



## **FY 2015 Namibia Country Operational Plan (COP)**

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on [www.PEPFAR.gov](http://www.PEPFAR.gov), reflect the approved FY 2015 COP for Namibia.

- 1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

**Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the “COP 15 Targets by Subnational Unit” sheets that follow for final approved targets.**

- 2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

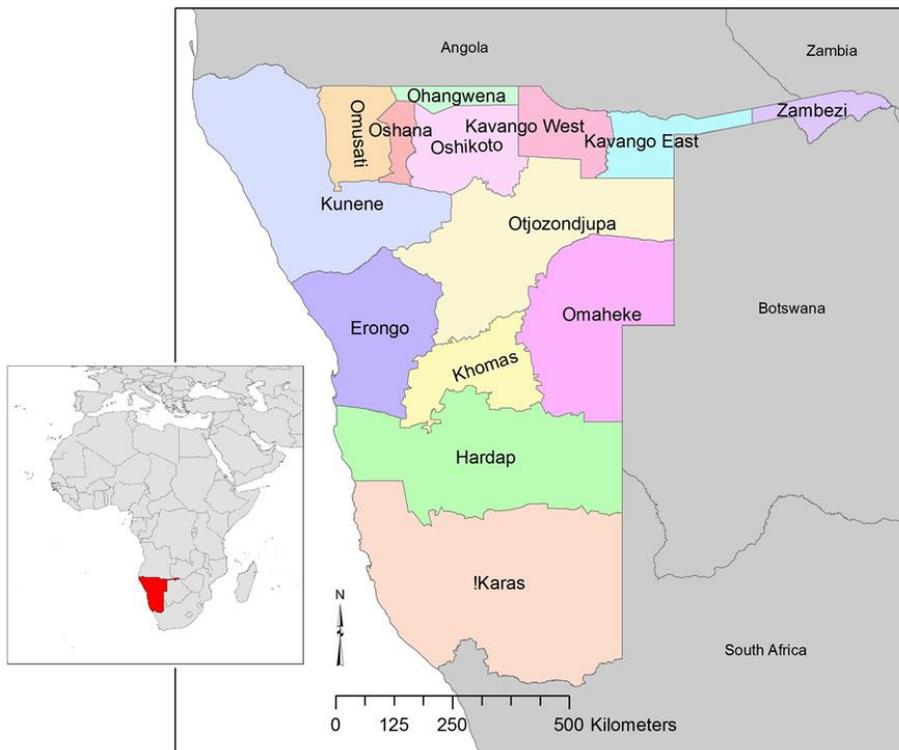
**Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on [www.PEPFAR.gov](http://www.PEPFAR.gov) in the “FY 2015 Country Operational Plan Budget and Target Report.”**

# Namibia

## Country Operational Plan (COP) 2015

### Strategic Direction Summary

May 15, 2015; Revised August 27, 2015



# Table of Contents

<b>Goal Statement</b> .....	7
<b>1.0 Epidemic, Response, and Program Context</b> .....	8
1.1 Summary Statistics, Disease Burden and Country Profile .....	8
1.2 Investment Profile .....	16
1.3 National Sustainability Profile .....	18
1.4 Alignment of PEPFAR Investments Geographically to Disease Burden .....	19
1.5 Stakeholder Engagement .....	21
<i>Host Country Government</i> .....	21
<i>Multilateral Partners</i> .....	22
<i>Private Sector</i> .....	24
<b>2.0 Core, Near-Core and Non-Core Activities</b> .....	24
<b>3.0 Geographic and Population Prioritization</b> .....	25
<b>4.0 Program Activities for Epidemic Control in Priority Locations and Populations</b> .....	27
4.1. Targets for Priority Locations and Populations .....	27
<i>ART Targets Process and Assumptions</i> .....	27
<i>Entry Stream Target Setting Process and Assumptions</i> .....	28
<i>VMMC Target Setting Process and Assumptions</i> .....	29
<i>Key and Priority Populations Target Setting Process and Assumptions</i> .....	30
<i>OVC and Pediatric Target Setting Process and Assumptions</i> .....	31
4.2. Priority Population Prevention .....	31
4.3 Voluntary Medical Male Circumcision .....	32
4.4 Preventing Mother-to-Child Transmission .....	32
4.5 HIV Testing and Counseling (HTC) .....	33
4.6 Facility and Community-Based Care and Support .....	34
4.7 TB/HIV .....	34
4.8 Adult Treatment .....	35
4.9 Pediatric Treatment .....	36
4.10 Orphans and Vulnerable Children (OVC) .....	36
4.11 Peace Corps .....	37
<b>5.0 Program Activities to Maintain Support for Other Locations and Populations</b> .....	37
5.1. Maintenance Package of Services in Other Locations and Populations .....	37

