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## Abbreviations and Acronyms

AGYW	Adolescent Girls and Young Women aged 15-24
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
CACOC	Constituency AIDS Coordinating Committee
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CHBC	Community Home Based Care
CHP	Country Health Partnership
CHS	Catholic Health Services
CLHIV	Children living with HIV and AIDS
CHCT	Couples HIV Counseling and Testing
CMO	Chief Medical Officer
CMS	Central Medical Stores
CODB	Cost of Doing Business
COP	Country Operational Plan
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
CSS	Community Systems Strengthening
DBS	Dried Blood Spot
DHIS	District Health Information System
DOT	Directly Observed Treatment
DR-TB	Drug Resistant TB
DSD	Direct Service Delivery
DSP	Directorate of Special Programmes
DTLC	District TB and Leprosy Coordinator
EA	Expenditure Analysis
EDT	Electronic Dispensing Tool
e-PMS	Electronic Patient Monitoring System
EID	Early Infant Diagnosis
EIMC	Early Infant Male Circumcision
eMTCT	Elimination of Mother to Child Transmission
EWIs	Early Warning Indicators
FBO	Faith-based Organization
FELTP	Field Epidemiology and Laboratory Training
FH	Family Health
FP	Family Planning
FSW	Female Sex Worker
FTE	Full Time Equivalent
GBV	Gender-based Violence
GF	The 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
GUHSR	Global Update on the Health Sector Response
HCW	Health Care Workers
HDP	Health Development Partners

HEI	HIV-exposed Infant
HEW	Health Extension Workers
HIE	Health Information Exchange
HFCA	Health Facility Capacity Assessment
HIA	HIV Impact Assessment
HIE	Health Information Exchange
HIS	Health Information System
HIVQUAL	HIV Quality of Care
HMIS	Health Management Information System
HR	Human Resources
HRH	Human Resource for Health
HTS	HIV Testing Services
HSS	Health Systems Strengthening
IBBSS	Integrated Biological and Behavioural Surveillance Survey
ICF	Intensified Case Finding
IEC	Information, Education and Communication
IMAI	Integrated Management of Adult Illnesses
INH	Isoniazid
IP	Implementing Partner
IPT	Isoniazid Preventative Therapy
IT	Information Technology
ITT	Interagency Technical Team
L&D	Labor and Delivery
LES	Locally Employed Staff
LMIS	Logistics Management Information System
MCH	Maternal and Child Health
MDR-TB	Multi-Drug Resistant TB
M&E	Monitoring and Evaluation
MER	Monitoring, Evaluation and Reporting
MGECW	Ministry of Gender Equality and Child Welfare
MIS	Management Information System
MNCH	Maternal, Neonatal and Child Health
MMC	Adolescent and adult male medical circumcision
MOHSS	Ministry of Health and Social Services
MOD	Ministry of Defense
MOF	Ministry of Finance
MOG	Ministry of Gender
MSM	Men who have Sex with Men
MTCT	Mother-To-Child Transmission
MTB	Mycobacterium tuberculosis
MTR	Mid-Term Review
NABCOA	Namibia Business Coalition on AIDS (now HealthWorks)
NAC	National AIDS Council
NACCATUM	Namibian Coordinating Committee for HIV/AIDS, TB and Malaria
NACS	Nutrition Assessment, Care and Support
NAEC	National AIDS Executive Committee
NANASO	Namibia Network of AIDS Service Organisations
NANGOF	Namibia Non-Governmental Forum
NASA	National AIDS Spending Assessment
NCF	National Coordination Framework
NA/ND	Not Available/No Data

NDF	Namibian Defense Force
NDHS	Namibia Demographic and Health Survey
NGO	Non-Governmental Organization
NIP	Namibian Institute of Pathology
NIMART	Nurse Initiated Management of Antiretroviral Treatment
NPC	National Planning Commission
NSA	Namibia Statistics Agency
NSF	National Strategic Framework
NTLP	National TB and Leprosy Programme
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PBAC	PEPFAR Budget Allocation Calculator
PBFW	Pregnant and Breastfeeding Women
PCR	Polymerase Chain Reaction (a test on DNA)
PDSA	Plan-Do-Study-Act
PEP	Post Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHCD	Primary Health Care Directorate
PHCS	Primary Health Care Supervisor
PHDP	Positive Health Dignity and Prevention
PIP	Performance Improvement Plan
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
POC	Point of Care
PPP	Public Private Partnership
PrEP	Pre-Exposure Prophylaxis
QA/QI	Quality Assurance/Quality Improvement
RACOC	Regional AIDS Coordinating Committee
RIF	Rifampicin
RM&E	Research Monitoring and Evaluation (Unit)
RMT	Regional Management Team
RT	Real Time
SBU	Sensitive But Unclassified (redact prior to making public)
SDM	Service Delivery Model
SDS	Strategic Direction Summary
SCM	Supply Chain Management
SHPA	Senior Health Programme Administrator
SID	Sustainability Index Dashboard
SLMTA	Strengthening Lab Management Towards Accreditation
SMO	Senior Medical Officer
SNU	Sub-National Unit
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TA	Targeted Assistance
TAC	Technical Advisory Committee
TB	Tuberculosis
TBIC	Tuberculosis Infection Control

UNAIDS	United Nations Programme on HIV and AIDS
UNAM	University of Namibia
UNICEF	United Nations International Children's Emergency Fund
USG	United States Government
VACS	Violence against Children and Young Women
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WISN	Workload Indicators of Staffing Need
WHO	World Health Organization

## Goal Statement

PEPFAR Namibia, collaborating across U.S. Government (USG) agencies, Government of the Republic of Namibia (GRN), multilaterals and the private sector, has developed the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Namibia Country Operational Plan for U.S. fiscal year 2016 (COP16). COP16 reaffirms the focus on scale-up to saturation (>80%) and the COP15 pivot to work in areas with the highest HIV burden and unmet HIV treatment need. This approach supports the GRN goal of 80% antiretroviral therapy (ART) coverage among all people living with HIV (PLHIV) by 2017. Consistent with principles set forth in the USG-GRN Country Health Partnership Letter of Intent (July 2014), PEPFAR works jointly with the GRN to plan, implement and monitor USG-GRN co-investments to achieve epidemic control and foster a sustainable response.

Starting in COP14, PEPFAR has used data analysis in pivoting geographic focus and intensifying targeted efforts at site and district levels to meet ART saturation targets and reduce AIDS-related deaths and new HIV infections. PEPFAR Namibia's focus is in eight regions containing eighteen districts with the highest HIV burden and unmet ART need and in eight urban hotspots, outside those regions, that have large key populations or high-volume ART sites. These high burden areas represent sites currently providing 80% of ART treatment. To close the ART gap in these districts/hotspots, an additional 25,685 adults and children need to be initiated on ART in COP16.

PEPFAR Namibia will continue to work with the Namibian government, civil society and private sector to expand ART access by assisting high-volume sites in high burden areas and decentralizing services to reach saturation. PEPFAR prevention, care and treatment interventions will align within these locations for synergistic impact. At the site level, PEPFAR Namibia will collaborate with the GRN and stakeholders to support activities that increase HIV testing services (HTS) yield with emphasis on increasing testing among men and adolescents; improving data capture for Option B+ and mother-baby follow-up; enabling rapid expansion of ART; introducing test and start; improving retention and adherence (especially among children and adolescents); and rolling out viral load (VL) testing to all ART sites. PEPFAR Namibia will improve integration of HIV/tuberculosis (TB) and HIV/maternal and child health (MCH) services and continue to provide care and support for orphans and vulnerable children (OVC) while strengthening linkages between HIV and social services, including pediatric HTS and ART. To increase treatment and care access and address retention and adherence, PEPFAR Namibia will continue to support the GRN's efforts to decentralize ART services from congested high-volume facilities to intermediary facilities and the community, and will support establishment and rollout of differentiated models of HIV care and treatment.

PEPFAR Namibia will facilitate monitoring, quality improvement, and scale-up of other components of the GRN's combination prevention efforts, especially voluntary medical male circumcision (VMMC) for men 15-29 years of age. PEPFAR Namibia will support targeted approaches for key populations (men who have sex with men [MSM] and female sex workers [FSW]) and address the inequitable HIV burden among adolescent girls and young women (AGYW) through HIV prevention and early ART access. PEPFAR Namibia will work with civil society and the GRN to foster stigma-free access to comprehensive



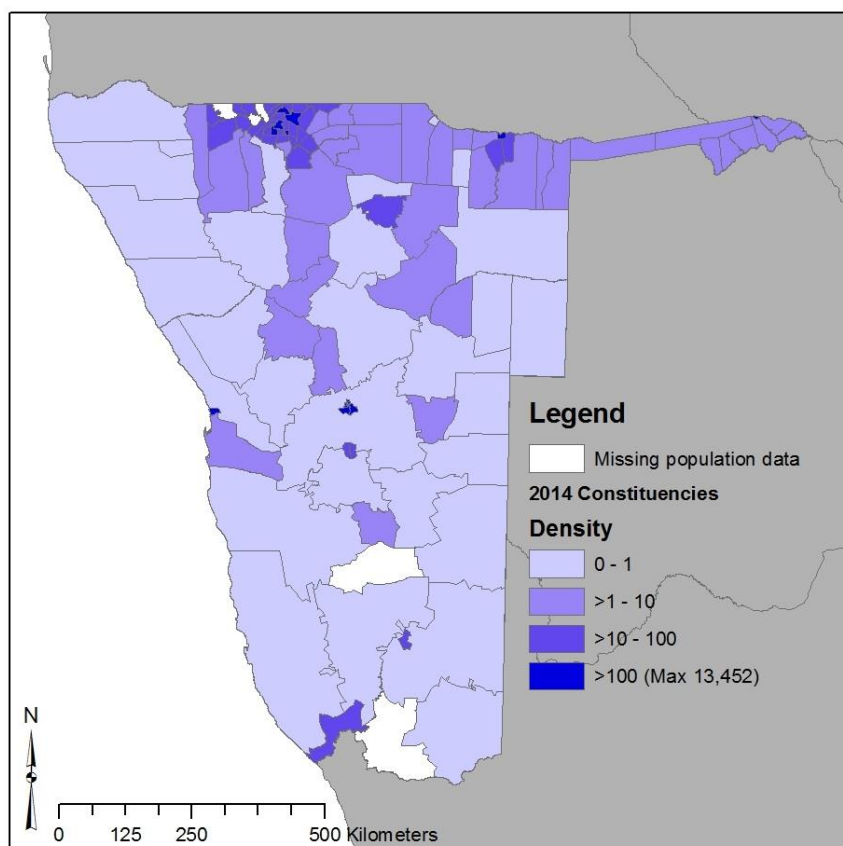
HIV services for key populations. At national, regional and district levels, PEPFAR Namibia will improve systems that support epidemic control, in particular quality assurance/quality improvement (QA/QI), HIV supply chain, human resources for health (HRH), and strategic allocation of funds. PEPFAR Namibia will also strengthen capacity to institutionalize HIV data availability, analysis and use.

PEPFAR Namibia’s efforts to expand ART coverage to 80% in high burden areas will require intensification of USG, GRN and multilateral co-investments. An Acceleration Plan for increased direct support to the GRN, using Central Funds, was proposed in COP15 and officially signed on December 11, 2015.

## 1.0 Epidemic, Response, and Program Context

### 1.1 Summary Statistics, Disease Burden and Country or Regional Profile

Namibia is a sparsely-populated desert country of 2.3 million people (World Bank, 2013) in an area twice the size of California. The population is concentrated in small urban areas scattered throughout the country and particularly in the north near the border with Angola.



Namibia is an upper-middle income country with gross national income (GNI) per capita of \$9,810 (World Bank, 2014) but starkly unequal income distribution. Namibia’s Gini coefficient is 0.5971, seventh-highest in the world (CIA Fact Book 2010). Poverty is high, with 21% of the population consuming less than \$1.25 per day (2009/10 household survey). Unemployment was estimated at 29.6% in 2013 (NSA, 2013).

Namibia is a success story. The country has made great strides in attaining the Millennium Development Goals related to access to education, gender parity in education and health.

**Figure 2.1.1: Population density in Namibia**



The national decrease in incidence to date has been predominantly due to a reduction in incidence among infants from scale-up of PMTCT. Spectrum (2016) estimates that the decline is not expected to continue if current treatment coverage levels remain unchanged. The northern districts, home to the majority of the population, border on Angola, Zambia and Botswana. Additional urban hot spots are located in the coastal towns and along the main road connecting southern and northern Namibia.

Namibia also has the fifth-highest TB incidence in the world (WHO 2014). TB/HIV co-infection is high among adults over 15 years of age (45% for women and 38% for men) and 17% among children under 15 years of age. While TB/HIV co-infection declined from 58% in 2009 to 40.4% in 2015 and ART coverage for co-infected persons increased from 80% in 2013 to 88% in 2015, this is still below the GRN target of 100% (NTLP, 2014).

HTS sites in Namibia are widespread. Overall, 79.6% of women and 62.6% of men over 15 years of age report having ever been tested and 49.4% of women and 38.8% of men reported being tested in the last year (NDHS 2013). Reaching men has been and continues to be a challenge. While the self-reported circumcision rate is 25.5% (NDHS, 2013), Namibia struggles to roll out VMMC for men aged 15-29.

Since ART was introduced in 2003, the number of PLHIV on ART has increased annually, rising from 75,681 in 2010 to 161,785 in 2016. This translates to more than doubling of ART enrollment over five years. In 2014, national guidelines changed eligibility for ART to: all children under 15, TB/HIV co-infected patients, all HIV/Hepatitis B co-infected patients, pregnant women, HIV sero-discordant couples, and patients 15 years of age or older with a CD4 count of  $\leq 500$ . These and other changes have resulted in a continued rise in the number of people eligible for treatment.

The majority of the population receives ART from the public sector. The MOHSS reports that the private sector is providing ART to about 15,000 PLHIV in 2016. By the end of 2017, with PEPFAR support, Namibia will have 176,040 PLHIV on treatment (76% coverage nationally).

More than 95% of pregnant women know their status or are tested during antenatal clinic (ANC) visits or at delivery (GUHRS, 2014). ANC coverage (at least one visit) is at least 95% and delivery in a health center is greater than 87%. Namibia has made significant progress in PMTCT and early infant diagnosis (EID) since the respective programs launched in 2003 and 2005. PMTCT services are now routinely provided in ANC, maternity and postnatal care settings in over 95% of public health facilities. Sixty-four percent of health facilities collect Dried Blood Spot (DBS) for EID. According to HIV sentinel surveillance 2014, HIV prevalence among pregnant women increased from 4.2% in 1992, reaching a peak of 22% in 2002, and slowly declined to 16.9% in 2014. Prevalence ranges from 3.9% to 36% across regions, however, with regions in the northern and northeastern parts of the country bearing the greatest burden (MOHSS ANC Sentinel Surveillance, 2014).



The GRN's Gender Protection Units provide a one-stop service for survivors of gender-based violence. However, the quality of the services being provided 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. PEPFAR Namibia's 2016 Gender Analysis Final Report outlines major findings and programmatic recommendations for inclusion and implementation.

