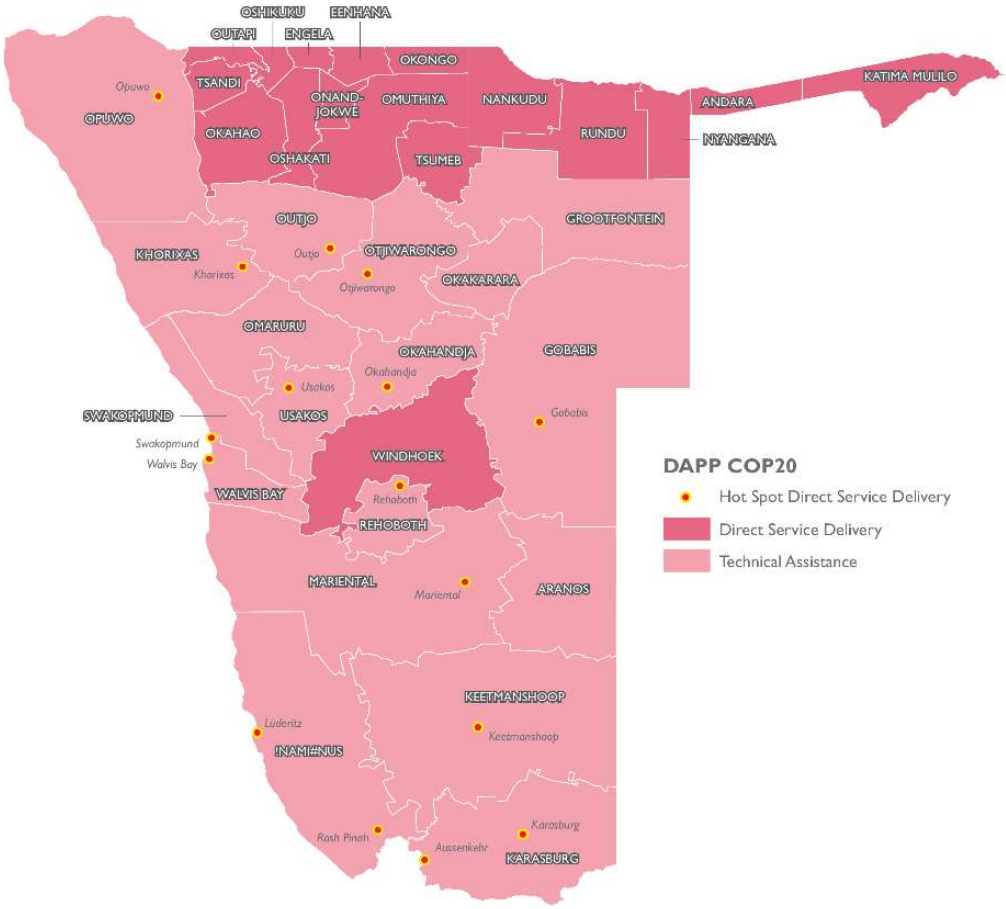
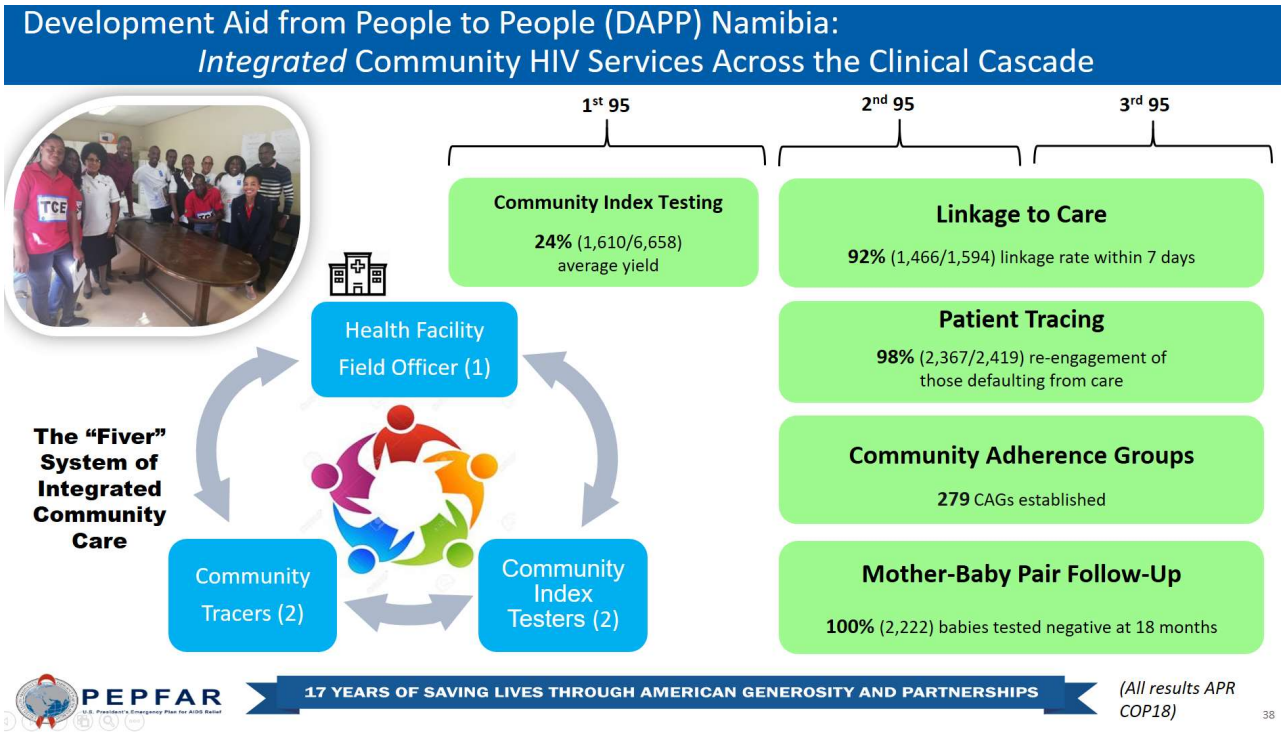


Figure 4.2.4 Integrated Community HIV Services Across the Clinical Cascade



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 (Figure 4.2.5). However, some districts with lower prevalence have room for improvement (Keetmanshoop, Rehoboth, Gobabis, Khorixas and Otjiwarongo). In order to close the remaining gap to reaching full epidemic control, an intensified and targeted focus will need to be implemented in COP20. PEPFAR Namibia will be targeting high volume sites with lower VLS performance for additional support (Figure 4.2.6). The PEPFAR Namibia COP20 vision for maintaining and improving viral load suppression includes: 1) ART Optimization through TLD adherence with urine TDF point of care testing and TLD drug resistance monitoring with CADRE; 2) Improving Adherence and Retention through Patient-Centered Models (MMD, CAG, CBART, PeleBox, SMS reminders); 3) Expanded Patient Tracing, 4) improving viral load monitoring (Clinical Mentorship Model, QI Collaboratives), and 5) Client-Centered Experience (CETA mental health, positive messaging, healthcare worker trainings in customer service through MenStar methodology).

Optimizing ARV regimens will be a critical component to achieving durable viral load suppression. Namibia will be fully transitioned to TLD in COP19 (see section 4.3), as per the updated national ART guidelines which include TLD as the first-line regimen for all eligible populations, and NVP-based regimens will be phased out. Viral load monitoring will be improved by providing near point of care VL testing for pregnant and breastfeeding women and patients failing treatment with GeneXpert machines. With the proposed targeted interventions to improve those few regions that are lagging, the aim is to achieve 95% VLS across all districts in Namibia by the end of COP20.

