Namibia

Country Operational Plan

COP 2017

Strategic Direction Summary

April 28, 2017

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Abbreviations and Acronyms

AGYW	Adolescent Girls and Young Women (aged 15-24)
ALHIV	Adolescents Living with HIV
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
CBART	Community Based ART Program
CDC	Centers for Disease Control and Prevention
CHCW	Community Health Care Workers
CLHIV	Children Living with HIV
CNR	Case Notification Rate
CODB	Cost of Doing Business
COP	Country Operational Plan
CSO	Civil Society Organization
DMPPT	Decision Makers Program Planning Tool
DBS	Dried Blood Spot
DHS	Demographic and Health Survey
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe Women
EDT	Electronic Dispensing Tool
EID	Early Infant Diagnosis
FP	Family Planning
FSW	Female Sex Worker
GBV	Gender-based Violence
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GNI	Gross National Income
GRN	Government of the Republic of Namibia
HCW	Health Care Worker
HEI	HIV-exposed Infant
HIVST	HIV Self Testing
HRH	Human Resource for Health
HTS	HIV Testing Services
HSS	Health Systems Strengthening
IBBSS	Integrated Biological and Behavioral Surveillance Survey
ICF	Intensified Case Finding
IPs	Implementing Partners
IPT	Isoniazid Preventative Therapy
LTFU	Loss to Follow Up
M&E	Monitoring and Evaluation

MER	Monitoring, Evaluation and Reporting
MGECW	Ministry of Gender Equality and Child Welfare
MOHSS	Ministry of Health and Social Services
MSM	Men who have Sex with Men
MTCT	Mother-To-Child Transmission
MTEF	Mid-Term Expenditure Framework
NAMPHIA	the Namibia population-based HIV impact assessment
NASA	National AIDS Spending Assessment
NDHS	Namibia Demographic and Health Survey
NPC	National Planning Commission
OVC	Orphans and Vulnerable Children
PBAC	PEPFAR Budget Allocation Calculator
PBFW	Pregnant and Breastfeeding Women
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counseling
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
RH	Reproductive Health
RTK	Rapid Test Kit
S/GAC	Department of State, Office of the Global AIDS Coordinator
SDM	Service Delivery Model
SDS	Strategic Direction Summary
SCM	Supply Chain Management
SID	Sustainability Index Dashboard
SIMS	Site Improvement through Monitoring System
SNU	Sub-National Unit
SOP	Standard Operation Procedures
STI	Sexually Transmitted Infection
TA	Targeted Assistance
TB	Tuberculosis
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	US Agency for International Development
USD	United States Dollars
USG	United States Government
VAC	Violence Against Children
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

1.0 Goal Statement

PEPFAR Namibia, collaborating across United States Government (USG) agencies and with the Government of the Republic of Namibia (GRN), multilaterals, civil society, and the private sector, developed its Country Operational Plan for U.S. fiscal year 2018 (COP17).

In COP15, PEPFAR Namibia selected several health districts requiring additional support due to a high number of people living with HIV (PLHIV) not on antiretroviral treatment (ART). PEPFAR Namibia invested resources to scale up HIV testing services (HTS), ART, and treatment monitoring through viral load (VL) testing at health facilities in these districts. In COP16, PEPFAR Namibia continued to scale up treatment by decentralizing HIV services and establishing community-based models of care. The focus of COP17 is to accelerate Namibia's achievement of treatment saturation (>81% treatment coverage across all age and sex bands) in the high-burden HIV districts and scale up evidence-based prevention activities among groups at highest risk for HIV.

Nationally, more than 70% of the estimated 237,127 PLHIV in Namibia were on ART at the end of FY16. In most PEPFAR-supported districts, ≥80% of PLHIV were on ART. Progress is uneven, however, with >60% of male and female PLHIV aged 20-24 and 45% of male PLHIV over 30 not yet initiated on ART. Since data show that sexual partnerships with older men are correlated with new infections among adolescent girls and young women (AGYW), identifying older HIV+ men and initiating them on ART is critical to epidemic control in Namibia. COP17 focuses on scaling up HTS strategies that are effective in identifying and reaching older men, young women and young men. Those strategies include index partner testing, provider-initiated testing and counseling (PITC), contact tracing of partners of HIV+ clients, and targeted outreach models. Although older women (aged 25-49) proportionally have higher rates of ART initiation, the absolute numbers of women in this age group not on treatment compel PEPFAR Namibia to continue to provide services to ensure they are tested and treated. The overall target for HIV testing in COP 17 is 403,138 out of which 30,515 patients will be newly diagnosed with HIV. PEPFAR Namibia also supports the GRN's full implementation of new ART guidelines, which are in line with WHO recommendations to treat all PLHIV and same-day ART initiation. The overall target for initiation of new patients on ART in COP17 is 31,040.

With significant TB and HIV co-infection rates, PEPFAR Namibia will continue support to maintain the high coverage of HIV screening and ART initiation in TB patients and strengthen TB screening in PLHIV. FY16 program data shows that 96 % of all TB patients have a documented HIV status and 91% of HIV+ TB patients initiating ART.

To protect AGYW from HIV, PEPFAR Namibia will support implementation of layered DREAMS-like (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe Women) core package of services in select districts, including HIV and gender-based violence (GBV) prevention, provision of post-GBV care, age-appropriate condom promotion, and provision of pre-exposure prophylaxis (PrEP) to those at risk. Services will also include adolescent-friendly sexual and reproductive health (SRH) and partner

notification referral to HTS or ART. For boys and young men, PEPFAR Namibia will continue to scale up voluntary medical male circumcision (VMMC). PEPFAR Namibia will also continue supporting OVC activities in high-burden districts to mitigate the effects of HIV and build resilience of OVC and families.

Key populations (KPs), especially men who have sex with men (MSM), female sex workers (FSW), and transgender women, continue to be at high risk for HIV. In COP17, PEPFAR Namibia will scale up evidence-based strategies to identify HIV-infected KPs and link them to ART services. In addition, PEPFAR Namibia will work with civil society organizations (CSOs) to scale up KP-friendly services in select districts, including pre-exposure prophylaxis.

The success of activities proposed in COP17 will depend on close performance monitoring of implementing partners (IPs). Monthly meetings and quarterly performance reviews with IPs will assess the effectiveness of implemented activities towards reaching targets. GRN leadership and CSOs will participate in quarterly regional data reviews to evaluate IP performance and build transparency.

Several data collection efforts are underway that will provide updated epidemiologic data to inform PEPFAR Namibia's COP17 implementation and future strategies. Data collection for the Namibia population-based HIV impact assessment (NAMPHIA) will begin May 2017 with data available in December 2017. Phase II Integrated Biological and Behavioral Surveillance Survey (IBBSS) will start in November 2017 with results available by the end of COP17, and the Violence Against Children survey (VACS) will begin in early 2018 with results available by April 2019.

2.0 Epidemic, Response, and Program Context

2.1 Summary Statistics, Disease Burden and Country Profile

Namibia is a sparsely populated desert country of 2.46 million people (World Bank, 2015) with an area twice the size of California. The population is concentrated in small urban areas scattered throughout the country, particularly in the north near the border with Angola (see Figure 2.1.1).

Namibia is an upper-middle income country with a gross national income (GNI) per capita of USD (US Dollars) 5,190 (World Bank, 2015), but with starkly unequal income distribution. Namibia's Gini coefficient is 0.5971, the seventh-highest in the world (CIA Fact Book 2010). According to a 2012 assessment of poverty dynamics in Namibia, approximately 29% of people in Namibia are poor (living on less than NAD (Namibian Dollars) 30/day) and more than 15% are severely poor (living on less than NAD 22/day). Unemployment was estimated at 28.1% in 2014 (CIA Fact Book 2014).

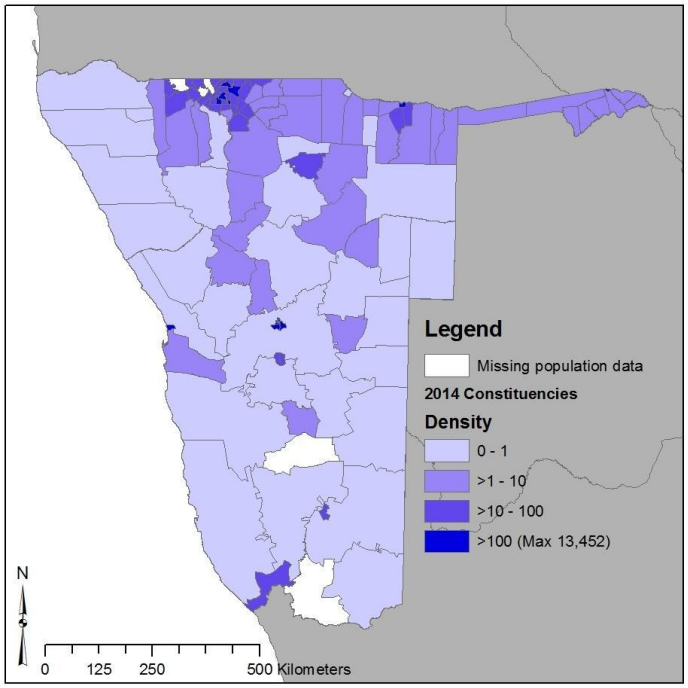


Figure 2.1.1 Population density (per hectare) in Namibia

Namibia has many success stories. The country has made great strides in attaining the Millennium Development Goals 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-5 deaths from 4,200 per year in 1990 to less than 3,000 in 2013.

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

Figure 2.1.2 Top 10 Causes of Death in Namibia (2015)	
1. HIV/AIDS	6. Diarrheal diseases
2. Lower Respiratory Infections	7. Road injuries
3. Ischemic heart disease	8. Diabetes
4. TB	9. COPD
5. Cerebral vascular disease	10. Neonatal preterm
Source: IHME, http://www.healthdata.org/namibia	

However, Namibia has made demonstrable progress in HIV epidemic control: over 70% of the estimated 237,127 PLHIV in Namibia were on ART at the end of FY16, new HIV infections have halved since 2004, and life expectancy increased from 56 in 2005 to 64 in 2013 (World Bank). The GRN's leadership also resulted in Namibia achieving high HIV treatment and prevention of mother-to child transmission (PMTCT) coverage levels, rapidly adopting new international guidelines and best practices, and increasing domestic financing for HIV programming.

HIV prevalence and incidence

Nationally, Namibia has a generalized HIV epidemic, with 13.3% of the 15-49 year old population living with HIV (2016 Spectrum Model). It is estimated that HIV/AIDS will be responsible for 3,369 deaths in 2017 (see Table 2.1.1) and it remains the leading cause of death among adults and sixth-leading cause among children under 5 years of age (MOH Child Survival Strategy, 2014). Among adults (>25 years of age), women bear a disproportionate burden of the HIV epidemic, with a prevalence of 19.8% compared to 14.9% for men. Although limited data is available on sex specific positivity rates among children, an estimated 1.2% of children under 15 years of age are HIV positive (HIV+). According to the 2016 Spectrum Model, the highest proportion of estimated new infections is among women ages 15-24, who are estimated to account for 21% of new infections. Men 15-24 years old are estimated to account for 12% of the new infections (2016 Spectrum Model).

Based on the 2016 Spectrum Model, the estimated HIV incidence rate among 15-49 year olds is 0.54 per 1000, which translates to 6,409 new infections in 2017. 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. The northern regions, home to the majority of the population, border Angola, Zambia, and Botswana. In addition to the northern regions, there are urban hot spots that have high incidence and are located in the coastal towns and along the main road connecting northern and southern Namibia.

The national decrease in estimated incidence to date has been predominantly among infants and children from the successful scale up of PMTCT (2016 Spectrum Model). To maintain a steady decline in incidence, Namibia will need to implement new ART coverage strategies among adults (2016 Spectrum Model).

Treatment coverage

Since ART was introduced in 2003, the number of PLHIV on ART has increased annually, rising from 75,681 in 2010 to 166,000 in 2016 (see Table 2.1.2). The majority of Namibians receive ART from the public sector. However, according to the Ministry of Health and Social Services (MOHSS), a small number of PLHIV (15,000 in 2016) receive ART from the private, for-profit sector. Disaggregated data by age and sex illustrate that the treatment gap is highest among males and females aged 20-24 (Figure 2.1.3). In July 2016, the "Treat All" policy, which recommends ART for all PLHIV, was rolled out in Khomas and two northern regions, Zambezi and Ohangwena. In December 2016, the national ART

guidelines were revised to incorporate the "Treat All" policy. By February 2017, the "Treat All" policy had been rolled out in the remaining regions of Namibia, with promises to enroll a record number of patients. PEPFAR's contribution will be 90% of the national total number of PLHIV expected to be on treatment by the end of COP18 (see Figure 2.1.3).

PMTCT

Based on the 2013 Demographic Health Survey, antenatal clinic (ANC) coverage (at least one visit) is 97% (see Table 2.1.1) and delivery in a health center is 87%. More than 95% of pregnant women know their HIV status or are tested during ANC or at delivery (APR16). PMTCT services are now routinely provided in ANC, maternity, and postnatal care settings in over 95% of public health facilities, and 85% of health facilities collect Dried Blood Spot (DBS) for early infant diagnosis (EID).

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 ranges from 5.2% to 32.9% across regions.
- 69% of HIV+ pregnant women at ANC had known HIV+ status (43% in 15-24 year olds, 77% in 25-49 year olds).
- 63% already on ART at 1st ANC visit (38% in 15-24 year olds and 69% in >25 year olds)

Infant HIV case identification through EID (including retesting during the first 18 months of life) is a Namibian policy, but execution remains challenging. EID coverage in 2016 was 65% within 2 months of age and 78% by 12 months (APR16). In FY17, PEPFAR Namibia supported 176 sites, addressing >85% of national PMTCT and EID needs.

TB/HIV

Namibia has the fifth-highest TB incidence in the world. In 2016, the TB Case Notification Rate (CNR) was 394/100,000 population, and overall incidence was reported at 489/100,000 population (World Health Organization, WHO, 2016). Children <15 years of age represent 9.5% of the TB burden. AGYW aged 15-24 years represent 7.5% of cases, slightly higher than males, aged 15-24, and (6.9%). The TB trend, disaggregated by sex, is similar to HIV incidence in the same age range. The majority of reported TB cases were identified in those >25 years of age (46.2% men, 29.8% women).

TB/HIV co-infection remains a concern in Namibia, with an overall coinfection rate of 38%. While TB/HIV co-infection declined from 59% in 2009 to 38% in 2016, the ART coverage for co-infected persons increased from 80% in 2013 to 90% in 2016, which is still below the GRN target of 100% (NTLP, 2016).

HTS

HTS sites in Namibia are widespread. Overall, 79.6% of women and 62.6% of men, over 15 years of age, reported having ever been tested and 49.4% of women and 38.8% of men reported being tested in the

last year (Namibia Demographic and Health Survey, NDHS 2013). Reaching men has been and continues to be a challenge.

VMMC

Based on the recent data, the population based self-reported circumcision rate is 25.5% among all ages (NDHS, 2013), which is significantly less than the recommended 80% target to help achieve epidemic control. Namibia has struggled to roll out VMMC for men aged 15-29. This past year, MOHSS developed and implemented an extensive VMMC demand creation campaign. As part of this campaign the PEPFAR program in collaboration with MOHSS began working with a popular Namibian musician to promote the benefits of VMMC. This campaign has led to an increasing number of VMMCs throughout the PEPFAR program. At the end of FY16, the PEPFAR program reported a record number of circumcisions (24,000 men; APR 2016).

OVC

The HIV epidemic in Namibia has generated a large population of OVC. Among the national total of 150,589 OVCs (Census, 2011), an estimated 50,000 are HIV-related. National-level data include AIDS-affected or HIV-infected OVC (i.e., children who are HIV+, have one or both parent(s) living with HIV, or have had one or both parent(s) deceased from HIV/AIDS).

Gender inequalities

The links between gender inequalities and HIV are well documented. In Namibia, gender norms and gender-specific roles are deeply entrenched. Women and girls are the most affected by the HIV epidemic, with their ability to protect themselves from HIV being negatively affected by cultural and economic gender inequalities. Cultural norms that encourage alcohol abuse or 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. 7% of women aged 15-49 experienced sexual violence since age 15, and 4% experienced sexual violence in the 12 months prior to the survey. Women who are not employed and less educated are more likely than other women 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 rare due to limited allocation of financial and human resources.

The GRN's Social Protection Units provide a one-stop service for survivors of GBV. However, the quality of the provided services appears inconsistent and often inadequate, according to key informants. The lack of coordinated data on GBV makes analysis difficult, and the lack of coordination generally is a barrier to better prevention and care. The planned Violence Against Children (VAC) survey, planned to begin in early 2018 with results available by April 2019, will provide critically important information about the burden of gender-based violence.

Key populations

Key populations in Namibia, especially MSM, FSW and transgender (TG) women are at high risk of HIV. Based on the Integrated Biological and Behavioral Surveillance Survey (IBBSS) conducted in 2013, among the estimated population of 6,508 MSM, 16% (1,054) are HIV+ (see Table 2.1.1), and among 8,082 FSW, 39% (3,136) are HIV+. No data are available for the transgender population. New data on FSW, MSM, and TG populations will be available by the beginning of COP18 implementation. Phase II of the IBBSS, scheduled to begin in November 2017, will include respondent-driven sampling linked to peer-driven interventions for FSW and MSM/TG

Table 2.1.1 GRN's Results															
	Total		**<15**				**15-24**				**≥25**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total population	2,368,747	100	427,509	18	434,835	18	246,403	10	239,615	10	543,302	23	477,083	20	Namibia Population Projections 2011-2041
HIV prevalence (%)		10		1.2		1.2		12		7.7		19.8		14.9	NDHS 2013, Calculated from PLHIV estimates/ population
AIDS deaths (per year)	3,369		98		99		142		88		1,789		1,180		Projected from 2016 Spectrum high bound estimate for 2017
# PLHIV	237,126		5,019		5,105		29,643		18,531		107,766		71,062		Projected from 2016 Spectrum high bound estimate for 2017
Incidence rate		0.54													Projected from 2016 Spectrum medium bound estimate for 2017 in ages 15-49

New infections	6,409														Projected from 2016 Spectrum medium bound estimate for 2017
Annual births	69,709	100													Namibia Population Projections 2011-2041
% of Pregnant women with at least one ANC visit	67,617	97	338	0.5			29,143	43.1			38,136	56.4			Projected from NDHS 2013 ANC rates, Namibia Population Projections 2011-2041 & ANC attendance by age in HIS 2016
Pregnant women needing antiretroviral drugs (ARVs)	11,989	17.2													Projected from HIV sentinel report 2016 and Namibia Population Projections 2011-2041
Orphans (maternal, paternal, double)	40,862														Projected from 2016 Spectrum medium bound estimate for 2017

Notified TB cases	9,420		387	4.1	436	4.6	597	6.3	517	5.5	2,824	30.0	4,389	46.6	Program Data *(Total = 9,614, includes cases with undocumented gender and age data)
% of TB cases that are HIV infected	3,581	38.0	39	1.0	39	1.0	138	3.9	84	2.3	1,427	39.8	1,788	50.0	Total includes 66 cases (1.8%) with missing age data and 17 cases (0.5%) with missing HIV status
% of males circumcised	39,775									29.6				34.4	Coverage end of 2016 (DMPPT2) Sum of cumulative of MOHSS and PEPFAR
Estimated population size of MSM*	6,508														IBBSS 2013
MSM HIV prevalence		16.2													IBBSS 2013
Estimated population size of FSW	8,082														IBBSS 2013
FSW HIV prevalence		38.8													IBBSS 2013

Estimated population size of PWID	N/A														
PWID HIV prevalence	N/A														
Estimated size of priority populations	See table 2.1.2														
Estimated size of priority populations prevalence	See table 2.1.2														

Table 2.1.2 90-90-90 Cascade: HIV Diagnosis, Treatment and Viral Suppression										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year**		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	2,368,747	14%*	237,126	181,069	166,000**	70%	87%	310,404	15,305	13,877
Population less than 15 years	862,344	1.2%	10,124	N/A	9,623	95%	76%	17,241	685	693
15-24 year olds	486,018	9.9%	48,174	10,676	9,978	21%	71%	103,125	3,365	2,293
25+ year olds	1,020,385	17.5%	178,828	129,746	121,258	68%	89%	190,038	11,255	10,891
MSM	6,508	16.2%	1,054					562	73	58
FSW	8,082	38.8%	3,136					2,699	218	200
PWID	Unknown									
Priority Pop	See above									

*15-49 years of age (DHS+ 2013)