**Table 1.1.1 Key National Demographic and Epidemiological Data**

	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	2,324,388	100.0%	419,580	18.1%	426,615	18.4%	775,054	33.3%	703,139	30.3%	Namibia Population Projections 2011-2014
HIV Prevalence (%)		14.0%		1.3%		1.3%		16.9%		10.9%	HIV prevalence is for 15-49 year olds, NDHS 2013
AIDS Deaths (per year)	2,639		142		127		1,145		1,225		Spectrum (2016)
# PLHIV	229,631		5,064		5,149		134,776		84,641		PLHIV population estimates (2011 Census Projections) against NDHS 2013 HIV prevalence and Spectrum (2015) for pediatrics
Incidence Rate (Yr)		0.54 per 1000									Spectrum (2016) 15-49 years
New Infections (Yr)	6421		213		218		3,438		2,553		Spectrum (2016) 15-49 years
Pregnant women	69,738										MOHSS 2015
% of Pregnant Women with at least one ANC visit	66,323	95.1%									MOHSS 2015
Pregnant women in need of ARVs	8,168	9.4%									National program data (2015); Spectrum (2015)
Orphans (maternal, paternal, double)	150,589		NA		NA		NA		NA		Census (2011)
Notified TB cases (Yr)	9570		NA		NA		3895		5675		TB National Data 2015 (Not disaggregated by age)
% of TB cases that are HIV infected		40.4%		NA		NA		44.5%		37.6%	TB National Data 2015 (Not disaggregated by age)
% of Males Circumcised	NA	NA			NA	NA			NA	NA	
Estimated Population Size of MSM*	6,538	NA									IBBSS (2013, unpublished)

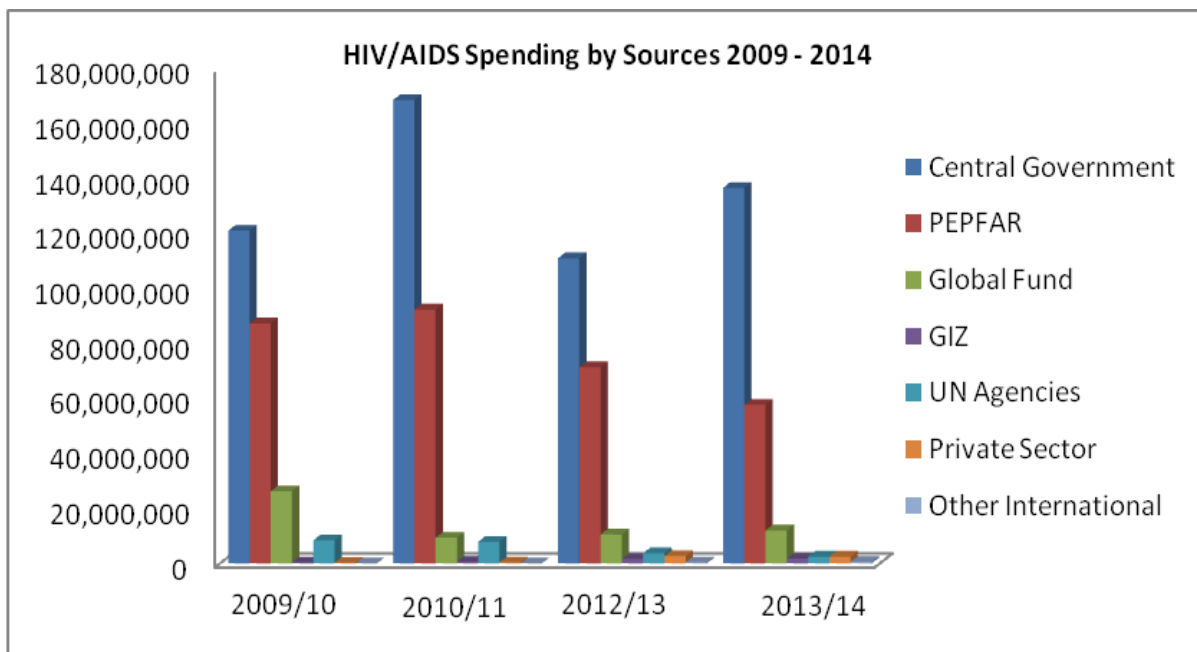
Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
MSM HIV Prevalence	NA	16.2%									IBBSS (2013, unpublished)
Estimated Population Size of FSW	8,082	NA									IBBSS (2013, unpublished)
FSW HIV Prevalence	NA	38.8%									IBBSS (2013, unpublished)
Estimated Population Size of PWID	NA	NA									NA
PWID HIV Prevalence	NA	NA									NA

*\*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*

Table 1.1.2 90-90-90 Cascade of HIV Diagnosis, Treatment and Viral Suppression (12 months)									
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
				On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV+ (#)	Initiated on ART (#)
Total population	2,324,388	14%	229,631	161,785	87%	89%	211,842	11,857	1,939
Population less than 15 years	846,195	1.3%	10,213	9,569	84%	72%	11,775	530	166
Pregnant Women	69,738	17%	11,856	10,670	NA	NA	43,619	7,847	7,274
<b>MSM</b>	6,508	16%	1,054	NA	NA	NA	NA	NA	NA
<b>FSW</b>	8,082	39%	3,136	NA	NA	NA	NA	NA	NA
<b>PWID</b>	NA	NA	NA	NA	NA	NA	NA	NA	NA

## 1.2 Investment Profile

Namibia completed a National AIDS Spending Assessment (NASA) in 2013/2014. The findings are as follows (in USD):



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 flat (GF and GIZ) or decreasing (PEPFAR and UN). Private sector funding is approximately 1% of the total HIV spending in Namibia, although the NASA indicates that this is probably an underestimate, as little hard data are available.

Namibia’s commitment to meeting its health budget is clear: in February 2016, when the Minister of Finance announced a NAD 66 billion budget (a 1.6% reduction from the previous year), the MOHSS’s budget was allocated NAD 7.3 billion, up from NAD 6.5 billion in FY2015/16. Unfortunately, the value of this increase has been eroded by the weakening Namibian dollar, which some forecasts predict will reach NAD 19 to USD 1 by the end of 2016. If that forecast is correct, the 2016/17 budget will decrease in US dollar terms by about USD 1 million. Such a decrease will not affect personnel (43% of the budgetary allocation) but will have an effect on GRN plans to procure commodities and an increased funding allocation will be needed for procurements.

The draft Namibia Investment Case document postulates that maximum gains in reducing HIV incidence and containing costs will be obtained by adopting an aggressive test and start approach, including improved technical efficiencies, such as adapting cost-effective testing and acquiring ARVs at the best global price. This scenario (indicated as “maximum” in the graph and table below) has the potential of reducing HIV incidence to 0.1%, well below the current estimated 0.54 per 1000 incidence among 15-49 year olds. The effect of maintaining constant coverage and/or continuing with the current National Strategic Framework (NSF) are also graphed, resulting in either increased incidence or a drop to 0.5% if the NSF is implemented.



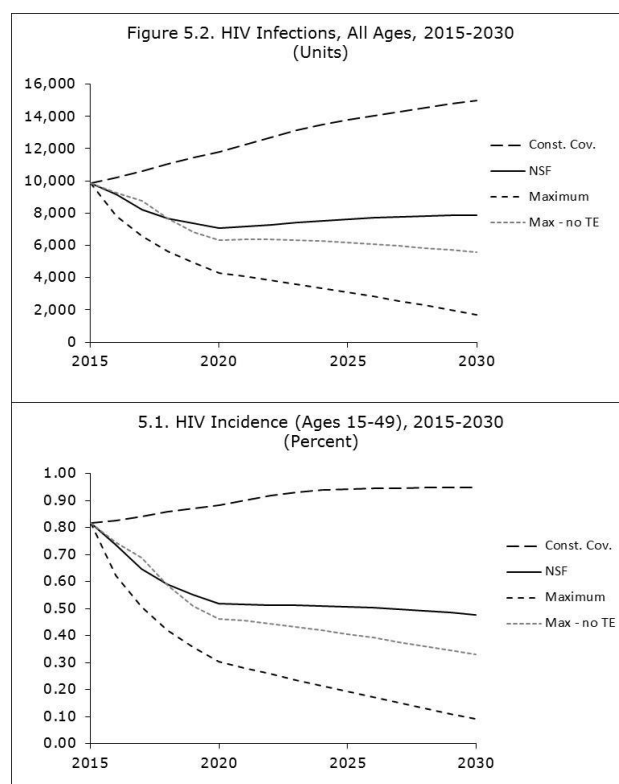


Table 3. Composition of Spending, 4 Scenarios, 2015-2030

	2015	2020	2025	2030
	(US\$ millions)			
<b>Const. Cov.</b>				
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
<b>NSF</b>				
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
<b>Maximum</b>				
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
<b>Max - no TE</b>				
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)			
<b>Total Costs</b>				
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 draft, UNAIDS, March 2016

Inadequate HRH (both in absolute numbers and from geographic mal-distribution) pose a major challenge to achieving targets. Namibia is faced with one of the most severe public-health workforce shortages in the world. Seventy percent of Namibian doctors work in the private sector, but 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 (doctors, nurses, pharmacists) to fill critical health positions. In the last three 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). This is in addition to the nursing and public health training at the MOHSS National Health Training Centre. In the medium- 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.

**Table 1.2.1 Investment Profile by Program Area<sup>1</sup>**

<b>Program Area</b>	<b>Total Expenditure</b>	<b>% PEPFAR</b>	<b>% GF</b>	<b>% GRN</b>	<b>% Other</b>
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%
<b>Total</b>	<b>213,346,629</b>	<b>27%</b>	<b>6%</b>	<b>64%</b>	<b>3%</b>

**Table 1.2.2 Procurement Profile for Key Commodities (April 2014 – March 2015)**

<b>Commodity Category</b>	<b>Total Expenditure</b>	<b>% PEPFAR</b>	<b>% GF</b>	<b>% GRN</b>	<b>% Other</b>
ARVs	37,440,559		15%	85%	
Rapid test kits	3,270,261			100%	
Other drugs	38,685,620			100%	
Lab reagents					
Condoms	2,019,780			100%	
VMMC kits					
Other commodities	17,140,239			100%	
<b>Total</b>	<b>98,556,459</b>				

<sup>1</sup> (GRP, National AIDS Spending Assessment , 2013/2014), all amounts in 2014 USD

Note that Table 1.2.3 is intentionally left blank, PEPFAR Namibia is not receiving any non-PEPFAR funding or co-funding.

**Table 1.2.3 Non-PEPFAR Funding and PEPFAR Co-Funding**

<b>Funding Source</b>	<b>Total Non-COP Resources</b>	<b>Non-COP Resources Co-Funding PEPFAR IMs</b>	<b>#Co-Funded IMs</b>	<b>PEPFAR COP Co-Funding Contribution</b>	<b>Objectives</b>
USAID MCH	\$ -	\$ -	0	\$ -	
USAID TB	\$ -	\$ -	0	\$ -	
USAID Malaria	\$ -	\$ -	0	\$ -	
Family Planning	\$ -	\$ -	0	\$ -	
NIH	\$ -	\$ -	0	\$ -	
CDC NCD	\$ -	\$ -	0	\$ -	
Peace Corps	\$ -	\$ -	0	\$ -	
DOD Ebola	\$ -	\$ -	0	\$ -	
MCC	\$ -	\$ -	0	\$ -	
Private Sector	\$ -	\$ -	0	\$ -	
<b>Total</b>					

**Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP,**

<b>Funding Source</b>	<b>Total PEPFAR Non-COP Resources</b>	<b>Total Non-PEPFAR Resources</b>	<b>Total Non-COP Co-funding PEPFAR IMs</b>	<b># Co-Funded IMs</b>	<b>PEPFAR COP Co-Funding Contribution</b>	<b>Objectives</b>
VMMC	\$2,240,000	\$ -		3	\$ 2,856,596	VMMC services in areas of high unmet MC need
Other PEPFAR	\$34,200,589	\$ -		11	\$ 9,767,765	Accelerate ART services in areas of high unmet ART needs
Pink Ribbon Red Ribbon	~/\$3,00,000	\$ -		TBD	\$ -	Increase access for women to preventive care and treatment for cervical and breast cancer
<b>Total</b>	<b>\$36,440,589</b>	<b>\$ -</b>	<b>0</b>	<b>14</b>	<b>\$12,624,361</b>	<b>COP15 funds approved. Central funds approved in FY15/16.</b>

### 1.3 National Sustainability Profile

The second Sustainability Index Dashboard (SID 2.0) resulted from a collaborative effort of stakeholders drawn from the MOHSS, the Ministry of Finance (MoF), UNAIDS, the private sector and CSOs. In February 2016, stakeholders reviewed the SID 2.0 tool and held group discussions on the four SID domains: Governance, Leadership and Accountability; Strategic Information; the National Health System and Service Delivery; and Strategic Investments, Efficiency and Sustainable Financing. Results from the sustainability analysis in SID 2.0 are mixed, but overall the country is moving toward sustainability. Four elements are most promising, having scored a light green. These are: Planning and Coordination, Public Access to Information, Laboratory and Domestic Resource Mobilization. The other eleven elements scored a yellow indicating they still required some investment. No elements scored a red. Elements that scored a yellow and are considered key to the HIV response include: Human Resources for Health; Commodity Security and Supply Chain; and Service Delivery.

Inadequate HRH remains one of the most serious sustainability challenges facing Namibia. Key weaknesses related to HRH in SID 2.0 include: an inadequate supply of HRH in the public health sector, with donors still contributing to over 10% of total HRH; lack of an official plan to transition donor support for HRH; and HR data not being fully used for HRH planning and management. The number of staff is insufficient and they are not distributed strategically to meet demand. For instance, more personnel are located at district and intermediary hospitals than at rural health centers and dispensaries. PEPFAR Namibia previously supported pre-service and in-service training for clinical and support staff and will continue to collaborate with GRN to build the capacity and increase the numbers of health personnel in regions where the HIV burden is the highest. For example, Project ECHO is a program supported by PEPFAR Namibia to provide weekly virtual training sessions to clinicians in high burden districts and creates a unique opportunity for in-service training for those working in remote areas. The ongoing restructuring process by the MOHSS, once completed, is anticipated to improve the staffing adequacy across the various levels of the public health sector. However the timeline for the final completion of this longstanding exercise remains unclear.

On the supply chain side, key weaknesses identified in SID 2.0 are related to stock, with ARVs not stocked according to plan 90% of the time, and a low score (under 80%) in the supply chain assessment (SCMS, 2013). In the past year, Namibia has experienced not only stock-outs of ARVs but HIV rapid test kits (RTK), as well. The RTK stock-outs are related to a changing testing algorithm impacting forecasting abilities.

For service delivery, the SID 2.0 assessment determined that public facilities are unable to tailor services to accommodate demand. For example, modifying or extending operation hours/days to cater to working adults, especially men and adolescents in school; and the fact that services for key populations are 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, some of the challenges in domestic financing included no specific budget allocation for interventions targeting key populations.

At \$2.33 for 178,002 PLHIV in high burden/prevalence districts in FY15, Namibia has one of the highest 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 that imbalance, Namibia recently revised its procurement procedures by working directly with manufacturers, with the first tender awarded to a CIPLA factory based in Uganda. The Namibia 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 assessment indicates that Namibia would benefit from increased transparency in working to achieve HIV/AIDS program targets and improved stewardship of HIV/AIDS resources. While the national HIV/AIDS program does produce annual progress reports, they are not disseminated beyond print 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 demonstrate 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, transgendered persons and FSW. The legislative framework in Namibia similarly does not make special provisions for CSOs engaged in the national response. While engagement exists between CSOs and the GRN, the GRN does not track and map all CSO HIV/AIDS activities. GRN engagement with the private sector is similar. Active coordination by the GRN with these two other sectors could improve the HIV/AIDS response, fill service delivery gaps and avoid unnecessary duplication of efforts.

PEPFAR continues to invest in: HRH, supporting additional personnel and task-shifting efforts; technical assistance to the supply chain intended to improve forecasting and quantification; and support of a differentiated service delivery model 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 in HRH shortfalls, but clearly there is a need to look at creating long-term sustainability to ensure ART clients' continuity of care.

#### 1.4 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 in the focus of expenditures on interventions to achieve epidemic control. In COP15, PEPFAR Namibia further focused activities and efforts with increased spending at the site-level in highest burden regions to achieve saturation and improve the continuum of care cascade. Development of COP16 included a detailed analysis of the epidemiological and program data and concluded that the COP15 high burden areas needed to remain as such. Thus, in COP16, PEPFAR Namibia will continue to focus on these high burden areas to achieve or exceed the national coverage goals.

Figure 1.4.1 Percent Spend on PLHIV per District in FY2015, Expenditure per PLHIV

### Namibia PLHIV Spend versus PLHIV by District – EA FY15

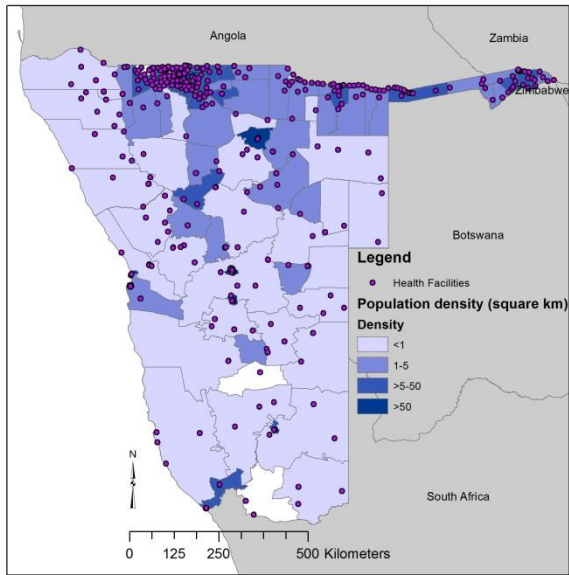
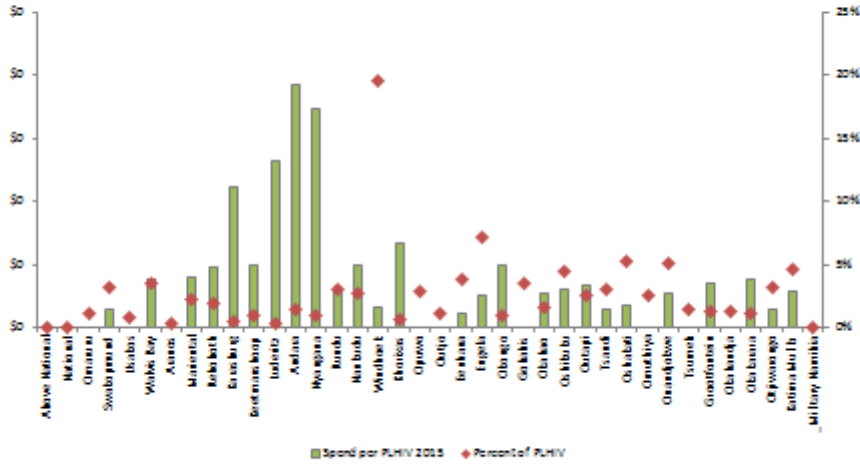


Figure 1.4.2 Population Density and Facilities

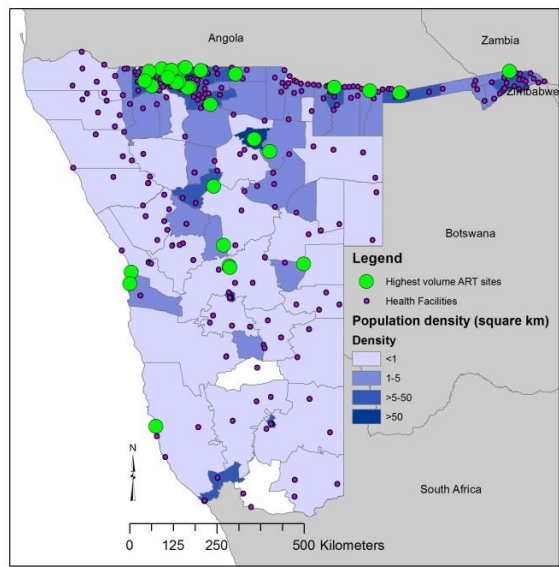


Figure 1.4.3 High Volume ART Sites

## 1.5 Stakeholder Engagement

### *Host Country Government*

PEPFAR Namibia is a Country Health Partnership (CHP) country. In July 2014, the GRN and USG signed a Letter of Intent with four objectives: to jointly plan to enhance coordination and improve the effectiveness of USG contributions; to develop an effective strategy for program monitoring and data use for evidence-based decision-making; to examine and refine USG operating procedures to foster transparent budgeting and financial monitoring of USG HIV/AIDS resources; and to develop more effective strategies for civil society and the private sector to partner with GRN in expanding access to and delivering HIV prevention, care and treatment.