Figure 4.2.5 Viral Load Suppression by Age and Sex

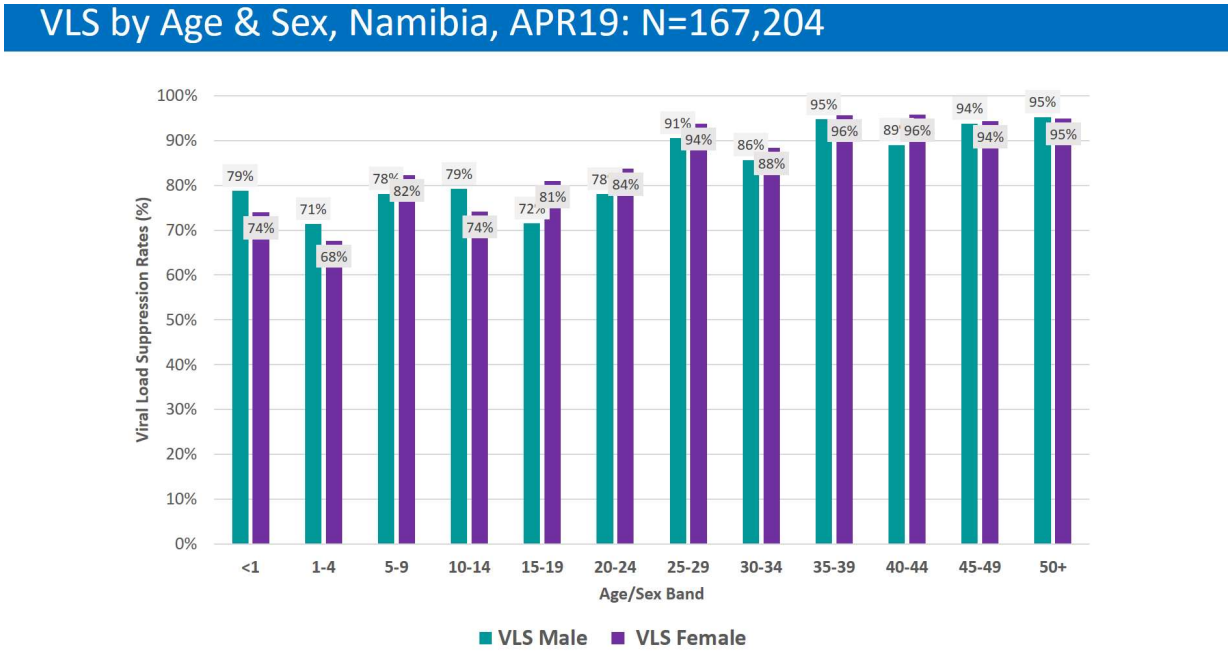
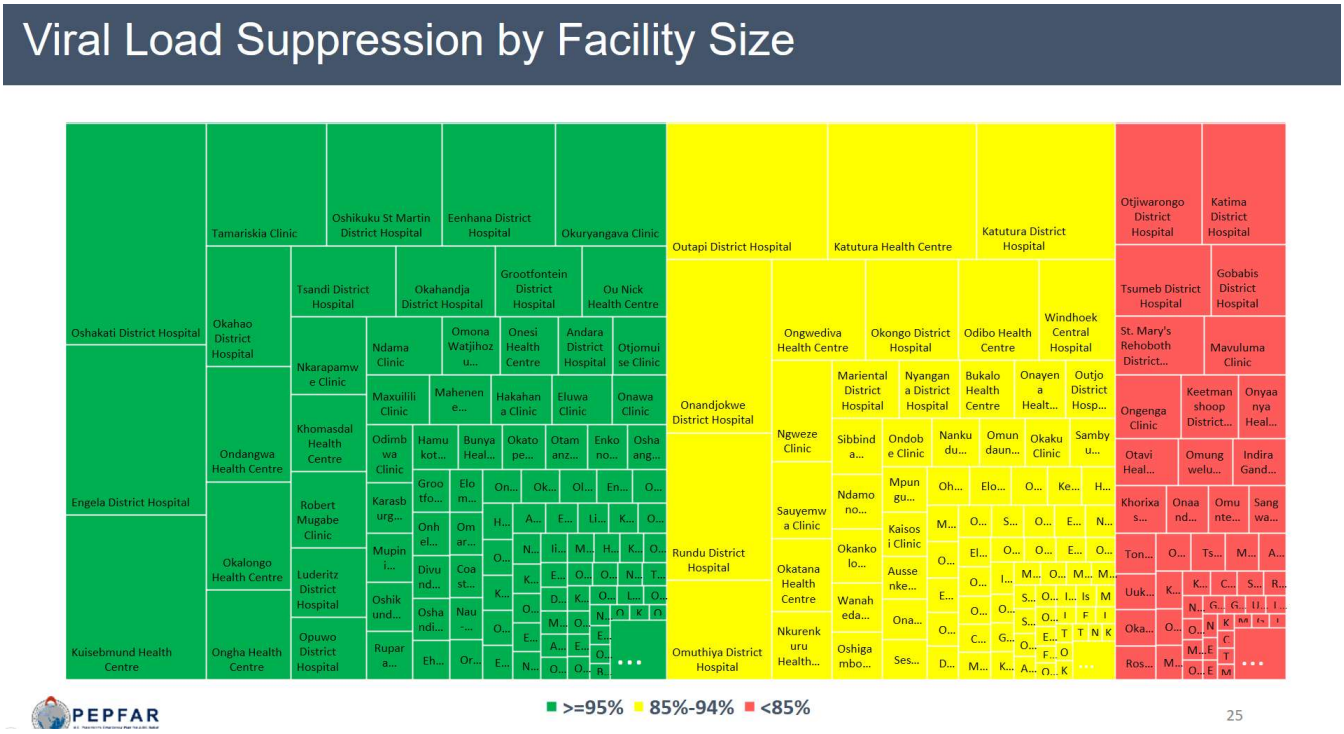


Figure 4.2.6 Viral Load Suppression by Facility Size



4.3 Prevention, specifically detailing programs for priority programming

HIV Prevention and Risk Avoidance for AGYW and OVC

PEPFAR-supported AGYW and OVC activities are implemented in partnership with the MGECW, MOHSS, Ministry of Sport, Youth and National Service, the Ministry of Education, Arts and Culture and Ministry of 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 and adult populations. The activities ensure that AGYW, OVC, and their caregivers receive PEPFAR assistance, and are linked to national strategies for support.

In COP20, PEPFAR Namibia will implement the approved DREAMS package to reach 75% saturation in all PEPFAR-supported districts and age bands. Important to note, is that districts like Omuthiya and Tsumeb are already closer to reaching 75% saturation in the younger age band of 10-14 in COP19. Implementation in COP20 will focus on closing the gap. PEPFAR Namibia is expanding AGYW interventions covering two (2) additional regions (inclusive of four additional districts of Rundu, Nyangana, Andara and Oshakati) through a new mechanism. These regions were selected based on HIV incidence among AGYW, HIV burden among the general population and 10-24-year olds, new HIV cases among AGYW and AGYW population size. Other factors considered included presence of trucking corridors, teenage pregnancy rates and presence of universities.

PEPFAR Namibia supports rapid implementation of a layered DREAMS package of services. Interventions include adolescent-friendly sexual and reproductive health (SRH) services and partner notification referral to HTS or ART. 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. All partners use a unified DREAMS layering, tracking and reporting system developed in COP17. Consolidated data will be reported by one partner in DATIM. Additionally, PEPFAR Namibia will draw on existing HQ mechanisms to assist local partners in accelerating DREAMS implementation in new

districts. These mechanisms have expertise in pediatric, youth and community-based programming as well as AGYW and OVC.

In COP20, PEPFAR Namibia will work with GRN and partners to saturate DREAMS districts by engaging with new schools to reach at-risk girls; increase the number of safe spaces, and support Peace Corps Volunteer placement in DREAMS districts. Through a new G2G agreement, PEPFAR Namibia will help the GRN to address implementation challenges for DREAMS and OVC, develop a sustainability strategy for DREAMS interventions, and strengthening the GRN coordination structure for AGYW. The G2G agreement will help build capacity of the Ministry, create stronger inter-government coordination with other ministries, and drive the institutionalization of DREAMS interventions within government systems.

At the end of COP18, the DREAMS project reached 13,462 individuals who completed the primary and secondary package of services. 4,117 AGYW were enrolled on PrEP and 1,774 AGYW received post-GBV care. PEPFAR Namibia is making sure PrEP is accessible to high-risk AGYW by bringing PrEP to safe spaces and by ensuring clinics are staffed with AGYW friendly nurses. In COP20, PEPFAR Namibia will continue to employ demand creation strategies such as engaging teachers, community members, disseminating IEC materials, routine healthcare worker sensitization, engaging AGYW champions as HIV prevention and PrEP ambassadors and considering medication repackaging to improve PrEP uptake. At the district level, DREAMS Ambassadors will jointly coordinate activities with existing program staff. At the OU level, the USG will recruit a DREAMS Coordinator responsible for program implementation. The PEPFAR Namibia program will create employment and leadership opportunities for AGYW as opportunities become available, such as jobs serving as district assistant coordinators/ advisors, mentors and community health workers.

In Q4 of COP18, the OVC program reached 31,855 beneficiaries, compared to its target of 37,107. Of those reached, 26,983 were OVC under the age of 18. The OVC program implements an HIV risk assessment for OVC and as a result, in Q4, 100% of OVC under 18 reached had a known HIV status. All children reported as HIV positive were on treatment. PEPFAR Namibia supports case management, deployment of healthcare workers (HCW) and uses tools and training to strengthen layering and to address comprehensive needs of children, caregivers, and families. In COP20, PEPFAR Namibia plans to reach saturation of existing OVC districts where current interventions are not at scale. The program will intensify interventions in four additional districts where only Peace Corps is currently present, but which have high HIV burden and high populations of CLHIV.

One of the important pivots the OVC program made in COP17 was the deployment of HCW in health facilities to facilitate identification of HIV positive children, children of HIV positive caregivers, teenage mothers or pregnant teenagers, and children of other priority populations. HCWs were also tasked with linking these children to both OVC and health services. This pivot continued through COP18 and is currently implemented in COP19. The OVC program continues to second community health workers (CHWs) at high volume clinics to ensure all CLHIVs are invited to enroll in the OVC program. In the current districts, 26% of pediatric ART patients are enrolled in the OVC program. In COP20, PEPFAR Namibia will invite 90% of children living with HIV in PEPFAR-supported districts to enroll into the OVC program.

The program additionally strengthens support for retention and adherence by monitoring viral suppression for CLHIV. PEPFAR Namibia will continue to implement and strengthen the index (HIV-infected) client-based household recruitment process. The OVC program works collaboratively with clinics to first identify HIV-infected children using the electronic dispensing tool (EDT) list and then offers family enrollment into the OVC program. This process provides needed psychosocial and family support to children, coupled with clinical care provided by health facilities. To improve linkage to testing and treatment, the program will work with local Namibian HIV support groups and networks at sites to identify children of support group members and at-risk children. The OVC program leverages

collaboration with pediatric, PMTCT, and treatment programs to ensure caregivers are trained on ART regimens and adherence support for CLHIV. As one example, CHWs identify children with adherence or viral load suppression issues and refer them to the nurses or mentors for house visits and follow-up for further interventions, including education on regimens and disclosure support.