**Includes approximately 15,000 from private sector which are not distributed by age, sex, or geography

Figure 2.1.3 National ART Gap by Age and Sex

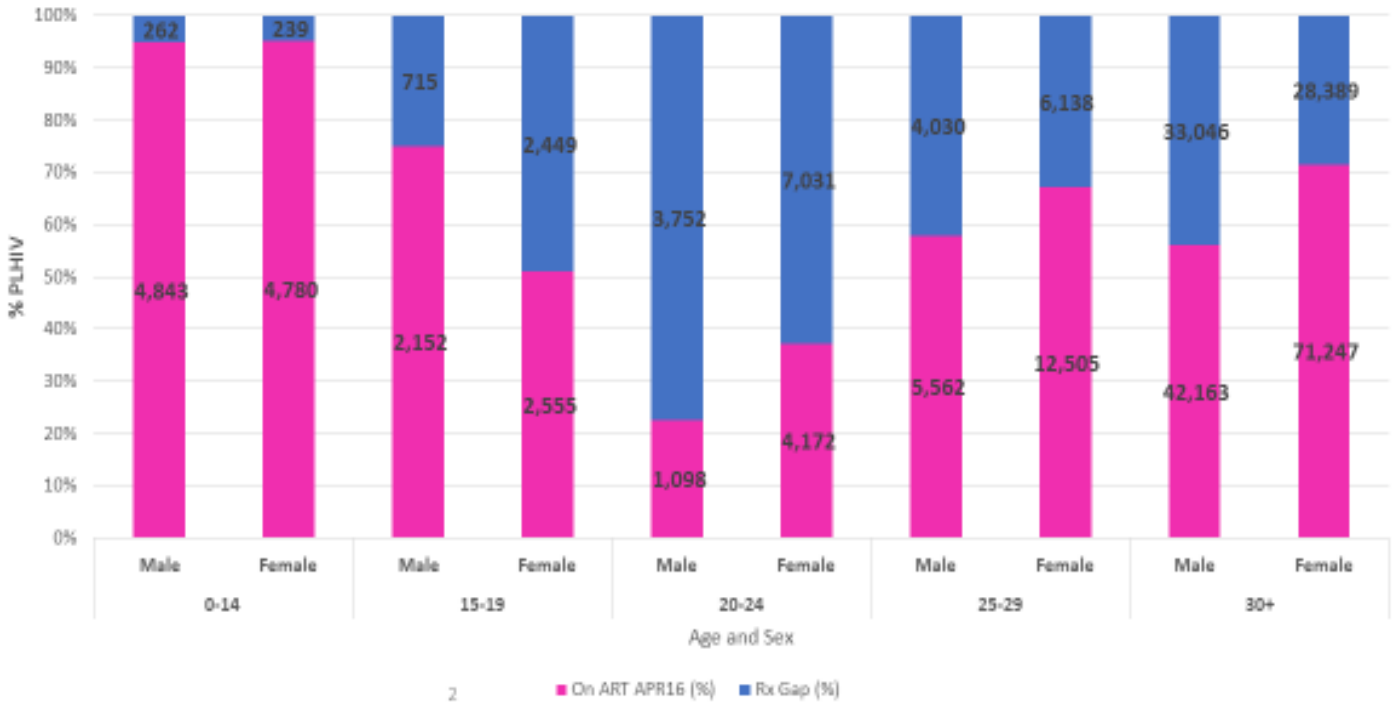
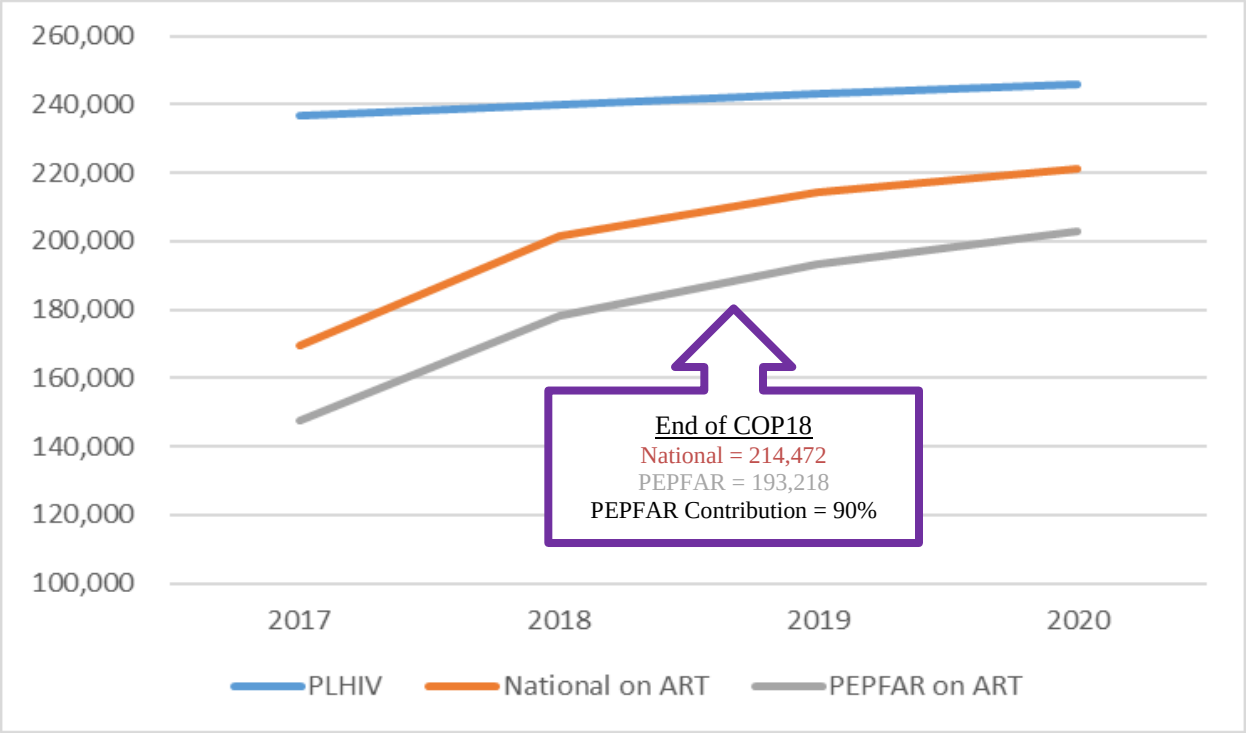


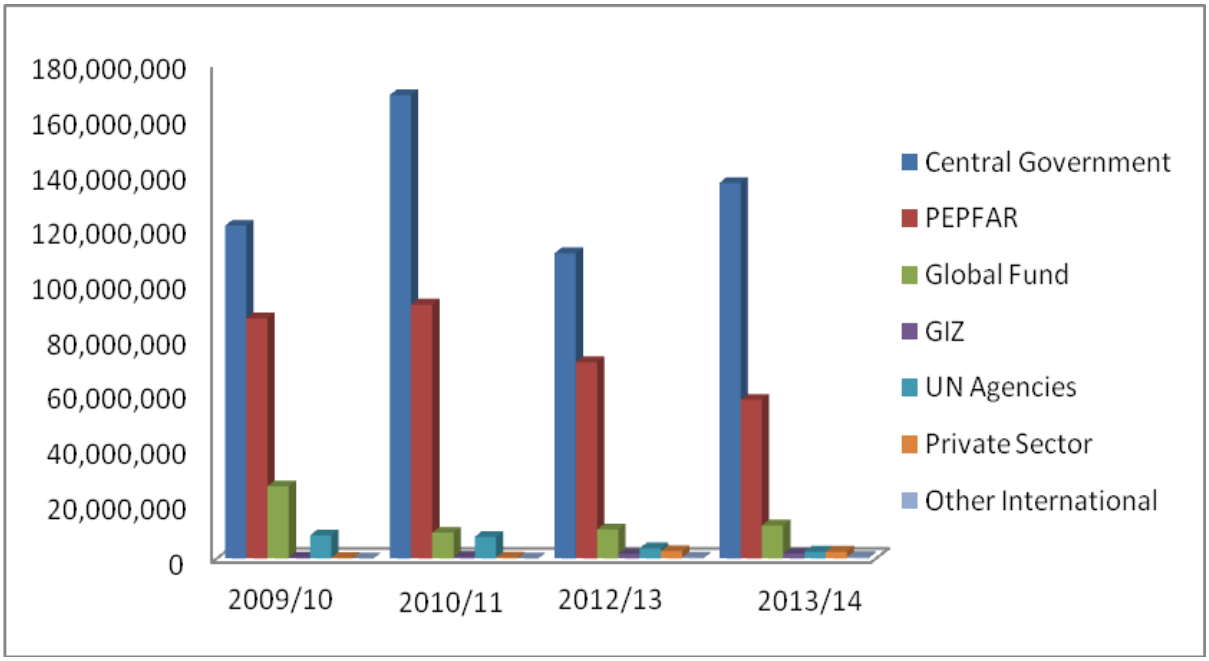
Figure 2.1.4 National and PEPFAR Trend for Individuals Currently on Treatment



2.2 Investment Profile

Namibia completed its last National AIDS Spending Assessment (NASA) in 2013/2014. The findings are summarized in Figure 2.2.1 (in USD).

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

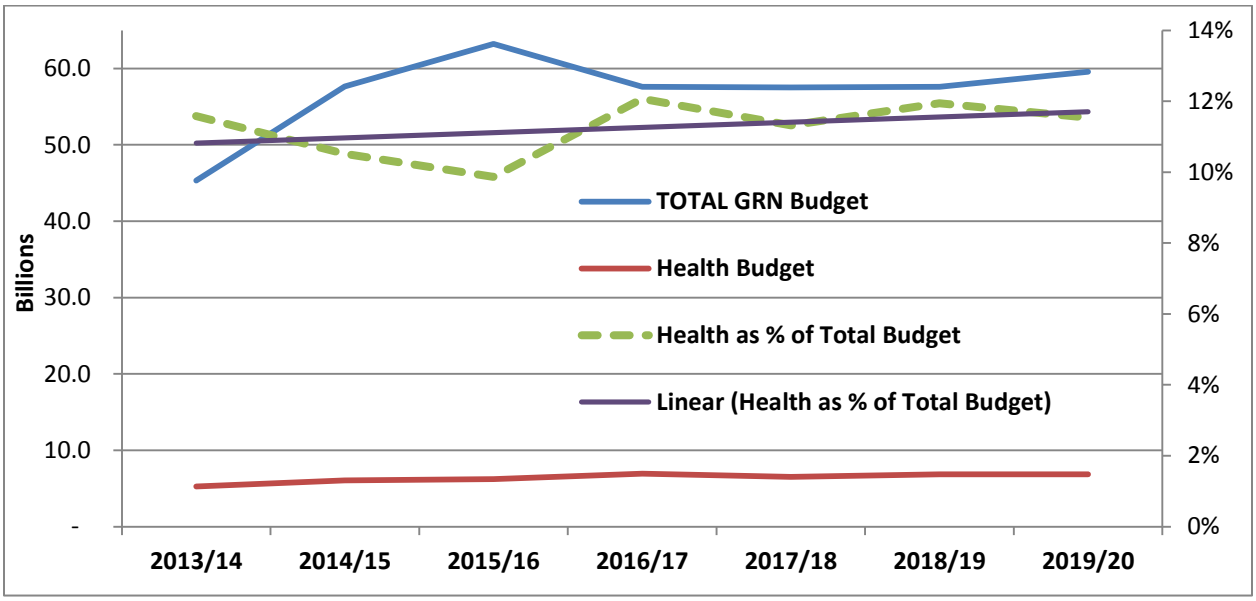


Source: National AIDS Spending Assessment (NASA), 2014

The NASA indicates that the major source of financing of the HIV response is the GRN (64%), followed by PEPFAR and the Global Fund (GF). GRN spending on HIV has fluctuated over time, but is making up an increasing proportion of total HIV spending. Donor money is on the decline, with GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit, the German development agency) concluding their "Multisectoral HIV and AIDS Programme" in 2016 and GF announcing the 2018-2020 funding envelope for Namibia at around 2/3 less than the previous round. Private sector funding is approximately 1% of the total HIV spending in Namibia, although the NASA indicates that this is probably an underestimate, as data are limited. The GRN is in the process of completing a 2014/15 National Health Accounts that will allow an update of the health financing data, with an additional HIV sub-account to specifically track spending.

Despite a tight fiscal environment, the GRN remains committed to health, maintaining an allocation of between 11% and 12% of the total GRN budget on health (see Figure 2.2.2). The 2017/18 allocation to health is approximately USD 521 million (with the exchange rate now improved to about NAD 12.5 to one USD). In terms of budget execution in health, the MOHSS has maintained a budget execution rate of between 96% and 105% (Note: The 105% was due to the exchange rate at the time and mid-term budget review and decreased allocation for that fiscal year).

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



The 2017-2020 Mid-Term Expenditure Framework (MTEF) indicates that the GRN will maintain tight control of its budget, with expenditures only rising in the 2019/20 financial year. In the three year rolling framework from 2017/18 to 2019/20, there is a modest increase in GRN allocation to health raising this year's budget from NAD 6.5 billion to NAD 6.87 billion and reaffirming the GRN commitment to health. However, this past fiscal year many of GRN's line ministries (including the Ministry of Health and Social Services) saw limits to hiring new personnel and budget renegotiation.

Namibia's Investment Case presented various scenarios and noted that maximum gains in reducing HIV incidence and containing costs would be obtained by adopting an aggressive test and start approach, including improved technical efficiencies, such as implementing cost-effective testing and acquiring ARVs at the best global price. This scenario (indicated as "maximum" in Figures 2.2.3, 2.2.4 and 2.2.5 below) was selected by the GRN and has the potential of reducing HIV incidence to 0.1%, well below the current estimated 0.54% among 15-49 year olds. The effect of maintaining constant coverage and/or continuing with the current National Strategic Framework (NSF) is also graphed, resulting in either increased incidence or a drop to 0.5% if the previous NSF continued. The newest NSF (2017/2018-2021/2022) is currently being finalized and has the goal to prevent new HIV infections and AIDS related deaths among adults and children. The NSF has prioritized high impact programs that have the potential to contribute to ending AIDS. A key focus is to support strategies that improve efficiency and effectiveness of at all levels of the response, ensure a strategic focus on populations most at risk and expand the response through the multisectoral approach.

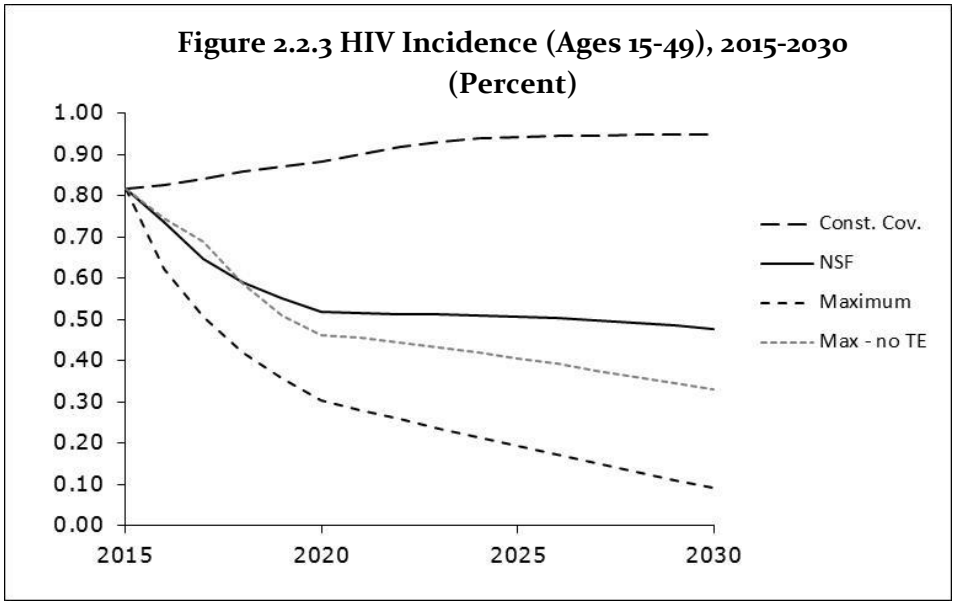


Figure 2.2.3 HIV Incidence (Ages 15-49), 2015-2030
(Percent)
1.00
0.90
0.80
0.70
0.60
0.50
0.40
0.30
0.20
0.10
0.00
2015
2020
2025
2030
Const. Cov.
NSF
Maximum
Max - no TE

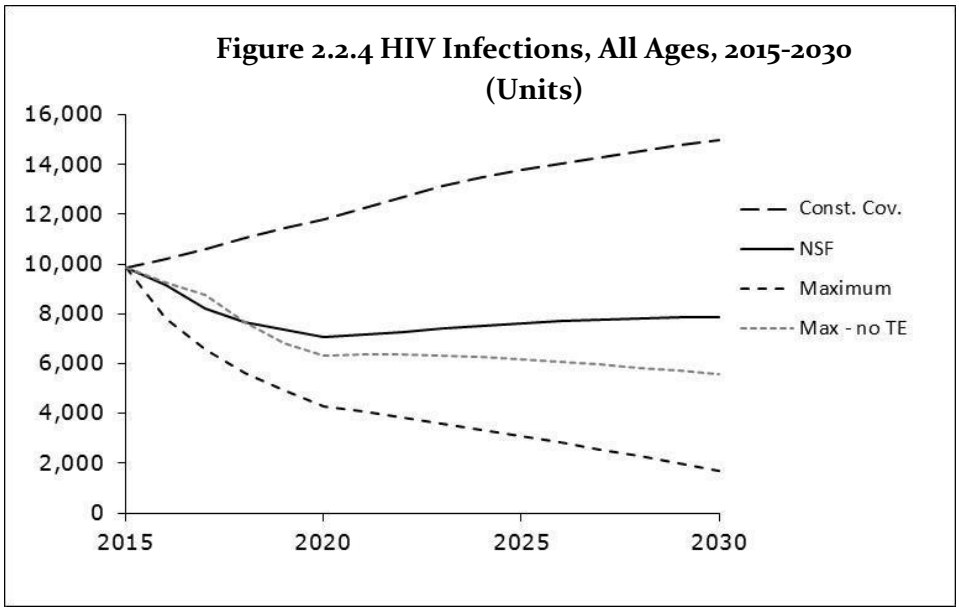


Figure 2.2.4 HIV Infections, All Ages, 2015-2030
(Units)
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
2015
2020
2025
2030
Const. Cov.
NSF
Maximum
Max - no TE

Figure 2.2.5 Composition of Spending, 4 Scenarios, 2015-2030

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

Source: Namibia Investment Case, UNAIDS, 2016

Inadequate HRH (both in absolute numbers and from geographic mal-distribution) remains a major challenge to achieving targets. Namibia is faced with one of the most severe public health workforce shortages in the world; while 80% of Namibian doctors work in the private sector, only 20% of the population seeks health care through the private sector (NAMAF, 2012). The Report of the Presidential Commission of Inquiry (2013) identified major systems barriers associated with HRH within the public health sector, including high vacancy rates, high attrition, and outdated staffing norms that do not accommodate current and emerging health system needs. Namibia relies mainly on expatriates to fill critical public sector health positions (doctors, nurses, pharmacists). Through its partners, the USG is able to assist Namibia in increasing its human resources for health capacity. Additionally, in the last four years and with PEPFAR support, the human and institutional capacity development in Namibia has been enhanced with the launch of the medical school and pharmacy degree training programs at the University of Namibia and the Bachelor degree programs in biomedical sciences and logistics at Namibia University of Science and Technology (formerly the Polytechnic of Namibia). In addition, the MOHSS has enhanced its nursing and public health trainings at their National Health Training Centre. In the mid- to long-term, the HRH crisis in Namibia will be alleviated through increased local training and decreased reliance on staff importation. Addressing the HRH crisis will require short, medium and

long-term investments. PEPFAR's "Treatment Acceleration Plan" (COP 15/16) is addressing the short-term HRH gaps in support of the GRN's HIV response albeit with some challenges – related to delays in obtaining work permits and registration with appropriate health professions authority due to huge backlog of applicants. In addition staffing remote areas remain a challenge due to lack of staff accommodation or transport.

Tables 2.2.1 and 2.2.2 summarize annual investments by program area and procurements for key commodities. GRN finances 64% of the HIV response, PEPFAR finances 27% and GF finances 6%. ARVs are procured primarily by GRN (85%) and GF finances the remaining 15%. PEPFAR covers the cost of all VMMC kits.

Table 2.2.1 Annual Investment Profile by Program Area

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

Table 2.2.2 Annual Procurement Profile for Key Commodities

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

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

Table 2.2.4 Annual PEPFAR Non-COP Resources		
Funding Source	**Total PEPFAR Non-COP Resources**	**Objectives**
PEPFAR Drought	$2,425,000	Assess and address drought related issues (malnutrition; WASH; therapeutic foods; referrals; etc.) that impact OVC and PLHIV in hard hit drought areas.
VMMC – Central Funds	$4,014,136	Complement COP17 resources to enable rapid expansion of targets towards achievement of 80% saturation VMMC coverage among 15-29 year olds in selected districts by 2018.
Total	**$6,439,136**	

2.3 Sustainability Profile

The 2016 Sustainability Index and Dashboard (SID) 2.0 results showed that, overall, Namibia is moving towards sustainability. Four elements scored light green: planning and coordination, public access to information, laboratory, and domestic resource mobilization. The other eleven elements scored yellow, requiring further investment, while no elements scored red. Elements that scored yellow which are considered key to the HIV response include: HRH, commodity security and supply chain, and service delivery.

As discussed in the previous section, inadequate HRH remains one of the most serious sustainability challenges facing Namibia. Key HRH weaknesses in the SID 2.0 included: an inadequate supply of HRH in the public health sector, with donors contributing to over 10% of total HRH; lack of an official plan to transition donor support for HRH; lack of commitment to overcome HRH shortages through eased visa regimes for imported workers; and HR data not being fully used for HRH planning and management. The number of medical staff is insufficient and staff are not distributed strategically to meet demand.

The MOHSS restructuring process is ongoing and, once completed, may improve staffing adequacy across the levels of the public health sector. However, the timeline for completing this exercise

remains unclear, especially in light of the current tight fiscal control. Significantly, Namibia produced its first graduating class of 35 medical doctors in April 2016, and a similar number of medical doctors are expected to graduate from the University of Namibia each year. Previously, PEPFAR Namibia supported pre-service and in-service training for clinical and support staff and will continue to collaborate with the GRN to build capacity of health personnel in regions with high HIV burden. Project ECHO, a program supported by PEPFAR Namibia, provides weekly virtual training sessions to clinicians in high-burden districts, creating a unique opportunity for in-service training for those in remote areas.

The GRN has created an enabling environment to respond to the HIV epidemic, signifying political will and country leadership. The MOHSS coordinates all HIV services in the country, contributes 64% of total HIV expenditure (NASA 2013/14), agrees to the "Three Ones" principles, and has in place a combination HIV prevention strategy that is inclusive of services to key populations. Recent evidence of this continued commitment includes: releasing the 2012-2014 IBBSS in December 2016; adopting the treat-all strategy, which was rolled out in three regions in 2016 and will be fully implemented in 2017; adopting PrEP for high-risk groups; and advocating for and receiving the second-highest allocation (10.4%) of the overall GRN 2017/18 financial year budget (NAD 6.51 billion of NAD 62.54 billion).

The SID identified several weaknesses in the supply chain, most notably stock outs, with ARVs not stocked fully according to plan. In 2016, Namibia experienced stock-outs of HIV rapid test kits (RTKs) particularly from April to June 2016, which affected HIV testing.

For service delivery, the SID ascertained that public facilities were not tailoring services to patient needs. For example, clinics did not modify or extend their operating hours/days to serve working adults, especially men and adolescents in school. Additionally, services for key populations remain largely donor-funded.

In the health financing and strategic investment domain, Namibia scored a light green on domestic resource mobilization, but a yellow on technical and allocative efficiencies. While the GRN funds 64% of the HIV response, one of the challenges in domestic financing is that there is no specific budget allocation for interventions targeting key populations. At USD 850/patient/year for 250,000 PLHIV in 2013/14, Namibia has one of the higher per-PLHIV expenditure rates in Southern Africa. Many of these expenditures are for ARV procurement, which are double the price of those purchased in neighboring South Africa. To address this imbalance, the MOHSS recently revised its procurement procedures by working directly with manufacturers, with the first tender awarded to a CIPLA factory based in Uganda. The Namibian HIV/AIDS response would benefit from improved allocative efficiencies through the use of data for program decision-making and enhanced technical efficiencies that would reduce unit costs and overall expenditure.

The SID 2.0 assessment indicated that Namibia should increase transparency in working to achieve HIV/AIDS program targets and improve stewardship of HIV/AIDS resources. While the national

HIV/AIDS program does produce annual progress reports, they are not disseminated beyond printed reports/presentations and thus are not available to the majority of Namibians. The GRN does not make the annual national HIV/AIDS program audit available to the public. Disseminating these documents more widely will assist Namibia in achieving accountability and transparency.