Since then, there have been ongoing consultations for COP15 and the accompanying Acceleration Plan, which will provide direct service delivery support to the national HIV/AIDS response and accelerate progress towards Namibia's achievement of the UNAIDS 90-90-90 goals.

On December 11, 2015, the MOHSS and the U.S. Embassy concluded an exchange of letters describing the GRN's agreement to take over Acceleration Plan activities funded by PEPFAR Namibia upon the conclusion of the Plan.

The MOHSS has endorsed phased implementation of an accelerated Test and Start approach in three PEPFAR supported regions scheduled to start in May 2016, with a completion of national roll-out planned for March 2017. PEPFAR Namibia also provides direct technical support to the MOHSS through the Cooperative Agreement between CDC and the MOHSS.

USG-GRN engagement in development of COP16 has been addressed through several GRN platforms, including meetings convened by the National Planning Commission (NPC). On October 22, 2015, at a meeting to review the progress of the fourth National Development Plan, PEPFAR Namibia presented a session on its strategic objectives and investments and their alignment with the GRN's goals and objectives. PEPFAR Namibia described the revised geographic focus of its program on high HIV burden areas in support of the national goal to achieve epidemic control. Several areas of interest included: staff retention and training; strategic information; and the Revised Regulatory Framework for HIV/AIDS, including the revision of the national HIV policy that outlines human rights issues and stigma and non-discrimination on the basis of HIV status. The meeting also focused on the pattern of funding for HIV/AIDS and the need to ensure a sustainable HIV response and maximize program efficiencies.

On February 10-12, 2016, PEPFAR Namibia hosted a meeting with stakeholders, including the MOHSS, regional MOHSS staff, CSOs, and other implementing partners, to discuss the following fiscal year's HIV/AIDS program. The meeting enabled PEPFAR Namibia to engage and receive input from regional representatives on strategies to strengthen the decentralization of PEPFAR funding to regional, district and site level, and how to better involve PLHIV in planning and programs to improve service quality. Each region devised a workplan with specific activities in line with the UNAIDS 90-90-90 and NSF goals and a budget in line with the PEPFAR two-year Acceleration Plan.

On February 25, PEPFAR Namibia met with the MOHSS to discuss strategies toward cost efficiency in bio-clinical HIV monitoring to ensure a sustainable response and affordability. PEPFAR Namibia has

moved out of funding bio-clinical monitoring, but strongly advocates for increased domestic funding. On April 7, PEPFAR Namibia held a technical meeting with the Prime Minister's Office, MOHSS, Ministry of Gender and Child Welfare and Ministry of Finance to review and come to consensus on key technical approaches outlined in COP16 to achieve 90-90-90.

#### *Multilateral Partners*

Engagement with multilateral partners is routine and ongoing. UNAIDS, UNICEF and WHO participate in PEPFAR stakeholder meetings. PEPFAR agency leads and the Coordinator attend the monthly Health Development Partners (HDP) meetings convened by WHO. On November 19, 2015, the PEPFAR Country Coordinator attended a consultative workshop to review the draft legal environment assessment (LEA). An updated draft of the LEA was circulated at the HDP meeting on February 24, 2016. PEPFAR Namibia reviewed key issues raised in the LEA for COP16. PEPFAR Namibia also provides technical input to, and is a member of, the Steering Committee for the development of the UNAIDS Investment Case for Namibia, now in draft form. PEPFAR Namibia also provides technical input to UNAIDS, currently leading the Stigma Index exercise.

The PEPFAR Namibia team collaborates closely with the GF, the second largest contributor to HIV/AIDS funding in Namibia. PEPFAR Namibia representatives meet with the GF Portfolio Manager during GF triannual missions to Namibia and hold monthly calls to coordinate and update each other on programming issues and topics. The USG has representatives on the newly revitalized Country Coordinating Mechanism (CCM) and engages in joint planning, with the PEPFAR Coordinator holding a seat on the Executive Committee and the USAID Health Office Director holding a seat on the Oversight Committee.

#### *Civil Society*

PEPFAR Namibia views civil society as a critical partner for achieving and sustaining epidemic control. PEPFAR Namibia strengthens CSOs through organizational and technical capacity building and CSOs are engaged in project implementation both directly and through sub-agreements with PEPFAR implementing partners. PEPFAR Namibia is committed to ongoing consultation and information-sharing with CSOs and community.

On February 9, 2016, PEPFAR Namibia convened a COP16 planning meeting for CSOs, the GRN and private sector stakeholders. The meeting included six CSOs, both funded and not funded by PEPFAR, and included organizations serving geographic areas with the highest HIV burden. Participants represented key affected populations, umbrella network groups, NGOs, activist and advocacy groups, women's organizations, and lesbian, gay, bisexual, transgender and intersex (LGBTI) populations. PEPFAR Namibia assured travel funding for CSOs based outside of the capital and supported regional GRN representatives to attend the meeting in person.

At that meeting, the PEPFAR team presented an overview of the HIV epidemic in Namibia as well as an explanation of the COP development process and timeline. Small breakout groups were formed on program areas including treatment, care and support; prevention (including discussions on VMMC, PMTCT, key populations, EID, and condoms); HIV counseling and testing; and orphans and vulnerable children. The groups also discussed what should be done differently in COP16 to improve



service delivery; and discussed lessons learned during 2015, focusing on the barriers and enabling factors, both above-site and at site level, to reaching the UNAIDS goal of 90-90-90.

On February 18-19, PEPFAR Namibia held a meeting with the Chiefs of Party. Many of these implementing partners are CSOs, and they have a strong understanding of community and CSO perspectives due to their implementation of programming in the field. At the meeting, Chiefs of Party identified challenges in HIV/AIDS service delivery and policy issues that needed clarification, and discussed new implementation methodologies for the 90-90-90 goals.

On April 4, 2016, the PEPFAR Namibia team distributed an online survey to 25 CSOs to get a better understanding of their technical and geographic focus areas, the populations they represent or are supporting, and their opinions on current and future engagement with PEPFAR. This survey asked for initial nominations for CSO representatives to attend the COP Review in Johannesburg in May 2016. The feedback gathered in response to the survey and letters have informed COP16 development and plans for ongoing CSO engagement.

The Draft COP16 SDS was sent to both CSOs and partner representatives on April 14, with a request for feedback to PEPFAR by April 18. CSOs were informed in advance that the COP would be shared on this date and there would be a short turnaround time for feedback. The response from CSOs and PEPFAR's response to written CSO feedback are included as a supplemental document to COP16. PEPFAR Namibia is planning a virtual consultation with CSOs to discuss stakeholder input to COP16 and focus on improved future collaboration between USG, CSOs and the GRN. The virtual format of the meeting will allow for greater participation for CSOs based outside of Windhoek. Greater partnership is needed between the GRN and CSOs to improve efficiencies, expand access to HIV services, and improve retention and adherence in the regions experiencing challenges in these areas. While there are existing ways for civil society to engage in the HIV response, there is room for greater inclusion in HIV program planning, monitoring and service provision. PEPFAR Namibia, in collaboration with the GF, plans to conduct a data interpretation and utilization workshop to build the capacity of local CSOs to understand and utilize PEPFAR generated data (APR, SAPR results and POART) and country specific epidemiological data for advocacy, program planning, service delivery and monitoring. The PEPFAR Coordinator's Office is recruiting a third year Peace Corps Volunteer to coordinate targeted engagement with civil society, particularly with key populations, including MSM, FSW and the LGBTI Community. The CSO engagement plan, submitted as a supplemental document, provides more details on how the PEPFAR Namibia team will address these issues.

#### *Private Sector*

PEPFAR Namibia primarily engages with the private sector through a private sector umbrella organization, Health Works. During the COP process, technical consultations were held with private medical providers to discuss their involvement in expanding VMMC. There were also discussions with private health insurance companies to understand their policies on reimbursing for HIV related services. PEPFAR Namibia recognizes that this private sector is an underutilized resource in the national response, and plans additional engagement to jointly seek out opportunities with the private sector.

## 2.0 Core, Near-Core and Non-Core Activities

Core activities will focus on accelerating the identification and diagnosis of HIV+ people through intensified and expanded HTS; initiating these individuals into treatment; and strengthening the care and treatment continuum among priority and key populations. Priority areas of intervention for PEPFAR-funded activities include decentralization and scale-up of Test and Start ART services to saturation; accelerated implementation of Option B+ and EID; increased VMMC coverage; implementation of evidence-based prevention strategies for key populations; improved alignment of the OVC program to HIV services; and strengthened linkages between clinical and community-based services to improve adherence, retention and achievement of viral load suppression.

Near-core activities will include technical assistance to the GRN. Activities will catalyze epidemic control including quality improvement approaches; strengthened health systems at sub-national levels, with emphasis on HIV components of the supply chain; HRH at service delivery sites; and laboratory systems.

Non-core activities are not included in COP16. The activities identified as non-core in COP15 have been transitioned or gradually ended. These include procurement of commodities and lab consumables except in emergencies and HRH support in lower-burden districts. These resources have been redirected to support Test and Start activities to scale-up to ART saturation.

## 3.0 Geographic and Population Prioritization

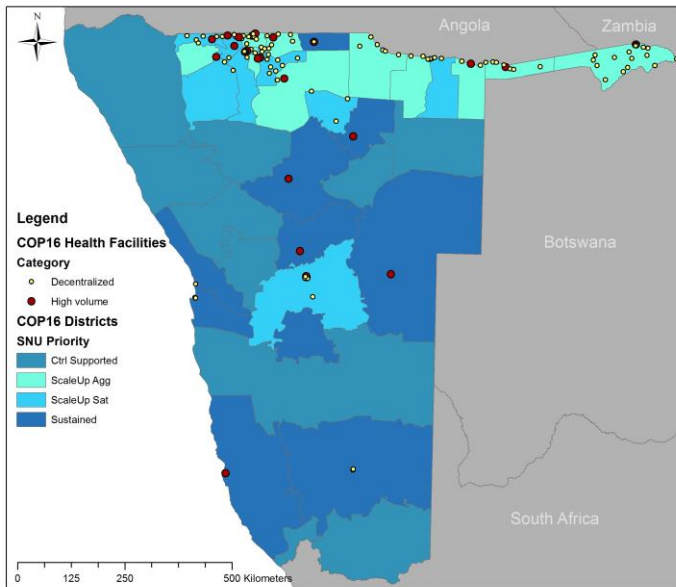
HIV prevalence, PLHIV burden and unmet need for ART vary across Namibia. Based on Namibia’s HIV epidemiological data, 18 districts out of 38 represent approximately 80% of the disease burden (see Table 3.1). In COP15, Namibia pivoted from regional TA to a site-based approach. PEPFAR will support treatment scale-up and other HIV services in 173 ART facilities in high-burden locations including DSD and TA sites.

Namibia has eight urban hotspots outside the eight regions with disproportionately higher than national HIV prevalence rate (see Table 3.1). 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. Special focus is needed to target these urban hot spots and ensure a continuum of prevention, care and treatment services to achieve ART saturation.

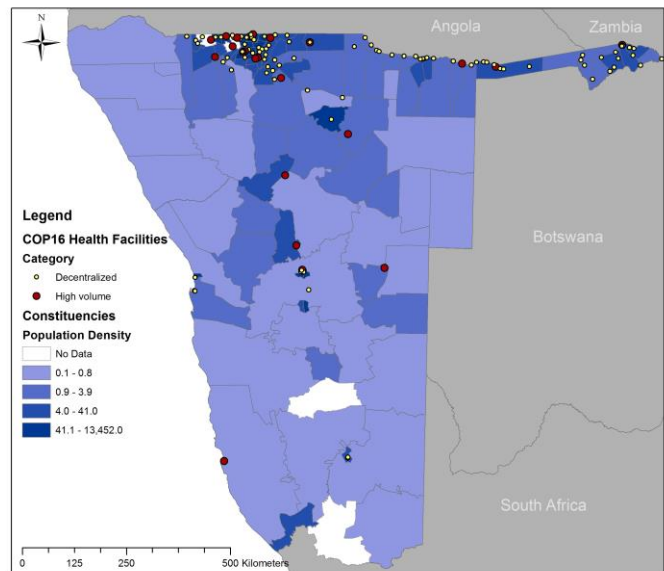
High Burden Districts and Hotspots for COP16	
High Burden Districts (18)	Urban Hotspots (8)
Andara	!Nami#nus
Eenhana	Gobabis
Engela	Grootfontein
Katima Mulilo	Keetmanshoop
Ncomongoro	Okahandja
Nkurenkuru	Otjiwarongo
Nyangana	Swakopmund
Okahao	Walvis Bay
Omuthiya	
Onandjokwe	
Ondangwa	
Oshakati	
Oshikuku	
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. This geographic confluence will prevent duplication, reduce gaps and improve coordination.

Peace Corps will target Health Volunteer placement within geographic focus areas and will complete transition from other parts of Namibia to selected high burden districts in FY16.



**Figure 3.1 TA and DSD sites for COP16 High Burden Districts**



**Figure 3.2 TA and DSD sites for COP16 Population Density**

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

### 4.1. ART Targets Process and Assumptions

The total number of PLHIV in Namibia is estimated at 229,631. The target for ART is 81% of this total population, or 186,001. Currently, there are 161,785 PLHIV on ART in Namibia. Of those, currently 142,359, or 88% (including the estimate of 15,000 from private sector) are located within the 18 high burden districts. The national ART gap is currently estimated at 24,216 to reach 81% treatment target of all PLHIV. With additional new infections, loss-to-follow-up, and unknown numbers of patients crossing into Namibia for ART over the next two years, PEPFAR Namibia will provide targeted support (both technical assistance and DSD) to assist the MOHSS and private sector to reach and maintain on treatment 81% of all PLHIV.

PEPFAR Namibia will support 171 sites in the 18 high burden districts and eight hotspots for ART scale-up. PEPFAR Namibia will focus technical assistance on 31 existing high-volume ART sites accounting for more than 80% of ART patients and 32 functioning IMAI sites. PEPFAR will provide DSD support to decentralize ART expansion in 81 sites.

**Table 4.1.1 ART Targets in Scale-Up Districts for Epidemic Control\*†**

District	Scale-Up Category	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) TX_CURR	Newly initiated (APR FY17) TX_NEW	ART Coverage (APR 17)
Andara	Scale-Up Aggressive	3,366	2,780	566	2,780	361	83%
Eenhana	Scale-Up Aggressive	8,813	5,906	2,149	5,906	768	67%
Engela	Scale-Up Aggressive	16,428	9,842	4,371	10,554	1,991	60%
Katima Mulilo	Scale-Up Aggressive	14,772	11,983	2,647	11,983	1,558	81%
Ncomongoro	Scale-Up Aggressive	5,511	1,316	3,047	1,864	720	24%
Nkurenkuru	Scale-Up Aggressive	8,520	2,034	4,708	2,882	1,112	24%
Nyangana	Scale-Up Aggressive	2,508	2,249	0	2,249	292	90%
Okahao	ScaleUp Saturation	4,099	3,353	206	3,353	436	82%
Omuthiya	Scale-Up Aggressive	5,313	3,737	628	3,737	486	70%
Onandjokwe	ScaleUp Saturation	10,242	8,518	37	8,518	1,107	83%
Ondangwa	Scale-Up Aggressive	8,337	2,438	4,270	3,115	994	29%
Oshakati	ScaleUp Saturation	12,370	18,903	0	18,903	2,457	153%
Oshikuku	ScaleUp Saturation	11,006	9,087	716	9,087	1,181	83%
Outapi	ScaleUp Saturation	6,461	8,542	0	8,542	1,110	132%
Rundu	ScaleUp Saturation	7,241	11,153	0	11,153	1,450	154%
Tsandi	Scale-Up Aggressive	7,492	3,880	2,720	4,313	938	52%
Tsumeb	ScaleUp Saturation	3,026	3,120	0	3,120	406	103%
Windhoek	ScaleUp Saturation	36,283	33,518	0	33,518	4,357	92%
<b>Total</b>		<b>171,788</b>	<b>142,359</b>	<b>26,063</b>	<b>145,578</b>	<b>21,725</b>	<b>83%</b>

\*excluding hotspots

†Total PLHIV per district are modeled assuming equal distribution of HIV within each region. This may result in inaccurate PLHIV distribution. Additionally, internal labor migration and service to non-Namibians may increase people accessing care in some districts. This contributes to some districts achieving well over 100% coverage.

### *Entry Stream Target Setting Process and Assumptions*

To reach the enrollment goal of 25,685, PEPFAR will focus on the following entry stream modalities: clinical care patients not on ART (pre-ART); TB-HIV co-infected patients not on ART; HIV+ pregnant women; OVC testing; and HIV+ patients identified among priority and key populations.

HTS target estimation was based on prioritization of high volume (50% of MOHSS sites supported by PEPFAR during 2014) and high-yield sites (with 20 or more HIV+s identified during 2014). Of the total 330 MOHSS HTS sites in the country, 166 are in high burden regions and account for 85% of the HTS volume and approximately 80% of the HIV+ in 2016. During COP16, additional volume will be achieved by supporting MOHSS to scale up in-patient provider initiated testing and counselling (PITC) at high-volume district hospitals (10 in 2015 and 21 additional in 2016). In addition, 79 community-based HTS sites (stand-alone VCT sites, outreach sites, home-based targeted testing sites and the health extension workers) will target key populations, partners of index patients and OVC. These approaches will increase the volume of HTS and achieve increased yield and volume of HIV+s newly identified.