In COP20, both DREAMS and OVC programs will ensure that the PEPFAR primary prevention of sexual violence and HIV modules for 9-14-year olds is implemented with fidelity to ensure that that children are not infected in the first place. The focus for this group is evidence-based programming that prevents sexual violence, delays sexual debut, and prevents HIV. PEPFAR Namibia implements violence risk assessments and reports experiences of violence at home and school for OVC. Additional support will strengthen disclosure for children and adults living with HIV. Parenting programs, such as the Families Matter! Program or other recommended programs, which focus on decreasing violence against children and promoting positive parenting to reduce adolescent HIV risk behaviors, will continue to be implemented. Through the OVC program, there will be an emphasis on reaching boys using specific curriculum such as Peace Corps Boys Respecting Others (BRO), Youth Exploring and Achieving in Health (YEAH) and Girls and Guys Leading Our World (GLOW). Household economic strengthening interventions to mitigate the impact of HIV will be conducted. Additionally, PEPFAR Namibia will provide technical assistance to GRN on social welfare grants, the development of a standardized case management system, social welfare training, service networks, and monitoring and evaluation (M&E) systems.

PEPFAR Namibia contributes to capacity building for local CSOs. As DREAMS and OVC programming is expanding to new districts, PEPFAR Namibia will engage in organizational capacity development services, primarily by using a central mechanism designed to rapidly prepare local organizations and governments to serve as prime partners for PEPFAR programming in African countries. The central mechanism serves as a support option for OU local partner strategies and assists with conducting Organizational Capacity Assessments (OCAs), Non-U.S. Organization Pre-Award Survey (NUPAS) assessments, capacity development technical assistance for financial, HR systems, PEPFAR reporting, and ensuring compliance with award requirements and performance.

Key Populations

In FY19, programmatic data demonstrate strong linkage to treatment for all KPs diagnosed with HIV. Overall, linkage to treatment was 102% among FSW and MSM. However, only 57% of newly diagnosed TGWs were linked to treatment.

In Q1 FY20, PEPFAR Namibia demonstrated improvements in linkage to treatment. Overall, 96% of KPs newly diagnosed were linked to treatment and 94% of those eligible were virally suppressed. This is a direct result of active partner management for focused and intensified peer education and referral. PEPFAR Namibia used the findings from the 2018 Priorities for Local AIDS Control Efforts (PLACE) study, as well as formative assessment and dialogue during the 2019 Namibia Integrated Bio-Behavioral Survey (NAM-IBBS), to facilitate and optimize targeting of high-risk individuals and development of a clear referral pathway.

The NAM-IBBS highlighted gaps in reaching KPs through engagement by peer educators. Only a small fraction of KPs have interacted with peer educators within the past six months; (15% FSW vs 9% MSM in Windhoek, 12% FSW vs 10% MSM in Walvis Bay/Swakopmund and, 3% FSW in Katima Mulilo). In COP20, PEPFAR Namibia will use the findings from the NAM-IBBS to further improve reach and linkage strategies for KP in Namibia. High quality comprehensive HIV prevention services for KPs will be expanded to cover three more districts (Swakopmund, Otjiwarongo and Gobabis) in addition to the current seven districts (Walvis Bay, Katima Mulilo, Oshikango, Oshakati, Rundu, Keetmanshoop, and Windhoek). This expansion will ensure the program addresses gaps identified in the NAM-IBBS to reach

previously unreached groups. In the ten priority districts, programmatic interventions will include engaging FSW, MSM and TGW-specific local CSOs. PEPFAR Namibia will also focus programmatic efforts towards training of peer educators and case workers within their networks to reach individuals. TGW and MSM peer educators will be trained and deployed to become agents to reach their peers and link them to clinical services at KP-friendly facilities through enhanced peer outreach approach (EPOA). In COP20 we will ensure the delivery of KP competent services through greater use of information, communication technology, social media for both prevention and retention services.

Programmatic approaches to improve HTS yield and increase case finding in COP20 will build on current activities supported in COP19. These include risk screening and optimized HTS among social networks, and assisted HIVST programming to complement outreach moonlight 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 program will continue to expand coverage of PrEP among KPs by addressing context specific barriers to PrEP through HCW competency, peer education and engaging private medical facilities to enable uptake among all groups, particularly MSM and TGW.

Building institutional and technical capacity of CSOs from the LGBTI community will form the foundation of PEPFAR Namibia's programming in COP20. Programmatic work with KP-led CSOs will also leverage resources from KPIF. KP-led CSOs will offer community monitoring and support violence response and reporting among key populations.

VMMC

The modeled national coverage for VMMC among priority age groups of 15-29 years old is 47.7% (Decision Makers Program Planning Tool, DMPPT-2 2019). PEPFAR Namibia's primary objective is to support MOHSS to increase coverage of VMMC services among priority age bands (15-29 years) in high volume priority regions/districts. As a result of PEPFAR Namibia support to the MOHSS in FY19, national VMMC coverage among young men aged 15-29 years old increased to 47.7% by the end of calendar year 2019. Regions with direct PEPFAR support recorded some of the highest coverage: Windhoek (Khomas region 62.2%), Katima Mulilo (Zambezi Region 70%), Oshakati (Oshana region 61%), Swakopmund and Walvis Bay (Erongo region 55%) (DMPPT, Version 2.0, 2019).

In FY20, PEPFAR Namibia completed an agency portfolio shift, building on existing strategies to focus on uncircumcised men 15+ years old in order to increase national VMMC coverage. Overall, the OU target for FY20 is 50,203. Priority regions include 12 of the 14 regions in Namibia, including Khomas, Hardap, Erongo, !Karas, Oshikoto, Oshana, Ohangwena, Omusati, Zambezi, Kavango West, Kavango East, and Otjozondjupa.

In FY21, PEPFAR Namibia will fully implement an age pivot and will achieve the overall OU target of 22,695. PEPFAR Namibia's COP20 target will rapidly saturate in seven priority regions (Khomas, Zambezi, Ohangwena, Omusati, Oshana, Erongo, and Karas) to 78% coverage of VMMC. The delivery of VMMC services in Khomas, Zambezi, Oshikoto, Oshana and Kavango East regions will complement PEPFAR Namibia's DREAMS program in these regions. As part of the comprehensive package of services for DREAMS, young men will be referred for VMMC.

PEPFAR Namibia will continue to support age-specific, scientifically proven and human-centered demand creation targeting for young men aged 15+, increase efficiencies of the clinical team at fixed and outreach sites, enhance site optimization, and provide direct service delivery to high volume sites. In FY21, the demand creation strategy will be refocused to reach priority age groups, 15-29 and geographic

areas with unmet needs utilizing existing institutions, traditional leaders, mobilizers within the community and churches. These include public messaging, peer promotion by recently circumcised men, improving facility setup to increase privacy, enhanced community mobilization, and engagement of female partners.

PEPFAR Namibia will also support MOHSS to develop a sustainability plan for the regions approaching saturation (Zambezi, Oshana and Khomas), proficiency assessment for clinicians, development of quality management (QM) and quality assurance (QA) to ensure client safety in COP20. In FY20, PEPFAR Namibia will support MOHSS to adopt WHO/PEPFAR adverse event management protocols and establish a system to improve adverse events prevention, management, reporting, and referrals. Health care providers will be trained based on WHO/PEPFAR standards using an online training hub (OTH), developing quality monitoring and patient safety standards and onsite supervision.

By the end of FY20, all PEPFAR-supported VMMC sites will fully transition to the reusable dorsal slit technique in line with SGAC guidance. In FY21 additional technical assistance will be provided to ensure the entire national program, including the Global Fund-supported activities, shifts to the dorsal slit method of circumcision. All new VMMC services providers will be trained on the dorsal slit method and refresher training for existing cadres will continue in FY21.

PrEP

PEPFAR's support for PrEP programs in Namibia has continued to show high performance. In FY18 and FY19, PEPFAR Namibia achieved over 300% and 232% of the overall OU target for PrEP_NEW. In FY19 the program enrolled more than 10,583 high risk individuals 15+years old on PrEP. Namibia is succeeding in reaching KPs, serodiscordant couples and AGYW through the different programs. With assistance from PEPFAR, the MOHSS has finalized and adopted PrEP standard operating procedures, training materials and demand creation, and M&E tools.

In COP20, PEPFAR Namibia will continue to expand PrEP services and will focus on the scale up of PrEP in four key priority service areas. PEPFAR will target PrEP to address key gaps for prevention among KPs and increasing numbers of new infections among pregnant and breastfeeding women. Programmatic targeting for PrEP will also be tailored to emerging evidence of new HIV infections from recency testing. As a result, PrEP will be scaled up through; 1. PEPFAR will engage ANC clinics to drastically 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 HIV- negative individuals who are at high risk of acquiring HIV infection are offered PrEP; and 4. PEPFAR will continue to prioritize KPs for PrEP expansion through both community and facility-based service delivery approaches.

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

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

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

The MOHSS has been leading the TLD transition, and formally launched the transition on October 1st, 2019 with a target date for completing the transition of June 30th, 2020. As of January 31, 2020, more than 24,000 patients were either transitioned to or newly initiated on TLD with the majority (60%) of them being women. To support the transition, PEPFAR Namibia allotted $300,000 in COP19 and will allocate a

further $475,000 for TLD 180-day pack procurement to complement the GRN's ongoing procurement of TLD as first-line drug. The COP20 procurement of about 11,000 packs of 180-day bottles of TLD, is designed to accelerate 6-month multi-month dispensing.

In terms of ARV optimization, PEPFAR Namibia will continue to support MOHSS to rapidly and vigorously phase out the use of NVP-based first line ART regimens among both adults and children. PEPFAR Namibia and MOHSS will no longer procure nevirapine-based and efavirenz-based ARVs in COP19 and COP20.