Results from the enabling environment domain demonstrated that Namibia could take further action to create policy and legal environments that remove obstacles to HIV prevention, treatment and care, and support the reduction of stigma and discrimination. This is particularly important for key populations, who are still negatively impacted by a lack of policies and laws that specifically provide social and legal protection for MSM, transgender persons, and FSW. The legislative framework in Namibia similarly does not make special provisions to fund CSOs engaged in the national response. While engagement exists between CSOs and the GRN, there is a need to strengthen the tracking and engagement of CSOs in HIV/AIDS activities. GRN engagement with the private sector is similar. Active coordination by the GRN with these two sectors could improve the HIV/AIDS response, fill service delivery gaps, and avoid unnecessary duplication of effort.

PEPFAR continues to invest in HRH, supporting additional personnel and task-shifting efforts; provide technical assistance to the supply chain to improve forecasting and quantification; and support a differentiated service delivery model (SDM) that will be more responsive to client needs and also help offload stable clients from health facilities. Investments in HRH are largely related to filling HRH shortfalls, but there is a need for a long-term HRH strategy and sustainability to ensure ART clients' continuity of care. The decline of donor funds, particularly the closure of GIZ HIV activities and decrease of the GF's funding envelope, signifies an urgent need to develop alternative sources of funding, especially for civil society activities and their role in the national HIV response.

2.4 Alignment of PEPFAR Investments Geographically to Disease Burden

PEPFAR Namibia is categorized as a co-financing, targeted service delivery program. COP14 represented a pivot in geographic focus and expenditure on interventions to achieve epidemic control. COP15 further focused activities to the highest burden regions, with increased site-level spending in these regions, in an effort to achieve saturation and improve the continuum of care cascade. For COP16, PEPFAR Namibia's analyses of epidemiological and programmatic data verified the high-burden areas and the appropriate resource allocation identified in COP15. Results of these analyses are summarized in Figures 2.4.1A, 2.4.1B and 2.4.1C below. Several program decisions for COP17 were made based on key findings from the team's APR16 analysis. Additional sub-national units (SNUs) for COP17 implementation include Rosh Pinah and !Nami#nus (high labor force involved in mining, migrant male population and high HIV prevalence among pregnant women age 15-24) and Opuwo (increased number of AIDS-related deaths). New DREAMS-like funding targets constituencies (i.e., one level below the prioritization SNU) demonstrating high levels of new infections among AGYW. Appendix A, SNU Prioritization, provides further details. Expenditure for the centrally supported regions totaled 1.45%.

Figure 2.4.1.A: Namibia COP17 ART Current and Unmet Need

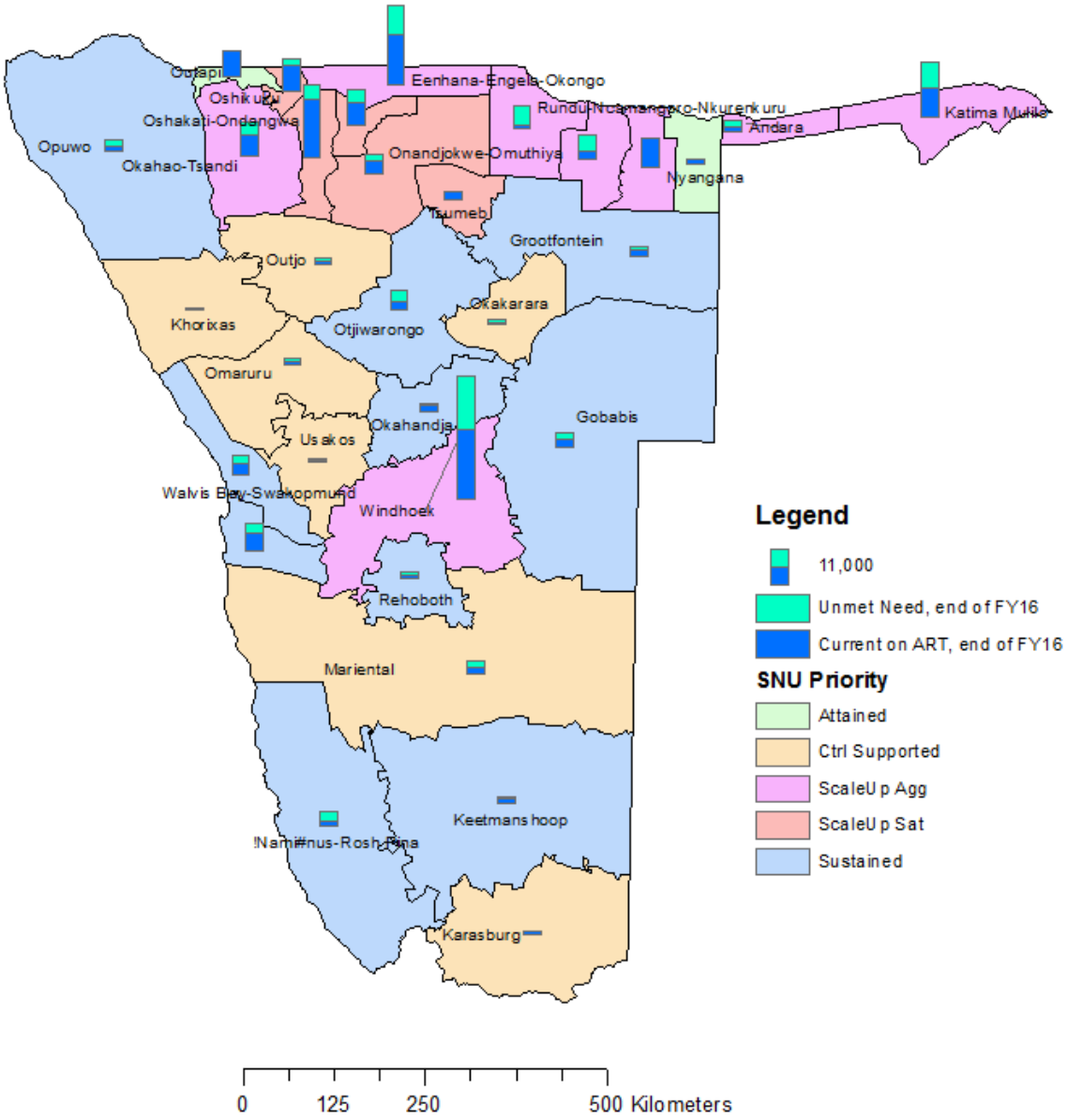


Figure 2.4.1.B: Namibia COP17 ART Current and Unmet Need by Age and Sex

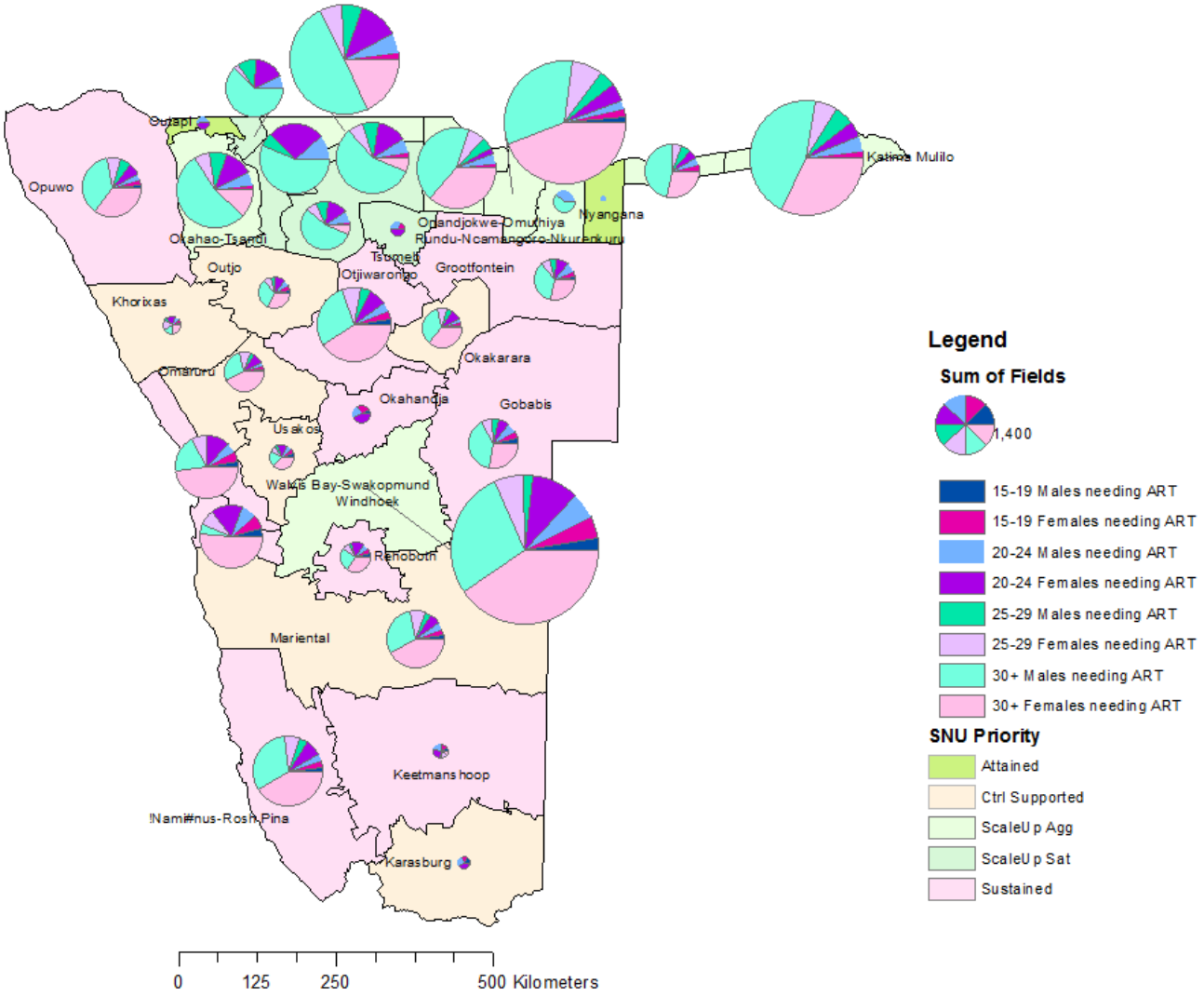
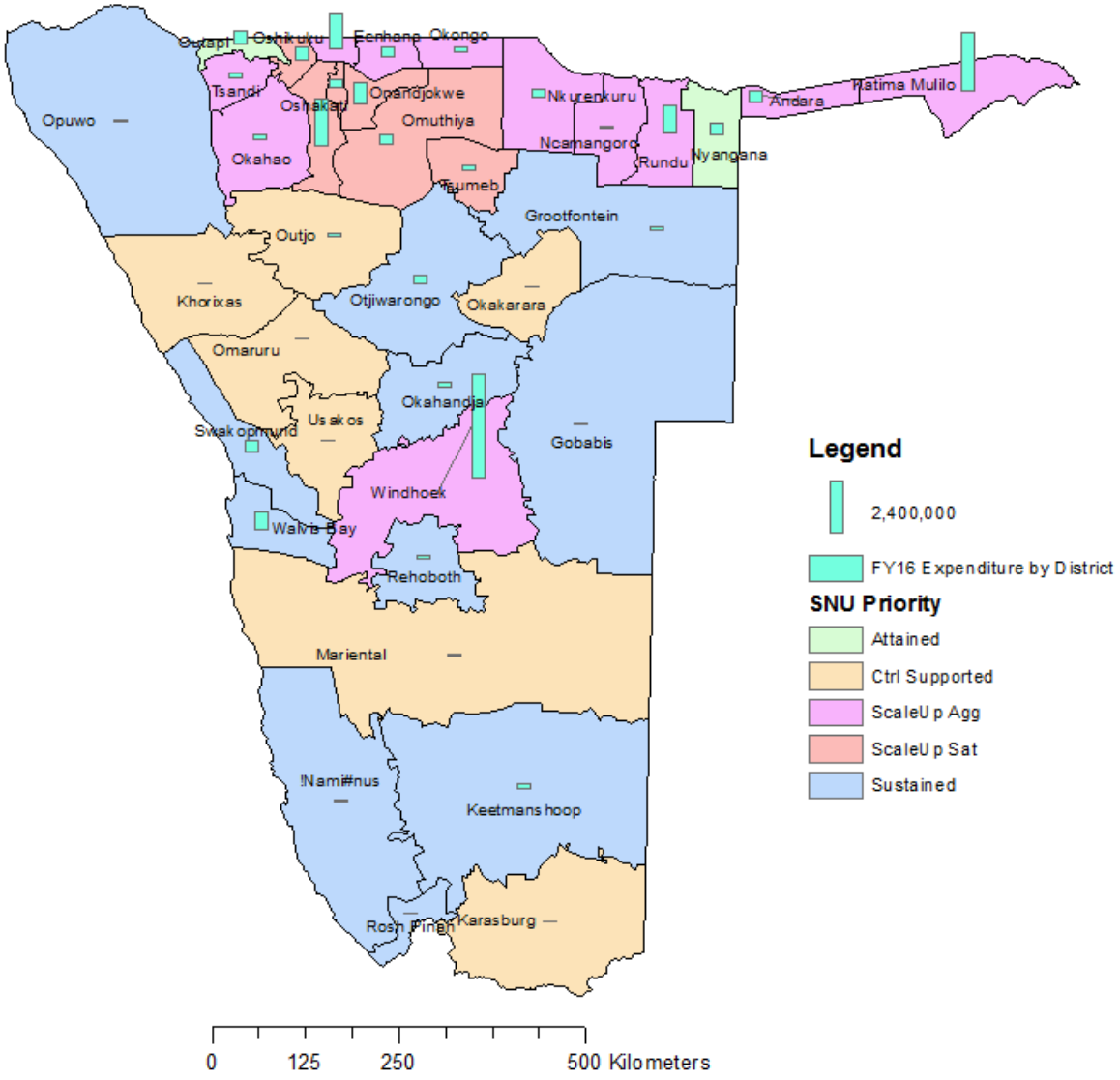


Figure 2.4.1.C: Namibia COP17 Expenditure by District



2.5 Stakeholder Engagement

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

PEPFAR Namibia also engaged in a number of individual meetings with government representatives, including a meeting with the Office of the First Lady, Ministry of Education, MOHSS, the National Planning Commission (NPC), and Ministry of Gender Equality and Child Welfare (MGECW).

In addition, representatives from the Office of the Prime Minister, National Planning Commission, MOHSS, the MGECW, the Ministry of Education, the Ministry of Finance, and the Ministry of Urban and Rural Development attended the national and regional COP17 development consultation meetings.

Global Fund and other external donors
Engagement with multilateral partners is routine and ongoing. Development partners attend PEPFAR stakeholder meetings and were part of the national COP17 development consultation meeting in Windhoek. Regular meetings with the GF Country Team occur by phone and in person when they are in Namibia. PEPFAR continues to hold a seat on the GF Country Coordinating Mechanism (called NaCCaTUM in Namibia). This year, special attention has been given to coordinating activities and sustainability planning with participation from S/GAC (Department of State, Office of the Global AIDS Coordinator), USAID (US Agency for International Development), CDC (US Centers for Disease Control and Prevention), and GF headquarters representatives. PEPFAR Namibia consulted with specific partners in FY17 regarding projects and programs in development to ensure that overlap was minimized and synergies were maximized and these consultations are ongoing into COP17.

Civil society/community
PEPFAR Namibia works closely with civil society organizations, including implementing partners and organizations not receiving funding. PEPFAR Namibia held individual meetings with key civil society organizations who have received PEPFAR funding in the past, such as the community based organization DAPP and also discussed ideas with organizations not currently funded, such as the youth-orientated organization Ombetja Yehinga Organisation. The purpose of these meetings was to better understand current projects and to brainstorm ideas for COP17. In light of DREAMS-like funding, PEPFAR Namibia made specific efforts to include organizations that focus on and individuals representing youth, gender, and young girls.

The coordination of civil society in Namibia has some challenges due to the closing of the umbrella group, Namibia Non-Governmental Organisation Forum Trust (NANGOF) in 2016. A number of sub-umbrella groups remain operational, however, including the Namibia Networks of AIDS Service Organisations (NANASO). PEPFAR Namibia works through these coalitions, as well as through a range of fora organized by government and development partners.

Private sector
PEPFAR Namibia works closely with its private sector health partners, particularly for VMMC programs. These ongoing interactions allow for continued engagement with the private sector.

The CEO of Healthworks Business Coalition has been a regular and active participant in our stakeholder meetings for the past several years, including COP17 development meetings.

Combined stakeholder engagement (government, external donors, civil society, and private sector)
PEPFAR Namibia convened a series of stakeholder meetings to incorporate a broad range of perspectives into our COP17 development. These meetings included:

- A national stakeholder meeting on January, 26, 2017 to launch the development of COP17. More than 110 national-level participants attended the meeting.
- A regional stakeholder meeting in Ongwediva on February 21, 2017, with 33 participants from the Oshana, Omusati, Oshikoto, and Ohangwena regions.
- A regional stakeholder meeting in Otjiwarongo on February 22, 2017, with 25 participants from the Kavango East and West, Zambezi, Otjozondjupa, and Erongo regions.

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

The objectives of the stakeholder meetings were:

- to review 2016 accomplishments and remaining challenges;
- to discuss the HIV transmission cycle in Namibia and interventions that can break the cycle;
- to present new strategies from the COP17 guidance;
- to outline the COP17 development process and timeline; and
- to brainstorm innovations for COP17 through discussions of the current data.

Following the three meetings, PEPFAR Namibia emailed the meeting reports to the stakeholders who attended, posted the meeting reports on the US Embassy website, and used US Embassy Facebook and Twitter sites to post photos about the national and regional consultations to encourage awareness about the COP17 development process. PEPFAR Namibia encouraged stakeholder participation through these channels as a means of ongoing communication, especially targeting the youth-led organizations and groups.

In follow up to the national and regional stakeholder meetings, PEPFAR Namibia attended the MOHSS Directorate of Special Programs weekly management meeting on February 27, 2017. PEPFAR Namibia updated the government on data analyses and program approaches for COP17.

The draft COP17 SDS was sent to all stakeholders, including CSOs and implementing partners, with a request for input prior to submission. Stakeholder input is incorporated into this final version of the document.

Stakeholder engagement in COP17 implementation

Many of the stakeholder comments on the draft SDS were related to guidance on implementation of the proposed activities rather than suggesting revisions to the document, and will be addressed in PEPFAR Namibia's implementation of COP17. For example, in response to feedback received from stakeholders, PEPFAR Namibia will include traditional leaders in stakeholder engagement activities. Similarly PEPFAR Namibia will involve CSOs and AGYW representatives and work closely with the GRN task force on AGYW and First Lady's initiative in planning and implementing DREAMS programming. Regarding stigma and discrimination, all new USG staff members will undertake online training on this topic which will ensure all staff are capacitated to integrate stigma and discrimination mitigation activities into their specific areas. Implementing partners will be requested and supported to integrate stigma and discrimination interventions into their activities. Implementing partners will be further capacitated through training from the PEPFAR team at planned stakeholder engagement events and upon request/identification of need. We have designated a PEPFAR team member as point of contact (POC) for gender and discrimination issues. The POC will organize a dedicated panel discussion event to discuss gender, stigma and discrimination.

It is anticipated that the MOHSS and the National AIDS Executive Committee, with the support of UNAIDS, will further explore with stakeholders how to implement the recommendations of the legal environment assessment conducted in 2016. PEPFAR Namibia will be actively involved and will address recommendations in our programming as relevant.

3.0 Geographic and Population Prioritization

HIV prevalence, PLHIV burden, and the unmet need for ART vary across Namibia. Based on Namibia's HIV epidemiological data, 18 out of 37 districts represent approximately 80% of the disease burden (see Table 3.1 and Figure 3.1). In COP15, PEPFAR Namibia pivoted from regional TA to a site-based approach in the 18 districts with the highest unmet ART needs and in urban hotspots. In COP17, PEPFAR will support continued treatment scale up and other HIV services in 175 ART facilities in these 18 districts and urban hotspots, including DSD and TA sites. In COP 17 PEPFAR Namibia will be collecting district level data but for some geographic areas several districts will form a cluster. Clustering will be done in areas where there is a lot of movement of clients between districts. Based on more detailed analysis by SNU and finer age disaggregation (see Figure 3.2), for COP17 PEPFAR Namibia will focus on finding and enrolling older men and young women ages 20-24 to attain saturation of HIV services (i.e., > 81% on treatment across all age and sex bands). Of note, PEPFAR Namibia's definition of attained includes reaching > 81% of ART among 20-24, a group with the highest HIV treatment gap. The PEPFAR definition includes this age group within the 15-24 year age band. The prioritization of older males with targeted HIV testing and ART services using innovative approaches will help Namibia achieve HIV epidemic control in the high epidemic areas by breaking the cycle of new infections. PEPFAR Namibia will continue to provide a full package of testing and clinical services to men and women not specifically highlighted as priority populations. PEPFAR Namibia supports the MOHSS' comprehensive HIV prevention and treatment package with technical assistance and clinical services for all ages and both sexes as is specifically outlined here. In addition to this core package we will work to provide additional services to priority populations, i.e., those not currently being adequately reached by standard services.