Based on the different HTS modalities, PEPFAR Namibia estimates that 289,218 people will need to be tested during FY17 under COP16 to achieve the goal of 25,685 newly enrolled on treatment.

A detailed description of the target calculations and accompanying assumptions for all programs is provided as a supplemental document to the data pack. A breakdown of ART entry streams and the expected number of newly initiated clients are shown in Table 4.1.2. PMTCT is a stream that is expected to enroll large numbers of individuals on ART. It is expected that approximately 11,856 HIV+ pregnant women will be identified through the national PMTCT program during FY17. Historical data indicates that approximately 50% of HIV+ pregnant women will already be receiving ART. PEPFAR Namibia will target 90% of the remaining newly identified HIV+ pregnant women to enroll on ART.

The TB program is expected to contribute significant numbers of HIV+ patients for ART enrollment. PEPFAR Namibia will enroll over 90% of newly identified TB/HIV co-infected patients on ART in line with national guidance. It is estimated that they constitute approximately 5% of the current number of patients on ART in the high-burden regions and districts. PEPFAR will target 50% of all TB with known HIV status (new/old) during COP16.

The remaining stream of entry to ART comprises PLHIV and other priority populations identified through different HTS modalities (Table 4.1.2). PEPFAR will enroll from PLHIV currently enrolled on pre-ART, increasing testing in in- and out-patient settings, and targeted community testing.

There is a significant gap in CHCT, as well as a need for identification of sero-discordant couples for timely linkage to HIV treatment services. Based on MOHSS reports (2010-2013), less than 4% of HTS adult clients receive CHCT, with similar trends observed in PMTCT. Approximately, 10% of couples tested in public health facilities are identified as discordant, while 85% are concordant negative and 5% concordant positive. Through scale-up of index-partner and CHCT, PEPFAR plans to increase this testing to about 15%, estimated at 30,000 clients tested as couples.

Based on current PMTCT data, an estimated 8,168 infants born to HIV+ mothers in PEPFAR supported areas will be tested during FY17 under COP16. Of these, 2.6% are expected to be HIV+ and will lead to approximately 200 infants under 1 year of age initiated on ART. PEPFAR Namibia will also increase the linkages between testing and OVC programs increasing the number of OVCs tested. In total, PEPFAR expects to enroll about 285 HIV+ OVC on ART under COP16.

**Table 4.1.2 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts**

Entry Streams for ART Enrollment	Tested for HIV (APR FY17)	Identified Positive (APR FY17)	Newly initiated (APR FY 17) TX_NEW
<b>Adults</b>			
Inpatient and outpatient testing (includes pediatrics)	109,081	7,993	7,194
Pre-ART	-	-	4,814
TB Patients	3,979	1,350	1,350
Pregnant Women	38,305	2,233	2,066
Other priority and key populations	22,456	2008	1807
<b>Pediatrics</b>			
HIV Exposed Infants	6,862	211	200
Orphans and Vulnerable Children	11,403	285	285
<b>Community</b>			
Home-based	55,519	4,454	4,009
<b>Total</b>	<b>247,605</b>	<b>18,534</b>	<b>21,725</b>

*VMMC Target Setting Process and Assumptions*

According to the NDHS 2013 report, only 25.5% of males aged 15-49 self-report being circumcised. PEPFAR Namibia will support DSD of VMMC to reach 80% MC coverage by 2017 in three districts and two hotspots (Table 4.1.3). In COP16, VMMC continues to target men aged 15-29. Since NDHS 2013 does not provide VMMC coverage estimates for the target age group, the current VMMC coverage estimate for males aged 15-49 was used to estimate circumcision coverage in each of the targeted districts and hotspots. To meet the 80% VMMC coverage goal by 2017, the projected APR16 coverages for each of the locations were used to calculate the number of VMMC procedures required.

**Table 4.1.3 VMMC Coverage and Targets by Age Bracket in Scale-up Districts**

Target Populations	Population Size Estimate (districts)	Current Coverage (in FY15)	VMMC_CIRC (in FY17)	Expected Coverage (in FY17)
Men, Ages 15-29				
Swakopmund	9,980	20%	3,986	39.9%
Walvis Bay	11,422	17%	4,446	38.9%
Zambezi	14,605	6%	5,503	37.7%
Windhoek	62,691	4%	12,508	20.0%
Oshakati	16,651	6%	8,293	49.8%
<b>Total/Average</b>	<b>115,349</b>		<b>34,736</b>	<b>30.1%</b>

### *Key and Priority Populations Target Setting Process and Assumptions*

Limited data are available for FSW, MSM, transgendered women and injecting drug users. The APR16 PEPFAR target for prevention services is set to achieve 90% coverage of FSW and MSM in six urban areas (Katima Mulilo, Oshakati, Oshikango, Windhoek, Walvis Bay, and Keetmanshoop) where the IBBS size estimation provides data and where PEPFAR activities are currently active. In COP 16, activities will provide training to health care workers in six areas of the country to sensitize them to their obligations and attitudes towards sex workers, other key populations and possible initiation on PrEP, as recommended by the PEPFAR Namibia 2016 Gender Analysis Report.

PEPFAR Namibia defines AGYW as a priority population. AGYW population size estimates are based on population projection estimates for 2016 using the 2011 census published by the NSA. Only scale-up districts are included. A national coverage target of 90% is defined in the NSF, 2010/11. PEPFAR recognizes the target and contributes approximately 45% coverage through multiple implementing mechanisms. Feedback from CSOs demanded for more adolescent-friendly facilities and more sensitivity training for health workers as stigma and unwelcoming attitudes were noted as a barrier to increased uptake of services for this age group.

<b>Target Populations</b>	<b>Population Size Estimate (scale-up SNU's)</b>	<b>Coverage Goal (in FY17)</b>	<b>FY17 Target</b>
AGYW	145,201	37%	54,000
MSM	3,026	29%	880
FSW	8,082	99%	8,000
<b>Total</b>	<b>156,309</b>		<b>62,880</b>

### *OVC and Pediatric Target Setting Process and Assumptions*

OVC targets include Children Living with HIV (CLHIV) age 0-15 and HIV-affected children [e.g. children of PLHIV including HIV Exposed Infants (HEI) or AIDS orphans]. The target for OVC served is based on the estimated number of orphans and vulnerable children from Spectrum (2015) and the number of orphans enumerated in the 2011 census. An anticipated 80% of OVC served will need specific HIV-based services within facilities and communities. These services include HTS, HIV prevention, psychosocial counseling for children affected by and infected with HIV, referrals to care and treatment, and support for ART adherence, retention and HIV disclosure.

Based on PEPFAR OVC program data, it is estimated that 47% of OVC being served have a known HIV status. OVC\_KNOWNSTAT is a subset of OVC\_SERV. During COP16, USAID will target 15,200 OVC\_SERV in high burden districts and will target OVC with unknown or undocumented OVC status to reach approximately 75% of active beneficiaries receiving support from PEPFAR OVC who should know their status. Of children newly diagnosed with HIV, 100% will be linked to care and treatment services. Peace Corps will target reaching 2,800 OVC served.

**Table 4.1.5 Targets for OVC and Linkages to HIV Services**

Focus SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY17 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target) OVC_KNOWNSTAT
Andara	811	598	448
Eenhana	2,264	374	281
Engela	4,220	1,601	501
Katima Mulilo	3,082	2,719	1,340
Ncomongoro	1,328	462	347
Nkurenkuru	2,053	480	360
Nyangana	604	1,537	453
Onandjokwe	2,978	989	742
Ondangwa	1,759	900	675
Oshakati	2,610	1,287	965
Oshikuku	2,590	765	574
Outapi	1,521	765	574
Rundu	1,745	1,426	1,070
Tsumeb	880	659	494
Windhoek	9,713	3,438	2,579
<b>TOTAL</b>	<b>38,158</b>	<b>18,000</b>	<b>11,403*</b>

\*75% of 15,200 for USAID OVC\_SERV target

#### 4.2. Priority Population Prevention

HIV prevalence among AGYW, a priority population, varies by region from 2.7% in Ohangwena to 19.2% in Zambezi among PEPFAR-supported regions. Spectrum estimates HIV incidence at 0.67/1000 among AGYW in comparison to 0.37/1000 among men in this same age group in 2016 (Spectrum 2016). Key populations – FSW and MSM - experience elevated HIV prevalence, based on unreleased MOHSS studies. Key populations continue to experience discrimination, harassment and stigma from society and self-report barriers to accessing health, HIV, social and legal services.

Namibia released a Combination HIV Prevention Strategy in 2015 focused on reducing new HIV infections by mobilizing populations to utilize essential interventions such as PMTCT, ART, VMMC, PEP and condoms. At the moment, national guidelines specify eligibility for pre-exposure prophylaxis (PrEP) among sero-discordant couples as associated with current/future pregnancy, but do not include other priority populations. To prevent new infections among priority and key populations in high burden areas, PEPFAR supports delivery of targeted risk reduction counseling, condom distribution, GBV activities and mobilization efforts to increase uptake of PMTCT, HTS, and VMMC. PEPFAR will support innovative models to pilot PrEP and deliver HIV care and treatment services to key populations through private and non-governmental HIV clinics and pharmacies. In addition, as recommended by the Gender Analysis report, COP 16 activities will increase AGYW access to all services in conducive environments without stigma and discrimination, ensure increased availability and involvement of adolescent girls and boys in ART adherence clubs, including building self-advocacy skills to enable them to serve as role models/spokespeople for other adolescents. PEPFAR



will assist MOHSS to integrate HIV services into the domestically-financed health extension program. In response to the Gender Assessment gender and sexual minority training will be provided to health service providers in six urban areas to sensitize them to their perceptions and practices towards sex workers and LGBTI.

PEPFAR will:

- Conduct social mobilization activities to improve utilization of HIV testing, PMTCT, VMMC and ART at the community level
- Support individualized risk reduction counseling, condom and lubricant distribution and HIV testing focusing on AGYW and key populations through clinic and community-based services
- Deploy community case management from key populations to engage their communities to find, test and link newly diagnosed HIV positive key populations to ART and support retention efforts for those already on ART
- Offer technical support and establish partnerships to expand the utilization of pre-exposure prophylaxis services for key populations and to expand utilization among sero-discordant couples through public and private clinics

Appendix A2 lists detailed activities.

#### 4.3 Voluntary Medical Male Circumcision

VMMC is a core component of PEPFAR's HIV prevention portfolio. Only 25.5% of the male population aged 15-49 self-report being circumcised. Early Infant Male Circumcisions (EIMC) and VMMC are not routinely offered in most health facilities.

The national strategy focuses on rapid scale-up of nurse-centered VMMC in eight high burden regions targeting 330,000 males aged 15-49 years. The national program is largely externally financed by PEPFAR and the GF. Program challenges to date include weak service demand among males 25 years and above despite favorable attitudes toward the service. MOHSS implements demand creation activities in conjunction with stakeholders. The GRN approved task-shifting to nurses in 2014 and continues to support nurse-centered procedures. Non-surgical devices are not currently in use and no country-specific implementation study has been conducted by MOHSS to date. However, the MOHSS has initiated preparations for conducting a pilot study for the PrePex® device and this is expected to be completed during FY17.

The VMMC program uses a mixed model of public and private health clinics and mobile sites. PEPFAR Namibia supports activities in six health districts (Katima Mulilo, Ondangwa, Oshakati, Swakopmund, Walvis Bay and Windhoek) in the public sector, and by private health practitioners in Windhoek. PEPFAR's VMMC activities are conducted in geographic alignment to the ART program. In FY17, about 34,736 MMC are required to achieve saturation among males aged 15-29 in these six districts. In FY15, 11,799 MC procedures were conducted and in FY16, PEPFAR's target is 26,099. Assistance will support service delivery, demand creation, quality assurance and M&E activities

The VMMC program has struggled to reach its intended targets in prior years. In FY15 the program achieved about 60% of the target of 16,500 procedures. During the implementation period however, there were very limited demand creation activities for VMMC. Furthermore, Ministry of Education

(MoE) policy limited access to in-school youth on school premises. The program also encountered implementation misalignment challenges related to separate implementing partners leading the demand creation and service delivery arms of the program. PEPFAR Namibia now has a single partner responsible for both the demand creation and service delivery arms of the program. This will ensure improved alignment of demand creation and service provision. PEPFAR Namibia has also enhanced accountability of implementing partners (IPs) to reach planned targets by putting in place a Performance Improvement Plan (PIP) for one of the largest IPs working with the public sector. This will challenge the IP to be more aggressive in pushing towards the attainment of planned results.

Moving forward however several changes have been put in place which are expected to positively impact demand for services. The MoE has now formally allowed the VMMC program access into school premises to mobilize school boys for VMMC during weekends and school holidays. The MOHSS supported through funding from the Global Fund has completed the development and formally launched a newly branded communication campaign for VMMC. The package includes materials which are now running in the print media and all the electronic media promoting VMMC. This is the first time that a fully-fledged media blitz promoting VMMC is running in Namibia. Dedicated national and regional demand creation personnel have now also been recently deployed to strengthen demand creation at all levels. Additional innovative demand creation approaches are also being implemented. The MOHSS with financial and technical support from PEPFAR is in the process of engaging a very popular and locally iconic music artist to act as an ambassador who will work to vigorously campaign and mobilize youths for VMMC services. Several modifications have also been introduced at facility level to maximize demand and program output including provision of services after hours and on weekends; ward-based recruitments, improved referrals and linkages between HIV testing services and VMMC services.

Alongside this effort is a private medical insurer's campaign for VMMC utilization among all members and dependents. With their own resources they have extended VMMC to clients who have insurance products but are not covered for surgical procedures with the intent of increasing utilization and reduced future costs. MOHSS and private sector demand creation is expected to increase volumes in 2016/17 significantly.

PEPFAR Namibia will support:

- Deployment of health care workers to implement VMMC services
- Provision of technical assistance in M&E, training, mentoring and quality improvement activities
- Partnering with the MOHSS, The Global Fund and private sector to coordinate demand creation and campaign activities
- Partnering with the private health sector to deliver VMMC services to insured and uninsured clients

Appendix A2 lists detailed activities.

#### 4.4 Preventing Mother-to-Child Transmission

PEPFAR Namibia has been supporting the GRN to scale up PMTCT, update its guidelines, and develop and implement an eMTCT action plan to reduce MTCT to less than 5% and increase EID to 95% by end of 2017. While the program has registered remarkable results, ongoing challenges include:

shortage of trained staff; inadequate mentorship; inconsistencies in quality of Option B+ and EID service delivery; lack of real-time data capturing and reporting tools for longitudinal monitoring from ANC to labor and delivery and the breastfeeding period; and weak linkages between facilities and communities for active follow up support during pregnancy and the breastfeeding period.

In COP16, PEPFAR Namibia will support critical health care providers and other health system improvements at primary health facility level through the treatment acceleration fund to resolve some of these challenges.

PEPFAR Namibia will also continue supporting the GRN to improve prevention and clinical outcomes by ensuring that all pregnant and breastfeeding women (PBFW), and HEIs at high-volume PMTCT sites are reached with early HIV testing and life-long ART (Option B+) if they are HIV+.

PEPFAR Namibia will support:

- Early and accurate maternal and infant case identification and initiation of life-long ART (Option B+) for all HIV+ PBFW
- Active follow-up and tracing using facility and community-based systems, including mother support groups and mobile health tools
- Improved mentorship and supervisory systems, including viral load monitoring and viral suppression of PBFW
- Standardized mother-baby follow-up care for HEI and EID
- Implementation of an integrated routine (including real-time) M&E systems and use of program data to improve the quality of PMTCT and EID
- Provision of appropriate messaging and health education to reduce HIV transmission to HEI during pregnancy and the breastfeeding period
- Implementation of prevention strategies to reduce HIV incidence among PBFW, including testing of male partners to identify sero-discordance and provide immediate ART/PrEP

#### 4.5 HIV Testing Services

HTS is provided through a mixture of public health facilities and non-governmental clinics, private providers and mobile/community-based services. As of 2013, 75.8% of adult Namibians (68.0% for men and 83.0% for women) aged 15–49 reported being tested at least once for HIV infection. In 2015, Namibia's HTS program tested 280,000 and diagnosed 17,360 persons. PEPFAR Namibia is supporting close to 80% of the overall HTS program in 161 testing sites. The national HIV testing yield was 6.7% - ranging from 4.0 % in CBHTS to 40.4 % in TB clinics (MOHSS, 2016). HIV test yield has generally been declining in Namibia over the last three to four years: the HIV+ rate among adults tested in public health facilities declined from 9.2% in 2011 to 7% in 2014. Cognizant of this trend and in a bid to increase the efficiency of PEPFAR support to the GRN, PEPFAR Namibia conducted an analysis of HTS volume and yield in 2014. Out of the 345 testing sites that were supported, 140 sites provided 85% of the test volume and close to 90% of the HIV+ tests. Based on this analysis, PEPFAR prioritized support to the 160 HTS sites in high burden regions and hotspots during COP15.

Namibia experiences gender and age disparity in HTS services. Facility HTS remains poorly accessed by OVC, adolescents, men, couples and key populations. PITC implementation is largely limited to TB, PMTCT, STI clinics and outpatient departments. Namibia domestically finances the majority of testing supplies and human resources; PEPFAR Namibia provides supplemental assistance in high

burden districts to contribute to the national response. As of April 2016, Namibia adopted a serial testing algorithm using WHO recommended test kits, which will partly alleviate the recurrent problem of stock-out of rapid HIV test kits in the country and reduce testing inefficiencies. PEPFAR Namibia will provide training and technical support to implement the rollout of the serial testing algorithm. Furthermore, Namibia is undertaking field validation of a second HIV testing algorithm to use with different HIV testing kits as an alternative to the primary one, should there be stock-outs in the future.