COP19 is in the final stages of protocol submission for the Cyclical Acquired HIV Drug Resistance (CADRE) monitoring. These data will provide information about drug resistance emerging in patients largely failing pre-TLD phase 1st and 2nd line ART regimens in Namibia. However, a second round of CADRE in COP20 will allow Namibia to detect early emergence of HIV drug resistance mutations during and after TLD transition. Additionally, establishing lab-based drug resistance monitoring will assist Namibia to sustainably be able to monitor TLD resistance in future years.

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

Differentiated Service Delivery (DSD) continues being scaled up in many regions and by the end of FY20 Q1, Namibia had 206 Comprehensive Community-Based Health Services (CCBHS); 859 Community Adherence Groups (CAGs) and 98 teen clubs across the country. The number of patients enrolled in community-based models continued to increase steadily through FY20 Q1 ending the quarter with 13,280 patients enrolled in the community-based models and 3701 teens enrolled in teen clubs. Further expansion of the differentiated service delivery model will be accelerated in COP19 and COP20, including population-specifics CAGs to address adolescents and men.

In terms of MMD, Namibia has made progress towards implementation of MMD. Review of data from the EDT system for the period January to December 2019 show that of the 160,000 patients who picked up their ART at sites with the EDT-the majority (53%) of them received medicines for three months or more. In COP19 and COP20, PEPFAR Namibia will continue to ensure that more patients eligible for MMD receive their medicines for up to six months with the goal to have 80% of TX_CURR receiving at least 3-6 months of medications at a time. The COP20 procurement of about 11,000 packs of 180-day bottles of TLD is designed to accelerate 6-months multi-month dispensing.

Alleviating the challenges of costs and transport for clients is one area identified as common reasons for missed pill pickups. Namibia is well poised for further expansion of CAGs and CCHBS. In COP19, a National Differentiated Service Delivery Coordinator was hired and placed at the MOHSS National Office, to lead a coordinated scale up of DSD, ensuring that all stakeholders both within facilities and communities are working together in a well-coordinated scale up effort, while also closely monitoring the volume and quality of DSD services. The DSD SOPs and training curriculum, completed in FY19 will be used to rapidly expand CAGs to more regions in a standardized manner. In COP20, a few high-volume regions will be resourced with regional coordinators to help further accelerate the scale up of CAGs. The eligibility criteria will be updated to include broader populations previously not included in DSD, including pregnant and breastfeeding women (PBFW), children and newly enrolled ART clients.

Addressing Low ART and VL Coverage in Four Low Burden Regions

Although most regions have been performing very well in terms of ART coverage and viral suppression, there are four regions that have been underperforming due to a lack of support as previous years have been focusing on high-burden regions (!Karas Hardap, Kunene, and Omaheke). In COP19, PEPFAR Namibia began providing targeted support to these areas in order to improve the quality of clinical services to achieve improved viral load outcomes. In COP20, PEPFAR Namibia will continue

strengthening support to these regions through targeted HR support, clinical mentoring, quality improvement and infrastructural modifications to ensure quality client-centered care.

Effective TB Case-Finding and TB Preventive Therapy for TB/HIV Co-Infected Populations

There has been a steady rise in PLHIV screened for HIV since FY17 Q2 (36%), peaking at 91% in FY19 Q2. Furthermore, Namibia has a high coverage of TB clients knowing their HIV status and HIV positive clients being started on ART. The number of people who know their HIV status rose from 88% in 2017 and has remained high at 99% since then. The percentage of HIV-positive TB-co-infected patients has declined over the years from about 60% in 2007 down to 32% in 2019. This has been coupled by an increase in clients being put on ART and cotrimoxazole preventative therapy, with rates reported at 98% and 99% in APR2019 respectively.

Although there has been an increase in the TB screening rates, there is a need to improve the quality of screening to achieve a positivity rate of 5% in those already on ART and at least 10% in those newly initiating ART. As part of strategies to improve TB case finding, TB LAM has been rolled-out since December 2019. Implementation is done using the revised WHO November 2019 criteria for both in- and out-patient settings. In COP20, PEPFAR Namibia will support the full implementation of TB-LAM in all Regions. NIP has also migrated to Xpert MTB RIF Ultra. In order to strengthen TB contact investigation for PLHIV with TB and scale up testing of their sexual partners and biological children for HIV, PEPFAR Namibia will capacitate TB field promoters to support HIV self-testing. The HIV CHWs will also be capacitated to support TB contact tracing.

Namibia has faced challenges in the past with health care workers who struggled to understand and correctly fill the patient record systems on the TB Screening Cascade. In COP19, Namibia developed job aids to assist in mentoring health care workers on properly screening and recording TB screening. Namibia is also implementing the revised TB sputum register, to include a section on HIV testing to ensure that all presumptive TB cases are also tested for HIV. These interventions will continue to be strengthened in COP20. TB infection control guidelines will be revised in COP19 with full implementation of activities in COP20.

TB Preventive Therapy data in DATIM shows a total of 35,000 having completed TPT by April 19. However, to understand the actual number of patients who completed TPT, data reviews were done as part of the NAMLIVE initiative at most of the sites. The data reviews showed that an additional 60,470 active clients had completed TPT and had TPT start and completion dates recorded in the electronic patient system. Utilizing ePMS as well as using the new definition of Tx_Curr of 28 days for LTFU, a total of 142,116 active patient had evidence of initiating TPT and 95,224 had documented TPT completion. This translates to a 67% TPT completion rate. There has been excellent improvement in completion rates in the last reported cohort (Q4, FY2019) with completion rates at 85%. COP19 funds will be used to translate developed posters and leaflets into six languages to improve demand,

3HP will be introduced in June 2020 to support TPT scale-up. COP19 resources will be used to roll-out 3HP with an additional 30,000 clients put on 3HP in COP20. This will be supported by conducting TPT scale up campaigns, continued quality improvement projects as well incorporating TPT in the DSD and community-based models.

Border Epidemic

Namibia has a growing population of non-Namibians accessing health services along its borders. In COP19, PEPFAR Namibia is already supporting many service delivery points along the northern border. Health system and service delivery challenges limit seamless access, utilization of services and availability

of strategic information for planning, decision-making, quality management, and tracking patient level data to determine health outcomes.

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. Data from the ePMS for ART patients was analyzed and stratified by nationality for the period January 2017 to September 2019, in four regions of Namibia that share a border with neighboring countries. Analyses show that for both the adults and children diagnosed with HIV in those four regions (2,732 immigrants, 20,805 Namibians), ART was rapidly initiated at the same rate regardless of citizenship. This indicates that Namibia is aggressively addressing the HIV epidemic at the border without regard to nationality.

PEPFAR Namibia will continue scaling up high quality, high yield case finding services in communities near the border in five key regions, namely Omusati, Oshana, Ohangwena, Kavango West, and Kavango East, inclusive of providing self-testing kits to newly diagnosed non-Namibians which they can give to sexual partners or family members. Care and treatment services will include uninterrupted 3-6 months ARV refill, retention interventions, viral load monitoring, and multi-month prescribing and dispensing to reduce cross-border burdens for the clients. TB preventive therapy and cervical cancer screening will continue being provided at fixed sites and through community outreach services. Health system strengthening will include adequate HRH and commodity assistance while continuing to support cooperative meetings between the national governments. PEPFAR Namibia will continue to ensure HIV and related services such as ANC, and TB client services including HIV testing and treatment and prevention, are provided free-of charge in the public sector for Namibians and non-Namibians. Finally, strategic information will also be strengthened, to gather patient-level data management, monitoring and reporting, and documentation of non-Namibians accessing services in Namibia.

Improve Access to HIV Services in Prisons

In the last mile to achieving sustained epidemic control, the GRN with PEPFAR support is prioritizing reaching people in prisons with case finding, same day ART initiation, and retention interventions. Namibia has an estimated prison population of 200 prisoners per 100,000 population and has 14 correctional facilities.

In COP19, as part of the DSD models PEPFAR and the MOHSS began supporting the Correctional Services in addressing the epidemic in prisons and police holding cells. Working with the MOHSS and the Ministry of Safety and Security, teams conducted a baseline assessment in all the 14 Correctional Services facilities across Namibia to determine the burden of disease (% current on ART on the day of assessment) and the quality of services. Site visit assessments were conducted using a standardized tool for quality assessment. Available Medical Officers/ Nurses, Health Assistants/Counselors, together with case management and programs or rehabilitation coordinator officers were interviewed. Monthly and quarterly reports and relevant records were also reviewed, and offenders' living quarters were inspected.

During the assessment, PEFPAR Namibia found that between 5 and 17% of the clients in the correctional facilities were on ART at the time of assessment. Several quality gaps were identified and needed to be addressed in order to ensure high quality of HIV services that comply with the national standards set by the MOHSS. Based on the findings from the assessment- Technical Assistance for the development of a Minimum Package of Services for the Prisons and Police Holding Cells will be provided. In COP20 PEPFAR Namibia will support the Ministry of Safety and Security to roll out the implementation of the Minimum Package of Services throughout all the Correctional Facilities as well as the Police Holding Cells.

Common Elements Treatment Approach (CETA)

In COP19, PEPFAR Namibia began supporting the Ministry of Health to introduce mental health care into HIV services. The Common Elements Treatment Approach (CETA) will be used, which is an integrated program fully delivered by lay providers and designed for low-resource settings. In COP19 a brief baseline assessment will be conducted to determine how the CETA approach can be adapted into the Namibia HIV Care and Treatment program setting. In COP20 PEPFAR Namibia will develop a package of interventions for multi-condition screening and treatment by lay workers using the CETA approach. A package of interventions will be rolled out to high volume ART sites which account for most cases needing mental health interventions.