Table 3.1 Current Status of ART Saturation

Prioritization Area	Total PLHIV/ % of all PLHIV for COP17	# Current on ART (FY16)	# of SNU COP16 (FY17)	# of SNU COP17 (FY18)
Attained	6,164 (2.6%)	10,100	0	2*
Scale-up Saturation	85,954 (36.2%)	57,240	8	5
Scale-up Aggressive	87,790 (37%)	61,397	10	5
Sustained	44,026 (19%)	18,535	10	9
Central Support	13,193 (5.6)	6927	10	7

* Outapi and Nyangana

Figure 3.1 Map of SNU Priority and PEPFAR Supported sites for COP17

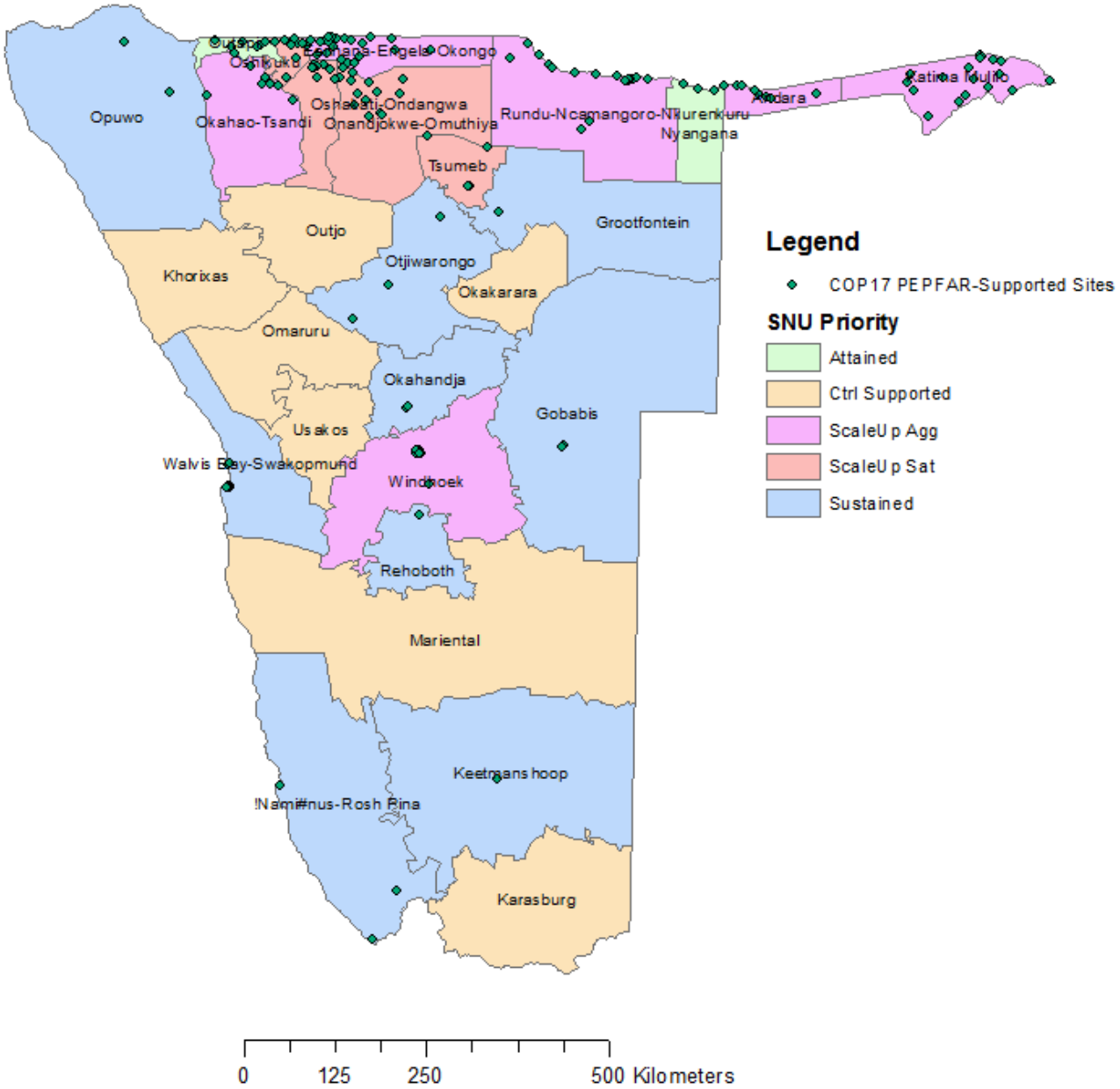


Figure 3.2 Age Disaggregation of Attained Status by SNU– COP15 Results

District	% 0-14 Males on ART	% 0-14 Females on ART	% 15-19 Males on A	% 15-19 Females on ART	% 20-24 Males on ART	% 20-24 Females on ART	% 25-29 Males on ART	% 25-29 Females on ART	% 30+ Males on ART	% 30+ Females ART
!Nami#nus	87%	100%	83%	61%	58%	45%	138%	138%	131%	
Andara	90%	112%	70%	27%	18%	48%	36%	58%	36%	
Eenhana	148%	132%	109%	64%	23%	36%	53%	69%	55%	
Engela	94%	94%	86%	55%	21%	30%	40%	53%	38%	
Gobabis	37%	37%	17%	27%	16%	46%	54%	60%	53%	
Grootfontein	44%	51%	47%	44%	9%	38%	56%	65%	60%	
Karasburg	64%	88%	29%	42%	17%	47%	105%	81%	100%	
Katima Mulilo	161%	154%	61%	52%	22%	52%	43%	57%	39%	
Keetmanshoop	105%	89%	58%	50%	37%	59%	78%	74%	83%	
Khorixas	60%	40%	28%	36%	17%	30%	58%	51%	73%	
Mariental	23%	20%	21%	24%	17%	37%	53%	45%	49%	
Ncamangoro	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Nkurenkuru	109%	89%	55%	50%	17%	61%	36%	52%	32%	
Nyangana	384%	297%	198%	127%	40%	126%	107%	157%	101%	
Okahandja	70%	66%	39%	19%	21%	34%	93%	84%	92%	
Okahao	178%	186%	182%	108%	28%	34%	61%	95%	69%	
Okakarara	31%	43%	20%	15%	12%	8%	25%	36%	29%	
Okongo	375%	346%	268%	147%	56%	64%	190%	184%	179%	
Omaruru	39%	110%	38%	35%	36%	20%	55%	44%	52%	
Omuthiya	159%	151%	117%	67%	20%	34%	47%	67%	53%	
Onandjokwe	105%	108%	99%	62%	22%	28%	46%	66%	48%	
Ondangwa	51%	49%	23%	24%	10%	18%	20%	27%	18%	
Opuwo	24%	27%	37%	18%	17%	24%	27%	42%	33%	
Oshakati	211%	235%	196%	131%	52%	47%	103%	121%	101%	
Oshikuku	173%	189%	180%	104%	37%	35%	47%	77%	56%	
Otjiwarongo	36%	39%	21%	18%	9%	17%	46%	43%	47%	
Outapi	390%	343%	281%	172%	48%	68%	104%	183%	116%	
Outjo	52%	33%	29%	30%	20%	28%	61%	60%	60%	
Rehoboth	25%	15%	18%	26%	21%	27%	66%	61%	66%	
Rosh Pinah	4%	6%	6%	2%	0%	3%	10%	8%	8%	
Rundu	225%	227%	101%	81%	39%	122%	83%	131%	77%	
Swakopmund	79%	77%	24%	24%	17%	21%	76%	56%	67%	
Tsandi	86%	100%	72%	38%	14%	22%	32%	43%	32%	
Tsumeb	132%	149%	105%	55%	30%	46%	126%	117%	126%	
Usakos	133%	128%	13%	30%	12%	28%	67%	58%	70%	
Walvis Bay	61%	89%	22%	20%	14%	19%	87%	64%	78%	
Windhoek	38%	39%	37%	26%	20%	32%	69%	63%	61%	

Green = attained (>81% on treatment)
Red = not attained

Namibia has nine urban hotspots outside the 18 priority districts (see Table 3.2). These hotspots have high concentrations of key populations and large ART sites (1,200+ patients). There are also high TB case rates and/or multi-drug resistant (MDR) TB burden in some urban hotspots in the south and west of the country. Special focus is needed to target these urban hot spots and ensure a continuum of prevention, care and treatment services to achieve ART saturation.

Table 3.2 High Burden Districts and Hotspots for COP17	
High Burden Districts (18)	**Urban Hotspots (9)**
Andara	!Nami#nus
Eenhana	Gobabis
Engela	Grootfontein
Katima Mulilo	Keetmanshoop
Ncomongoro	Okahandja
Nkurenkuru	Otjiwarongo
Nyangana	Swakopmund
Okahao	Walvis Bay
Omuthiya	Opuwo
Onandjokwe	
Ondangwa	
Oshakati	
Oshikuku	
Outapi	
Rundu	
Tsandi	
Tsumeb	
Windhoek	

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. DREAMS-like interventions are proposed for implementation in high HIV prevalence areas, high prevalence of GBV, teen pregnancy rates, and overall feasibility in the districts of Katima Mulilo, Omuthiya, Onandjokwe, Tsumeb and Windhoek. DREAMS-like activities will target 10-24 year-old AGYW in an effort to decrease the HIV incidence and ultimately keeping them HIV-negative. In these districts, PEPFAR Namibia will prioritize high risk girls as young as nine years old and ensure layered age-appropriate programming up to age 24. PEPFAR Namibia will also ensure that AGYW receive HIV and GBV risk reduction interventions from multiple sources.

PEPFAR Namibia will continue to support VMMC programs in Windhoek, Oshakati, Katima Mulilo, and Swakopmund, and will add activities in Ohangwena and the Rosh Pinah-!Nami#nus Cluster, all located within PEPFAR priority districts.

The focus age group for VMMC remains 15-29 year olds. In late 2016, however, the GRN introduced a policy that expanded the age prioritization focus of the program to include young boys aged 10-14 years using the dorsal slit surgical method. While PEPFAR Namibia will not actively invest in demand creation for this younger age group, any young men within this age group presenting for services will be provided the service. This geographic confluence between the DREAMS-like, OVC, VMMC key populations, and other PLHIV programs will prevent duplication, reduce gaps, leverage resources between various activities, and improve program coordination.

Peace Corps geographically transitioned health Volunteers into high-burden priority districts in FY17. The FY 18 cadre of health Volunteers will be placed throughout scale-up districts in Kavango, Ohangwena and Zambezi. They will continue to work under the auspices of MOHSS and community health facilities, but will shift from predominantly facility-based to community-based activities, targeting youth aged 15-24 with testing, adherence support, and linkages/referrals to care treatment and social services. Volunteers will liaise with community- based organizations, schools (where there are no education Volunteers) and health extension workers where possible to create a three-pronged approach to meet the HIV prevention, care and treatment needs of adolescents with a special focus on AGYWs.

In an effort to address the growing incidence among adolescents, Volunteers will strategically focus on enhancing youth friendly sexual reproductive health, reducing risky health behavior and improving life skills. Volunteers working with OVCs will focus on intervention to support adherence and retention by Adolescents Living with HIV (ALHIV) in combination with positive parenting and economic strengthening for caregivers. Peace Corps has also clustered a portion of its education and community and economic development Volunteers who will work together with health Volunteers to support the DREAMS HIV prevention package in DREAMS-like districts.

In COP17, 20 PEPFAR-funded Volunteers will be assigned to this program. The reduction in Volunteer numbers is due to the delayed intake of health Volunteers in 2017. In COP17,

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

4.1 Targets for Scale-Up Locations and Populations

HTS - Entry stream target setting process and assumptions
For COP17, PEPFAR Namibia's TX_NEW target is 31,040 comprised of 27,542 (See Table 4.1.1) from scale-up districts and 3,498 from sustained and attained districts (see Section 5.1). To reach this goal, the team's HTS strategy will focus primarily on identifying HIV+ individuals through the following entry stream modalities: newly diagnosed, PLHIV clinical care patients not on ART (pre-ART); TB-HIV co-infected patients not on ART; newly identified HIV+ pregnant women and their newborn infants; OVC testing; and HIV+ patients identified among priority and key populations.

The COP17 HTS target is based on the prioritization of high volume public sites with a relatively high number of reported HIV+ cases during 2015/16 (with 20 or more HIV+s identified). Of the total 367 HTS sites in the country, 177 sites are in high burden regions and account for 85% of the HTS volume and approximately 90% of the HIV+ cases in 2016. With the anticipated achievement of attained status in two districts, Outapi and Nyangana, two more districts, Opuwo and Rosh Pinah (hot spot SNUs), with two facilities each, have been added to the list of PEPFAR supported hotspot SNUs for COP17.

PEPFAR Namibia will implement high-yield testing and new case finding strategies targeted at men and AGYW. PEPFAR will support HTS that will reach a total of 403,138 individuals with the goal of identifying 30,515 HIV positives. As with COP16, 85% of the HTS volume and 90% of the positives will be identified from scale-up districts during COP17. Facility-based PITC makes up the majority of test volume, followed by VCT (voluntary counselling and testing) (co-located or standalone). Sexual partner tracing and testing and in-patient PITC will account for about 22% of the testing volume and over 36% of the HIV+ cases identified.

The 30,515 new PLHIV identified during COP17 is an increase of 50% from COP16 targets; 27,031 will be from scale up SNUs and 3,484 from sustained/attained SNUs. HTS data from FY16 indicated that partner tracing and testing and in-patient PITC were the key strategies for effective HIV case finding, including for older males. Similarly, community-based door-to-door testing provided a low yield and was a relatively expensive strategy, and thus will be significantly scaled down (below 5% of total HTS volume) during COP17. Other community based testing as well as mobile outreach testing where yield is high (15-25%) for key populations will be maintained. Young men and women aged 20-24 years and men aged 30+ will be the priority target populations for testing.

ART - Entry stream target setting process and assumptions The total number of PLHIV in Namibia is estimated at 237,126, using the Joint United Nations Programme on HIV/AIDS (UNAIDS) Spectrum High Bound Estimates. The overall national saturation target for ART is 81% of this total population, or 192,072. In 2016, 166,000 patients were active on ART including 151,000 in public sector and 15,000 in private sector. For COP16, the PEPFAR Namibia treatment current target was 181,387 and the planned target for COP17 is 193,218.

In developing the COP17 treatment targets, PEPFAR Namibia was committed to ensure that all 18 districts, mostly in the high-burden northern regions of Namibia, would achieve attained status (i.e., saturation across all age (including 20-24 year olds) and sex bands) by the end of FY18, while maintaining steady progress towards saturation for districts where urban hotspots are located. Many of the 18 districts have treatment coverage ≥81%, but only two districts (Nyangana and Outapi) have coverage of ≥81% across all age and sex bands. As previously noted, the largest treatment gap is among males 30+ and youths aged 20-24.

Overall retention on ART is estimated at 93%. This is based on ARV refill data from the national electronic dispensing tool (EDT). Although the overall retention on ART rate in the Annual Progress Report 2016 was about 80%, this is an underestimation of the true retention. This rate is obtained from the electronic patient management system (ePMS). At each visit, health care providers capture patient follow up information in paper-based patient care booklets. Data entry clerks are supposed to transcribe this information and enter the data into the ePMS including the date of the next appointment. However, many of the sites have a large data entry backlog resulting in under reporting of retention within the electronic patient management systems. The EDT captures ARV refill data and the data are entered into this system every time that a patient picks up their ARVs, which is a more accurate estimate.

Given the mobility of PLHIV in the northern regions and the fact that people seek HIV services across district lines, five clusters were created for PEPFAR programming for those districts targeted to achieve "attained" status by end of FY18, combining contiguous districts as follows:

- Oshakati-Ondangwa Cluster
- Okahao-Tsandi Cluster
- Engela-Eenhana-Okongo Cluster
- Omuthiya-Onandjokwe Cluster
- Ncamangoro-Nkurenkuru-Rundu Cluster

These five clusters, combined with five additional standalone districts (Windhoek, Andara, Katima Mulilo, Oshikuku, and Tsumeb), constitute the geographic areas targeted for attainment by end of FY18. These geographic areas will collectively contribute 153,236 (79%) of the total 193,218 FY18 treatment current target. Similarly, these districts will contribute 27,542 (89%) of the 31,040 FY18 PEPFAR treatment new target, which demonstrates PEPFAR Namibia's focus on the geographic areas with the greatest burden and need.

PMTCT - Entry stream target setting process and assumptions

Approximately 10,372 (2,804 new) HIV+ pregnant women will be identified through the national PMTCT program during FY18. The 2016 HIV National Sentinel Survey reported that >63% of HIV+ pregnant women were already receiving ART. PEPFAR Namibia will target 2,677 of the remaining newly identified HIV+ pregnant women to enroll on ART. In total, 9736 (7,059 already on ART and 2,677 newly enrolled) HIV + pregnant women will receive ART in PEPFAR supported sites in FY18. Achieving these targets will enable the country to achieve ≥90% of HIV+ pregnant women receiving ART.

Based on current PMTCT data, an estimated 9,873 infants born to HIV+ mothers in PEPFAR supported areas will be tested during FY18. Of these, 2.0% are expected to be HIV+ and will lead to approximately 184 (100%) infants under 1 year of age initiated on ART.

Table 4.1.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY18) HTS TST	Newly Identified Positive (APR FY18) HTS TST POS	Newly initiated on ART (APR FY 18) TX_NEW
Adults			
TB Patients	2,118	629	666
Pregnant Women	37,066	2,148	2,468
VMMC clients	8,410	215	215
Key populations	18,257	1,908	1,815
Partner tracing and testing	55,735	8,360	7,209
In-patient PITC	15,201	1,961	1,890
Home-based testing	17,950	411	392
VCT	70,482	3,965	3,996
Other Testing	83,507	6,404	7,759
Total Adults	**308,726**	**26,001**	26,410
Pediatrics (<15)			
HIV Exposed Infants	7,775	123	141

Other pediatric testing	23,122	907	990
Total Pediatrics	**30,897**	**1,030**	1,132
TOTAL	**339,623**	**27,031**	**27,542**

VMMC - Entry stream target setting process and assumptions

The estimated number of VMMC who are HIV+ are assumed to be incorporated within the overall HTS POS estimates because the data pack does not allow for generation of a separate entry stream of positives from the VMMC program (see Other Testing category in Table 4.1.1). Furthermore with the launch and wider implementation of "Treat All," and the current aggressive process of actively tracing patients previously on Pre-ART before the "Treat All" policy and putting them on ART during FY17, PEPFAR Namibia anticipates a limited number of patients still on Pre-ART during FY18 who will require ART initiation.

In FY16, PEPFAR Namibia provided TA to the MOHSS to update the national VMMC targets for all geographic areas through a consultative process using the Decision Makers Program Planning Tool (DMPPT Version 2.0). PEPFAR Namibia used the outputs from this updated tool with the data pack as a basis for considering targets for FY18. VMMC coverage among 15-29 year olds in two districts (Oshana and Zambezi) supported by PEPFAR over the last three fiscal years is approaching saturation (80% coverage). However, several other VMMC saturation districts, namely Windhoek and Engela-Eenhana cluster, continue to have very low VMMC coverage.

FY18 targets were thus set to ensure that the saturation threshold is achieved or exceeded in Zambezi (99%) and in Oshana (80%). Consequently targets were set at 6,179 and 3,695 for Oshana and Zambezi respectively. Aggressive scale-up targets were set for the remaining saturation districts in which PEPFAR is already supporting VMMC (Windhoek, Engela-Eenhana cluster) where the coverage remains very low and is not anticipated to reach saturation levels by end of FY18. Targets in these districts were set at 20,152 for Windhoek and 5,707 for Engela-Eenhana cluster to achieve VMMC coverage of 56% and 30% respectively by APR18. PEPFAR Namibia will work with local and international stakeholders to explore additional strategies that may attract more men for VMMC services. In addition, PEPFAR Namibia welcomes suggestions of any innovative strategies that for this program.

With the anticipated achievement of saturation in Oshana and Zambezi by APR18, PEPFAR Namibia will begin transitioning to new aggressive saturation SNUs with low VMMC coverage in COP17. The Rosh-Pinah-!Nami#nus cluster, a scale-up aggressive SNU and mining town with an anticipated low VMMC coverage of 15% by the end of FY17, was selected in order to increase VMMC services and coverage. The target of 1,538 for this area will allow establishing new VMMC services, with anticipated aggressive scale up in FY19 after saturation has been achieved in Zambezi and Oshana.

Table 4.1.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts				
SNU	**Total male population, aged 15-29**	**Cumulative Number of Circumcised Men, aged 15-29 (end of FY16)**	**Expected Cumulative Number of Circumcised Men, aged 15-29 (end of FY17)**	**FY18 Target**
!Nami#nus-Rosh Pinah Cluster	8,591	57	1257	1,538
Oshakati-Ondangwa Cluster	27,873	4,670	16,201	6,179
Okahao-Tsandi Cluster	14,564	0	445	0
Engela-Eenhana-Okongo Cluster	37,444	2,826	5,676	5,707
Ncamangoro-Nkurenkuru-Rundu Cluster	27,406	0	2,304	0
Omuthiya-Onandjokwe Cluster	24,065	0	1,424	0
Katima Mulilo	14,605	1,851	10,703	3,695
Oshikuku	13,829	0	567	0
Tsumeb	4,681	0	240	0
Walvis-Bay, Swakopmund cluster	27,455	2,548	17,607	6,332
Windhoek	62,692	12,468	14,700	20,152
TOTAL	**231,495**	**21,815**	**52,498**	**43,603**

Key Populations - Entry stream target setting process and assumptions
PEPFAR Namibia set the COP17 targets for KP_PREV in the scale-up districts by taking into consideration the population size estimates from the 2013 IBBS. In addition, case workers in the program completed micro-mapping and size estimation activities, which helped set targets for this year. Overall, the COP17 targets align with the goal of reaching 90% of the estimated key populations in these areas.

Priority Populations - Entry stream target setting process and assumptions
PP_PREV targets were set by assessing the previous year achievements in most districts and recognizing the need for improved prevention activities, especially among young girls. In DREAMS-like districts, targets were added to the PP_PREV base to account for increased PP_PREV programming.

Table 4.1.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate (scale-up SNUs)**	**Coverage Goal (FY17)**	**FY18 Target**
KP_PREV	N/A	N/A	**13,212**
KP_PREV PWID	N/A	N/A	0
KP_PREV MSM/TG	N/A	N/A	3,730
KP PREV_FSW	N/A	N/A	9,482
PP_PREV	**525,640**	**100,880**	**150,709**
TOTAL	**N/A**	**100,880**	**163,921**

OVC and Pediatric - Entry stream target setting process and assumptions
OVC targets include Children Living with HIV (CLHIV) aged 0-15 and HIV-affected children (e.g., children of PLHIV including HIV-Exposed Infants (HEI)). The target for OVC served is based on the estimated number of orphans and vulnerable children from 2016 Spectrum Model and the number of orphans enumerated in the 2011 census. An anticipated 80% of all OVC infected and affected by HIV in PEPFAR Namibia sites will need specific HIV-related services within facilities and communities. These services include HTS, HIV prevention, psychosocial counseling, referrals to care and treatment, and support for ART adherence, retention and HIV disclosure.

PEPFAR Namibia will reach a total of 35,021 OVC in PEPFAR supported SNUs. Of these, 32,263 (92%) are in scale-up locations with the highest HIV burden (Table 4.1.4). In FY16, only 60% of the OVC served had documented HIV status. In COP17 we will enhance screening of OVC to ensure 90% coverage. Priority interventions include strengthening the community response for HIV prevention in and out of schools; providing educational, psychosocial, food and nutritional support, and child protection and legal services; improving linkages of OVC program to facility-based HIV services particularly PMTCT and pediatric care and treatment; strengthening capacity of families as primary caregivers of children; and household economic strengthening activities.