Community-based HTS is dependent on external assistance. While community-based HTS is necessary for hard-to-reach populations (such as men, couples, key populations, AGYW), achieving high testing yield continues to be a challenge. PEPFAR Namibia is working with CSOs to target high HIV burden communities in scale-up districts for HIV testing and shifting its strategy from door-to-door testing to targeted testing to increase test yield.

According to MOHSS program data, HIV testing uptake by men remains low and has continued to decline during the last 3 years despite high HIV test yield. To address this challenge, PEPFAR Namibia has devised innovative strategies to improve access and uptake of HTS among men, one of which is expansion of PITC in hospital wards and outpatient departments. Preliminary results of implementation in five hospitals indicated significant increase in the proportion of male clients and children under age 15 tested as well as a 40-50% increase in the HIV test yield. In COP16, PEPFAR Namibia will support the expansion of these services to all 34 hospitals in the country. Further, PEPFAR Namibia will implement and expand workplace testing, index partner testing, and flexible testing hours that are male-friendly (e.g. making testing available on Saturdays and evenings), as well as increase the number of male HIV testers.

PEPFAR Namibia's approach was guided by feedback from civil society organizations, who also noted the need for a reliable HTC monitoring and evaluation process at site level, better linkages to care and ART, and strengthening of PITC and community-level testing, including reaching more OVC.

PEPFAR Namibia will also support additional strategies that will increase the coverage and yield of HIV testing such as:

- Expanding HTS for children and OVC
- Implementing peer-driven interventions to increase the uptake of males and AGYW into HTS
- Integrating HTS into community case management activities for sex workers and LGBTI
- Assessing the role of HIV self-testing services to expand utilization among underserved groups
- Integrating HTS into the MOHSS Health Extension Program
- Developing partnerships with medical insurers, private clinicians and laboratories to promote early diagnosis and initiation on ART
- Strengthening supply chain forecasting and management processes at national and site-level

#### 4.6. Facility and Community Based Care and Support

The number of HIV+ clients either newly diagnosed as HIV+ and receiving pre-ART care, or provided with chronic care services is not properly documented. PEPFAR Namibia will provide targeted technical assistance in scale-up districts to increase ART initiation, linkage, adherence and retention

of patients in care and treatment using civil society organizations, expert patients, community volunteers and health extension workers.

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

- Start and stop cotrimoxazole and isoniazid (INH) prophylaxis
- Adherence counseling and TB symptom screening of PLHIV
- Bi-annual clinic visit and annual VL testing for stable patients
- In-service training to health care providers to improve continuum of care and quality of services
- Referral and linkage to community-based ART delivery points for stable patients

At the community level, PEPFAR will 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 targeted technical support to improve pediatric care and support by:

- Expanding the EID system and point of care (POC) testing for HEI
- Strengthening PMTCT-ART-care linkages and follow-up of mother-baby pairs to improve retention of HIV-infected children in care
- Supporting community cadres to track lost-to follow-up patients

#### 4.7. TB/HIV

According to WHO's 2015 Global TB report, Namibia has the fifth highest incidence of TB in the world. The most recent MOHSS TB program data (2015) reported 9,953 cases of TB, a slight increase from the 9,882 notified in 2014. This increase in the number of cases is primarily due to the improvement in diagnostics through the use of the latest technology for TB diagnosis such as GeneXpert. However, true prevalence of TB is not known as the program relies on case reporting, so it is unknown how many cases are going undetected. Drug-resistant tuberculosis TB (DR-TB) continues to be a significant challenge with 333 cases in 2015, also a slight increase from the previous year. In COP 16, PEPFAR/Namibia will address these challenges by:

- Providing technical assistance and funding lab services to support the first national TB disease prevalence survey in Namibia
- Scaling up infection control to reduce TB-associated morbidity and mortality
- Supporting regional and district training on programmatic management of DR-TB

TB/HIV coinfection continues to be a key challenge in Namibia. Program data from the TB program shows that the proportion of TB patients with documented HIV status has improved over the years to 95% and 92% of HIV+ TB patients have initiated ART; however, an evaluation done in 2015 to review uptake of ART among TB patients revealed that less than 60% of co-infected patients are documented as being on ART and most are not started on ART within 8 weeks as recommended by national guidelines. In COP 16 PEPFAR Namibia will improve these program indicators by:

- Scaling up HIV testing using a diversity of entry streams to ensure universal HIV testing for TB patients and persons with presumptive TB, as well as extended HTC to partners and family members

- Increasing the number of IMAI sites and integrating key HIV services such as testing and ART into dedicated TB platforms in high-burden settings
- Expansion of physical integration of TB and HIV clinical services in high-burden TB or HIV care settings

Intensified case finding (ICF) and referral to appropriate prevention or diagnostic services is critical to minimizing the burden of TB among HIV+ patients. In Namibia, challenges remain in effectively ensuring successful referrals between the various TB and HIV services using a cascade approach. In clinical care settings where TB/HIV services are not closely located, no clear patients fast tracking systems in place patients fail complete the full cascade. An assessment conducted at select facilities found that close to 20% of PLHIV (pre-ART/ART) were not screened for TB. Among those who were screened, 16% were referred for TB testing and 31% of those were initiated on TB treatment. For those in whom TB disease was excluded, only 45% were initiated on IPT, among whom 51% completed IPT. In COP 16, PEPFAR Namibia will address these gaps in ICF and IPT by:

- Improving referral of HIV+ patients to appropriate TB prevention or treatment services by expanding the cadres involved in TB screening and referral to ensure all patients receive comprehensive and integrated care across levels of services, including:
  - Supporting clinical and nurse mentors in the ART clinics to develop quality improvement projects focused on TB screening and assisted referral systems as well as IPT initiation and follow-up
  - Training lay cadres in TB screening and assisted referral systems in the ART clinics using the TB/HIV cascade approach, including recording of TB screening, referral, and prevention or treatment services.
  - Integrating services to provide one stop shops for essential TB and HIV services such as HIV testing and ART initiations with considerations of assisted referrals to laboratory and pharmaceutical services to prevent delays in patients joining long ques.
- Coordinating TB case finding in PLHIV in all high risk settings including ANC, adolescents, and key populations using a wide variety of implementation modalities
- Ensuring better documentation of IPT initiation and outcome through QI by the clinical and nurse mentors and integrated data reviews

Improving access to and quality of TB/HIV services is part of MoHSS's decentralization and off-loading strategy. TB services are already decentralized and integrated into primary health care. Loss to follow up, adherence and retention are additional challenges related to TB and HIV care and treatment. Furthermore, Namibia faces particular difficulties due to its sparse population and vast and rugged terrain, limiting patient access to facilities. The focus in COP 16 is to leverage the TB system for further ART decentralization to improve TB and HIV adherence through establishment of community-based TB care settings as well as incorporating HIV testing and care services to such settings. Specific activities for COP 16 that aim to improve ART and TB decentralization include:

- Increasing the number of IMAI sites and integrating key HIV services such as testing and ART into dedicated TB platforms in high-burden settings
- Expanding ART decentralization to sites having 30 or more TB patients

- Integrating models for TB and HIV care through a variety of TB/HIV treatment platforms including outreach, community and DOT points
- Supporting a coordinated and collaborative service delivery approach between the TB and HIV programs to achieve greater efficiency and reduced cost for stable patients to improve adherence and retention on ART, TB and IPT
- Supporting the GRN's adoption of WHO guidance on use of GeneXpert MTB/RIF to identify HIV+ TB patients and subsequent universal ART for all HIV+ TB patients

In addition to the above targeted interventions, systematic integration of TB and HIV services requires cross-cutting activities. In COP 16, PEPFAR/Namibia will also support integrated trainings for regional, district, and facility staff on national guidelines for TB and HIV care.

#### 4.8. Adult Treatment

PEPFAR Namibia will continue to support the GRN to attain UNAID's 90-90-90 goals, and to support the MoHSS to review, adopt and adapt the new WHO guidelines, including differentiated service delivery models (SDM) of care, the phased implementation of the Treat All approach, multi-month scripting, and community involvement in linkage, adherence, and retention.

The Ministerial Management Committee, the highest decision making body within the MOHSS late last year gave the green light to the adoption of the Treat All strategy and assigned the MOHSS technical team to work on the technical details and timeline towards implementation of the strategy. Subsequently, the MOHSS Treat All TWG set up a solid timeline towards adopting the Treat All strategy. This will begin with the first phase of implementation, involving 13 health facilities from three of the 14 regions in Namibia (Khomas, Ohangwena and Zambezi). These are three of the regions with the highest burden of disease and the largest treatment gaps, all located in the PEPFAR supported regions and carry an estimated 30% of the PEPFAR targets.

To date the MOHSS Treat All TWG has drafted an implementation plan, Standard Operating Procedures (SOPs) and finalized HCW training materials for facilities that will be involved in the first phase of the Treat All strategy. Training of health care workers in the 3 regions is scheduled for end of June 2016 and implementation is immediately planned to begin at the beginning of July 2016. The first phase will be evaluated after 9 months of implementation.

Parallel to this process however, beginning the month of June 2016, the GRN with support from PEPFAR, WHO and other stakeholders is also working on revising the national ART guidelines to align them with the WHO 2015 Consolidated Guidelines. The MOHSS plans to launch implementation of Treat All nationally (i.e. beyond the phase 1 facilities) immediately after the national ART guidelines have been finalized and formally launched. This is anticipated to occur during the last quarter of the 2016 calendar year.

In terms of PEPFAR contributions and impact on the process of moving towards Treat All, PEPFAR Namibia is actively supporting the GRN by:

- Providing salary support for technical staff seconded to the MOHSS who are involved with the guideline development and implementation of the Treat All strategy (clinical mentors, health facility staff, technical advisors)

- Providing logistical support for the technical working group supporting the planning of Treat All (conferencing, travel and logistical supplies)
- Technical assistance by USG staff in the drafting and review of protocols and guidelines
- Forecasting and Quantification of commodities such as RTKs and ARVs for the program including those that will be required for Treat All
- Providing emergency procurement of commodities such as RTKs and ARVs

Under COP16, PEPFAR Namibia will support the GRN to increase the number of adults linked and newly initiated on ART by:

- Providing salary support for technical staff seconded to the MOHSS who are involved with the guideline development and implementation of the Treat All strategy (clinical mentors, health facility staff, technical advisors)
- Providing logistical support for the technical working group supporting the planning of Treat All (conferencing, travel and logistical supplies)
- Providing technical assistance by USG staff in the drafting and review of protocols and guidelines
- Forecasting and quantifying commodities such as RTKs and ARVs for the program including those that will be required for Treat All
- Providing emergency procurement of commodities such as RTKs and ARVs

The GRN with support from PEPFAR and other stakeholders is also planning to start revising the national ART guidelines to align them with the WHO 2015 Consolidated Guidelines during the month of June 2016. PEPFAR will provide direct technical assistance in the guideline review process and indirectly through funding provided to the WHO Country Office which will provide technical and logistical support to the guideline review process.

Under COP16, PEPFAR Namibia will support the GRN to increase the number of adults linked and newly initiated on ART by:

- Supporting direct service delivery for PLHIV related to linkage, adherence, retention, and clinical monitoring at facility and community level in scale-up districts
- Building the capacity of the laboratory network to improve access to VL services and timely return of laboratory results to providers
- Providing in-service training for clinicians and other providers on ART and OI screening and treatment
- Continuing the phased implementation of Treat All strategies in three regions
- Working with the GRN to develop a scale up plan for a differentiated SDM

In addition, PEPFAR Namibia will continue to contribute to the saturation of ART in scale-up districts by supporting the GRN to decentralize services from over-burdened, high-volume sites to lower-level facilities and community-care groups through task shifting. PEPFAR Namibia will support the phased implementation of customized models of community-based ART service delivery. This support will include procurement of pre-fabricated containers that will be placed at community-ART service points in some high volume districts where infrastructure is limited. Preliminary evidence from some districts which have started implementing the community-based ART model have demonstrated high levels of retention and viral load suppression among patients enrolled in the



programs. Moving ahead, PEPFAR Namibia will provide TA to implement demonstration projects for additional community-based ART delivery models. The proposed new models will initially target stable ART patients on treatment for at least one year with at least two most recent successive suppressed viral load results.

PEPFAR Namibia will continue helping to build health care worker (HCW) capacity to provide quality HIV care in targeted decentralized facilities through didactic targeted in-service training and the clinical mentoring program by hiring medical and nurse clinical mentors.

Through the Acceleration Plan, PEPFAR Namibia will continue providing time-limited HRH support for DSD in sites with existing vacancies and conduct minimal space modifications at some clinical sites to enable them to provide ART services. PEPFAR Namibia will also provide time-limited technical assistance to build HCW capacity in continuous quality improvement (CQI) through collaborative QI initiatives to ensure quality of care and improve operational efficiency. This will ensure that several health facilities will jointly target key quality gaps (e.g., viral load suppression), learning from each other to rapidly implement QI changes in clinical practice within their individual facilities. Promotion of adherence and retention in care will be supported through technical assistance to strengthen supply chain management (ARV selection, quantification and forecasting) and ensure the use of electronic dispensing tool (EDT) at all facilities dispensing ARVs. PEPFAR will support the roll out of the electronic stock card (e-card) to strengthen real-time tracking facility-level commodity stocks and allowing more timely and accurate stock management. In addition deployment of SMS reminders for adherence support through the EDT will be expanded.

Three months scripting is the standard in Namibia; multi-month dispensing is practiced but currently not a national standard. With the planned revision of the current guideline, PEPFAR Namibia will support the GRN to standardize both multi-month scripting and dispensing as a strategy of decongesting health facilities, and decreasing associated patient travel and treatment cost. The exact standardized duration of multi-month scripting (3-6 months) will however be finalized in consultations with the GRN and other stakeholders. In COP16, laboratory access will be expanded at the point of care (e.g., VL specimen collection through DBS) and capacity of laboratory networks, especially for VL testing will be further strengthened, facilitating linkage to care, early ART initiation and timely monitoring of ART clinical outcomes.

PEPFAR Namibia will also work with the GRN as guidelines are being revised and support the differentiated SDM of care at selected facilities in scale-up districts that will be adapted to address specific needs of subgroups of clients. The differentiated SDM will take into account the key cost drivers to either a specific population, or increase in the scale of service delivery, yet reduce cost to enable efficient scale-up. In COP16, PEPFAR Namibia will consider supporting differentiation using the following categories: (1) Provider: “Task-shifting” from doctors and nurses, towards alternative cadres of community health care workers; (2) Location: Shifting from hospitals and clinics towards community-based treatment or drug delivery points; (3) Frequency: decreasing clinic visit intervals for stable treated populations and increasing frequency of clinic visits for unstable patients presenting with opportunistic infections (OI) or history of poor adherence; and (4) Intensity: considering an alternative models of treatment or pharmacy visits to the clinic or community center to provide an alternative models of adherence support for stable patients. The table below is intended to provide an overview of the PEPFAR Namibia’s differentiated SDM.

**Table 4.8.1 PEPFAR Namibia’s Differentiated Service Delivery Model (SDM)**

	<b>Current SDM</b>	<b>Stable Client* SDM</b>	
Visits	4 Clinical assessment and refill visits	1 Clinical assessment	1-3 multi-month refills by peer group)
Provider	<b>Nurse or medical officer</b>	<b>Nurse or medical officer</b>	<b>Expert client, CSO, HEW,CHV, Social workers, dispenser, client-led groups, and TB field promoters</b>
Services	<ul style="list-style-type: none"> <li>• ARV and CTX</li> <li>• Nutrition monitoring</li> <li>• TB screening</li> <li>• Adherence support (enhanced)</li> <li>• Client tracking and M&amp;E</li> <li>• STI and OI screening and treatment(Rx)</li> </ul>	<ul style="list-style-type: none"> <li>• ARV and CTX</li> <li>• Nutrition monitoring</li> <li>• TB screening</li> <li>• Adherence support</li> <li>• Client tracking and M&amp;E</li> <li>• STI and OI screening &amp; Rx</li> </ul>	<ul style="list-style-type: none"> <li>• ARV,CTX, and FP refill</li> <li>• TB screening</li> <li>• Adherence support</li> <li>• Client tracking and M&amp;E</li> <li>• Lab specimen collection</li> <li>• Bi-directional referral pathway</li> </ul>
Lab testing	<b>Baseline CD4,Hb and CrAg for CD4&lt;100 (for new clients) Annual viral load</b>	<b>Annual viral load, annual urine protein dipstick analysis</b>	

\* Stable Client- an adult patient who was on treatment at least for one year, without an advanced disease and OI and ARV toxicity, and responding for treatment

#### 4.9 Pediatric Treatment

PEPFAR Namibia supported the GRN’s roll-out of updated national ART guidelines that included expansion of eligibility and initiation of treatment to all CLHIV under 15 years, regardless of CD4 count or clinical staging. Since the change in guidelines, ART coverage among pediatrics has increased, but challenges in the pediatric treatment program remain. These include lower levels of viral load suppression (72%) as compared to adults (87%), limited service-delivery options as children are still primarily enrolled and managed at large health centers and district hospitals, and weak linkage of pediatric treatment program with OVC and PMTCT/EID services. Additionally, pediatric disclosure tools and adolescent/teen clubs are not available everywhere.