4.5 Commodities

PEPFAR Namibia currently provides program-critical support to MOHSS, and particularly the Central Medical Stores (CMS), to prevent maldistribution, stockouts, and wastage of HIV-related commodities. This support will continue in COP20, the aim of which is to avoid HIV service interruptions. The program will focus on improved supply chain strategy and planning, supporting efforts to optimize treatment regimens and expand multi-month ARV dispensing, and strengthening in-country systems and capacity to undertake timely and best value commodity procurement. PEPFAR Namibia will also support the systematic triangulation and analysis of distribution, dispensing, and patient data, and the adoption of GS1 standards for greater transparency and traceability.

In October 2019, Namibia began a nine-month transition to TLD as the first-line regimen for eligible adults. By the end of January 2020, approximately 24,000 individuals initiated TLD. For COP20, PEPFAR has allotted $475,000 for procurement of TLD-180 to complement the GRN's procurement of first-line drugs, and to catalyze increased multi-month dispensing.

With relatively few pediatric ARV patients, the GRN has struggled to locate suppliers for small batches of drugs. In COP20, PEPFAR Namibia will procure 5,623 bottles of dolutegravir 10mg tablets; 25000 boxes of Lopinavir/Ritonavir/Abacavir/Lamivudine 40/10/30/15 mg granules in capsules; 600 bottles of atazanavir 200mg; 60 boxes of raltegravir 100mg granules sachets, and 150 bottles of darunavir 75mg tablets. PEPFAR will also procure 7,001 100 mL bottles of 10mg/mL suspensions of nevirapine and 1,000 100mL bottles of 10mg/mL suspensions of zidovudine for infant prophylaxis.

In COP20, PEPFAR Namibia will also procure 30,300 packs of Rifapentine/Isoniazid 300/300mg tablets, along with 2,449 bottles of 1,000 tablets of pyridoxine 50mg to continue supporting the introduction of shorter-course TB regimens. To support the VMMC program in COP20, the program will procure 2,947 disposable VMMC surgical kits, 500 reusable kits, and 8,001 single-use kits of essential consumables.

To support COP20 PrEP expansion, PEPFAR will procure 266,358 bottles of 30 tablets of Emtricitabine/Tenofovir 200/300 mg, and corresponding HIV rapid tests (230,000 Colloidal Gold, 32,300 Uni-Gold, and 1,000 SureCheck). PEPFAR Namibia will also procure 39,195 HIVSTs and 15,000 HIV recency tests. Laboratory support will include the procurement of 18,400 urine LAM assays 4,500 Urine TDF tests, and GeneXpert cartridges (2,300 Ultra and 1,000 EID).

4.6 Collaboration, Integration and Monitoring

PEPFAR Namibia's interagency coordination has been enhanced over the past year, with the completion of the realignment of programs. This has resulted in fewer international partners, and more ability for the MOHSS to lead a unified, coordinated nationwide HIV program. No clients' services have been disrupted, which was a primary goal during realignment of programs. Further, program areas form an integrated

cascade across the three 95s, with the community, facility, and health system partners, successfully providing comprehensive services. Some are PEPFAR-funded, and some are funded by the MOHSS or other stakeholders, or in combination. This model represents Namibia's vision of streamlined, efficient partners, coordinated as one portfolio by the Ministry. This extends to a comprehensive and integrated prevention approach, with a focus on highest risk or unreached populations. This structural sustainability model in Namibia is expected to increase domestic ownership, financial responsibility, and quality of care with successful outcomes (Figure 4.6.1). With this framework, results and plans will be used to guide the development of plans for the different program areas.

Working with host government structures and international implementing partners to increase the capacity of indigenous partners is a continued key focus for COP20 collaboration, integration and monitoring. Approximately 72% of PEPFAR Namibia funds are currently allocated to indigenous organizations and there is potential for this to increase up to 92% once the to-be-determined (TBD) mechanisms are awarded. PEPFAR Namibia is accomplishing a higher percentage of funds to indigenous partners through the following:

- Increasing the delivery of direct HIV services, along with non-direct services provided at site level, through local organizations;
- Supporting local partners to establish enough capacity, capability, durability and impact through transition planning mandates in cooperative agreements with international partners; and
- Pursuing new agreements through indigenous partners by using the PEPFAR waiver (HIV/AIDS Expedited Procurement Procedures, EPP) and/or limiting competition to local organizations, as legally appropriate.

In coordination with the GRN, civil society organizations, private sector and other key donors/agencies (i.e., Global Fund, UN, U.S. Treasury, and World Bank), 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. In FY 2018/2019, HRH planning and analysis, social contracting, efficiency technical assistance and studies, and a public health expenditure review were completed, and the results are informing COP20 implementation for HRH support to develop a strategy for transitioning HRH functions. Furthermore, PEPFAR Namibia will support integration of sample referral and result reporting in the GRN systems.

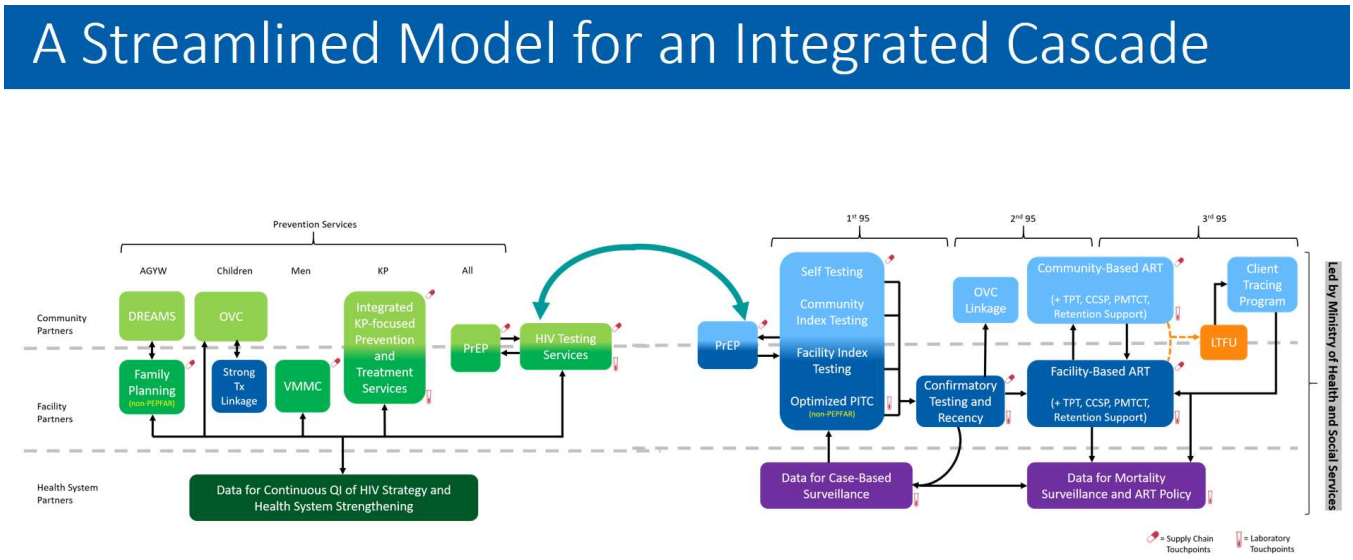
PEPFAR Namibia and agencies are represented in the Health Development Partners group, a coordinating body led by WHO and comprised of multilateral and bilateral partners. Collaboration is also strengthened through a strong presence by all agencies on technical working groups within the MOHSS. PEPFAR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

CDC and USAID conduct active management of implementing mechanisms via in-person meetings with partners, agency project officers, and respective technical advisors. Reviews of quarterly national and SNU performance against MER and custom indicators and an analysis of SNU and site-level data are conducted. Reviews also focus on quarterly disbursements, accruals and upcoming expenditures, and SIMS findings. Feedback or technical direction is provided during these meetings.

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

The interagency team will also improve service delivery quality and efficiency by scaling-up implementation of viral load suppression in younger age groups; accelerating multi-month dispensing of ARVs in COP20 by procuring a limited supply of TLD 180 packs; and introducing innovative technologies such as SMS reminders for ARV refills, PeleBox for SmartLockers for ease of repeat medicine collection in urban settings, and urine TDF point-of-care testing to monitor TLD adherence among patients who are not suppressed. The use of Table 6 and the Funding Allocation to Strategy Tool (FAST) ensures that targeted above-site activities are mapped to optimize country systems to govern and manage the HIV response by focusing on key programmatic barriers.

Figure 4.6.1 Streamlined Model for an Integrated Cascade



4.7 Targets for scale-up locations and populations

PEPFAR Namibia does not have any scale up locations.

Table 4.7.2 VMMC Coverage and Targets by Age and Bracket in Priority Regions (2020 SDS)

Target Populations [Specify age bands for focus]	Population Size Estimate(Gap per SNUs)	Current Coverage (Expected)	VMMC_CIRC	Expected Coverage
	(SNUs)	FY20	(in FY21)	(in FY21)
Male Population, Age 15-29	28,443	82%	863	83%
Male Population, Age 15-29	21,491	57%	3,440	80%
Male Population, Age 15-29	21,078	51%	3,426	80%
Male Population, Age 15-29	18447	49%	4,257	80%
Male Population, Age 15-29	15,298	45%	2,617	80%
Male Population, Age		72%	1,955	80%

15-29	15,055			
Male Population, Age 15-29	13,519	39%	1,742	80%
Male Population, Age 15-29	10,999	84%	358	88%
Male Population, Age 15-29	10,266	27%	1,889	80%
Male Population, Age 15-29	7,245	54%	1,324	80%
Male Population, Age 15-29	4,523	90%	211	91%
Male Population, Age 15-29	3,133	41%	609	80%
Total COP20 Target			22,695	

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 (NAM-IBBS), which provided updated information on population size estimates for FSW, MSM and TG people. A summary of population size estimates is provided in standard table 4.7.3.