Table 4.1.4 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of OVC**	**FY17 Expected OVC_SERV**	**FY18 Target OVC_SERV**
Andara	627	970	3,189
Oshakati-Ondangwa Cluster	3,769	1,287	1,287
Okahao-Tsandi Cluster	2,064	-	
Engela-Eenhana-Okongo Cluster	5,063	2,367	3,625
Walvis Bay-Swakopmund Cluster			110
Ncamangoro-Nkurenkuru-Rundu Cluster	3,866	2,846	8,717

Omuthiya-Onandjokwe Cluster	3,453	2,039	5,028
Gobabis			40
Katima Mulilo	1,975	2,386	1,959
Nyangana		1,004	1,243
Oshikuku	1,969	765	2,266
Otjiwarongo		765	100
Outapi		765	765
Rundu			500
Tsumeb	434	1318	2,754
Windhoek	8,477	3,438	3,438
Total	**31,697**	**17, 416**	**35,021**

4.2 Priority Population Prevention

Namibia's combination HIV prevention strategy focuses on reducing new HIV infections by targeting essential, evidence-based interventions such as HTS, PMTCT, ART, VMMC, PrEP, and condoms to specific high-risk groups within the epidemic profile. AGYW, serodiscordant couples, FSW, transgendered communities, and MSM are populations at substantial risk of HIV acquisition and should receive HIV prevention interventions. Namibia's 2016 National ART Guidelines adopted "Treat All' for newly diagnosed individual with HIV and PrEP for people at substantial risk. The Namibian constitution and numerous government policies, including the National Gender Policy (2010-2020) and accompanying Plan of Action (2011), aggressively address GBV. PEPFAR will support innovative models to deliver prevention services including DREAMS-like interventions targeting these prioritized populations.

To avert new HIV infections among priority and key populations in high burden areas, PEPFAR will assist the GRN to deliver targeted risk reduction counseling, condom distribution, GBV activities and social mobilization efforts to increase uptake of PMTCT, HTC, PrEP and VMMC service. PEPFAR Namibia will also assist GRN in using existing clinical and community health platforms to conduct advocacy, communications and social mobilization activities.

In FY2018 PEPFAR Namibia will provide targeted assistance to the GRN to implement PrEP, focused on MSM, FSW, high-risk young women, and serodiscordant couples in instances where the index partner does not achieve viral suppression. GRN's prevention programs will be strengthened to enhance linkages to HTS and ART in state and non-state health facilities. Key population activities will be conducted in five scale-up districts based on MOHSS' IBBSS size estimations. Activities are integrated to serve SW and MSM with HIV prevention and treatment interventions in communities where they reside. PEPFAR will demonstrate innovative peer-driven interventions among FSW, MSM and TG communities to increase HTS and linkage to PrEP/ART and other HIV services.

Detailed activities for priority population prevention are as follows:

1. Supporting individualized risk-reduction counseling, condom and lubricant distribution and HIV testing focusing on priority populations through clinic and community-based activities.
2. Supporting partner notification/contact tracing for sexual partners and the offering of HIV self-testing.
3. Scaling-up community case management for key populations to find, test and link key populations to PrEP and ART, and supporting retention and adherence efforts for those already on ART.
4. Conducting communications and social mobilization activities to improve utilization of HIV testing, PMTCT, VMMC and ART at the community level.
5. Offering targeted assistance to introduce PrEP service for key populations, high risk AGYW and serodiscordant couples in state health facilities and special clinics focused on youth and special populations.
6. Supporting health innovations to reach, test and link men within workforce, informal sector and trade to HIV care and treatment services.

DREAMS-like prevention activities in 5 districts will provide layered interventions for AGYW focusing on sexual and reproductive health education, condom distribution, GBV prevention, HTS and linkage to care and treatment for HIV positives, interventions to support progression and education of adolescent girls in school, adolescent-friendly sexual and reproductive health (SRH) services and partner notification services to ART and VMMC. USAID OVC and KP programs currently use a system of tracking which has been developed based on the REDCAP software. PEPFAR Namibia will work with one of our partners to tailor a system such as this for DREAMS-like programming to ensure we are able to track the layered programming for high risk girls.

DREAMS-like activities include:

1. Targeting assistance for PrEP as above with focus on AGYW, especially those seeking care at SRH clinics and ANC.
2. Strengthening school-based HIV, violence and education progression activities by employing school nurses as part of the MOHSS school health program.
3. Conducting social and behavioral interventions in coordination with religious and community leaders to address gender norms and risk of GBV and HIV.
4. Introducing family-based programming targeting families of high-risk AGYW (ages 10-19) focused on GBV and HIV prevention and youth-based programming for older adolescents and young adults (15-24).
5. Strengthening the linkage between HIV prevention and other GRN social welfare services for AGYW
6. Enhancing linkages to social asset building programming via Peace Corps Volunteer clubs/safe spaces or other community based partners.

7. Strengthening the quality of post-violence care at the clinic level and enhancing community level awareness of services available.
8. Conducting Peace Corps Volunteer training of teachers on GBV, comprehensive SRH risk, gender sensitive curriculum/ teaching methods and youth programming to reduce teenage pregnancy to keep girls in school.
9. Creating linkages to Peace Corps community-based programming focusing on GBV prevention, adolescent SRH, economic strengthening, and school retention.
10. Introducing approved youth programming for GBV and HIV risk reduction at community youth centers and/or other youth friendly locations.
11. Improving the knowledge of health care workers and the promotion of a contraceptive mix to cater to the full needs of adolescents.
12. Developing youth friendly condom promotion campaign and logistical support to ensure condoms are available at youth outlets (MOHSS procures condoms)
13. Developing an above site' keep girls in school/GBV reduction campaign in collaboration with Namibia's First Lady and her expressed interest in girls and schools.
14. Promoting the provision of sanitary pads and AGYW safe spaces at schools to limit absenteeism.

4.3 Voluntary Medical Male Circumcision (VMMC)

Historically the VMMC program in Namibia has struggled to achieve its goals. In 2008 a situational assessment of the VMMC showed that only one fifth of men aged 15-29 were circumcised. Most circumcisions were done by traditional circumcisers. Moreover the northern regions (Omusati, Ohangwena, Caprivi and Oshana) had the lowest VMMC coverage and the highest HIV prevalence.

In 2010, the Namibian MOHSS set out an ambitious goal to increase VMMC coverage to 80% for neonates, adolescent, and adult males by 2015, which would require approximately 400,000 additional circumcisions. In September 2016, the MOHSS issued training guidelines for clinicians to start circumcising males 10-14 years old. Until then, VMMC supported by GF and PEPFAR, was focused only on males aged 15+. In some districts, VMMC coverage among males aged 15-29 was approaching 80% and this factored into MOHSS decision to revise the VMMC national strategy to include 10-14 year olds.

The reduction of the age of consent for surgical procedures from 16 years to 14 years as enacted in the new Namibia Child Care and Protection Act of 2016, has not yet been implemented due to the absence of enabling regulations. Once implemented, this policy will remove potential bottlenecks in access to VMMC services for younger boys aged 14 years and older, as they will no longer require parental/guardian consent for surgery.

The program performance during COP15 continued to go on an upward trajectory (16,507 compared to 9,927 in COP14). PEPFAR Namibia results from FY17 Q1 (3,084) were the highest Q1 achievement since the PEPFAR Namibia VMMC program was relaunched in 2014. The program

also performed well with regard to the age pivot, with 67% of all circumcisions being conducted among the target 15-29 year-old age group. PEPFAR Namibia will build upon these successes to further strengthen the program achievements in FY18.

For COP17, PEPFAR Namibia will support GRN efforts to scale-up VMMC within the national framework using state health facilities and private health clinics. Within scale-up districts, PEPFAR Namibia will focus on 15-29 year-olds, which is in line with past performance; this is critical in achieving immediate impact. However, boys 10-14 years old presenting to any of PEPFAR Namibia VMMC sites will not be turned away and will be offered services. In addition, targeted assistance will be provided to GRN to develop policies on early infant medical circumcision.

The low demand for VMMC services in some districts continues to hamper achievement of targets, especially among the older men aged 25+ years. Strategies that have proved effective during FY16 and that will continue include:

1. Building on the successful use of the Celebrity VMMC Ambassador (i.e. "The Dogg Campaign") by refining and diversifying the use of this strategy for mobilizing men; and
2. Strategically deploying electronic and print media mobilization campaigns.

A PEPFAR-supported National Demand Creation Manager seconded to the MOHSS will spearhead coordination of the demand creation strategies.

The country will also implement a continuous quality assessment/evaluation training to support external quality assurance assessments (EQA) to improve the quality of service delivery at all VMMC providing sites. Monthly meetings will also be conducted with implementing partners to discuss program implementation, review progress, and address challenges. PEPFAR Namibia will collaborate with country teams and with HQ technical teams to strength the VMMC program.

4.4 Preventing Mother-to-Child Transmission (PMTCT)

In 2016, MOHSS revised national guidelines to improve maternal and infant HIV case identification and prevention through:

1. HIV retesting three months after the first test, at 36 weeks of pregnancy, six weeks after delivery, and every six months until cessation of breastfeeding for those testing negative;
2. Birth testing and NVP +AZT prophylaxis for higher risk infants (infants born to mothers of unknown HIV status, HIV+ mothers not on ART, or HIV+ mothers on ART but not virally suppressed or with unknown viral load count); and
3. Maternal VL monitoring every three months until cessation of breastfeeding.

PMTCT program challenges in Namibia include: SNUs with low rates of EID; inadequate mentorship and supervision; inconsistent HIV re-testing (based on the national guideline); lack of measurement of final outcomes for mother-infant pairs; and shortage of trained staff.

In COP17, PEPFAR Namibia will support activities that ensure all pregnant and breastfeeding women (PBFW) and HEIs in 136 sites in scale-up SNUs are reached with HIV testing and ART for HIV+s by:

1. Ensuring routine maternal HIV testing at ANC, delivery, after delivery, and retesting of HIV- pregnant and breastfeeding women at recommended intervals;
2. Ensuring routine EID for HEIs, including retesting of HIV- infants at recommended intervals up to 18 months to improve case identification;
3. Conducting systematic follow-up and care of mother-infant pairs using facility and community-based systems;
4. Training and mentorship of health workers who work with PMTCT/EID and maternal viral load monitoring;
5. Strengthening PMTCT M&E systems, including electronic systems for improved longitudinal follow-up care and data quality;
6. Implementing prevention strategies to reduce HIV incidence among PBFW, including male partner testing and provision of PrEP; and,
7. Assessing partner performance in scale-up districts through PEPFAR's Site Improvement through Monitoring System (SIMS) and regular financial and performance reviews of the relevant MER indicators.

4.5 HIV Testing Services (HTS)

PEPFAR Namibia will support 177 of the 367 GRN testing sites during COP17. These sites are expected to provide 85% of the test volume and 90% of the new HIV diagnoses. This translates to a total HTC_TST of 403,138 and HTC_POS of 30,515.

Based on the 2013 DHS, an estimated 75% of adult PLHIV (aged 15–49 years) reported knowing their HIV status. Since 2013, an additional 30,000 PLHIV were newly diagnosed with HIV and initiated on ART. This suggests that about 80% of PLHIV in Namibia know their status.

In COP15, PEPFAR Namibia achieved its overall HTS_TST targets but was unable to reach HTS_POS targets. The number of PLHIV identified remained low. Reasons for this underperformance include limited scale-up of strategic targeted testing and sub optimal implementation of provider-initiated testing and counseling (PITC) services within health facilities in scale-up SNUs. Additionally, continued implementation of low yield strategies such as community door-to-door testing coupled with low HTS coverage among men >30 years of age have contributed to the low performance. To address this gap, PEPFAR Namibia reviewed its HTS approaches and significantly scaled down door-to-door untargeted HTS and closed three standalone HTS centers in COP16.

During Quarter 1 of COP16, PEPFAR Namibia assisted the GRN to implement PITC within outpatient and inpatient departments in 22 hospitals and satellite sites. In addition, PEPFAR

Namibia piloted index partner tracing and testing services for individuals newly diagnosed as HIV-positive as well as individuals enrolled in HIV treatment services. These efforts increased the number of adult men tested and achieved HIV positivity rates as high as 25%, (compared with about 6% reported from routine services).

In-patient PITC and index partner tracing and testing will be aggressively scaled up and maintained in all supported sites for the remainder of COP16 and in COP17. As indicated in table 4.1.1., these testing modalities are expected to have 12-15% yield rate which is double the rate seen in routine PITC program. Community-based mobile outreach services that offer integrated multi-disease screening (hypertension, diabetes mellitus, lipid profile, liver diseases, etc.) will be implemented to reach and test men and their sex partners in the community. An HIV self-testing (HIVST) strategy will be an integral part of index partner tracing, reaching clandestine groups such as FSWs, transgendered women, and MSM. HIVST will also be demonstrated at selected ANC sites to increase HTS among partners of women who use PMTCT services. Careful attention will be paid to ensure that all individuals screening HIV-positive during HIVST are linked to confirmatory testing and HIV treatment services.

In addition, current ART gap analysis indicates that a large number of PLHIV among young people (aged 20-24) need to be identified during COP17 to attain saturation in scale-up SNUs. HTS strategies that target young people in health facilities and communities will be implemented to address this gap. In particular, PITC services will be expanded in reproductive health (RH), family planning (FP), and sexually transmitted infections (STI) clinics, hospital emergency rooms, and OB/GYN clinics to identify young PLHIV. Community-based incentivized social network HIV testing will also be implemented in tertiary schools and at youth centers as an innovative approach for reaching young men. HTS will also be offered during weekend and evening hours to improve young men's access to these services. In addition, all men (≥ 15 years of age) receiving VMMC services will continue to be offered HIV testing.

As stated above, PEPFAR Namibia will support 177 of the 367 GRN testing sites during COP17, of which 135 (76.3% of the 177) are located in scale-up SNUs.

The GRN finances HTS in public health facilities, procures HTS commodities, and provides most HRH for the national HIV response. PEPFAR Namibia provides supplemental HRH and targeted assistance in scale-up SNUs and in non-state health facilities serving special populations. In COP17, PEPFAR Namibia will also provide targeted assistance to the GRN for:

1. Expanding HTS for OVC to know their status;
2. Integrating HTS into community case management activities for key populations;
3. Integrating HTS into the MOHSS Health Extension Program for long-term sustainability of HTS;
4. Expanding partnerships with medical insurers, private clinicians, and laboratories to introduce HIVST to populations at substantial risk;
5. Strengthening linkage to HIV treatment services through patient escorts and navigators as well as follow-up phone calls and home visits for PLHIV who fail to self-enroll in HIV

treatment services within 30 days of an HIV diagnosis;

6. Revising national data reporting tools to capture HTS information and testing modalities from the private sector; and
7. Continuing partner performance management to ensure that IPs track achievements vis-a-vis targets for HIV case finding and linkage to treatment in order to re-focus their testing efforts on HIV case finding, not volume of tests conducted.

Finally, in 2016, GRN adopted a serial HIV testing algorithm using WHO-recommended HTS assays. This policy revision improved the cost and efficiency of HTS within the country. PEPFAR Namibia will continue to provide training and technical support to strengthen national supply chain forecasting and management during COP17, in close collaboration with the GFATM. Additionally, PEPFAR Namibia will provide limited funding to support HIVST, including procurement of OraQuick self-test kits, to pilot the effectiveness of this approach at reaching hard-to reach populations (e.g., key populations and young men).

4.6 Facility and Community Based Care and Support

Namibia adopted the "Treat All" policy in FY17. The National ART Guidelines were revised accordingly to allow for same day initiation and differentiated models of care. As a result, enrollment of clients to pre-ART became obsolete. In order to ensure 100% ART coverage among PLHIV, PEPFAR Namibia supports case management, patient escorts, bi-directional referral through expert patients, community volunteers, health extension workers, community-based ART program (CBART) managed through outreach services by clinical support staff and CSOs to ensure all newly diagnosed PLHIV are linked to and retained on ART.

PEPFAR Namibia has shifted strategically from traditional home-based care service and repurposed community-based care and support partners to improve linkages to treatment, adherence to ART and retention strategies. Adherence and retention of PLHIV on treatment is crucial to achieve treatment success: viral suppression. Based on routine program assessments, the ART program in Namibia is predominantly facility-based and health care worker driven. Small demonstration projects of differentiated models of care, including CBART implemented in COP16, have shown favorable outcomes: over 90% of patients have viral suppression. In COP17, PEPFAR Namibia will continue to expand support to adherence and retention initiatives at a facility and community level including patient managed community adherence clubs and patient tracing and re-engagement in treatment strategies. To ensure that patients are equal partners in their care, PEPFAR will support empowering PLHIV to participate in their own care by educating them on preferable HIV treatment outcomes as measured by VL testing. In addition, to improve partner performance, PEPFAR Namibia will work with implementing partners on timely reporting, program quality improvement, and enabled data driven corrective measures. Additionally, PEPFAR will support decentralized reporting tools and systems for community-based treatment, care and support services to enable local ownership of programs.

At scale-up districts and facility level, PEPFAR will support the following packages of services:

1. Lifelong cotrimoxazole and isoniazid (INH) prophylaxis as per national GLs;
2. Adherence counseling and TB symptom screening of PLHIV;
3. Bi-annual clinic visit and annual VL testing for stable patients;
4. In-service training to health care providers to improve continuum of care and quality of services; and
5. Referral and linkage to community-based ART delivery points for stable patients.

At the community level, PEPFAR will support CSO and PLHIV networks to refill ARVs for stable patients, provide TA to deliver child-focused OVC services that integrate HIV case finding among OVC, and nutrition care for malnourished HIV+ adults and children. PEPFAR will also provide technical support to improve adult and pediatric care and support services by:

1. Expanding the EID system and point-of-care (POC) testing for HEI;
2. Strengthening PMTCT-ART-care linkages and follow-up of mother-baby pairs to improve retention of HIV-infected children in care;
3. Supporting community cadres to track lost-to follow-up patients;
4. Empowering PLHIV networks, adherence support groups and other cadres to refill ARV for stable patients;
5. Improving OVC program linkage to HIV testing, care and treatment;
6. Strengthening and leveraging drought funding to improve nutrition assessment, counseling and support activities of the Namibia drought interventions; and
7. Training the health extension workers to strengthen the integration of health and HIV services at community levels.

4.7 TB/HIV

According to WHO's 2015 Global TB report, Namibia has the fifth-highest incidence of TB in the world (489/100,000 population) (WHO 2015). FY16 program data reported 9,614 confirmed cases of TB, a slight decrease from the 9,953 cases in 2015. Currently, the true prevalence of TB is unknown in Namibia, and the first TB disease prevalence study is planned for 2017. Namibia also has recently adopted universal use of GeneXpert as the first line laboratory test for evaluation of all presumptive TB cases. Drug-resistant TB (DR TB) is a growing challenge with 387 cases reported in FY16 – an increase from 337 cases in 2015. HIV co-infection in TB patients is estimated at 38%. Of the SNUs in Namibia, 10/28 are scale-up saturation or scale-up aggressive, based on HIV testing and treatment targets. Current program data shows that the rate of all TB patients with a documented HIV status has improved to 96%, and HIV+ TB patients initiating ART is reported at 91%. However, significant data and clinical quality gaps remain in some SNUs, where less than half of the co-infected patients could be traced to documented HIV care and delays in ART initiation were noted. The MOHSS also has identified four high-burden TB sites in the country that should receive focused attention for TB/HIV services, three sites being part of scale-up aggressive or saturated SNUs: Engela, Onandjokwe and Windhoek.

In COP17, PEPFAR Namibia will provide assistance to support strengthening of TB/HIV collaborative activities in these SNUs by:

1. Implementing interventions to attain high coverage of TB screening in PLHIV, including ICF, IPT and ART uptake;
2. Providing TA to maintain high coverage of HIV testing and ART initiation in TB patients through referral, linkage and integration of services. Conduct operational research and surveillance strengthening as part of monitoring and evaluation (M&E);
3. Improving TB/HIV data capture, recording and reporting through supervision, mentoring, training, updating of reporting tools, and development of standard operating procedures (SOPs). Improvements in data capture will be facilitated with use of MOHSS clinical mentors and existing telehealth platforms (e.g., Project ECHO);
4. Maintaining PITC for confirmed TB patients, scaling up PITC in persons with presumptive TB, and extending HTC to direct contacts and family members;
5. Integrating TB and HIV clinical services in high-burden TB and HIV care settings;
6. Providing TA to establish TB screening /IPT initiation as a standard of care in the ART sites, as well as ART initiation in TB sites;
7. Providing training for health care workers on DR TB;
8. Providing guideline implementation TA on universal GeneXpert testing as the first diagnostic test for all presumptive cases of TB including PLHIVs;
9. Providing site level coordination of TB/HIV services between care providers, including on site trainings, clinical case reviews and data reviews.
10. Introducing innovative referral models including expanding the number and cadres conducting TB screening and assisted referrals;
11. Coordinating a collaborative service delivery approach between TB and HIV programs to achieve greater efficiency and reduced cost, as well as improved adherence and retention for HIV and TB treatments. Ensure coordinated, same-day clinic appointments, routine lab draws and medication refills, for both TB and HIV diagnoses;
12. Scaling up infection control efforts to reduce TB-associated morbidity and mortality;
13. Providing limited TA support to implementation of the TB disease prevalence survey (DPS). Most of the funding for field work to collect data, perform data analysis and disseminate results will be supported with Global Fund resources and domestic MOHSS resources. Additionally, a small carry-over budget for laboratory testing has been dedicated to the DPS during COP16, with a larger laboratory testing budget for the DPS planned for COP17;
14. Providing guideline implementation TA on screening and management of drug-resistant TB using rapid molecular testing; and
15. Providing TA for new TB drugs supplied from a USAID donation program. The Namibia in-country drug resistant TB expert will be supported to provide HCW training and revise guidelines to include new TB drugs into the Namibian essential medicine list, thus enabling the Namibian government to take procurement ownership of these medications.

4.8 Adult Treatment

In 2016, PEPFAR Namibia supported MOHSS to revise the National ART Guidelines, expanding clinical eligibility to all newly diagnosed HIV+ cases. In addition, PEPFAR Namibia assisted MOHSS in rolling out "Treat All" in three priority SNUs during FY15/FY16. These policy changes have now been rolled out nationally and will help PEPFAR Namibia achieve the aggressive COP17 treatment targets, saturate ART services for all age and sex bands, and lead to the achievement of the 90-90-90 goals across scale-up SNUs. COP15 ART performance achieved 89% and 121% of TX_NEW and TX_CURR targets respectively.

While many districts in saturation areas generally have relatively high overall treatment coverage rates, key challenges include low ART coverage rates among specific age and sex bands, specifically young adults aged 20-24 (22% among males and 38% among females; APR16) and males aged 30+ (APR16 treatment coverage 55%). This resulted in several SNUs with ≥80% ART coverage failing to achieve "attained" status.