In COP16, PEPFAR Namibia will continue its targeted assistance to high burden regions and sites in Namibia to improve pediatric treatment services by:

- Ensuring linkages to HIV care and treatment for all CLHIV through decentralization of ART services
- Promoting pediatric case finding and expanding clinical laboratory monitoring of children and adolescents on treatment
- Integrating pediatric HIV treatment services into maternal newborn and child health and GRN-led Health Extension Program to reduce loss to follow up and improve long-term outcomes
- Delivering in-service training to providers on the monitoring, supervision, documenting and provision of pediatric HIV services
- Supporting clinical mentorship, mobile health technology for data capture and retention, and community volunteers to improve adherence and retention in treatment

- Engaging HIV+ adolescents to better understand their challenges and unique needs in order to improve treatment support

#### 4.10 Orphans and Vulnerable Children (OVC)

Spectrum (2015) estimates 109,737 OVC are a result of HIV in Namibia, with about 38,158 in the highest HIV prevalence and burden areas where USG implements OVC activities. PEPFAR Namibia's current OVC activities support 16,069 OVC in 22 sites in areas of highest prevalence. It is estimated that 47% of OVC being served know their HIV status. PEPFAR Namibia made pivots to align activities to high-burden regions based on epidemiologic data, shifting focus to high-burden/high-volume sites. Some activities in non-high-burden regions were transitioned, while others will be transitioned by end of FY16. The OVC program pivoted to ensure HIV testing for children and caregivers by strengthening linkages to child health and HIV services. The PEPFAR OVC program directly aligns with: the highest HIV burden areas in Namibia; areas with greatest unmet need for pediatric care, treatment and prevention programs for AGYW; and the MOHSS health extension and community based health care program.

PEPFAR Namibia will continue to support partners and the GRN to implement case management to address comprehensive needs of children, caregivers and/ or families. Through 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, and targeted support to keep at-risk AGYW and OVC in school. PEPFAR Namibia will implement prevention activities for HIV-negative AYGW and OVC. For at-risk and or HIV+ AYGW and OVC, PEPFAR Namibia will support adolescent-friendly sexual and reproductive health services, and referral to health services (including post-violence care.). Based on recommendations from civil society engagement consultations, OVC activities will continue to build care giver awareness of available resources and services and of the benefits of testing and treatment. CSO feedback also affirmed COP16 plans for longitudinal follow-up of children and caregivers to ensure access to comprehensive services, including non-HIV services. CSOs also indicated that it is important to utilize community health extension workers and other community volunteers/structures to identify and refer OVC to services; for OVC activities to improve linkages with adult treatment support groups in order to identify OVC and better support beneficiaries; and finally for improved 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 COP16. By the end of FY17, it is expected that 15% will age out from the OVC program in Namibia.

#### 4.11 Peace Corps

Volunteers will be placed in the high HIV burden regions of Kavango, Ohangwena and Zambezi. They will continue to work under the auspices of health facilities but will shift from predominantly facility-based to community-based activities, targeting youth aged 15-19 with testing, adherence support,

and links to care and PMTCT services. In FY17 (COP16), 23 PEPFAR-funded volunteers will be assigned to this program, using a three-pronged approach of collaborating with health extension workers, educators at schools, and community-based counterparts.

The volunteers will work with OVCs and caregivers at different community intervention points in the high-burden sites. They will conduct a comprehensive assessment of youth friendly services in their communities. Peace Corps is transitioning out of non-high burden districts and will complete the transition by June 2017.

## 5.0 Program Activities in Sustained Support Locations and Populations

### 5.1 Package of Services in Sustained Support Locations and Populations

PEPFAR Namibia began transitioning the OVC program in “sustained” supported areas during COP15 and it is expected that the remaining Peace Corps OVC program in these SNU’s will be transitioned by FY16. In COP16, Peace Corps Volunteers will continue to work with counterparts in the sustained areas to strengthen their capacity to identify and link OVC to HIV services, provide adherence support and provide life skills training for youth.

In areas where transition has taken place, an analysis of the OVC program was conducted to determine beneficiaries of high vulnerability to ensure that transition/end of services did not jeopardize their safety and wellbeing. OVC and care givers in transitioned SNU’s completed a household economic strengthening program (Village Saving Groups) over nine months and the groups were then graduated. PEPFAR facilitated linkages to government services, including social welfare grants and registrations to national documents to be able to access government services. In addition, care givers trained in income generation will sustain their income generating projects to mitigate the impact of HIV/AIDS on their families.

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

Sustained Support Volume by Group	Expected result APR 16	Expected result APR 17	Percent increase (decrease)
HIV testing in PMTCT sites	10,159	9,104	-10%
HTS (only maintenance ART sites in FY 17)	30,390	32,423	7%
Current on ART	30,462	30,462	0%
OVC	1,629	0	-100%

### 5.2. Transition Plans for Redirecting PEPFAR Support to Scale-Up Locations and Populations

This section is not applicable to PEPFAR Namibia. The PEPFAR Namibia supported activities outside of priority areas and populations have already transitioned or have come to a close. This also includes transition of procurement of commodities and lab consumables, except in emergency situations, and HRH support in lower-burden districts. These resources have been redirected to support 'Test and Start' activities to scale-up to ART saturation in the highest burden, greatest need districts. The transition of Peace Corps' OVC program will be completed in FY16.

## 6.0 Program Support Necessary to Achieve Sustained Epidemic Control

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The PEPFAR Namibia team reviewed their key programmatic gaps in attaining the 90:90:90 targets and agreed on the following:

For the first 90 related to testing it was noted that current testing models have plateaued with low numbers of HIV+ identified in the scale-up districts and with low uptake of testing amongst men, adolescents, girls and young women.

Key systems barrier are:

- An inadequate supply chain system for HIV testing kits with stock-out of HIV test kits witnessed at several public facilities and community based testing locales. This is largely due to a new testing algorithm creating forecasting difficulties for commodities as well as an inefficient tendering process.
- HRH shortages at hospitals and clinics with health worker overload resulting in an inability to provide HIV testing to all patients regardless of condition. In addition job descriptions for nurses do not include HIV testing and therefore nurses are reluctant to carry out testing.
- Limited service delivery models that result in lack of availability of HIV testing during non-traditional hours; no follow-up of male partners of HIV positive ANC clients; limited implementation of PITC opt-out policy in all public health facilities; and, lack of targeted HIV testing at the workplace and in the community.
- M&E gaps in data collection and reporting as evidenced by the M&E system only able to report on number of tests done rather than number of uniquely identifiable individuals tested.

For the second 90 related to ART it was noted that there was low treatment coverage in the scale-up districts.

Key systems barriers are:

- Inadequate infrastructure and saturation at existing ART sites as evidenced by lack of space to accommodate expanded ART services.
- HRH shortages, particularly a shortage of nurses and other health care workers to take over decentralized ART treatment.
- Limited service delivery models able to respond to patient reality e.g. long distances to health facilities, cost, the need to provide child care when attending the clinics and long queues at health facilities.
- M&E gaps including poor decentralization of the M&E system to the NIMART sites and limited quality and completeness of ART data.
- Feedback from civil society organizations identified the need for more outreach teams, patient support groups for ART pick-up, better integration of TB/HIV and other services,

better use of HEW and index cases, as was additional training and supervision for health staff involved with ART initiation.

For the third 90 related to viral load suppression there is a need to scale up and sustain services. This is evidenced by data indicating limited access to HIV viral load testing and issues with viral load data quality. The HIV viral load coverage (estimated % of ART patients eligible for viral load testing who actually received the test) stands at 71% nationally but is as low as 23% in some districts.

Key systems barriers are:

- Service delivery issues, including an absence of IEC material on the importance of viral load testing; limited knowledge by health care workers at lower health facility levels on viral load results use and subsequent management; and low viral load literacy amongst patients and providers and a high number of patients that are lost to follow-up. In addition, the fragmented service delivery approach is not responsive to client needs and there are still unaddressed issues of substance abuse and lack of food that impinge on adherence. Civil society organizations provided feedback on the need for improved patient identification, reliable case monitoring, and improved patient literacy on viral load results.
- Laboratory issues. Key amongst these include lack of a standard specimens' transport system; limited decentralization of viral load testing; dried blood spot not used to collect specimens; and the inability to disaggregate viral load results by patient.

Table 6.1.1 Key Programmatic Gap #1: Plateauing of current testing models in the scale-up districts							
Key Systems Barrier	Outcomes expected after 3 years of investment	Milestone by APR17	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Inadequate supply chain management for HIV Testing Kits	Facility reporting stock-out of RTKs reduced to less than 10%.	<ul style="list-style-type: none"> <li>RTKs stock status included in LMIS reporting system.</li> <li>Accurate RTK forecasting and quantification occurs annually and is reviewed every quarter to inform procurement.</li> <li>Facility reporting stock-out of RTKs reduced to 30%. (Baseline 60%).</li> </ul>	TA to national supply chain	OHSS	\$150,000	GHCSF	8. Commodity Security and supply chain
			Hiring pharmacy assistants (site level)	OHSS	\$579,00*	UTAP, Potentia, MoHSS	
HRH issues	75% of health providers in scale up districts are able to do rapid HIV testing.	1,000 health workers trained and certified in Rapid HIV testing.	Training of HCWs in rapid HIV testing.	HTXS, HVCT	\$200,000	UTAP, Potentia, MoHSS, ITECH, TBD/CBC	7. Human Resources for Health
			Hiring of 100 counselors & health assistants to provide HTC		\$1,000,000*		
Limited diversity of service delivery models	100% of health facilities in the scale-up districts conduct PITC.	No. of health facilities implementing routine PITC – 80% (from 60% baseline in 160 PEPFAR supported sites).	Health worker, management and community sensitization on PITC	HVCT	\$650,000	UTAP, KNCV, MOHSS, ITECH, TBD/CBC	6. Service delivery
			Training of all health workers and dissemination of SOPs				

Table 6.1.1 Key Programmatic Gap #1: Plateauing of current testing models in the scale-up districts							
Key Systems Barrier	Outcomes expected after 3 years of investment	Milestone by APR17	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Gaps in data collection and reporting (M&E)	Fully integrated HTS data with other health information systems.	100% of PEPFAR supported high volume testing sites will report using integrated HTS/ART (DHIS2) system.	Hiring 70 additional data clerks	SI	\$839,000*	UTAP, MOHSS, TBD/CBC, Potentia	15. Performance data
			Regular data quality audits	SI	\$75,000	MOHSS, UTAP	
			Support activities on data integration - HIV testing data integrated with other health information systems.	SI	\$35,000	UTAP, MOHSS, TBD/CBC	
<b>TOTAL</b>					\$3,528,000		

\*Highlighted figures represent Acceleration funds

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	Milestones by APR17	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Inadequate infrastructure including saturation of existing ART sites	Improved infrastructure at 80 health facilities to enable ART services.	40 sites with improved infrastructure.	Minor modification, Prefabs and rollout of DOTS containers	HTXS, PDTX	\$365,000*	MOHSS, ITECH, UTAP, KNCV	6. Service delivery
	Implement differentiated ART service delivery model in scale-up districts.	<ul style="list-style-type: none"> <li>Differentiation criteria established.</li> <li>Basic package defined.</li> <li>Pilot conducted.</li> <li>25 high volume sites implementing differentiated service</li> </ul>	Redesign and implementation of differentiated service delivery model that seeks to minimize visits by “stable” ART clients (differentiated service model) in pilot sites.	HTXS PDTX	\$250,000		



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	Milestones by APR17	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
		delivery model – covering 2 districts.					
HRH shortages	100% of Health Centres/clinics are NIMART sites in scale up districts.	<ul style="list-style-type: none"> <li>150 Nurses trained and proficient on NIMART.</li> <li>63 NIMART sites established.</li> </ul>	Hiring enrolled and registered nurses (200)	HTXS PDTX	\$4,800,000*	MOHSS, ITECH, UTAP	7. Human Resources for Health
			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
M&E system	Data capturing and timely reporting from all ART sites increased to 95%.	<ul style="list-style-type: none"> <li>90% of sites reporting in a timely manner.</li> </ul>	Hiring data clerks* (repeat activity)	HTXS, PDTX, OHSS, HVSI	\$839,000*	MOHSS, UTAP, ITECH, Potentia, MCSP	15. Performance Data
			Implementing mobile data collection		\$150,000		
	All HIV data management systems fully integrated.	80% of PEPFAR supported ART sites will report using integrated HTS/ART (DHIS2) system.	Improved data system interoperability and integration* (repeat activity but additional 25 data clerks to be hired under this ACTIVITY)		\$500,000		
<b>TOTAL</b>					<b>\$7,639,000</b>		

\*Highlighted figures represent Acceleration funds

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	Milestones by APR17	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Service delivery issues	95% of HCWs trained and competent in HIV VL results management in ART sites.	150 HCWs trained on VL results management.	Review of training curricula to address VL management	HBHC, PDCS, HTXS/PDTX	\$15,000	MOHSS, ITECH,EGPAF TBD/CBC, ARP, HRSA/HEALTHQUAL	6.Service Delivery
			Support community based activities to improve linkage, retention and adherence to treatment		\$250,000		
			Hiring and training of community health workers (repeat activity)		\$1,000,000*		
			Build capacity for systemic use of site level CQI using collaboratives		\$300,000		
	Reduce 12 month LTFU to less than 10% of patients.	90% of patients retained in HIV care after 12 months in PEPFAR	Training and development of SOPs for linkage, retention, adherence monitoring and tracking of LTFU patients	HBHC, PDCS	\$475,000	MOHSS, ITECH, EGPAF,UTAP, TBD/CBC, ARP, KNCV	
Laboratory issues	All patients have access to HIV VL testing	<ul style="list-style-type: none"> <li>Validation of DBS for VL testing completed – a once off.</li> <li>Logistics system for specimen collection in place – once off.</li> <li>85% of ART patients in scale up districts have routine VL (baseline 71%).</li> </ul>	Strengthen specimen transport	HLAB	\$50,000	NIP	10. Laboratory
			Introduce DBS for VL	HLAB	\$20,000	NIP	
			Increase lab capacity for VL testing	HLAB	\$100,000	NIP	

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	Milestones by APR17	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
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.	Align NIP patient level unique identifier with ePMS and EDT at site level (part of creating interoperability)	SI, HTXS	\$75,000	UTAP, SIAPS, MOHSS, NIP	15. Performance data
<b>TOTAL</b>					<b>\$2,285,000</b>		

\*Highlighted figures represent Acceleration funds

TEST and START

Table 6.2.1 Test and Start( T and S)

Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones by APR 17	Proposed COP/ROP <sup>16</sup>	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	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 Approved national guidelines for Treat All Full national scale up by March 2017.	Support MoHSS to review, adopt and adapt the new WHO guidelines, including differential models of care, multi-month scripting, and community-based refill	OHSS	300,000	17531(Intra) ITECH, MoHSS-	2. Policies and Governance
			Support training and task-shifting, mentorship and supervision	HTXS	600,000*	17531(Intra)and ITEC, MoHSS	2. Policies and Governance
			Scale-up the phased implementation of Treat All in scale-up districts	HTXS	1,000,000*	17531(Intra), ITECH MoHSS	6. Service delivery
Weak supply Chain Management system	Facility reporting stock-out of ART reduced to less than 10%  Completion of costing of clinical pathways for use by the MOHSS.	Roll out LMIS to all ART clinics  Develop draft of costing model for circulation among partners	Provide TA to MoHSS to quantify, forecast and distribute RTKs and ARVs for T and S and Differentiated	HTS	500,000	USAID/SIAPS	8. Supply Chain
			Procure emergency RTKs and ARVs to stop the gap in the scale-up districts	HTXD	1,900,000*	USAID/Chem onics	8. Supply chain
			Conduct a national costing model for HIV treatment taking into account Treat All and clinical pathways	OHSS	300,000	Interagency lead by CDC	8. Supply chain
<b>TOTAL</b>					4,600,000		

\*Highlighted figures represent Acceleration funds

NEW SERVICE DELIVERY MODELS

Table 6.2.2 New and efficient service delivery models							
Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones by APR17	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	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	<ul style="list-style-type: none"> <li>National guidelines updated to include specific language addressing the CHCW cadre role in</li> </ul>	Advocacy to update the guideline per SDM with CHCW	OHSS	200,000	ITECH/MoHSS and 17351/Intra	2.Policies and Governance
			Train adequate HCW on new SDM	HTXS	700,000	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	Expand mobile EDT	HVSI	200,000	SIAPS	15.Strategic Information
Weak integration of SDM to other programs	Full integration of the various categories of SDM  Complete evaluation of SDM and scale-up nationally	Conduct at least 1 training in each district per new SDM guidelines  Submit the SDM evaluation protocol for	Train program managers and districts to integrate SDM with management supervision	HTXS	400,000	ITECH/MoHSS -17531/Intra	6.Service Delivery
			Evaluate the differentiated SDM of care	OHSS	100,000	Interagency CDC/USAID	15.Strategic Information
<b>TOTAL</b>					1,600,000		

### 6.3 Proposed Systems Investments outside of Programmatic Gaps and Priority Policies

Table 6.3 Other Proposed Systems Investments							
Systems Category* (only complete for categories relevant to country context)	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	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
<b>Finance</b>							
Expenditure tracking, costing/cost modeling	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.	300,000	OHSS	HFG	12. Technical and Allocative Efficiencies
<b>Laboratory</b>							
Implementation and evaluation of diagnostics (POC and VL monitoring)	Implement RTQII	3) Third 90	All patients have access to HIV monitoring tests including VL	50,000	HLAB	NIP	10. Laboratory
	Implement POCT QA system			50,000	HLAB	NIP	10. Laboratory
<b>Strategic Information</b>							
Improved SI systems	Enhanced Primary health care level data for HIV services	4) Sustained Epi control	Data capturing and timely reporting from all ART sites increased to 95%.	100,000	SI	HISP, UCSF	15. Performance Data
Improved SI systems	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.	200,000	SI	JHPIEGO, MSH, IntraHealth	15. Performance Data
<b>TOTAL</b>				<b>800,000</b>			

\*Reference Appendix C for a list of activity types that fit in each category.