The PEPFAR Namibia COP20 target for KP_PREV in scale-up districts has taken into consideration the population size estimates from the 2019 NAM-IBBS and program data from seven districts. Additionally, findings from the 2018 PLACE study have also been used to validate size estimates for MSM and FSW in Windhoek. Overall, the COP20 targets align with the goal of reaching 90% of estimated KP through peer-driven interventions and linkage to clinical services that include HTS, PrEP and ART. Other vulnerable groups will be reached alongside reaching key populations with HIV prevention interventions. These include children living with key populations in hot spots and other high-risk groups, such as seafarers at the coast.

Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY21)	FY21 Target
FSW (KP_PREV)	*8,082 2,440↑, 970↑↑, 890↑↑↑	90%	14,872
MSM (KP_PREV)	2,210↑, 670↑↑	90%	6,234
TG Women (KP_PREV)	N/A	90%	-
AGYW (PP_PREV)	**102,832	90% (Eligible high risk)	52,058

*IBBS 2013
**2018 Projected Population for girls 10-24 years old (Oshikoto, Zambezi and Khomas)
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 FY20. All beneficiaries living in households that were not affected or infected by HIV (24% of households) were marked for graduation in COP20. The number of HIV+ OVCs in FY 20 was also compared to the number of actively enrolled pediatric ART patients, with the OVC_SERV target increasing in each SNU so that all 100% of all CLHIVs on ART are enrolled in the OVC program. The COP20 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 2020 Spectrum and 2020 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 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 COP20, PEPFAR Namibia will reach a total of 54,868 OVCs in all implementation SNUs (70% of which represent active OVC beneficiaries as just over 16,000 are expected to be graduated), of which 15,859 will be AGYWs in DREAMS SNUs. Targets have increased from 34,719 in COP19 to 54,868 in COP20 due to increased expansion of the DREAMS and OVC programs, as well as the new enrollment of all pediatric ART patients into the OVC program. HIV risk assessments will be conducted to ensure that 100% of all 50,847 OVC under age 18 have a known HIV status. 100% of OVC infected with HIV in PEPFAR Namibia supported sites will be linked to treatment and have their viral load monitored.

Table 4.7.4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children***	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*
Andara	2,305	1,366	1,290
Nyangana	2,200	1,409	1,356
Rundu	12,021	5,455	5,132
Okongo	2,959	370	290
Eenhana	6,464	3,656	3,285
Engela	15,861	7,671	6,901
Katima Mulilo	10,484	7,998	7,428
Keetmanshoop	3,567	108	90
Luderitz	1,809	50	44
Aranos	449	24	21
Rehoboth	2,552	67	56
Mariental	2,355	48	42
Nankudu	2,581	928	836
Nkurenkuru	1,251	162	146
Okahandja	2,032	40	34
Otjiwarongo	3,075	42	36

Okakarara	775	54	45
Grootfontein	1,976	44	39
Omuthiya	6,309	2,643	2,562
Onandjokwe	9,942	4,390	4,279
Tsumeb	2,819	2,570	2,501
Oshakati	20,402	6,255	5,852
Oshikuku	11,055	1,676	1,507
Outapi	8,756	1,361	1,074
Tsandi	4,237	514	399
Okahao	3,060	577	452
Gobabis	5,638	56	48
Outjo	1,329	27	22
Opuwo	3,478	16	14
Khorixas	1,167	13	11
Swakopmund	3,438	162	135
Omaruru	971	38	33
Usakos	794	13	11
Windhoek	26,850	5,065	4,876
Total	184,960	54,868	50,847

*COP20 Datapack
***COP20 Datapack population estimates, DHS 2013 orphanhood estimates

4.8 Cervical Cancer Program Plans

Namibia formally started providing screen and treat services in February 2019, and over the course of COP18 was able to successfully establish 42 static sites providing VIA, cryotherapy or thermal coagulation, along with decentralizing LEEP services from one hospital in Windhoek, to 11 district hospitals nationally. Of these 11 active LEEP sites, seven are fully integrated cervical cancer screening and treatment service units. The fully integrated prefabricated units are in Khomas, Zambezi, Ohangwena, Omusati, Erongo, Kavango and Oshikoto regions. These units offer VIA, cryotherapy, thermal coagulation and outpatient LEEP procedure all in one location, allowing more women who screen positive immediate access to the appropriate treatment modality. As of December 2019, this service has screened 8,011 WLHIV, of which 1,170 HIV positive women were VIA positive and 103 of those who screened positive received treatment, translating into 86% treatment rate for the country. This expansion will continue in COP19 to an additional 18 ART sites.

By the end of COP20, the country is planning to expand access of cervical cancer screening services and to increase targeted screening and treatment rates for WLHIV to 80%. Additionally, a Mixed Model Approach will be introduced to provide cervical cancer screening at fixed and mobile outreach services with emphasis on the outreach model to CBARTs, CAGs, rural ART clinics by using mobile vans for outreach services. Organized campaigns will occur, targeting specifically WLHIV and optimizing ART/PMTCT visits to increase same day screening of WLHIV as standard of care. Additionally, other priority areas for the program will include strengthening the referral system for treatment of invasive cervical cancer, in order to ensure that women diagnosed through the screen and treat program will be able to be treated for invasive cervical cancer, preventing further disease progression. Thermal coagulation will continue to be scaled up in order to increase the rate of same day treatment of eligible pre-cancerous cells to 100%. An increased public-private partnerships and stakeholder involvement is needed to create a sustainable national program. There is a need to standardize data collection tools and implement M&E into national reporting framework in order to improve data quality and timeliness of reporting.

A total of $1.75 million USD will be programed across three partners to scale up services and expand outreach services. A target of 48,576 WLHIV to be screened in COP20. In addressing specific policy related activities that will increase access and scale up of cervical cancer screening the country will develop a 5-year strategic plan for the MOHSS) to expand national programing of the CECAP program outside of PEPFAR. A circular to communicate the change in VIA screening intervals for WLHIV to every other year will be developed and later incorporated in the CECAP guideline once formally reviewed. Further to this, a CECAP Technical Working Group (TWG) will be established that will meet on a regular basis to discuss issues pertaining to CECAP and to advise programing. In order to ensure quality assurance in the program mentoring, supervision and clinical oversight to CECAP providers are provided and regular program data analysis is conducted.

4.9 Viral Load and Early Infant Diagnosis Optimization

Namibia on the national level is well poised to meet the testing needs of patients for VL, IVT and GeneXpert for TB testing. To work towards further optimizing the system, in COP20 the proposal is to do a full analysis of the current utilization and workflow at all molecular sites (high throughput and GeneXpert). Currently, there are eight regional high throughput VL laboratories with 14 total instruments. These instruments at 250 working days have a capacity of 533,000 tests per year. The approximate usage, based on COP18 (FY19) MEDITECH testing numbers, is 33% of capacity (Table 4.1).

Table 4.9.1 Viral load testing overview COP18 (FY19) quarters one through four

Laboratory	Region	District	Catchment Area (number of districts)	Instrument (# of instruments)	Capacity per day (1-8hr shift/1 staff)	HR	Capacity per year (250 working days)	Utilization (%)	Testing Need (% coverage)
Walvis Bay	Erongo	Walvisbay	1	Genexpert 16 (1)	80	1	20,000	4,404 (22)	7040 (63)
Rundu	Kavango West	Rundu	5	Panther (1)	270	1	67,500	22,607 (34)	19652 (87)
Windhoek	Khomas	Windhoek	18	CAPCTM (2- also used for EID)	252	1	184,500 (total)	45,283 (24)	50470 (90)
				C4800 (2)	372	1			
				M2000 (2)	114	1			
Engela	Ohangwena	Engela	1	CAPCTM (1)	126	1	31,500	18,371 (58)	14696 (125)
Outapi	Omusati	Outapi	3	Panther (1)	270	1	67,500	20,659 (31)	23084 (89)
Oshakati	Oshana	Oshakati	3	CAPCTM (2)	252	1	63,000	19,910 (32)	23584 (84)
Onandjokwe	Oshitoto	Onandjokwe	4	CAPCTM (1)	126	1	31,500	25,186 (80)	29391 (86)
Katima Mulilo	Zambezi	Katima	1	Panther (1)	270	1	67,500	16,440 (24)	11523 (143)

Data source: MEDITECH
* Capacity based on 250 working days with one technician during an 8 hour day
+ Approximate usage is per test and includes duplicates and controls and therefor is without true deduplication which is not possible without patient unique identifier
Testing need (FY19Q2)- utilization and coverage numbers are due to incomplete data for all districts and due to movement of samples to backup laboratories

For IVT, testing is centralized to a single laboratory with two instruments and a capacity of 63,000 tests per year, of which approximately 31% is used (Table 4.2). For TB, there are 35 GeneXpert testing sites with 48 machines and capacity 380,000 tests. The approximate usage is 9% (Table 4.2). There are an additional 15 GeneXperts owned and operated by the MOHSS that are in the process of being operationalized for targeted VL testing in COP19 (Table 4.2). The aim is to add additional testing capacity to those machines in COP20.

Table 4.9.2 Summary of laboratories at the national level.