Identification of HIV+s and immediate linkage to treatment of these population sub-groups with the largest treatment coverage gaps will be the key focus for PEPFAR Namibia in FY18. Within the PEPFAR Namibia HTS portfolio, HIV testing strategies that target young people in health facilities and communities will be implemented. In particular, PITC service expansion in RH/FP/STI clinics, hospital emergency rooms, and OB/GYN clinics should identify young PLHIV. Community-based incentivized social network HIV testing will be implemented in tertiary schools and at youth centers on weekends and during evening hours. Ensuring almost 100% linkage to care and treatment for those identified as HIV-positive will be critical in rapidly increasing treatment coverage among these sub-groups. Strategies to enhance linkage to treatment include assigning unique ART numbers when tested, and use of patient escorts in large health facilities to help patients navigate from testing service points to treatment service points. The implementation of the "Treat All" policy and more specifically "same-day ART initiation" in all facilities will also facilitate increased linkage to treatment by decreasing the time it takes for patients to be initiated on ART. The national ART guidelines recommend that "*Patients should be initiated on ART immediately when they are ready, either on the same day or as soon as possible within one week*". With the ongoing wider national roll out of the implementation of these new guidelines, this strategy will minimize loss of patients, which tends to occur between the period after being tested and before being initiated on ART. It is also anticipated that decentralizing treatment services to locations more convenient to the young adults and older men such as community-based ART (CBART) sites, as well as the use of flexible hours for ART service provision in some high volume facilities will enhance linkage to treatment and care.

Achieving VL suppression among all age and sex sub-groups is another significant program challenge. While data from the laboratory information system (MEDITECH) demonstrates that the overall VL suppression was 86% for all populations (APR16), it was significantly lower (71%) among young adults (aged <24) in FY17 Q1, when compared with 86% among adults aged 25+

years. This is a significant challenge that will demand innovative strategies to ensure retention and adherence to treatment, especially among young adults and older men. PEPFAR Namibia will support the wider use of teen clubs (especially for the older teens), adult treatment literacy materials, and community ART outreach services to youth and community centers as well as to other convenient locations identified by communities and PLHIV network groups. The implementation of various models of community ART distribution such as community adherence clubs will be scaled up, as will the innovative use of technologies to support adherence and retention for these sub-groups.

In COP17, PEPFAR will support aggressive scale-up of ART in scale-up SNUs to achieve a minimum of 81% treatment coverage across all age and sex bands. In addition, PEPFAR will support other hotspot sites/districts to maintain clinical services coverage and progress steadily towards saturation; implement differentiated service delivery models including CBART among scale-up SNUs; and achieve COP17 treatment targets (TX_NEW 31,041, and TX_CURR 193,218).

Scale-up SNUs will receive intensive PEPFAR support to reach a minimum of 81% treatment coverage across age and sex bands by:

1. Continuing salary support for dedicated health care workers to deliver scale-up ART;
2. Conducting small-area renovation and patient flow modifications at decentralized and outreach sites to accommodate ART patient volumes, continue scale-up, and reduce congestion;
3. Continuing expansion of community-based ART and community-adherence clubs for the increasing numbers of stable patients;
4. Conducting linkage to care, adherence, and retention interventions;
5. Promoting adherence and retention in care and treatment particularly targeting the age/sex bands with the poorest outcomes (i.e., young adults aged 15-24 and older men aged 30+);
6. Ensuring quality of care and operational efficiency through in-service training, clinical mentorship, and expanding the ECHO platform to all SNUs;
7. Strengthening the supply chain management (SCM) functions for ART, including ARV drug regimen use, quantification, electronic dispensing and tracking, and implementation of Logistics Management Information System (LMIS) at each facility dispensing ARVs;
8. Strengthening laboratory network services for VL testing to ensure monitoring of VLS, including VL tests linked with unique patient ART numbers for timely monitoring of ART clinical outcomes for further clinical management;
9. Implementing the Quality Improvement Collaborative to improve key program outcomes such as retention and adherence;
10. Strengthening GRN/private-sector collaboration to expand ART distribution points; and
11. Monitoring implementing partners' performance in scale-up districts through SIMS, financial, and activity report reviews; quarterly performance reviews of MER indicators and site visit reports; and monthly performance reviews using a standard tools and POART feedback to all partners.

4.9 Pediatric and Adolescent Care and Treatment

PEPFAR supports the GRN in scaling up pediatric treatment services to CLHIV (< 15 years), regardless of CD4 count or clinical staging. The revised ART guidelines further strengthened pediatric treatment in scale-up locations. The COP15 (Q1-Q4 POART) program performance assessments and new 2017 SPECTRUM estimates showed that most scale-up SNUs reached saturation for CLHIV and 95% (9,623 of 10,124) of CLHIV are already on treatment. However, challenges in pediatric treatment services remain. These include lower levels of VL suppression than in adults and weak linkage of pediatric treatment programs with OVC. Limited experience among nurses at lower health facilities in pediatric ART care and the related lack of confidence in managing pediatric cases at these decentralized facilities continues to be a bottleneck towards full decentralization of pediatric ART services. The diminishing numbers of new pediatric HIV cases that present at individual lower level health facilities further limits the opportunities for routine exposure of nurses to the management of pediatric cases Having pediatric center-of-excellence-service-delivery options (as children are still primarily enrolled and managed at large health centers and district hospitals) presents an opportunity for nurses from lower clinics to come to a center where they can be exposed to a number of pediatric cases. Working under the mentorship of experienced clinicians would allow theses nurses to rapidly build their capacity and confidence to manage children within a shorter period of time. The implementation of the pediatric center of excellence will thus be a strategy of aiding the roll out of differentiated care models, as once these nurses go back to their facilities they will be able to manage pediatric cases without the continued need of routine referrals to higher centers of care. In addition, pediatric care and treatment lacks an analysis of the ANC/PMTCT/EID services linkage and lack of M&E framework around "aging out" for pediatric populations in order to ensure data quality on retention. Loss to follow up (LTFU), and service quality are also key challenges of CLHIV in scale-up SNUs. Furthermore, while the national guideline (2016) has included differentiated service models for adults, they lack mention for stable children.

During COP17, PEPFAR Namibia will support the GRN to achieve 100% coverage of pediatric treatment and improve the quality of pediatric treatment services in scale-up locations. In COP17, PEPFAR Namibia will assist the GRN to address the challenges highlighted above by providing technical assistance to improve pediatric treatment services coverage and quality through:

1. Conducting ANC/PMTCT/EID cascade analysis;
2. Including pediatric services in quality improvement/retention collaboration activities;
3. Strengthening pediatric/adolescent activities at national and sub-national levels, including pediatric HIV disclosures and teen club initiatives;
4. Updating pediatric- and adolescent-friendly curricula to include family planning and referrals to GBV services at primary health care centers;
5. Ensuring linkages to OVC programming for all CLHIV through decentralization of ART services;
6. Developing M&E around "aging out" for pediatric populations, adopt the UNAIDS's M&E

framework and conduct LTFU analysis using SOP;

7. Piloting integrated implementation models of differentiated care for children that are deemed stable with stable adult patients using community ART support groups for adolescents, expert patients, and health extension workers and adolescent-friendly after school and weekend work hours;
8. Promoting pediatric case finding, disclosure, and expansion of VL monitoring of children and adolescents on treatment;
9. Supporting clinical mentorship, mHealth, and community volunteers to improve adherence and retention in treatment;
10. Developing a standard M&E platform for teen club activities; and
11. Monitoring IP performance and quality in scale-up districts through SIMS, financial, and activity report reviews; quarterly performance reviews of MER indicators and site visit reports; and monthly performance reviews using a standard tools and POART feedback to all partners.

4.10 Orphans and Vulnerable Children (OVC)

PEPFAR's OVC activities align to geographic areas of the highest HIV burden and greatest unmet ART needs for children, adolescent and adult populations. OVC activities are implemented in partnership with the Ministry of Gender Equality and Child Welfare (MGECW) to ensure that OVC and their caregivers receive PEPFAR assistance and domestically-financed social grants to reduce vulnerability. Additionally, there is coordination with the MOHSS and Ministry of Education where the OVC program intersects with education, health and social protection.

PEPFAR Namibia will support partners and the GRN to implement an OVC program within 10 scale-up aggressive and scale-up saturation SNUs (see Table 4.1.4, page 44). OVC targets increased from 17,416 to 35,021 as the activity will provide layered programming for OVC. The OVC program will increase reach among adolescent girls aged 15-17 to access a comprehensive package of prevention/treatment services; strengthen health facility-community linkage; and ensuring HIV testing of OVC in collaboration with pediatric/adolescent and adult care/treatment.

In COP17, strategies for reaching OVC (ages 10-17), will include coordinating with clinical service providers that serve HIV+ children, PLHIV support group members, and mother-to mother support groups. PEFPAR Namibia will also collaborate with the constituency offices and MGECW.

PEPFAR Namibia conducts quarterly performance meetings with partners to track and improve performance. Regular update meetings are also conducted with partners and results/targets are discussed and remedial actions put in place, as necessary. SIMS visits are also conducted at partners' sites.

In COP17, PEPFAR Namibia will support the development of case management to address comprehensive needs of children, caregivers and/or families. Using case management OVC,

including most-vulnerable adolescents, are identified through an assessment tool and use of family-centered approach and health facility referrals and linked to HIV services. Recognizing that the needs of children, caregivers and/or families vary at different stages of life, PEPFAR Namibia's needs-based approach includes an assessment at enrollment and then quarterly to determine the types of support to be provided. PEPFAR Namibia will strengthen linkages to socio-economic support to mitigate the effects of HIV and build resilience and increase the assets of OVC, AGYW, and their families through household savings schemes, cash transfers, and income-generating projects. PEPFAR Namibia will also support interventions such as psychosocial support, child protection (birth registration), education support, parenting programs, social protection efforts such as social welfare grants, and targeted support to keep at-risk AGYW and OVC in school. PEPFAR Namibia will implement prevention activities for HIV negative AYGW and OVC, both in and out of school.

For at-risk and/or HIV+ AGYW and OVC, PEPFAR Namibia will support adolescent-friendly sexual and reproductive health services and ensure that girls and adolescents aged 15-17 have access to a comprehensive package of prevention and treatment services.

OVC activities will continue to build caregiver awareness of available resources and services and the benefits of testing and treatment; and facilitate access to HIV and health services. OVC activities will continue to ensure that there are linkages and referrals to HTS, prevention, pediatric care, treatment and psychosocial support for children with HIV and their care providers. OVC activities will also provide peer support activities and home visits for CLHIV. OVC activities will: continue to utilize community health extension workers and other community volunteers/structures to identify and refer OVC to services; improve linkages with adult treatment support groups in order to identify OVC and better support beneficiaries; and improve linkages of OVC in the communities to facility services.

PEPFAR Namibia will continue to provide capacity building to the GRN and CSOs around OVC in COP17. PEPFAR Namibia will provide technical assistance to the GRN on social welfare grants, development of standardized case management system, social welfare and service networks and M&E systems, data availability and utilization. By the end of FY18, it is expected that 15% will graduate (age out) from the OVC program in Namibia.

Peace Corps

Volunteers will target a subset of OVC populations focusing on the most vulnerable AGYW, ALHIV and their caregivers. OVC interventions will provide risk reduction and avoidance for AGYW and provide psychosocial, adherence and retention support for ALHIV in combination with positive parenting and economic strengthening for their caregivers.

In DREAMS-like districts, clusters of health, education and community economic strengthening Volunteers will conduct a comprehensive assessment of needs and services of AGYW in their communities. By strategically working on school- and community-based interventions,

Volunteers will support the layering effect by focusing on HIV prevention and testing, risk avoidance and GBV. Volunteer activities will include co-facilitation of girls' empowerment clubs/safe space, focusing on SRH and life skills, discussions on gender norms and GBV education in schools and communities. Focusing on strengthening families, Volunteers will also work to support parent child communication and engage men as partners as a means to combat GBV, and garner support for girls' education and to keep girls in school.

4.11 Addressing COP17 Technical Considerations

PEPFAR Namibia has incorporated the key tenants of the COP17 technical considerations in our COP17 plans as described below.

PEPFAR Namibia will implement targeted testing and improve testing yield among priority populations by optimizing HIV case finding, ensuring high-quality HIV testing services in scale-up locations, ensuring partner testing and notification, promoting self-testing, and improving linkage to care and treatment. The roll out of these high yield testing strategies are in line with the COP 17 technical considerations and are critical to the PEPFAR Namibia goal of meeting the first 90 especially in the currently hard to reach populations such as young men. In addition, PEPFAR Namibia will support interventions to improve retention in care by implementing differentiated care models. Community-based ART is currently being rolled out in several communities with aggressive plans to expand these models. Differentiated models of care including multi-month scripting improve retention in communities that typically had more difficulty with access to care and provide patients with diverse options to meet his/her personal needs.

PEPFAR Namibia will also support strengthening of PLHIV network and community-based healthcare workers or lay cadres to increase access to high-quality HIV services and increase referrals to clinics and differentiated care models. PEPFAR Namibia's success in improving access to VL testing will continue to be scaled up in COP 17 with the inclusion of DBS for hard to reach populations. PEPFAR Namibia continues to work closely with the MOHSS and NIP to streamline the testing and reporting of test results to ensure that clients are being appropriately tested and critical results are returned to clients, entered into patient charts and also included in routine data monitoring for national and PEPFAR reporting.

PEPFAR Namibia will implement DREAMS-like activities in 5 districts in 3 regions , providing layered HIV and GBV prevention for girls aged 10-24. PEPFAR Namibia will address norms and practices that increase risk among adolescent girls in these regions through facility-, community-, and school-based prevention programs. The new programs planned via the DREAMS-like funding is critically important to the prevention of HIV and GBV among high risk girls and will include a full package of school and community based intervention with the goal of increasing knowledge, empowering young girls, and increasing access to key preventive interventions such as PrEP, post violence care, family centered preventive services and linkages with government grant programs

to make sure each girl is provided with the tools she needs to keep herself safe. PEPFAR Namibia will also work with high risk girls to identify their sexual partners (including both peer and older male partners) and through these referral networks we will expand index partner testing and referral to VMMC. In all 5 districts, testing strategies will be honed to identify and provide accessible HTC to men 20-29 years of age through the expansion of high yield index partner testing, self-testing, and options for work-friendly HTC services. Strengthened integrated family planning services in these districts will focus on providing youth friendly services with dignity and respect, comprehensive STI screenings and linking positive patients to care. For COP17, PEPFAR Namibia will expand community adherence clubs especially for teens and priority populations and as previous mentioned, increase the number of clients receiving care through community models.

4.12 Commodities

In 2016, Namibia experienced stock-outs of ARVs and HIV rapid test kits (RTK). The RTK stock-outs were related to a changing testing algorithm impacting forecasting abilities. Fortunately, the situation has since improved, and the GRN remains committed to cover costs for HIV-related commodities. Data on HIV medicine fulfillment rates has improved at all levels of service delivery and PEPFAR Namibia will support supply chain management in COP17. Due to the GRN's commitment to cover projected ART and test kit needs, PEPFAR Namibia has neither planned nor budgeted for any commodity procurements in COP17 with the exception of VMMC and HIVST commodities.

4.13 Collaboration, Integration and Monitoring

PEPFAR Namibia will continue its strong history of working collaboratively across all agencies via active engagement in technical working groups. HQ-provided TDYs are better coordinated, allowing for shared expertise across agencies and complete programmatic improvement. External stakeholder consultation occurs throughout the year in many fora. PEPFAR is represented in the Health Development Partners group, a coordinating body comprised of multilateral and bilateral partners; coordinates closely with Namibia's Global Fund Country Team; engages with civil society; and provides routine support to MOHSS technical teams at both the national and regional levels. Interagency IP feedback meetings improve site-level knowledge and share performance progress. HRH continues to support service provision throughout the cascade. Site-level monitoring is improving through active SIMS follow-up, written plans to address weaknesses and planned follow-up visits. The number of patients managed at community sites will continue to increase, decreasing the burden on facilities while maintaining comprehensive quality care.

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

While the majority of PEPFAR Namibia's targets are in scale up districts, we will continue to provide services tailored to attained and sustained districts, as described in the sections below.

5.1 Targets for Attained and Sustained Locations and Populations

In developing the FY18 treatment targets, PEPFAR Namibia committed to maintain or exceed the attained status in the attained and sustained SNUs. By the end of FY17, PEPFAR Namibia will achieve attained status in most of these districts and will have maintained progress towards saturation or attainment for districts where urban hotspots are located. Based on these assumptions, targets were set to achieve or maintain saturated/attained status in four districts of Keetmanshoop (83%), Nyangana (100%), Okahandja (90%), and Outapi (100%).

Seven additional districts will progress towards saturation, with FY18 anticipated ART coverage as follows:

- Rosh Pinah - !Nami#nus Cluster (45%)
- Walvis Bay - Swakopmund Cluster (77%)
- Gobabis (50%)
- Opuwo (48%)
- Grootfontein (65%)
- Otjiwarongo (50%)
- Rehoboth (50%)

Collectively, for the FY18 treatment current target, these 11 SNUs will contribute 39,911 (21%) of the total 193,218. Similarly, for the FY18 treatment new target, these districts will contribute 3,498 (11%) of the 31,040. With this strategic plan for target setting, PEPFAR Namibia continues to focus efforts in the geographic areas with the greatest burden and need.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts*

Attained Support Volume by Group		Expected result APR 17	Expected result APR 18
HIV testing (all populations)	*HTS*	20,377	14,175
HIV positives (all populations)	*HTS_POS*	1,548	1,293
Treatment new	*TX_NEW*	1,427	760
Current on ART	*TX_CURR*	10,862	10,862
OVC	*OVC_SERV*	1,769	2,008
Key populations	*KP_PREV*	0	0

Table 5.1.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts			
Sustained Support Volume by Group		**Expected result APR 17**	**Expected result APR 18**
HIV testing in PMTCT sites	*PMTCT_STAT*	10,994	10,407*
HTS (only sustained ART sites in FY 17)	*HTS*	41,582	37,049*
HTS (only sustained ART sites in FY 17)	*HTS_POS*	2,605	2,037*
Current on ART	*TX_CURR*	28,460	29,120*
OVC	*OVC_SERV*	0	250*

*The expected results reflect COP17 Sustained districts/clusters, which are not the same as COP16 Sustained districts.

5.2 Priority Population Prevention

PEPFAR Namibia will support the GRN to implement its combination HIV prevention strategy within the 11 attained and sustained SNUs. Activities for key populations, namely FSW, MSM and transgender, are currently conducted in two of the 11 attained/sustained SNUs (Walvis Bay and Keetmanshoop). These SNUs were selected based on 2013 IBBSS KPs size estimations. Detailed activities will mirror the activities described in Section 4.2 (see pages 48). In addition, PEPFAR Namibia will support health extension workers activities to deliver health information on HIV prevention, care, and treatment as well as HIV index case testing.

5.3 Voluntary Medical Male Circumcision (VMMC)

Within the attained and sustained SNUs, PEPFAR will support VMMC programs in the two district clusters of !Nami#nus-Rosh Pinah Cluster and Walvis-Bay- Swakopmund Cluster. Rosh Pinah is a mining town with most of the migratory male population coming down from the Northern regions' scale up SNUs in search of job opportunities. These males spend part of the year at their homes in the north (i.e., the scale-up SNUs). VMMC and treatment coverage remain low in the !Nami#nus-Rosh Pinah Cluster and PEPFAR Namibia intends rapidly to scale both treatment and VMMC coverages in this cluster. For the Walvis Bay-Swakopmund Cluster, although DMPPT2 models show high coverage of VMMC, PEPFAR Namibia will continue to support VMMC in the two clusters as the team expects a continued need for these services in COP17 given the high labor related migration of young men from northern districts seeking employment opportunities in Swakopmund and Walvis Bay.

In COP17, PEPFAR Namibia will provide direct service delivery assistance through both fixed-

facility and outreach service delivery models to increase VMMC coverage from 15% in APR17 to 33% by APR18 among men aged 15-29 in the !Nami#nus-Rosh Pinah Cluster. The Walvis Bay-Swakopmund Cluster will achieve VMMC coverage of 87% by APR18. PEPFAR Namibia's support for VMMC within the attained and sustained SNUs will be within the framework of the technical considerations and best practices: focusing on the 15-29 years age pivot for immediate impact and emphasizing safety and efficiency for program quality.

5.4 Preventing Mother-to-Child Transmission (PMTCT)

In FY16, PEPFAR supported PMTCT services in 39 health facilities in the 11 treatment attained and sustained SNUs. FY16 APR analysis showed that 4 SNUs met both PMTCT ART and EID targets. Program data in 2016 showed higher coverage rates than reported in FY16APR with PMTCT-ART and EID coverage of >90% in all SNUs except Opuwo and Rosh Pinah-!Nami#nus. In the latter two SNUs, some of the program challenges include: insufficient longitudinal follow-up; infrequent mentorship; measurement of final outcomes for mother-infant pairs; and data reporting challenges.

In COP17, PEPFAR Namibia will support activities to strengthen the existing mentorship platform, support the SNUs to generate quality and accurate maternal and infant HIV case identification and reports, and improve quality of PMTCT-EID services.

In COP17, PEPFAR Namibia will continue supporting the following activities:

1. HIV testing for ALL women at 1st ANC visit to ensure ≥95% of pregnant women know their HIV status and retesting of the HIV-s at recommended intervals to identify seroconversion during pregnancy and breastfeeding periods;
2. Providing EID testing to >80% of HEIs within 2 months, and more than 95% by 12 months
3. Strengthen systematic follow-up and care of HIV exposed infant using facility and community-based systems
4. Support activities for repeat testing based on the national guidance to determine the final HIV outcomes in HEIs.
5. Continue mentorship and stopgap training of health workers on ANC/PMTCT/EID and maternal viral load monitoring; and
6. Generate real time and quality PMTCT/EID data through PMTCT M&E systems strengthening, including electronic system.

5.5 HIV Testing Services (HTS)

Eight SNUs fall within the attained and sustained/hotspots (cited above), these are districts where PEPFAR provides support to selected locations and facilities, in order to maintain the current momentum of obtaining coverage. Based on program data collected between 2003 and 2013, HTS

in these SNUs are well established, with high uptake among population subgroups. For instance, the 2013 DHS+ data indicate that the Erongo region, where the Swakopmund and Walvis Bay SNUs are located, had the highest percentage of PLHIV (for both men and women) who knew their HIV status.

In COP17, PEPFAR Namibia will continue to provide technical support on implementing high-yield targeted testing services, through training and strengthening of M&E systems, in these SNUs. In the newly added Rosh Pinah district, which has a large population of migratory male workers, PEPFAR Namibia will support increased access to HTS among men and their sex partners through implementation of index partner testing, mobile outreach testing, and HIVST. Similarly, PEPFAR Namibia will create synergy with the GFATM's work on HRH provision in Opuwo district by providing training and management support to the HTS program.