## 7.0 Staffing Plan

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### 7.1 Analysis of Staffing Footprint

As a result of the COP14 pivot, PEPFAR Namibia has been focusing on epidemic control since COP15. COP16 staffing continues to align with PEPFAR Namibia's strategic decision to focus on achieving epidemic control in the highest-burden areas of the country.

PEPFAR Namibia promotes LES empowerment and leadership roles, for example, the CDC field team is headed by an LE Staff member and LE Staff members serve on different interagency committees. PEPFAR Namibia has ensured an appropriate balance between technical assistance and partner management to cover program coordination, stakeholder engagement, and reporting. Points of contact have been identified in USAID to address cross-cutting issues, including gender and environment.

PEPFAR Namibia works through interagency technical teams to ensure quality technical implementation and coordination of activities across all agencies. PEPFAR Namibia holds regular interagency meetings at various levels to discuss business procedures, partner coordination and technical roles. Technical staff members also meet independently with their counterparts across agencies to discuss program management and best practices, as needed.

Both USAID and CDC repurposed several positions and aligned staff with team leads for better coordination.

#### USAID

- Conducted a revalidation exercise and position descriptions were reviewed in order to align them with pivot goals and to maximize effectiveness and efficiencies. The revalidation exercise ensured that the split between PEPFAR-funded and OE-funded positions accurately reflected the level of effort (LOE) dedicated to PEPFAR.
- Three vacant OE-funded positions and four vacant PEPFAR-funded positions were deleted, decreasing the USAID staffing footprint by seven positions.
- One deleted position, the OVC advisor, has been consolidated with the existing Care & Support Advisor, as the portfolio of care, support and OVC has natural alignment and synergies.
- The SI Team Leader position was changed from a Global Health Fellows Program II (GFHP-II) position to a US/TCN PSC position.
- In total, there are now 33 USAID/Namibia positions: 4 USDH, 5 US/TCN PSC, and 24 FSN.

#### CDC

- The Field Epidemiology position was repurposed to an LES position (Health Policy Communications) that will play a vital role in coordinating and communicating activities within the Agency, the MOHSS, and the interagency as well as with the regional office staff.
- The Deputy of Programs position was repurposed to a Medical Officer TB/HIV which will improve the collaboration between HIV and TB services, improve initiation of TB patients on ARV and improve patient care.
- The HIV Counselling and Testing position was repurposed to Prevention Advisor. This position will look widely at combination prevention and not be only specific to HCT. This serves to better address the programmatic requirements of the first 90 for HCT scale-up, key populations, bio-medical

prevention programs, linkage to care, treatment as prevention and other related prevention activities.

- CDC has three field offices located in some of the high HIV burden regions of the country of which all the field officer and driver positions have been filled. These field officers also cover the nearby regions as they are in close proximity. SIMS visits are aligned with geographic prioritization.

The PEPFAR Coordinator's Office through State Department is increasing the number of FTE's from four (Coordinator, Deputy Coordinator, Small Grants/Communications Specialist and Health Assistant) to five, to include a full-time SI Liaison. This position was included prior to COP15. The headquarters POART team specifically requested that we add this position back into our staffing configuration and we agree that it is very much needed. The PEPFAR Coordinator's Office also hopes to recruit a third year Peace Corps Volunteer to be located in the North to assist with CSO engagement.

## 7.2 SIMS

All PEPFAR technical staff members have LOE dedicated to SIMS visits. CDC has opened two more offices in additional high HIV burden regions and all the field officer positions have been filled. These field officers will support the improvement of service quality, conduct quality assurance at these sites, provide technical assistance to the facilities, and conduct SIMS visits in addition to technical staff at the head office.

USAID/Namibia calculates that, when fully staffed, each team member will dedicate five days per quarter to SIMS visits. Three Quality Assurance/Quality Improvement (QA/QI) Field Officers (approved in COP15) will be co-located with CDC field offices and be responsible for monitoring site performance. The QA/QI team will be integral in coordinating and executing SIMS requirements, analysis of results, post-SIMS follow up and addressing quality assurance and improvement efforts to achieve epidemic control in Namibia.

## 7.3. Vacant Positions

PEPFAR Namibia was unable in the past to fill numerous local hire vacancies due to a non-competitive salary structure. This changed in late 2015 when Embassy Windhoek successfully negotiated a more comparable local compensation plan for LES positions, greatly increasing the attractiveness of advertised USG positions to local, qualified candidates. CDC and USAID are working to fill these local positions.

USAID has 11 positions vacant for more than six months, all of which are in the stages of recruitment. USAID/Namibia expects near or full staffing by November 2016. All positions currently align with the PEPFAR business model and Namibia country program priorities.

CDC has two vacancies that exceed six months. The Prevention Advisor position was advertised twice locally without any success as no qualified staff were able to apply. Despite the salary increase that was implemented in 2015, the offered salary still fails to attract qualified individuals. The second vacant position was submitted for classification as it was repurposed from Deputy of Programs to Medical Officer TB/HIV. The intention is to advertise the two positions as Third Country National positions.

The PEPFAR Coordinator's Office has two vacant positions, the PEPFAR Country Coordinator and the Small Grants/Communications Specialist. The Coordinator position was posted through the USAID PSC mechanism and candidates have been interviewed, and we expect to fill this position soon. The Small Grants/Communications position has been posted and resumes have been received. We anticipate filling this position within the next several months.



For PEPFAR Namibia, there are no new positions for COP16. Certain positions were repurposed and others deleted in COP16.

#### 7.4 Cost of Doing Business

Overall, the cost of doing business (CODB) for USAID/Namibia has increased by 65% for COP16 (when compared to FY2015 actual outlay) due to several factors. COP16 requests include costs for positions that were vacant in FY15 and thus incurred no expenses. In addition, the local compensation plan is being revised and a percentage increase for salaries and benefits has been factored into COP16 requests.

The CODB for CDC remains relatively stable due to favorable exchange rates. There are no major changes to staffing and some of the activities, e.g., relocation and recruitment, were accounted for in COP15. Changes in the CODB are reflected in the CODB data tab of the Financial Supplement Worksheet.

## APPENDIX A: Core, Near-Core and Non-Core Matrix

Table A.1 Goals per Program Core, Near-Core, and Non-Core Activities for COP 16			
Level of Implementation	Core Activities	Near-Core Activities	Non-Core Activities
<b>Site level</b>	Pivot assistance to high burden districts and sites, scale-up SNUs and sites to increase HTC yield and ART enrolment to achieve 80% coverage	Target assistance for AGYW to receive integrated clinical HIV prevention, care and treatment services in high burden districts	Conduct school-based OVC activities  TB/HIV commodity procurement
	Accelerate identification and diagnosis of HIV+ people through intensified and expanded HTC modalities	Provide TA to strengthen and implement case management by government and CSO OVC programs	
	Ensure immediate and lifelong ART for all patients living with ART especially the sickest	Develop strategy to devise, implement and monitor targeted interventions to address cross-border TB and HIV, particularly as it relates to Angola-Namibia including baseline assessment	
	Improve HIV continuum of care and treatment cascade among priority and key populations, including OVC		
	Achieve viral suppression among 90% of pediatric and adult clients on treatment	Strengthen capacity to institutionalize and improve service data quality, use and reporting	
	Implement “Test and Start” approach		
	Implement differentiated service delivery model (SDM) for stable patients		
	Strengthen linkages between clinical and community-based services for improved adherence and retention		
Support acceleration of Option B+ roll out, including EID			
Increase VMMC in high burden districts			

	<p>Support innovative models to deliver ARV-based prevention services, including post-exposure prophylaxis, to high risk young women and pilot pre-exposure prophylaxis to key populations</p> <p>Align OVC programming with other HIV services in high burden districts and hot spots</p> <p>Improve OVC program linkages to HIV services, particularly testing and treatment</p> <p>Support socio-economic mitigation interventions for OVC</p> <p>Target program support to site level to ensure adequate stock of ARVs/commodities and HRH for HIV services</p> <p>Support one-time investments to fill critical gaps for the short term to scale up ART, including vehicles, equipment, time limited HR support (acceleration plan)</p>		
<p><b>Sub-national level</b></p>	<p>Support ART expansion in high burden districts through the intensification of GRN and PEPFAR resources (Acceleration Plan)</p> <p>Support contingency stock of essential HIV prevention commodities (PMTCT, HTC and VMMC) in priority locations to prevent service delays caused by domestic shortage or stock-outs</p>	<p>Provide TA to MOHSS to implement prevention-based guidelines, SOPs and activities to strengthen quality, coverage and M&amp;E</p> <p>Improve sub-national coordination of OVC programs to address barriers to HTS, engagement/enrolment, adherence and retention, including gender inequality, GBV, stigma and discrimination</p> <p>Technical assistance to regional leadership to use data</p>	<p>Hold routine data review meetings</p> <p>Conduct routine trainings</p>

		<p>to better understand their HIV epidemic, identify gaps and develop local solutions</p> <p>Provide TA at regional/district levels to institutionalize QA/QI, improve technical efficiencies and streamline workflow in select high-volume facilities</p>	
<b>National level</b>	<p>Support to adapt and adopt the national ART guideline for “Test and Start”</p> <p>Support to adapt and adopt the national ART guideline for differentiated SDM.</p> <p>Improve ART data/measurement</p> <p>Provide TA to strengthen Namibia’s supply chain ensuring availability of adequate HIV commodities</p> <p>Provide QI (PDSA, measurement, monitoring) to improve linkage of OVC programs to HIV care and treatment services</p>	<p>Develop guidelines for decentralization of ART services and integration into lower-level health facilities</p> <p>Assist MOHSS to implement prevention-based guidelines, SOPs and activities to strengthen quality, coverage and M&amp;E</p> <p>Technical assistance to MGECCW to implement national policies, update SOPs and job aides to align with national HIV policy documents (HTC- age of consent, ART, HIV prevention)</p> <p>Improve national level coordination and quality assurance of OVC services.</p> <p>Address cross-border TB and HIV services, particularly as it relates to Angola-Namibia</p> <p>Provide TA for HRH strategy revision and implementation</p> <p>Provide TA to streamline registration and licensing of pharmacy personnel</p> <p>Provide TA for improving routine expenditure tracking from site level</p>	<p>Assist with laboratory accreditation and SLMTA implementation</p> <p>Provide TA that is addressed by other development partners or the MOHSS</p> <p>Support routine procurement of HIV-related commodities</p> <p>Support national level GBV activities</p>

		<p>Support MOHSS to identify cost savings and efficiencies in the HIV program</p> <p>Build capacity of local PLHIV networks and CSOs to improve quality of services, increase engagement in the national response, and HIV-related advocacy</p>	
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**Table A.2 Program Area Specific Core, Near-Core, and Non-Core Activities for COP 16**  
 (\*\* indicates activities in ART Acceleration Proposal)

	<b>Core Activities</b>	<b>Near-Core Activities</b>	<b>Non-Core Activities</b>
<b>Other Prevention</b>	<p>Support interventions serving key populations in urban hotspots to increase HTC uptake, support GBV activities, distribute condoms and pilot PrEP and PEP for sex workers and MSM</p> <p>Conduct assessment of the implementation of current guidelines for the use of PrEP among sero-discordant couples high prevalence districts</p>	<p>Provide technical assistance to sub-national civil society and government stakeholders to implement combination prevention strategies</p> <p>Provide technical assistance to increase access for AGYW to friendly, integrated SRH/HIV clinical services in high burden districts</p> <p>Community-based social mobilization, risk reduction counseling, condom promotion, HTC and onward linkage in selected communities in high burden districts</p> <p>Provide technical assistance to selected high burden districts to integrate HIV services into the Health Extension Program</p> <p>Technical assistance to HIV-specific health information systems and selected studies</p>	

		to generate information on adolescent girls and young women, men, and key populations	
<b>VMMC</b>	<p>Provide targeted assistance to MOHSS in high burden districts to achieve VMMC coverage targets (including health care worker salaries and training, commodity procurement and M&amp;E)</p> <p>Provide targeted assistance (training, standardizing surgical techniques and implementing CQI) to private clinicians to deliver affordable, high quality VMMC in high burden districts</p>		
<b>PMTCT</b>	<p>Support implementation of Option B+ through clinical skills building of health care workers in delivery of services (PMTCT/EID) in high burden districts</p> <p>Support male involvement activities to support Option B+ service delivery (transitioned from male involvement activities to support the Namibia First Lady's campaign)</p> <p>Recruit additional time-limited health care workers and data clerks to fill gaps in service delivery in high burden districts**</p> <p>Support site-level physician and nursing mentorship at health facilities in high burden districts</p> <p>Implement technical assistance to integrate FP/HTC services including</p>	<p>Provide technical assistance on PMTCT guidelines, SOPs, M&amp;E, supply chain management and linkage to care</p> <p>Support community-based PMTCT services by health extension workers and community health volunteers to increase adherence and retention of mothers through mother support groups and postpartum follow-up activities in high burden districts</p> <p>Provide TA to HIV-specific health information systems to support Option B+ implementation and HEI services</p>	

	<p>linkage to care and confirmation retesting into ANC, L&amp;D, maternity and PNC settings in high burden districts</p> <p>Support scale-up of EID and mother-baby follow-up care, including breast feeding support in health facilities in high burden districts</p> <p>Support quality assurance activities (transitioned from support for health communications on PMTCT activities)</p>		
<b>HTC</b>	<p>Support training and mentoring of existing health care workers and HTC counselors in high-volume health facilities and adolescent-friendly SRH/HIV clinics in high burden districts</p> <p>Recruit additional time-limited HTC counselors to fill gaps in provider-initiated HIV testing and counseling (PITC) services in high-volume health facilities and adolescent-friendly SRH/HIV clinics in high burden districts**</p> <p>Support increased uptake of HTC and linkage to HIV care and treatment among key populations in high burden districts through peer- and community-based HTC models</p> <p>Support increased uptake of HTC and linkage to HIV care and treatment among OVC in high burden districts through health facility and community-based HTC models **</p> <p>Support HTC quality assurance activities at service delivery points in high burden districts</p>	<p>Provide technical assistance on HTC guidelines (including the new 2015 WHO treatment guidelines), SOPs, age of consent; monitoring and evaluation and supply chain and linkage to care functions</p> <p>Support increased uptake of HTC in high yield locations among priority populations through community-based targeted HTC and other methods</p> <p>Provide technical assistance to integrate HTC into the government’s Health Extension Program through a pilot intervention</p> <p>Conduct site-level technical assistance to link newly diagnosed individuals with HIV to care and treatment services</p> <p>Conduct sensitivity training for health care workers on key populations to reduce stigma and discrimination</p>	

<p><b>TB/HIV</b></p>	<p>Improve early TB/HIV diagnosis:</p> <ul style="list-style-type: none"> <li>• Scale up PITC for TB patients using a diversity of entry streams to increase identification of HIV in suspected and confirmed cases of TB</li> <li>• Expand use of Gene Xpert for TB diagnosis in PLHIV, children and DR TB</li> <li>• Coordinated TB case finding in PLHIV in all high-risk settings</li> </ul> <p>Improve ICF and IPT through clinical and patient flows to improve the cascade to TB treatment or IPT based on eligibility</p> <p>Train existing cadres (field promoters, HEW, and community counselors) on TB/HIV and TB infection control measures</p> <p>Expand service integration model for ART in TB settings</p> <p>Conduct mentoring sessions for health care workers to improve TB screening among PLHIV</p> <p>Support increased IPT uptake through quality- assured TB screening, patient awareness and education and documentation of IPT clients completion</p> <p>Support coordination and collaboration service delivery approaches between TB and HIV programs to achieve greater efficiency and reduce cost for stable patients to improve adherence and retention on ART, TB and IPT treatment and prevention courses.</p>	<p>Conduct baseline assessment to determine magnitude of TB/HIV in the mining sector (implementation of SADC Declaration of TB in the Mining Sector)</p> <p>Provide TA to the MOHSS with the planning of the first national TB prevalence survey</p> <p>Provide time-limit</p> <p>ed HRH for community-based providers, including TB field promoters and sustainability planning for HEW to continue TB/HIV adherence and retention interventions</p> <p>Provide training and demonstration PPP/TB/HIV integration model into workplace wellness programs to expand TB/HIV screening, linkages to HIV care/treatment and DOTs in key settings in fisheries, mining, farming, transport, retail, etc.</p>	<p>Routine data review meetings</p> <p>Routine trainings</p>
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	<p>Support training, supervision, quality assurance and M&amp;E integration of TB/HIV, DR TB into clinical mentorship support to clinicians and nurses</p> <p>Routine supervisory support visits</p> <p>Address unique needs for screening, diagnosis and treatment of children, adolescents, pregnant women and other vulnerable congregated populations</p> <p>Strengthen cross-cutting coordinated TB/HIV M&amp;E activities at facility, district and regional including decentralized electronic data capture and reporting of TB/HIV health information systems</p> <p>Scale up IC to reduce TB associated morbidity and mortality</p>		
<b>Laboratory</b>	<p>Increase lab capacity for HIV VL testing</p> <p>Provision of QA for RT, VL, EID and CD4 POC</p> <p>Expand SMS printers to priority sites for rapid return of laboratory results</p>	<p>Expansion of POC testing for CD4, creatinine, hepatitis (as required by Namibia national guidelines)</p> <p>Support specimens referral system</p>	<p>Auditing of laboratories and testing sites to assess implementation of continuous QA</p>
<b>OVC</b>	<p>Implement holistic, family-centered services that support case management at household and community level to ensure children and families are enrolled and linked to services that overcome barriers to adherence and access to services to improve health outcomes of children infected and affected by HIV</p> <p>Increase the number of OVC who know their status and improve linkages to HIV services, particularly testing and treatment, prevention,</p>	<p>Technical assistance to integrate case management into existing government's and CSO's OVC program:</p> <ul style="list-style-type: none"> <li>• Provide case management training, including tracing of children LTFU</li> <li>• Support the development and implementation of case management SOPs, and job aids</li> </ul>	<p>Transition Peace Corps Program from sustained districts to high burden districts</p>