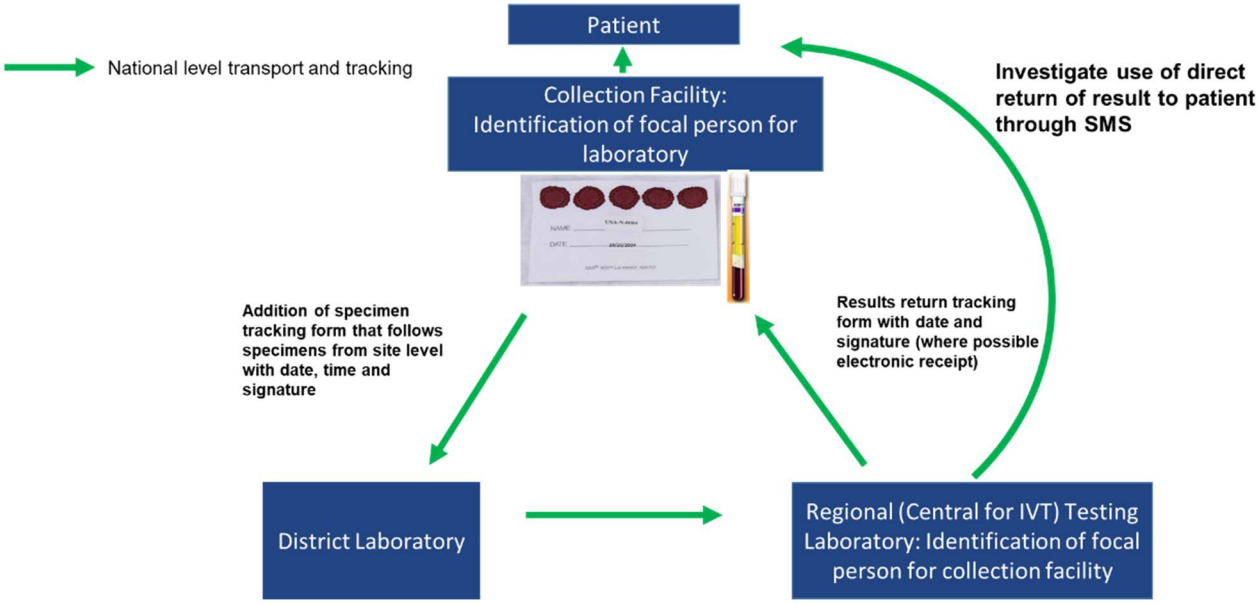
Number of Laboratories	Test Type	Number of Instruments	*Capacity per year	+Approximate Usage (%)	Testing Need	Coverage(%)
8	Viral Load (2 also used for EID as needed)	14	533,000	166,000 (31)	180,000	92%
1	Infant Virological Testing	2	63,000	19,228 (31)	15,000 (x2)	64%
35	GeneXpert TB (35 GX4, 12 GX16, 1 infinity)	48	380,000	34,500 (9)	48000	72%
15	~GeneXpert (not currently in use)	15 (10 GX4, 5 GX16)	150,000	N/A	N/A	N/A

Data source: MEDITECH, Spectrum and Panorama based on COP18 (FY19) quarters one through four.
*Capacity based on 250 working days with one technician during an 8 hour day
+ Approximate usage is per test and includes duplicates and controls and therefor is without true deduplication which is not possible without patient unique identifier
~ Owned and operated by MoHSS and out of the laboratory system
Testing need VL (FY19Q2)- utilization and coverage numbers are due to incomplete data for all districts and due to movement of samples to backup laboratories

Due to low coverage matters and long time to initiation on ART of positive babies, for COP20, the proposal is to expand IVT testing to all capable VL laboratories. Three laboratories in Outapi, Rundu and Katima, have Hologic Panther systems. These systems do not currently do DBS specimens, but laboratories do have GeneXpert platforms for TB that can be utilized for this expansion. Once that is complete, further expansion of access to IVT will be done by adding multiplexing of existing GeneXperts currently used for TB in sites with high need and low coverage for IVT.

Further optimization activities involve assisting the country to towards a national specimen transport, tracking, and results return system. Currently, there is no tracking of specimens or results and movement of specimens and results from the facilities and back to the facilities is largely done in an ad hoc manner. Between laboratories and in a few designated clinical settings, NIP manages specimen transport. In COP20, PEPFAR support will move Namibia closer to a national system by hiring personnel and developing a team that involves both MoHSS and NIP to investigate best practices and develop a framework for a national system (Figure 4.9.1).

Figure 4.9.1 Proposed national specimen transport, tracking and results return system.



Continuous quality improvement (CQI) will continue in COP20, by supporting SLMTA training for laboratory technicians and accreditation activities for the regional laboratories. By the end of COP19, six VL molecular laboratories will be 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, and addition of PT production for recency and GeneXpert TB.

COP20 will also see support through the laboratories continuing for recency including quality control site assessments and VL testing, as well as addition of urine TDF laboratory assessment to screen patients for current ART use. PEPFAR will capacitate NIP to support the MoHSS for a clinical evaluation of urine TDF for TLD adherence monitoring, as well as continued support for CADRE HIV drug resistance genotyping to detect early emergence of TLD resistance. PEPFAR Namibia will further fund NIP to support the MoHSS rollout and scale-up of TB-LAM through completing the validation of the assay to fulfil requirements for MoHSS procurement.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Key Systems Barrier or Minimum Requirement	Expected Outcome	Expected Outcome 2 (if applicable)	Expected Outcome 3 (if applicable)
Fragmented data systems hinder case-based surveillance, impede decision-making, and limit transparency and accountability	Improved data system integration and interoperability (national roll out of harmonized ePMS for HIV C&T with EDT HMIS interoperability)	Unique identifier incorporated into all data systems	Improved disease case surveillance and site level reporting
Weak forecasting, supply planning, and procurement	Reduced site-level stock-outs of key HIV commodities	Increased visibility of site-level HIV commodities	Optimized treatment through implementation support for TLD, NVP, and future prioritized ARV transitions
Limited quantity and capacity of GRN-funded Human Resources for Health	Improved supply and more efficient deployment of GRN-funded HRH	Transition plan for donor-funded HRH	HRIS development and HRH planning/management institutionalization
Lack of optimized and coordinated laboratory systems to support site level service delivery	Optimized laboratory system for service delivery	Develop NIP capacity to generate and analyze laboratory data	Improved laboratory operational sustainability
Limited capacity for public financial management and ability to manage sub-awards	Improved program implementation and budget execution	Social contracting mechanism developed	
Limited coordination and management of in-service trainings	Improved coordination of in- service trainings	Improve Continuous Professional Development (CPD)	Institutionalize in-service trainings and support transition plan to e-learning modalities
Outdated or non-existent national policies, guidelines and regulations	Updated national policies, guidelines, and regulations	Increased public access to information	
Insufficient domestic resources to fully finance the HIV response	Greater efficiency in the use of health system resources	Increased private sector engagement in HIV	GRN-led health and HIV expenditure tracking

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

PEPFAR Namibia's COP20 vision for achieving epidemic control employs an agile and adaptive approach to management, operations and staffing that is aligned with PEPFAR Namibia's focus on preventing new infections and maintaining the treatment cohort while 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 repurpose existing staff through revised position descriptions, fill all vacant positions, transition to locally employed staff (LES) positions where feasible.

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

- CDC converted the Locally Employed Staff (LES) Workforce Management Officer into a Senior Prevention Advisor to focus on enhanced case finding strategies.
- A Donor Coordination and Community Care Advisor LES position is currently under recruitment by USAID to replace the TB/HIV Advisor. This new position will coordinate community-based prevention activities across key program areas in DREAMS, OVC, VMMC and KP mechanisms, as well as facilitate coordination with GRN ministries and other donors working in this space. This new position is expected to be filled by the end of Q3 2020.
- USAID's vacant LES SI Advisor position was repurposed as a Supply Chain Specialist. This new position will provide necessary technical assistance to Central Medical Stores for continuous supply of commodities. The new candidate is expected to start by May 2020 pending security clearance.
- USAID's US Direct Hire Health & Population Development Officer (Deputy Health Director) is being repurposed as a USPSC – DREAMS Coordinator. The position will be filled before the end of this fiscal year pending clearances.
- USAID's vacant LES HIV Treatment Advisor position is being replaced by an LES Biomedical HIV Prevention Advisor to support PEPFAR's clinical work with key populations and VMMC. Recruitment is underway and the new candidate is expected to begin work by summer 2020.

While no new positions are requested in COP20, there are seven vacant positions, which the team is actively working to fill, including:

- CDC's HIV Treatment Advisor, Health Systems and Sustainability Team Lead, and Associate Deputy Director for Management and Operations are currently all in the recruitment process. Interviews will be conducted in March 2020.
- The CDC LES Senior Prevention Advisor is currently under classification.
- There are three USAID positions being repurposed above that are vacant as they were only recently advertised (including the Donor Coordination and Community Care Advisor, DREAMS Coordinator, and a Biomedical HIV Prevention Advisor). All positions are expected to be filled before the end of COP19.