During COP17, PEPFAR Namibia will support HTS delivery in 35 GRN sites located in attained/sustained SNUs with a target of reaching 63,515 individuals with HTS and identifying about 3,486 positive cases.

5.6 Facility and Community Based Care and Support

PEPFAR Namibia strives to ensure that program resources are used in geographic locations and populations most in need and where new HIV infections will occur. Two SNUs (Outapi and Nyangana) achieved attained in COP16 (≥ 81% ART coverage among all sex and age bands). However, program data from the two SNUs shows continued identification of a high number of newly diagnosed PLHIV – 355 and 250 from Outapi and Nyangana, respectively (APR16) – contributing 4% of the total OU TX_ New in FY17. In COP17, PEPFAR Namibia will ensure standards of care are upheld for the patients on life-saving care, treatment and support services, with the result that limited support will be continued to these SNUs in anticipation of the NAMPHIA results to further inform SNUs prioritization and transition planning by the end of FY18.

5.7 TB/HIV

Of the 28 SNUs in Namibia, 11 are sustained/attained. TB results (TB_STAT and TB_ART) for these SNUs are similar to results seen in scale-up SNUs. Two sustained SNUs, Opuwo and Rosh Pinah, were newly added for COP17, based on HIV data. MOHSS has identified four high burden TB sites in the country to receive focused attention for the above TB services, and one of these sites is within a sustained SNU per HIV target data (Otjiwarongo). Within sustained and attained SNUs, PEPFAR Namibia will continue to provide technical support to maintain and strengthen high coverage of TB screening in PLHIV, including ICF, IPT and ART uptake, as well as maintaining high coverage of HIV testing and ART initiation in TB patients in facilities. TB/HIV data capture, recording and reporting will also continue to be enhanced through training and strengthening of M&E. Technical assistance for implementation of universal GeneXpert testing,

continued integration of TB and HIV services at the site level, scale up of new drugs and regimens, expanding rapid molecular testing options, and continued strengthening of TB infection control efforts will be provided for these SNUs.

5.8 Adult Treatment

The availability of more refined treatment coverage data at district level based on the outcomes of the Small-Area Estimates exercise conducted in 2016 enabled the PEPFAR Namibia team to develop a better understanding of district level treatment gaps by finer age and sex bands. This necessitated some reclassification of the geographic prioritization matrix used in COP16 and resulted in some districts being clustered together while other districts were reclassified. Specifically Nyangana and Outapi transitioned from COP16 scale-up aggressive districts to attained districts in COP17; Opuwo and Rosh Pinah transitioned from centrally supported to sustained districts and finally Okongo transitioned from sustained to the scale-up aggressive Engela-Eenhana-Okongo Cluster.

In COP16, PEPFAR supported the GRN to revise the ART guidelines to implement a chronic care model in attained and sustained locations and populations. According to the COP15 (Q1-Q4 POART) program performance assessments, only two SNUs (Nyangana and Outapi) achieved "attained" status. Some of the FY17 sustained SNUs have high ART gaps that need further prioritization and should be re-classified as scale-up SNUs in FY18 to reach 90-90-90 goals. Seven additional districts in urban hotspots will progress towards saturation, with FY18 anticipated ART coverage as follows:

- Rosh Pinah - !Nami#nus Cluster (45%)
- Walvis Bay - Swakopmund Cluster (77%)
- Gobabis (50%)
- Opuwo (48%)
- Grootfontein (65%)
- Otjiwarongo (50%)
- Rehoboth (50%)

Collectively, for the FY18 treatment current target, these SNUs in sustained (FY18 Tx Curr 29,120) and attained (FY18 Tx Current 10,862) districts will contribute more than 39,982 (21%) of the total 193,218. Similarly, for the FY18 treatment new target, these districts will contribute 3,498 (11%) of the 31,040.

Programmatic challenges in the sustained and attained areas are largely similar to those found in scale-up SNUs, namely low treatment coverage among young adults aged 20-24 and older males aged 30+; low adherence and retention; and low VLS outcomes in young adults aged 20-24. The PEPFAR Namibia portfolio within the sustained and attained areas largely focuses on work concentrated around health facilities located within the urban hotspots rather than the whole district. In COP17, for the attained and sustained SNUs, PEFPAR Namibia will focus on clinical

mentorship to ensure quality services at sites with significant client volumes. PEPFAR Namibia will continue to maintain or will exceed the 80% ART coverage goal and will ensure high VLS at these sites, in line with the 90-90-90 targets. In COP17, PEPFAR Namibia will contribute to the implementation of DSM of care for stable patients, multi-month scripting, community-based ART (CBART), passive enrollment via HIV testing and counseling, and targeted technical assistance to the laboratory network to ensure greater access to essential laboratory services for PLHIV.

In COP17, PEPFAR Namibia will support prioritized activities in attained and sustained locations and populations to maintain or exceed the 80% ART coverage threshold across all age/sex bands by:

1. Supporting surveillance in case-finding and outbreak investigations to identify networks with ongoing or new transmission;
2. Monitoring ARV drug resistance and clinical services to break onward transmission;
3. Supporting essential laboratory services for clinical monitoring of patients to reach at least 73% of patients virally suppressed;
4. Continuous quality assurance and improvement;
5. Providing clinical mentoring to maintain clinical services for 80% ART cohort coverage without site expansion in attained and sustained SNUs; however given the ongoing ART service decentralization, the spoke sites which feed into the main hub sites will also be considered for enhanced mentoring.
6. Supporting client-based ART retention services based on specific age, sex, and HIV risk factors;
7. Supporting MOHSS structures to improve supportive supervision, M&E, and data quality and management systems; and
8. Monitoring implementing partners' performance in attained and sustained SNUs through SIMS, financial, and activity report reviews and quarterly performance reviews of MER indicators.

5.9 Pediatric Treatment

As described in Section 4.9 (page 56), all PEPFAR-supported SNUs have achieved more than 95% of pediatric treatment coverage. However, similar to scale-up locations, reduced VL suppression (as compared with adults) is a key challenge for CLHIV in attained and sustained SNUs.

Activities in scale-up SNUs and attained/sustained SNUs are almost the same as activities in scale-up locations, except we will not monitor partner performance in attained/sustained SNUs every month. In COP 17, PEPFAR will continue its focus on health facilities located within the urban hotspots, providing technical assistance to improve quality of pediatric treatment services, retention in care, adherence, and VLS in these attained and sustained SNUs by:

1. Providing essential laboratory services (VL testing) for CLHIV;
2. Implementing pediatric-specific supportive ART retention services through standardization of an active follow-up and tracking system;

3. Integrating pediatric and adolescent care and treatment services within the GRN-led community Health Extension Program, to track children loss to follow up;
4. Generating real-time program M&E data;
5. Maintaining pediatric clinical services through stop-gap in-service training, clinical monitoring, and supervision;
6. Engaging HIV+ adolescents and civil society organizations to improve adherence and retention of CLHIV; and
7. Monitoring implementing partners' performance on a quarterly basis in attained and sustained SNUs through SIMS, financial, and activity report reviews and quarterly performance reviews of MER indicators.

5.10 Orphans and Vulnerable Children (OVC)

During COP17, PEPFAR Namibia will support partners and the GRN to implement an OVC program in attained and sustained SNUs and will reach 2,758 OVC which is 7.8% of the total OVC target. The OVC program will focus on reaching girls and adolescents ages 15-17 to access a comprehensive package of prevention and treatment services, strengthening health facility-community linkage, and ensuring HIV testing of OVC in collaboration with pediatric/adolescent and adult care and treatment.

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

In line with COP17 guidance, PEPFAR Namibia established a package of service for the attained and sustained districts. A mix of strategies is supported to reach the last patient, including key populations, AGYW and OVC, with care and support services.

Prioritized activities for attained SNUs include:

1. Ensuring quality surveillance, program monitoring, and laboratory systems;
2. Promoting clinical services and retention;
3. Targeting demand creation for testing among key populations and linking them to care and HIV- prevention programs to keep at-risk key populations HIV free; and
4. Continuing outreach, prevention, testing, and clinical services for key populations.

Prioritized activities for sustained SNUs include:

1. Targeting HIV testing and counseling on request or as indicated by clinical symptomology or identified risk behaviors;
2. Ensuring quality HIV care and treatment services for PLHIV focusing on prompt ART initiation for HIV positives, retention and viral load;
3. Providing treatment services including routine clinic visits, ARVs, and care package; and
4. Ensuring essential laboratory services for PLHIV.

5.12 Commodities

Consistent with scale-up locations (described in section 4.120, PEPFAR Namibia has not budgeted for any commodity procurements for attained and sustained locations in COP17.

5.13 Collaboration, Integration and Monitoring

PEPFAR Namibia will take the same approach to collaboration, integration and monitoring activities for attained/sustained locations as described in Section 4.13 for scale-up locations.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

PEPFAR Namibia reviewed Table 6 to validate the identified barriers, three-year outcomes and evaluate our progress toward closing system barriers. Our assessment of progress and remaining challenges in attaining the 90-90-90 targets is summarized below, focusing on areas of significant and limited progress. The updated Table 6 is in Appendix C.

Testing
Areas of progress in testing include:

- Improving supply chain management by adding rapid test kits (RTK) status into the electronic logistics management information system (eLMIS);
- Improving access to testing by hiring additional HRH, diversifying service delivery models and training staff on more effective testing modalities, including PITC, thus requiring no additional funding for COP17; and
- Addressing gaps in data collection and reporting by hiring additional data clerks.

All activities to address challenges in testing showed progress in FY17. Conducting an Integrated Bio-Behavioral Surveillance Survey (IBBSS) and associated peer-driven interventions among key populations is a proposed new activity in COP17 to address the issue of inadequate data on key populations.

Treatment
Areas of progress in treatment, and thus not included in COP17, include:

- Installing prefab clinics and completing construction and renovations to address inadequate health infrastructure and saturation in existing ART sites; and
- Addressing HRH shortages by hiring different cadres particularly nurses, but also some

doctors and pharmaceutical technologists to take over decentralized ART treatment.

Low treatment coverage in the scale-up districts continues to pose challenges, particularly among adolescents and men. A new activity proposed to address this challenge is the innovative use of social media and teen clubs to reach youth. Another new activity is to establish a pediatric center of excellence to train nurses on pediatric care and treatment and improve outcomes.

In addition reporting in a timely and accurate manner from the ART sites remains a key challenge that PEPFAR Namibia will continue to addressed in COP17.

All other treatment activities are progressing as expected.

Viral Load Suppression
For the third 90 (VL suppression), areas of progress, and thus not funded in COP17, include:

- Training Health Care Worker (HCWs) on VL management;
- Including a unique ART number on lab request forms; and
- Increasing laboratory capacity by adding a VL laboratory and procuring new high-throughput instruments for four laboratories.

Data indicate limited access to HIV viral load testing and issues with viral load data quality. The HIV viral load testing coverage (estimated percent of ART patients eligible for viral load testing who actually received the test) stands at 90% overall and 88% among pediatric population. Despite this high national coverage, in some districts the coverage is as low as 49%.

Areas experiencing challenges include:

- Inability to disaggregate VL results by patient. Only 32% of VL tests requested have the required unique ART number included in the request form. The key indicator is having 90% of all VL testing request forms having the unique ART number.
- Lack of a standard specimens' transport system, limited decentralization of VL testing and DBS use for VL testing not routinized.

New activities proposed in COP17 to address low VL suppression in pediatric patients include providing support for pediatric disclosure, conducting an ANC/PMTCT/EID analysis aimed at improving the pediatric VL suppression rate, and conducting training on management and monitoring of pediatric HIV drug resistance. In addition, DBS use for VL testing will be implemented.

6.2 Critical Systems Investments for Achieving Priority Policies

Test and start
Test and start, called "Treat All" in Namibia, was adopted as a national policy in December 2016 and the MOHSS is in the process of ensuring nationwide rollout.

PEPFAR Namibia will continue to provide support for training approximately 500 health care workers on the new treatment guidelines and provide TA on implementing the guidelines.

New and efficient service delivery models
Achievements, and therefore not funded in COP17, include:

- National guidelines were updated to include new service delivery models and address the role of community health care workers (CHCW); and
- Roll out the EDT to all community service providers to ensure data capturing.

6.3 Proposed System Investments outside of Programmatic Gaps and Priority Policies

PEPFAR Namibia will continue to support the National Health Accounts and ensure improved quality in laboratory care by supporting international accreditation of five laboratories.

Other areas proposed in COP16 have progressed as expected.

This section of Table 6 has been expanded to include all above-site activities that are in the PEPFAR Budget Allocation Calculator (PBAC) tool, with most of the activities supporting sustained epidemic control.

The key areas addressed include finance, institutional and organizational development, governance, systems development, and strategic information.

The key goal of the support to the M&E system is to ensure accurate and timely reporting from interoperable data systems. The current ePMS is based at individual facility level. This system needs a new data architecture (currently being transitioned with PEPFAR support) to create the option of being connected to a network to allow for better coordination of patient data thus allowing better tracking of patients and recording of LTFU.

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

Analysis of the staffing footprint and interagency organizational structure
PEPFAR Namibia has negligible staffing changes from COP16. Our staffing continues to align with PEPFAR Namibia's strategic decision to focus on achieving epidemic control in the highest burden regions in the country. In addition, there are few changes in terms of the geographic regions we cover since COP16. In order to maximize effectiveness and efficiencies, the USG staff made every effort to ensure that all the positions are filled. Additionally, some position descriptions were reviewed in order to align with the strategic focus.

Further actions were taken to shift staff to appropriate teams in order to yield stronger results. Similarly, in order to prevent service delivery gaps and to maintain continuity of services, temporary staff were hired to fill the immediate needs until positions were permanently filled.

In order to address the needs as well as to propel Namibia to reach its goal, a few changes are notable:

- To fill the gap of the vacant Prevention Advisor position, the CDC Monitoring, Evaluation and Research Advisor's job description was modified to include additional responsibilities in HTS. When the Prevention Advisor position is filled, the staff member will mostly work with combination prevention, in order to better address the programmatic requirements of the first 90 for HTS scale-up, reaching key populations, bio-medical prevention programs, linkage to care, treatment as prevention, and other prevention related activities.
- The CDC key population responsibilities were also added to the Maternal and Child Health Technical Lead Advisor, until the Prevention Advisor position is filled.

CDC has three offices that are based in the high HIV burden regions (Oshana, Zambezi, and Kavango-East regions). By April 2017, USAID's three new Regional Advisors for Performance Monitoring will have started their regional duties, sharing CDC office spaces in Oshana and Kavango East. These staff members' main responsibilities are to facilitate capacity building and to provide technical assistance in order to improve the quality of services at the operational level. These field officers are strategically located to cover the remaining high burden regions of Oshikoto, Ohangwena and Kavango-West. Consequently, the field officers not only focus on the specific region in which their offices are based, but also travel to other regions to provide quality assurance and improvement support, conduct SIMS visits and provide technical assistance.

The Communications and Small Grants Advisor position in the PEPFAR Coordinator's office was filled with a locally employed staff member in mid-2016.

Long-term Vacant Positions
CDC has two vacancies remaining – the Prevention Advisor and the HIV-Treatment Medical Officer Position. CDC Namibia advertised these positions twice locally, but due to the unavailability of qualified applicants, was unable to fill the positions. These positions are now classified as Third Country National (TCN) positions and will be advertised regionally. CDC Namibia, in collaboration with CDC headquarters, is working on strategies to fill the positions. The positions will be advertised as soon as possible. In the meantime, some of the responsibilities of the positions are delegated to other staff members in the office, as previously mentioned.

USAID has two vacancies remaining – the Treatment Advisor and Accountant. The Treatment Advisor position was previously a Third Country National (TCN). The former incumbent now serves as the Continuum of Care Advisor. USAID is currently in the process of advertising the vacant position locally and, if no suitable candidates are found, will be re-advertised as an off-shore US/TCN position.

The vacant FSN Accountant position will be re-purposed to fill USAID Namibia's PEPFAR support and management needs. In early FY17, USAID's U.S. direct hire Executive Officer (EXO) position was eliminated. While USAID Namibia is transitioning to receive more remote support services (contracting, management, human resources) from the USAID Southern Africa office and through ICASS services from Embassy Windhoek, the absence of an on-site management officer has caused challenges in meeting administrative needs of the office. The team aims to advertise the FSN position by summer 2017.

The Deputy PEPFAR Coordinator position remains vacant. The position was posted locally and the interview process will commence by April 2017.

Peace Corps has four vacancies: Health Program Manager, HIV/PEPFAR Coordinator, Language and Cross Cultural Coordinator and General Service Assistant. These positions are vacant due to staff departures in COP 16. Peace Corps is currently recruiting for the Health Program Manager position and expects to fill the remaining positions during COP 17. The Program Manager and HIV/PEPFAR Coordinator positions are considered essential towards coordinating the Peace Corps health program and training, stakeholder engagement and managing Peace Corps participation and alignment within PEPFAR interagency priorities and programming. The General Service Assistant and Language and Cross Cultural Coordinator will be recruited as we prepare to bring on the COP 17 intake of PEPFAR funded health Volunteers.

Justification of Proposed New Positions
No new positions are requested.

Major changes to Cost of Doing Business (CODB)
The CODB remains similar to COP16 due to favorable exchange rates. There are no major changes to staffing. The deployment of three recently hired USAID staff to shared field offices is not

expected to supersede the amount that was budgeted for in COP16. In addition, the existing vacant CDC positions and the USAID Treatment Advisor position were budgeted for in COP16 as third country nationals and therefore the expenditure related to hiring of these staff members is expected to be substantially the same for CDC and less or unchanged for USAID.

APPENDIX A: Prioritization

Table A.1 SNU Prioritization

SNU COP15	SNU Priority COP15	Achievement APR COP15	SNU COP16	SNU Priority COP16	Expected Achievement COP16	SNU COP17	SNU Priority COP17	COP17 Target: (APR18)
!Karas	2 Hot spots	55%	Andara	ScaleUp Agg	63%	Nyangana	Attained	100%
Erongo	2 Hot spots	59%	Eenhana	ScaleUp Agg	72%	Outapi	Attained	100%
Hardap	Non-PEPFAR	47%	Engela	ScaleUp Agg	72%	Okahao-Tsandi Cluster	ScaleUp Sat	81%
Kavango	Priority	84%	Katima Mulilo	ScaleUp Agg	62%	Oshakati-Ondangwa Cluster	ScaleUp Sat	81%
Khomas	Priority	61%	Ncamangoro	ScaleUp Agg	92%	Oshikuku	ScaleUp Sat	100%
Kunene	Non-PEPFAR	48%	Nkurenkuru	ScaleUp Agg	92%	Tsumeb	ScaleUp Sat	90%
Ohangwena	Priority	64%	Nyangana	ScaleUp Agg	161%	Windhoek	ScaleUp Sat	80%
Omaheke	Hot spot	56%	Omuthiya	ScaleUp Agg	105%	Andara	ScaleUp Agg	90%
Omusati	Priority	91%	Ondangwa	ScaleUp Agg	76%	Engela-Eenhana-Okongo Cluster	ScaleUp Agg	82%
Oshana	Priority	80%	Tsandi	ScaleUp Agg	62%	Katima Mulilo	ScaleUp Agg	73%
Oshikoto	Priority	110%	Okahao	ScaleUp Sat	62%	Ncamangoro-Nkurenkuru-Rundu Cluster	ScaleUp Agg	97%
Otjozondjupa	3 Hot spots	56%	Onandjokwe	ScaleUp Sat	105%	Omuthiya-Onandjokwe Cluster	ScaleUp Agg	109%
Zambezi	Priority	53%	Oshakati	ScaleUp Sat	76%	!Nami#nus-Rosh Pinah Cluster	Sustained	45%
			Oshikuku	ScaleUp Sat	90%	Gobabis	Sustained	50%

			Outapi	ScaleUp Sat	181%	Grootfontein	Sustained	65%
			Rundu	ScaleUp Sat	92%	Keetmanshoop	Sustained	83%
			Tsumeb	ScaleUp Sat	166%	Okahandja	Sustained	90%
			Windhoek	ScaleUp Sat	76%	Opuwo	Sustained	48%
			!Nami#nus	Sustained	41%	Otjiwarongo	Sustained	50%
			Gobabis	Sustained	60%	Rehoboth	Sustained	50%
			Grootfontein	Sustained	59%	Walvis Bay-Swakopmund Cluster	Sustained	77%
			Keetmanshoop	Sustained	81%	Karasburg	Ctrl Supported	0%
			Okahandja	Sustained	89%	Khorixas	Ctrl Supported	0%
			Okongo	Sustained	72%	Mariental	Ctrl Supported	0%
			Otjiwarongo	Sustained	53%	Okakarara	Ctrl Supported	0%
			Rehoboth	Sustained	58%	Omaruru	Ctrl Supported	0%
			Swakopmund	Sustained	79%	Outjo	Ctrl Supported	0%
			Walvis Bay	Sustained	79%	Usakos	Ctrl Supported	0%
			Karasburg	Ctrl Supported	0%			
			Khorixas	Ctrl Supported	0%			
			Mariental	Ctrl Supported	0%			
			Okakarara	Ctrl Supported	0%			
			Omaruru	Ctrl Supported	0%			
			Opuwo	Ctrl Supported	44%			
			Outjo	Ctrl Supported	0%			
			Rosh Pinah	Ctrl Supported	41%			
			Tsumkwe	Ctrl Supported	0%			
			Usakos	Ctrl Supported	0%			

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY 17)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY18) *TX_CURR***	**Newly initiated (APR FY 18) *TX_NEW***	**ART Coverage (APR 18)**
Attained	6,164	10,862	0	10,862	760	>100%
Scale-Up Saturation	85,954	67,274	1,489	72,572	11,184	84%
Scale-Up Aggressive	87,790	71,726	0	80,665	16,358	92%
Sustained	44,026	28,460	6,761	29,120	2,739	66%
Central Support	13,193	6,927	3,627	N/A	N/A	N/A
Commodities (if not included in previous categories)	N/A	N/A	N/A	N/A	N/A	N/A
Total	**237,127**	**185,249**	**11,877**			

APPENDIX B: Budget Profile and Resource Projections

B.1 Planned Spending in 2017

Table B.1.1 Total Funding Level		
Applied Pipeline	**New Funding**	**Total Spend***
$1,748,412	**$66,551,588**	**$68,300,000**

*Not including Central Funding of $4,014,136 for VMMC.