	<p>pediatric care, routine child health services, such as immunizations,</p> <p>Refer to prevention programs for HIV negative OVC, especially AGYW</p> <p>Increase access to adolescent and reproductive health information and empower AGYW to make choices and take action on matters of their own health and well-being</p> <p>Improve services:</p> <ul style="list-style-type: none"> <li>• Train caregivers and social workers about HIV disclosure support for children and universal treatment</li> <li>• Provide psychosocial support to address the needs for children with HIV and their care providers and strengthen linkage to referral services and adherence to treatment</li> <li>• Facilitate group-based household economic strengthening activities such as savings schemes focusing on OVC caregivers, HIV+ families, young girls and children living and affected by HIV.</li> <li>• Provide positive parenting skills training to caregivers (including ECD communication on adolescent risk, HIV disclosure)</li> <li>• Provide support to OVC and caregivers for access to and uptake of social protection efforts such as social welfare grants</li> <li>• Fund small grants to support</li> </ul>	<p>Implement guidelines/ SOPs on HIV disclosure and the provision of PEP for sexually assaulted children</p> <p>Improve national level coordination and quality assurance for OVC services</p> <ul style="list-style-type: none"> <li>• Provide TA to MGECW/ MOHSS to revise national policy documents and SOPs including job aides to align with national HIV Policy documents (HTC-age of consent, treatment, prevention)</li> <li>• Provide TA to MGECW on M&amp;E and to operationalize the Child Protection Act (HIV Section)</li> </ul> <p>Facilitate referrals for birth registrations of OVC and caregivers</p> <p>Provide technical assistance to CSO and GRN to improve OVC data systems for PEPFAR funded programs</p> <p>Conduct OVC MER Essential Indicators Survey</p> <p>Provide funding to continue support to the 611 counselling line to reach and help children</p> <p>Provide targeted educational support such as cash transfers to facilitate school enrollment, progression and completion of OVC</p> <p>Improve sub-national</p>	
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	socio-economic and household economic strengthening interventions	<p>coordination of OVC programs:</p> <ul style="list-style-type: none"> <li>• Provide TA to MGECW National and Sub national level structures (high burden districts) to coordinate OVC program</li> <li>• Provide TA to sub-national level child protection and response activities, and referrals to other services</li> </ul>	
<b>National Surveys and Surveillance</b>		<p>Provide capacity building and technical support to high-volume districts to operationalize use of routine PMTCT data for ANC program monitoring and surveillance activities</p> <p>Provide capacity building and technical support to national-level MOHSS staff to implement incidence surveillance activities</p> <p>Provide technical capacity support to MOHSS staff for the implementation of the acquired HIV drug resistance survey</p> <p>Implement national Health Impact Assessment, including HIV biomarkers and VACS, in collaboration with key GRN institutions</p> <p>Support MOHSS to conduct HIV data triangulation based on nationally representative HIV surveys</p>	
<b>Health Management Information</b>	Support HIV care and treatment sites in linking ART patient VL tests to their HIV care and treatment files	Provide targeted assistance to high-volume ART sites for implementation of Logistics	

<b>Systems</b>	through linking the unique ART number to the lab information system	Management Information System (LMIS)  Provide focused capacity building at high volume ART, PMTCT and other key program area sites to improve the ability of facility staff to disseminate and use routine program data for real-time decision making, program planning and epidemic control  Create interoperability and integration of HIV patient level data systems through development of a Health Information Exchange  Support Directorate of Pharmaceutical services to implement LMIS in high burden regions	
<b>Monitoring and Evaluation</b>		Coordinate with regional level MGEWC offices to implement MER OVC outcomes survey  Build capacity of national and sub-national staff in priority regions to conduct HIV mathematical modeling activities  Provide HRH support to high-volume sites and districts through hiring of 32 data clerks to allow for continued high-quality data collection and reporting	
<b>HRH</b>	Support HRH assessments in high burden districts to determine gap between available staff and required staff. Help regional leadership develop localized solutions  Improve the performance of existing	Technical assistance on HRH at the MOHSS <ul style="list-style-type: none"> <li>• Support the revision and implementation of the MOHSS HRH strategy</li> </ul>	Transition salary support for faculty positions at UNAM as part of pre-service training  Transition HRH capacity building support to

	<p>health care workers by providing NIMART training in the 18 high burden districts and hot spots**</p> <p>Hire dedicated, time-limited clinical and support staff for ART initiation and management in selected high-volume, high-yield sites to fill vacancies**</p> <p>Hire clinical mentors for HRH capacity building at selected high-yield high-burden sites**</p>		<p>Polytechnic</p> <p>Transition FELTP to GRN</p> <p>Transition bursaries to GRN</p>
<b>Supply Chain</b>	<p>Support national-level supply chain management including quantification, selection and projection to meet the accelerated scale-up of ART needs</p> <p>Support site-level supply chain management, including the electronic dispensing tool.</p>	<p>Provide support to ensure availability of clinical diagnostic supplies for HIV and AIDS</p> <p>Expand LMIS to all ART sites</p>	
<b>Service Delivery</b>	<p>Support scale up and QA/QI efforts</p> <ul style="list-style-type: none"> <li>• Provide capacity building to private-sector medical practitioners (physicians and nurses) to adopt the HIV national guidelines scale up PITC , ART, PMTCT and VMMC in targeted districts and hot spots</li> <li>• Support private sector recording/reporting of HIV services to better understand how many people are receiving treatment through the private sector</li> </ul>	<p>Support QA/QI efforts helping regional teams to develop QA/QI teams to review ART performance at regional level</p> <p>Train PLHIV as expert patients to enhance adherence and retention in care and treatment of others with PLHIV</p>	
<b>Health Finance</b>		<p>Build MOHSS capacity to design and conduct cost-effectiveness analyses of various laboratory/ diagnostic, HTC, ART and PMTCT service delivery models to improve</p>	

		<p>program efficiencies</p> <p>Build capacity of GRN for expenditure analysis and unit cost estimation to inform budgeting and planning</p>	
<b>Leadership &amp; Governance</b>		<p>Build PLHIV networks' capacity to participate in HIV program planning and review activities at the subnational level.</p> <p>Support stakeholders to conduct a legal environment assessment and implement recommendations</p>	
<b>Care and Treatment</b>	<p>Expand HIV care and treatment service delivery (including Option B+) through decentralization of services from high-burden facilities and districts to IMAI/NIMART sites**</p> <p>Promote adherence and retention through the mobile-health technologies to remind patients of appointments and to trace defaulters</p> <p>Improve patient and data flow (including updating Pre-ART register); delivery supported by: clinical mentors (MD) and QI nurses (RN)</p> <p>Provide TA to support integrated service delivery models (TB/HIV; MCH/PHC-HIV)**</p> <p>Provide site-level technical assistance to conduct service quality assessment and implement CQI training, coaching and mentorship (Clinical and Nurse Mentors)**</p> <p>Support tracking strategies for all</p>	<p>Pilot community ARV distribution and expand treatment support group**</p> <p>Develop and/or revise clinical pathways, SOPs, job aids to streamline and shorten patient time in the care system</p> <p>Develop national guidelines and standard tools for decentralized ART services; conduct Health Facility Capacity Assessment (HFCA); Develop clinical mentoring and QA/QI tools</p> <p>Expand access to mobile EDT data collection tools to more ART facilities</p> <p>Strengthen lab specimen logistics system to reduce turnaround time for the VL hubs including Short Message Service (SMS) platform-based lab result printers</p> <p>Provide CQI for lab testing in high burden regions</p> <p>Strengthen data use for</p>	<p>Rollout Visual Inspection with Acetic acid (VIA), develop guidelines and train on the revised cervical cancer preventive interventions for HIV+ women</p> <p>Fund CD4 POC commodities, TB diagnostics and supplies</p> <p>Improve the lab information system to generate programmatic data</p> <p>Laboratory Accreditation and Strengthening Laboratory Management Towards Accreditation (SLMTA) implementation</p> <p>Maternal and child health care services including Emergency Management of Obstetric and Neonatal Care (EMONC), Integrated Management of Neonatal and Childhood Illnesses (IMNCI)</p>

	<p>clients with bidirectional referral between facility and community**</p> <p>Provide targeted in-service training of healthcare workers to provide high quality HIV care and treatment services.**</p> <p>Provide technical assistance for adolescent-friendly health services in all sites including sites providing HIV prevention, care and treatment services and at community level (provide integrated Sexual and Reproductive Health (SRH) services, strengthen retention in care and support for treatment adherence, teen clubs)</p> <p>Expand adolescent HIV disclosure program</p> <p>Increase point of care testing (CD4, Creatinine, Hepatitis B) and access to laboratory testing for VL testing</p> <p>Train health care workers to properly dispense cotrimoxazole and INH prophylaxis to eligible clients</p>	<p>decision making, including patient tracking and management at site and district level</p> <p>Assess and mitigate factors contributing to sub-optimal ART outcomes (pediatric/OVC and adolescents) at the site level</p> <p>Renovate space at health facilities for confidential counselling, treatment and dispensing of medicines to support decentralization**</p> <p>Procure emergency supply of ARVs and rapid test kits in case of supply chain challenges at the scale-up sites**</p>	<p>Audit labs and testing sites to assess implementation of continuous QA</p>
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\*\* Denotes activity funded through the non-COP, 2 year treatment acceleration plan

**Table A.3 Transition (Central Support) Plans for Non-Core Activities**

Transitioning Activities	Type of Transition	Funding in COP 16	Estimated Funding in COP 17	# of IMs	Transition End date	Notes
Lab procurements: <ul style="list-style-type: none"> <li>• CD4 POC commodities and supplies</li> <li>• Provision of PT for TB diagnostics EQA</li> <li>• Retesting of samples for HIV RT QA</li> <li>• Xpert consumables</li> </ul>	Non-core	----	----	2		Transitioned to GRN/MOHSS and NIP
	Non-core	----	----	1		Transitioned to NIP
Coordination for implementation of activities toward lab accreditation including SLMTA	Non-core	----	----	1		Transitioned to GRN/MOHSS
Support for establishment of National Public Health Laboratory						
Implementation of full PMTCT impact evaluation	Non-core	----	----	1		Baseline assessment completed; prospective component discontinued due to costs
Maternal and child health care services including EMONC, IMNCI and immunization, neonatal resuscitation	Non-core	----	----	1		Transitioned to GRN/MOHSS
Commodities for NACS, including anthropometric supplies	Non-core	----	----	1		Transitioned to GRN/MOHSS
Rollout of VIA	Non-core	----	----	1		
Guidelines development and training on revised cervical cancer preventive interventions for HIV+ women	Non-core	----	----	1		Completed
Palliative care and nursing care home visitation components of community home-based care in non-priority regions	Non-core	----	----	1		Completed
Household Economic Strengthening for PLHIV in	Non-core	----	----	1		Completed



non-priority areas						
Two day community-based PHDP for newly enrolled ART clients	Non-core	----	----	1		Discontinued due to cost per client and coverage
Direct funding support to pharmacy regulatory body capacity strengthening	Non-core	----	----	1		Completed
Direct funding support for training of pharmacy assistances at UNAM School of Pharmacy	Non-core	----	----	1		Transition to UNAM
Transition salary support for faculty positions at UNAM as part of pre service training	Transition to UNAM	----	----	1	March 30, 2016	
Transition support to Polytechnic for HRH capacity building	Transition to Polytechnic	----	----	1	March 30, 2016	
Transition FELTP to GRN	Transition to GRN		----	1	Sept 30, 2016	
Transition bursaries	Transition to GRN	----			March 30, 2016	
Commodity procurement	Non-core	----	----	1		Transitioned to GRN/MOHSS
Routine supervisory support visits and trainings	Non-core	----	----	1		Transitioned to GRN/MOHSS
Routine data review meetings	Non-core	----	----	1		Transitioned to GRN/MOHSS
Provide HRH support to non-priority sites through maintaining 6 regional M&E officers to allow for continued high quality data collection and reporting, pending transition	Salary support		----	1	Sept 2016	
Transition Peace Corps OVC Program from sustained SNUs to high burden districts	Non-core	\$89000	----	N/A	June 2017	Peace Corps activities are transitioned from sustained sites to align with PEPFAR areas of high burden
<b>Totals</b>						

## Appendix B: Budget Profile and Resource Projections

### B.1 Planned Spending in 2016

**Table B.1.1 Total Funding Level**

Applied Pipeline	New Funding	Total Spend
\$US 20,644,006	\$US 20,655,996	\$US 41,300,000

**Table B.1.2 Resource Allocation by PEPFAR Budget Code**

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	487,532
HVAB	Abstinence/Be Faithful Prevention	221,590
HVOP	Other Sexual Prevention	69,648
IDUP	Injecting and Non-Injecting Drug Use	0
HMBL	Blood Safety	0
HMIN	Injection Safety	0
CIRC	Male Circumcision	165,864
HVCT	Counseling and Testing	385,013
HBHC	Adult Care and Support	361,541
PDCS	Pediatric Care and Support	374,896
HKID	Orphans and Vulnerable Children	2,561,323
HTXS	Adult Treatment	8,151,621
HTXD	ARV Drugs	0
PDTX	Pediatric Treatment	1,299,540
HVTB	TB/HIV Care	485,356
HLAB	Lab	174,684
HVSI	Strategic Information	741,457
OHSS	Health Systems Strengthening	294,068
HVMS	Management and Operations	4,881,863
<b>TOTAL</b>		<b>20,655,996</b>

## B.2 Resource Projections

**Epidemiological and Program Data Analysis:** The PEPFAR Namibia SI and technical working groups started the process with an in-depth analysis of epidemiological and programmatic data to identify regional geographic high burden areas based on the disease burden and ART unmet need. These data and service delivery data from the MOHSS were further analyzed to determine areas with the greatest potential for rapid acceleration of ART (had high volume TB/HIV clinics, needed to roll out Option B+, had high HTS yield but no nearby ART facility, or were lower level facilities of overly congested ART facilities). As a result, these facilities were selected for DSD. Facilities already providing high-volume ART were selected for site-level TA. The team further analyzed data to determine which facilities and/or community sites would receive support for HTS, PMTCT, OVC, and key population interventions.

**Gap Analysis:** During the COP process, PEPFAR Namibia worked closely with the GRN to identify gaps. In particular, PEPFAR Namibia worked with regional health directorates to identify gaps and bottlenecks and recommend solutions to address these gaps. At that point during the planning, a fully accurate gap analysis for the GRN to meet its program goals and country investment case was reviewed with stakeholders. However PEPFAR Namibia and GRN recognize that specific gaps to address the continuum of HIV services vary by district. PEPFAR Namibia is working closely with the GRN, with support from OGAC and agency headquarters, to develop a methodology for quantifying these gaps.

**PBAC:** Namibia EA data served as the basis for unit expenditures needed to complete PBAC. 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 unit expenditures by implementing mechanism. Outlier levels were set at either three or five times the average unit expenditures, depending on the type of service (e.g., FBCTS was reviewed at 5x and community services at 3x). PEPFAR Namibia had only a few outliers largely restricted to serving priority populations, such as clandestine communities of MSM and FSW, or in cases where there was substantial start-up costs to reach adolescent girls and young women. In cases where there are demonstrated outliers, a number of decisions were made as part of the review and implementation planning. These decisions included ending the activities or agreements of outlying partners that are not contributing to core activities, and working closely with implementing partners to reposition staff to ensure greater client enrollment, achievements and yields at the same overall costing levels. Please see appendix C in the PBAC tool for further information.

## Appendix C: Systems Investments for Section 6.o

Included Activities	Exclude Activities
<b>Human Resources for Health (HRH): Systems/Institutional Investments</b>	
Pre-service training; in-service training systems support and institutionalization; HRH performance support/quality; HRH policy planning and management; HR assessments and information systems; other HRH activities not classified as above	N/A
<b>Human Resources for Health (HRH): Personnel Costs for Service Delivery</b>	
In-service training; all HRH support at sites and community across all program areas	Other site-level investments such as purchase of vehicles, equipment and furniture, construction and renovation, and site-level recurrent categories such as ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, building rental and utilities
<b>Governance</b>	
Technical area-specific guidelines, tools, and policy; general policy and other governance; other governance activities not classified as above	N/A
<b>Finance</b>	
Expenditure tracking; efficiency analysis and measurement; health financing; costing/cost modeling; other health financing activities not classified as above	N/A
<b>Systems Development</b>	
Supply chain systems; health information systems (HIS); laboratory strengthening; other systems development activities not classified above	ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, freight for transport of commodities to sites and other supply chain costs incurred at the site-level
<b>Institutional and Organizational Development</b>	
Civil society and non-governmental organizations (NGOs); government institutions; social welfare systems strengthening; other institutional and organizational activities not classified above	N/A
<b>Strategic Information</b>	
Monitoring and evaluation; surveys; operations research; geographic mapping, spatial data, and geospatial tools; surveillance; other strategic information activities not classified above	N/A
<b>Laboratory</b>	
Quality management and biosafety systems; implementation and evaluation of diagnostics (POC and VL monitoring); laboratory information and data management systems; laboratory workforce; quality management system; sample referral systems; accreditations; technical assistance to assure or improve quality of laboratory services	Vehicles, equipment and furniture, construction and renovation for site labs, and recurrent categories from site labs such as lab reagents an supplies, travel and transport, building rental and utilities will not be included