In terms of the cost of doing business (CODB), there is a 3% decrease from $15.1 million in COP19 to $14.7 million in COP20. The largest efficiency gain was with USAID, whose CODB decreased by 7%, mostly due to reductions in costs associated with staff program travel, management meeting/professional development, and institutional contractors. While CDC's CODB also decreased by 2%, Peace Corps CODB increased by 5% to support the doubling of their program budget.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

APPENDIX A -- PRIORITIZATION

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
!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. COP20 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP20 Budget by Program Area

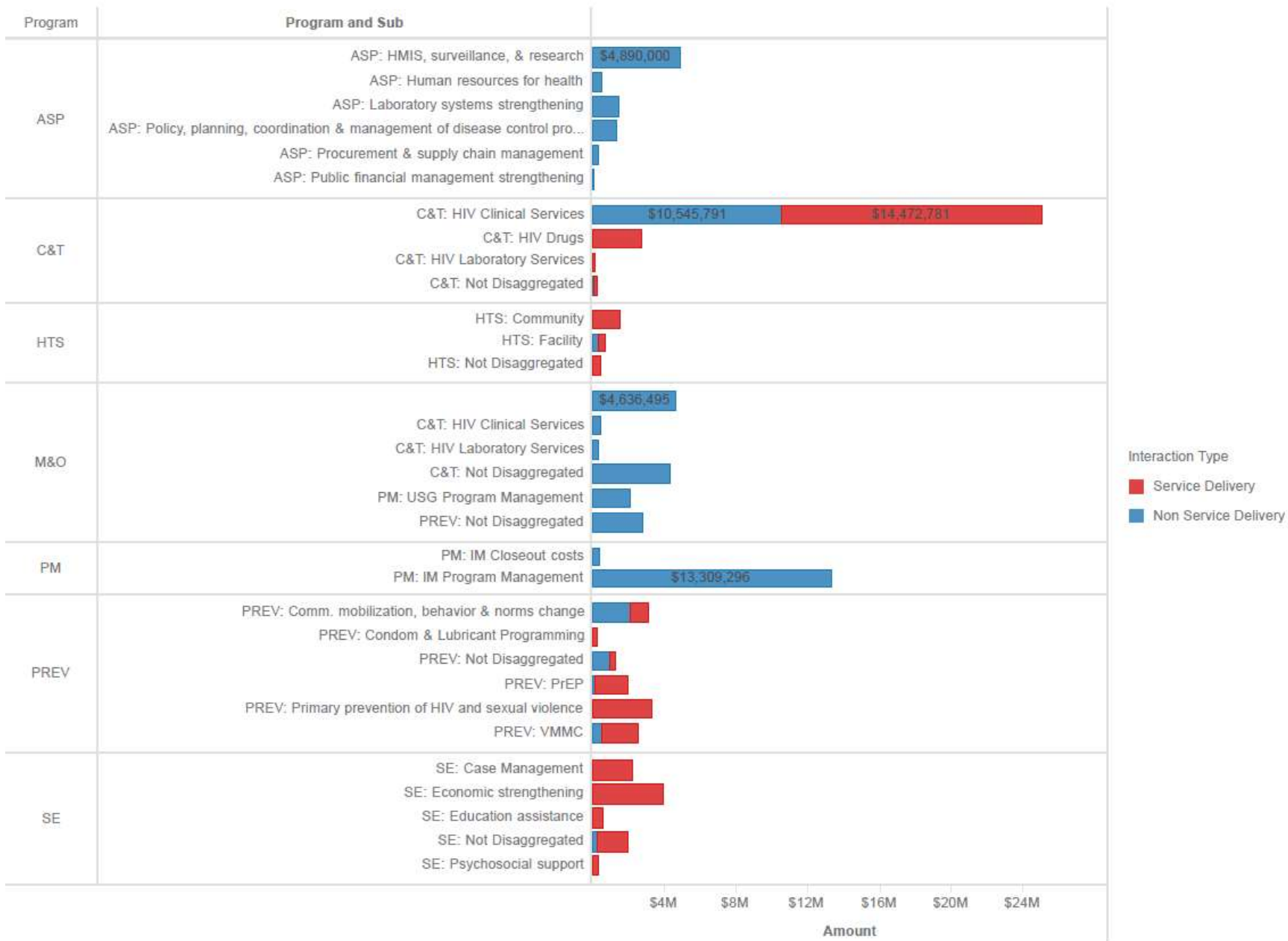


Table B.1.2 COP20 Total Planning Level

Applied Pipeline	New Funding	Total Spend
$US 11,222,020	**$US 78,462,386**	**$US 89,684,406**

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

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$ 845,041
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$ 1,677,538
HVOP	Other Sexual Prevention	$ 8,448,920
IDUP	Injecting and Non-Injecting Drug Use	$0
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$ 100,000
HVCT	Counseling and Testing	$ 2,116,926
HBHC	Adult Care and Support	$ 5,250
PDCS	Pediatric Care and Support	$ 201,303
HKID	Orphans and Vulnerable Children	$ 12,704,525
HTXS	Adult Treatment	$ 32,366,074
HTXD	ARV Drugs	$ 1,984,385
PDTX	Pediatric Treatment	$ 150,000
HVTB	TB/HIV Care	$ 3,423,364
HLAB	Lab	$ 1,424.772
HVSI	Strategic Information	$ 5,449,395
OHSS	Health Systems Strengthening	$ 2,129,282
HVMS	Management and Operations	$ 5,435,614
TOTAL		**$ 78,462,386**

*Data included in Table B.2.2 should match FACTS Info records.

B.2 Resource Projections

Epidemiological and Program Data Analysis

PEPFAR Namibia SI team, the budget team especially the Expenditure Reporting team and the Interagency Technical Teams began the prioritization process with an in-depth analysis of epidemiological and programmatic data to identify district-level geographic high-burden areas based on the volume of disease burden, highest prevalence, HIV incidence and ART unmet need. Similarly, the team also looked at the availability as well as lack of data reporting systems from the private sector and how it can be addressed. Moreover, the team made use of the latest SID and the NAMPHIA results to better understand the epidemic. The latest Spectrum data were also used as well as the National AIDS Spending Assessment conducted by MOHSS to determine the expenditure per category. The team analyzed these data by age, sex disaggregation and program area of expenditure to determine areas' thresholds for coverage by considering the number of PLHIV, ART coverage, HTS and yield, VMMC, pre-exposure prophylaxis, cervical cancer screening among HIV positive clients and retention on ART.

The team also reviewed programmatic data on VL suppression by age, sex, and geography. In addition, the partners currently funded by PEPFAR's capacity was assessed in order to determine the possibility of expansion to other geographic areas or scale down when needed. Also, the modus operandi (direct service delivery or technical assistance) for each partner and how best it will contribute to epidemic control was considered during this process. Based on these analyses, the team allocated targets by district, Partner, and classified sites, and determined the resources needed. Similarly, PEPFAR Namibia being tasked with continued strengthening its services alongside the northern borders, and expansion into low performing regions previously not PEPFAR supported and the team tried to estimate the magnitude of such services. Expansion of community-based ART having proven to contribute to better patients' outcomes, budgeting for such services in terms of the need for HRH was also considered. The team conducted further analyses to determine which facilities and/or community sites should receive support for HTS, PMTCT, OVC, VMMC, key population interventions, and DREAMS-like services.

The team also looked at the impact of the proposed new GF's Grant Proposal for the period 2021-2024 as well as the change in focus area for the USG partners on the service provision and how this can be realigned in order to minimize loss of expertise as well as to prevent disruption of services.

Gap Analysis

PEPFAR Namibia continues to work closely with stakeholders, particularly GRN representatives, Bilateral and CSOs to identify gaps and bottlenecks and mutually recommended solutions to address these gaps. During COP20 planning consultation meetings with stakeholders, the participants were presented with the achievements and challenges with COP19 implementation as well as soliciting their inputs into COP20 priority areas based on the gaps identified. PEPFAR Namibia and GRN recognized that specific gaps to address the continuum of HIV services, (especially adherence and retention) vary by district and program, and the strategies have been adjusted to meet the specific needs accordingly, with the primary goal of ensuring maintenance of the treatment current cohort (Retention) as well as providing client-centered care.

Funding Allocation to Strategy Tool (FAST)

The interventions as identified through COP19 expenditure reporting were used as the basis for funding activities in COP20 in order to fill the identified gaps. However, not all the interventions that were applicable in COP19 were identified as priorities in COP20. Thereof, new interventions were identified, and others discontinued in line with the implementing mechanisms' (IMs') focus in COP20. The total notional budget of **$89,684,406** is inclusive of $500,000 dedicated to cervical cancer, DREAMS funding of $20,000,000 and $3,500,000 for VMMC. Activities with appropriate budget codes were allocated to IMs with the highest probability of achieving PEPFAR targets taken into consideration.

APPENDIX C – Tables and Systems Investments for Section 6.0

The 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. (attached as separate document)

APPENDIX D– Minimum Program Requirements

Adoption and implementation of Test and Start with direct and immediate (>95%) linkage of clients across age, sex, and risk groups	✓
Adoption and implementation of DSD models, including 6-month MMS and delivery models to improve identification and ARV coverage of men and adolescents	✓
Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg, transition to other DTG-based regimens for children weighing >20kg, and removal of all NVP-based regimens	✓
Scale up of index 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 must be tested for HIV.	✓
All eligible PLHIV complete TPT by end of COP20, and cotrimoxazole, where indicated, is fully integrated into HIV clinical care package at no cost to the patient	✓
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 VL testing and results delivered to caregiver within 4 weeks	✓
Elimination of all user fees in the public sector for access to all direct HIV services and related services affecting access to HIV testing, treatment, and prevention	✓
Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity	✓
Direct and Immediate assessment for and offer of prevention services, including PrEP, to HIV-negative clients found via 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, KPs and adult men engaged in high-risk sex practices)	✓
Evidence of host government assuming greater responsibility of the HIV response, including demonstrable evidence of year after year increased resources expended	✓
Scale-up of case-based surveillance and unique identifiers for patients across all sites	✓
Alignment of OVC service packages and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) 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 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV	✓
Clear evidence of agency progress toward local, indigenous partner prime funding	✓
OUs assure program and site standards are met by integrating effective QA and CQI practices into site and program management. CQI supported by IP work plans, Agency agreements, and national policy	✓
Evidence of treatment and VL literacy activities supported by MOHSS and other host country leadership offices with general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention	✓