Table B.1.2 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$1,804,417
HVAB	Abstinence/Be Faithful Prevention	$1,600,000
HVOP	Other Sexual Prevention	$5,650,325
IDUP	Injecting and Non-Injecting Drug Use	N/A
HMBL	Blood Safety	N/A
HMIN	Injection Safety	N/A
CIRC	Male Circumcision	$3,980,975*
HVCT	Counseling and Testing	$3,639,713
HBHC	Adult Care and Support	$2,517,757
PDCS	Pediatric Care and Support	$1,186,860
HKID	Orphans and Vulnerable Children	$4,454,141
HTXS	Adult Treatment	$23,214,985
HTXD	ARV Drugs	N/A
PDTX	Pediatric Treatment	$2,835,895
HVTB	TB/HIV Care	$3,660,507
HLAB	Lab	$930,291
HVSI	Strategic Information	$3,819,094
OHSS	Health Systems Strengthening	$1,995,037
HVMS	Management and Operations	$5,261,591
TOTAL		**$66,551,588**

*Not including Central Funding of $4,014,136 for VMMC.

B.2 Resource Projections

Epidemiological and Program Data Analysis

The PEPFAR Namibia SI team and TWGs began the prioritization process with an in-depth analysis of epidemiological and programmatic data to identify district-level geographic high-burden areas based on the volume of disease burden, highest prevalence, and ART unmet need. In addition to the study results that were available during COP 16, the team made use of the PEPFAR-supported Small Area Estimation and the latest HIV Sentinel Survey Report (2016) to better understand the epidemic. The team analyzed these data by age and sex disaggregation to determine areas' thresholds for coverage by considering the number of PLHIV, ART coverage, HTS test and yield, and retention on ART. Additionally, we looked at programmatic VL suppression by age, sex, and geography. This assisted the team to allocate targets by district, determine what classification the site should fall under, and the amount of resources needed. Similarly, PEPFAR Namibia determined whether to continue supporting the same districts, if additional districts should be added (either as a whole or as a hot spot), and whether such districts should be supported at the same level as COP16. 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.

Gap Analysis

During the COP17 process, PEPFAR Namibia worked closely with stakeholders, particularly regional health directorates and regional-level CSOs, to identify gaps and bottlenecks and recommend solutions to address these gaps. During the planning and regional consultation meetings, a gap analysis for the GRN to meet its program goals and country investment case was reviewed with stakeholders. PEPFAR Namibia and GRN recognize that specific gaps to address the continuum of HIV services vary by district.

PBAC

Namibia EA data served as the basis for unit expenditures (UE) needed to complete PBAC. National level FY16 or pre-populated UE listed in PBAC was used as a starting point. Reasons why the applied unit budget was different from pre-populated UE were also provided. In addition, to the core COP17 funds, PEPFAR Namibia received performance funds, DREAMS-like funds, and VMMC central funds. However, when calculating earmarks, the DREAMS-like funds and VMMC central funds were not included. High-burden districts, sites, and activities were allocated to budget areas and subsequently apportioned to IM with the highest probability of achieving PEPFAR targets.

Outlier Analysis

PEPFAR Namibia performed an outlier analysis of UE by IM. Outlier levels were set at three times the average UE. PEPFAR Namibia had only a few outliers, which were primarily in programs serving MSM and FSW and some providing HTC. In cases with demonstrated outliers, a number of decisions were made as part of the review and implementation planning. Agencies will closely monitor the performance of outliers by SNU and EA category.

APPENDIX C: Section 6 Tables and Systems Investments

See attached Excel table.

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
Table 6.1.1 Key Programmatic Gap #1: Plateauing of current testing models in the scale-up districts									
Inadequate supply chain management for HIV Testing Kits	Facility reporting stock-out of RTKs reduced to less than 10%.	· ~~RTKs stock status included in LMIS reporting system.~~ **Completed** · Accurate RTK forecasting and quantification occurs annually and is reviewed every quarter to inform procurement.	90% of facilities reporting on eLMIS	% of facilities reporting on eLMIS	Provide TA to MoHSS to quantify, forecast and distribute HIV commodities including RTKs and ARVs	OHSS, HVCT	$ 216,000	PSM	8. Commodity Security and supply chain
Limited HRH capacity to offer PITC	100% of PEPFAR supported facilities provide PITC	No. of health facilities implementing routine PITC – 80% (from 60% baseline in 160 PEPFAR supported sites).	100% of PEPFAR supported facilties offer PITC	% of PEPFAR supported facilites offering PITC	Training of HCWs in rapid HIV testing.	HTXS, PDTX, HVCT	$ 700,000	UTAP, Potentia, MoHSS, ITECH, TBD/CBC	7. Human Resources for Health
					Support national level activities to coordinate HTS program in the MOHSS - QA, suppervision		**$ 97,741**		
Limited diversity of service delivery models					Health worker, management and community sensitization on PITC. Activities ongoing no additional COP 17 funds needed	HVCT	$ -	UTAP, KNCV, MOHSS, ITECH,TBD/CBC	6.Service delivery
					Training of all health workers and dissemination of SOPs				
Gaps in data collection and reporting (M&E)	Fully integrated HTS data with other health information systems.	Program data exchange rate increased 0 to 30%	Program data exchange rate increased by 50%	% of facilities reporting via integrated HTS data system	Regular data quality audits	SI	$ 75,000	MOHSS	
					Support activities on data integration – HIV testing data integrated with other health information systems.	SI	$ 35,000	MOHSS	
	Inadequate data on Key pops		IBBSS conducted	Increased testing and linkage amongst Key pops	**Conduct IBBSS and associated peer-driven intervention (PDI) among FSW and MSM.**	HVOP	**$ 400,000**	UCSF	
TOTAL							$ 1,523,741		

Table 6.1.2 Key Programmatic Gap #2: Low treatment coverage in scale-up districts									
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP/ ROP16) Annual Benchmark**	**Year Two (COP/ ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP/ROP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**
Saturation of existing ART sites	Implement differentiated ART service delivery model in scale-up districts.	· Differentiation criteria established. · Basic package defined. · Pilot conducted. · 25 high volume sites implementing differentiated service delivery model – covering 2 districts.	Ratio of number of patients receiving care in high volume to differentiated sites	Number of patients receiving care in high volume sites (expect a reduction)/ratio of patients in high volume to differentiated sites (>60% of patients receiving care in differentiated sites).	Redesign and implementation of differentiated service delivery model that seeks to minimize visits by "stable" ART clients (differentiated service model) in pilot sites. Not funded in COP 17.	HTXS PDTX	$ -	MOHSS, EGPAF, UTAP, ARP, KNCV	6.Service delivery
Low treatment coverage among adolescents	Adolescent treatment coverage equal to adults		Adolescent treatment coverage increased to 81%	% of HIV positive adolescent on treatment	**Innovative use of social media and teen clubs to reach adolescent and youth to improve treatment coverage and retention**	HTXS	$ 100,000	MOHSS, UNICEF	
HRH capacity to provide ART	100% of health centres/clinics are NIMART sites in PEPFAR supported districts	· 150 Nurses trained and proficient on NIMART. · 80% of health centers and clinics offer NIMART	95% of health centres/clinics are NIMART sites	% of health centres/clinics in PEPFAR supported districts NIMART sites	Improved task-shifting – NIMART. Will require the provision of training, rolling out of decentralized sites and mentorship support.	HTXS, PDTX	$ 350,000	UTAP, MOHSS, ITECH, UTAP	7. Human Resources for Health
	Pediatric Center of Excellence in Place		Framework for a Pediatric Center of Excellence in Place	# of HCWs accesssing expert advice; increased # of decentralized PEPFAR ART sites caring for pediatric patients; increased % of pediatric patients at decentralized sites	**TA to improve paediatric treatment and coverage including plans for paediatric center of excellence**	PDTX	**$ 255,130**	EGPAF, MOHSS	
M&E system not providing timely and complete data	Data capturing and timely reporting from all ART sites increased to 100%.	· 90% of sites reporting in a timely manner (currently 60% reporting by quarter end).	95% of sites reporting in a timely manner	% of facilities reporting on time	Implementing mobile data collection	HVSI	$ 150,000	MOHSS, UTAP, ITECH, Potentia, MCSP	15. Performance data
	All HIV data management systems fully integrated.	30% of PEPFAR supported ART sites will report using integrated HTS/ART (DHIS2) system.	50% of sites reporting using integrated HTS/ART system	% of facilities reporting using integrated system	Improved data system interoperability and integration		$ 500,000		
TOTAL							**$ 1,980,130**		

Table 6.1.3 Key Programmatic Gap #3: Need to scale up and sustain viral load suppression									
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP/ ROP16) Annual Benchmark**	**Year Two (COP/ ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP/ROP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**
Service delivery issues - no documentation of linkage of viral load test results to individual patients	100% of all viral load tests have unique ART number included.	50% of all viral load tests have unique ART number.	90% of all viral load tests have unique ART number.	Inclusion rate of unique ART number to lab requests and results and linkage to patient files. (benchmark 32%)	Review of training curricula to address VL management - ongoing no COP 17 funds needed	HBHC, PDCS, HTXS/ PDTX	$ -	MOHSS, ITECH,EGPAF TBD/CBC, ARP, HRSA/ HEALTHQUAL	6.Service Delivery
					Support community based activities to improve linkage, retention and adherence to treatment		$ -		
					Build capacity for systemic use of site level CQI using collaboratives		$ -		
					Develop tools for HCW for HIV VL collection		**$ 20,000**		
	Reduce 12 month LTFU to less than 10% of patients.	90% of patients retained in HIV care after 12 months in PEPFAR supported sites.	90% of patients retained in HIV care after 12 months in PEPFAR supported sites	% of LTFU at 12 months.	Training and development of SOPS for linkage, retention, adherence monitoring and tracking of LTFU patients	HBHC, PDCS	$ -	MOHSS, ITECH, EGPAF,UTAP, TBD/CBC, ARP, KNCV	
Service delivery issues - inadequate HRH capacity in dealing with paediatric patients resulting in Low viral load suppression amongst paediatric patients	Improved viral load suppression in paediatric patients		Tools and guidelines for pediatric disclosure available at 100% of PEPFAR supported sites.	Improved viral load suppression in paediatric patients	**Tools and guidelines for paediatric disclosure**	PDTX	**$ 40,000**	MOHSS	
			ANC/PMTCT/EID cascade analysis done		**ANC-PMTCT-EID Cascade Analysis at scale up SNUs to improve EID**	PDTX, PDCS, MTCT	**$ 400,000**	Technical Support Project	
			Compliance with WHO regulations re Infant HIVDR	Surveillance system for Infant HIVDR in place	**Implementation of Infant HIVDR, training and printing of relevant materials**	SI	**$ 50,000**	MOHSS	
Laboratory issues (define barrier in SDS)	All patients have access to HIV VL testing	85% of ART patients have at least one viral load result/year	95% of ART patients have at least one viral load/year	% of patients with documented viral load tests in lab information system	**Strengthen specimen transport**	HTXS	$ 300,000	NIP	10. Laboratory
					scaleup DBS for VL	HLAB	$ 10,000	NIP	
					Decrease TAT (85% of all viral loads decreased to less than 5 days)	HLAB	$ 50,000	NIP	
					~~Increase lab capacity for VL testing - COMPLETED~~	HLAB	$ -	NIP	
M&E	All PEPFAR supported high volume sites have integrated Lab/ART record system.	70% of PEPFAR supported high volume sites have integrated Lab/ART record system.	90% of PEPFAR supported high volume sites have integrated Lab/ART record system	% of PEPFAR supported high volume sites with integrated Lab/ART record system	Align NIP patient level unique identifier with ePMS and EDT at site level (part of creating interoperability)	SI, HTXS	$ 20,000	UTAP, SIAPS, MOHSS, NIP	15. Performance data
TOTAL							**$ 890,000**		

Table 6.2.1 Test and Start(T and S)

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
Implementation of national policy on Treat All	Full implementation of national policy & guidelines for Treat All Implementation of SOP for clinical service sites.	~~Phase I of Treat All begins in 3 regions~~ - **~~DONE~~** ~~Approved national guidelines for Treat All~~ - **~~DONE~~**			Support MoHSS to review, adopt and adapt the new WHO guidelines, including differential models of care, multi-month scripting, and community-based refill	OHSS	$ -	17531(Intra) ITECH, MoHSS-	2. Policies and Governance
		Full national scale up by March 2017.	100% of PEPFAR supported sites implementing Treat all approach	SIMS visit indicate that all PEPFAR supported facilites use new treatment guidelines.	Support training and task-shifting, mentorship and supervision	HTXS	$ 237,701	17531(Intra)and ITEC, MoHSS	2.Policies and Governance
	Implementation of SOP for clinical service sites. New treatment guidelines implemented country-wide	Train 200 HCWs on new guidelines	Train 500 HCWs on new guidelines Operational plans and SOPs developed	No. of HCWs trained on new guidelines Operational Plan and SOPs developed	**Train 500 HCWs on new guidelines** **TA to support implementation of new treatment guidelines**	HTXS	**$ 100,000**	WHO	6. Service delivery
Weak supply Chain Management system	Facility reporting stock-out of ART reduced to less than 10%	70% of facilities reporting on eLMIS by end month	90% of facilties reporting on eLMIS by end month	% of facilities reporting stock on eLMIS	Provide TA to MoHSS to quantify, forecast and distribute RTKs and ARVs for T and S and Differentiated service delivery model (repeat activity)	HTS	$ -	USAID/SIAPS	8. Supply Chain
	Completion of costing of clinical pathways for use by the MOHSS.	Develop draft of costing model for circulation among partners - **AT PROTOCOL development stage**		Costed Clinical Pathways	Conduct a national costing model for HIV treatment taking into account Treat All and clinical pathways . NOT funded in COP 17	OHSS	$ -	Interagency lead by CDC	8. Supply chain
TOTAL							$ 337,701		

Table 6.2.2 New and efficient service delivery models

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
Shortage and capacity of HCW including community health care workers (CHCW) and recognition of CHCW	100% of HCW including Community HCW in scale-up districts provided skills training on the new SDM	~~National guidelines updated to include specific language addressing the CHCW cadre role in SDM.~~ **~~DONE~~** · Conduct at least 1 training in each district per new SDM		New national guidelines updated Number of new SDM trainings conducted in each district		OHSS	$ -	ITECH/MoHSS and 17351/Intra	2.Policies and Governance
					Train adequate HCW on new SDM	HTXS	$ -	ITECH/MoHSS- 17351/Intra, ARP/SIAPS	6. Service delivery
Weak monitoring, evaluation and data reporting	Ensure all SDM community sites have data capturing tool(EDT)	Roll out EDT to 100% of community sites		Number of community sites equiped with EDT	Expand mobile EDT	HVSI	$ -	SIAPS	15.Strategic Information
Weak integration of SDM to other programs	Full integration of the various categories of SDM	Conduct at least 1 training in each district per new SDM guidelines		Number of new SDM guidelines trainings conducted in each district	Train program managers and districts to integrate SDM with management supervision	HTXS	$ -	ITECH/MoHSS-17531/Intra	6.Service Delivery
	Complete evaluation of SDM and scale-up nationally	Submit the SDM evaluation protocol for clearance		SDM evaluation report	Evaluate the differentiated SDM of care	OHSS	$ -	Interagency CDC/USAID	15.Strategic Information
TOTAL							$ -		

Activity	For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)	Outcomes expected after 3 years of investment	Year One (COP/ROP16) Annual Benchmark	Year Two (COP/ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Table 6.3 Other Proposed Systems Investments									
Finance									
NHA & costing support	4) Sustained Epi control	Data driven model in place to allocate GRN resources with 50% of GRN HIV resources targeting high burden districts	NHA complete	Expenditure tracking system in place	MTEF, Government Accountability Statement	OHSS	$ 300,000	HFG	12. Technical and Allocative Efficiencies
Laboratory									
Implement RTQII	3) Third 90	Support Accreditation for 5 Labs		5 laboratories internationally accredited	Accreditation certificates	HLAB	$ 223,089	CLSI	10. Laboratory
Implement POCT QA system						HLAB	$ -	NIP	10. Laboratory
Inst. & Org. Development									
Electronic Dispensing Tool for ART system support	3) Third 90, 4) Sustained Epi Control	95% adherence to treatment regimens	70% of decentralized sites have functional EDT.	100% of decentralized sites have functional EDT.	% of decentralized sites with functional EDT.	HTXS	$ 150,000	ARV phamacy service	
Develop clinical mentor/partner demonstration project for TBIC education for hosoital staff	4) Sustained Epi control	Improved TB Infection control in high burden TB clinics		Infection control report in high burden TB clinics	Analysis of TB infection control in high burden TB clinics and action plan developed to share with GRN.	HVTB	$ 12,600	MoHSS	
Governance									
Technical assistance to medical regulatory council to ensure registration of new molecules/uses	2) Second 90 3) Third 90	New molecules/new uses registered for use in prevention treatment program within a month		Within 3 months	Turn around time for drug registration	OHSS	$ 126,000	ARV pharmacy service	
Support UNAIDS to work with two cities (Gobabis and Outapi) to develop HIV implementation plans based on the National Startegic Framework (NSF) 2017/2018 -2021/2022	4) Sustained Epi control	HIV implementation plan based on new NSF developed		HIV implementation plan based on new NSF Developed in two cities	Development of an HIV implementation plan,(Gobabis and Outapi) based on the new NSF 2017/18 – 2021/22	OHSS	$ 30,000	UNAIDS	
Support UNAIDS to adapt the 2019-2022 UNAIDS Joint Programme on HIV/AIDS for Namibia to prevent the HIV/AIDS epidemic from becoming a severe pandemic in line with the UNAIDS goals of advocacy; improved Strategic information; HIV response monitoring and evalaution, CSOs engagement and resource mobilization.	4) Sustained Epi control	UNAIDS Joint Programme on HIV/AIDS plan for Namibia		UNAIDS Joint Programme on HIV/AIDS plan for Namibia developed	Development of the 2019 - 2022 Joint Programme of Support	OHSS	$ 10,000	UNAIDS	
Collaboration with the office of the first lady of Namibia	4) Sustained Epi control	Advocacy with CSOs on fast track initiative to improved HTS & ART access to women in informal settlements		Advocacy on fast track initiative to improved ART access to women in informal settlements developed	Advocacy on Fast track initiative- start Free -Stay free and AIDS free in collaboration with the Office of the first lady (OFL) Advocacy to increase HTC and access to ARVs for Pregnant women in informal settlement	HTXS	$ 20,000	UNAIDS	
Mass media communication	4) Sustained Epi control	Increased uptake of VMMC services		VMMC increased by 21,000	Increased uptake of VMMC services	CIRC	$ 100,000	MOHSS	
Provide regional Supervision, leadership, M&E and proficiency assessment for VMMC	4) Sustained Epi control	95% of VMMC sites meet required minimum standards		Sites assessment report	Provide regional Supervision, leadership, M&E and proficiency assessment.	CIRC	$ 33,333	MoHSS	
TA for revision of TB/HIV policy and guidelines; Global Fund Support; and CQI.	4) Sustained Epi control	Decrease TB/HIV co-morbidities from the current 40% HIV among TB patients by 30%		Finalized revised policy and guidelines for TB/HIV care	Revised TB/HIV guidelines; at least 90% of budgeted GF TB funds utilized in stated period	HVTB	$ 275,000	Challenge TB, ITECH	
Advocacy, KP-led accessible services, data partnership and collaboration with MOHSS	2) Second 90; 3) Third 90; 4) Sustained Epi Control	Improved service access for KP - increasing linkage from the current 70% to 90%. KP indicators included in National M&E framework		Increase KP friendly services points from the current 7 to 10.	Number of KP friendly service points in place.	HTXS	$ 75,000	SFH	
Improvement of national, regional, district level program management and COAG activities implementation and monitoring	4) Sustained Epi control	Improved MOHSS leadership over PEPFAR supported program	Target achieved; improved expenditure rate	90% of the directly supported regions achieve their targets; 95% expenditure rate for the COAG budget	Improvement of national, regional, district level program management and COAG activities implementation and monitoring	OHSS	$ 55,056	MOHSS	
TA to MOHSS re PREP/HIVST	4) Sustained Epi control	Routine PREP/HIVST program in place for Key populations		500 Key pop on PREP	No. of individuals on PREP	HVOP	$ 161,034	SFH	
Systems Development									
Management of the condom supply chain and logistics at the district and site level	4) Sustained Epi control	Management of the condom supply chain and logistics to include non-standard outlets including schools, youth and teen centers as part of the DREAMS-like activities		Availability of condoms at every location where DREAMS activities are occurring	Number of condoms accessed from DREAMS activity locations.	HVOP	$ 100,000	ITECH	DREAMS
TA to MGECW for OVC Management Information System	4) Sustained Epi control	OVC Management information system in place	30% of OVCs in PEPFAR supported districts registered	50% of OVCs in PEPFAR supported districts registered	No. of OVCs registered on system	SI	$ 145,000	Community care and support	
Strategic Information									
Enhanced Primary health care level data for HIV services	4) Sustained Epi control	95% of all ART sites reporting on time		Data capturing and timely reporting from all ART sites increased to 95%. No COP 17 funds required	Number of ART sites reporting by the deadline	SI	$ -	HISP, UCSF	15. Performance Data
Implement redesigned and interoperable patient level HIV systems e.g. clinical, pharmacy, HIV commodities.	4) Sustained Epi control	All HIV data management systems fully integrated		All HIV data management systems fully integrated. No COP 17 funds required	Number of HIV data management systems interoperational	SI	$ -	JHPIEGO, MSH, IntraHealth	15. Performance Data
OVC MER Outcome Study 2nd YR & PLACE Study 2nd YR	4) Sustained Epi control	Improved OVC and KeyPops service quality	OVC MER outcome 1st year findings; PLACE study protocol and tools developed	Final OVC MER Study report; PLACE study report	Study report	SI	$ 600,000	Measure Evaluation	
TA for Subnational HIV estimates	4) Sustained Epi control	Subnational HIV estimates available and used for planning		Subnational HIV Estimates	Improved subnational denominator data	SI	$ 20,000	UNAIDS	
Improved M&E for Key pops	4) Sustained Epi control	Key pop data included in national M&E		M&E support for key pop data	National M&E system includes key pop data	SI	$ 75,000	SFH	
Provide TA for synthesis of key population data to inform planning, target setting and selection of appropriate evidence-based interventions for key population programming	4) Sustained Epi control	Context appropriate evidence-based interventions identified for Key pop programmiing in Namibia		National synthesis of Key pop data completed;	Recommendations for context appropriate evidence-based interventions identified for Key pop programmiing documented & shared with relevant stakeholders.	SI	$ 20,000	UNAIDS	
Improved MoHSS capacity for surveillance & epidemiology including regional data reviews and support for DHS	4) Sustained Epi control	Seven MOHSS stafffs with enhenced epi capacity		Data quality assessment and reviews, surveillance systems assessment conducted by MOHSS staff	Support Data Reviews and quality assusrance, surveillance system assessment and build epidemiology capacity for 7 MOHSS staff	SI	$ 296,115	MoHSS, ICFMacro	
TOTAL							$ 2,827,227		