5.2 Transition (Central Support) Plans for Redirecting PEPFAR Support to Priority Locations and Populations.....	38
<b>6.0 Program Support Necessary to Achieve Sustained Epidemic Control .....</b>	<b>39</b>
6.1 Laboratory Strengthening .....	39
6.2 Strategic Information (SI).....	41
6.3 Health System Strengthening (HSS).....	46
<b>7.0 Staffing Plan .....</b>	<b>51</b>
7.1 Analysis of Team in Context of Pivot.....	51
<b>APPENDIX A: Core, Near-Core and Non-Core.....</b>	<b>53</b>
Table A.1 Goals per Program Core, Near-Core, and Non-Core Activities for COP 15 .....	53
Table A.2 Program Area Specific Core, Near-Core, and Non-Core Activities for COP 15 (** indicate activities in ART Acceleration Proposal) .....	56
Table A.3 Transition (Central Support) Plans for Non-Core Activities .....	67
<b>APPENDIX B: Planned Spending.....</b>	<b>70</b>
B.1 Planned Spending in 2016.....	70
B.2 Resource Projections .....	71

## 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
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
CQI	Continuous Quality Improvement
CSO	Civil Society Organizations
CSS	Community Systems Strengthening
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
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
FTE	Full Time Equivalent
GBV	Gender-based Violence
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GRN	Government of the Republic of Namibia
GUHSR	Global Update on the Health Sector Response
HCT	HIV Counselling and Testing
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
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
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	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
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
OVC	Orphans and Vulnerable Children
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
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)
SCM	Supply chain management
SHPA	Senior Health Programme Administrator
SLMTA	Strengthening Lab Management Towards Accreditation
SMO	Senior Medical Officer
SOPS	Standard Operating Procedures
SRH	Sexual and Reproductive Health
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
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), civil society, multilaterals and private sector, developed the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Namibia COP15. COP15's focus on scale-up to saturation supports the national goal of 80%<sup>1</sup> antiretroviral therapy (ART) coverage among all people living with HIV and AIDS (PLHIV) by 2017. Consistent with principles set forth in the USG-GRN Country Health Partnership Letter of Intent (July 2014), PEPFAR works to jointly plan, implement and monitor USG-GRN co-investments to achieve epidemic control and foster a sustainable response.

In COP14 and continuing in COP15, PEPFAR used data analysis to pivot geographic focus and intensify targeted efforts at site and regional levels to meet ART saturation targets, reduce AIDS-related deaths and reduce HIV incidence. PEPFAR's focus is in seven regions with the highest HIV burden and unmet ART need and eight urban hotspots outside those priority regions with large key populations or high-volume ART sites. Priority areas represent 80% of all PLHIV. To close the ART gap in priority regions/hotspots, an additional 38,615 adults and children need to be initiated on ART (16,246 in COP15 and 22,369 in COP16).

PEPFAR will work with GRN, civil society and private sector to expand ART access by assisting high-yield sites in priority areas and by decentralizing services to reach saturation. PEPFAR prevention, care and treatment interventions will align within priority locations for synergistic impact. At the site level, PEPFAR will collaborate with GRN and stakeholders to support activities that increase testing and counseling yield, accelerate Option B+ roll out, enable rapid expansion of ART, and improve retention and adherence (especially among children and adolescents). PEPFAR will improve integration of HIV/tuberculosis (TB) and HIV/maternal and child health (MCH) services and continue providing care and support for orphans and vulnerable children (OVC) while strengthening linkages between HIV and social services, including pediatric HIV testing and counseling (HTC) and ART. To increase treatment and care access and address retention and adherence, PEPFAR will support GRN's efforts to decentralize ART services from congested high volume to intermediary facilities.

PEPFAR will facilitate monitoring, quality improvement, and scale up of GRN's combination prevention: (1) test and treat for children under 15, pregnant women, discordant couples, and HIV/TB co-infected individuals; (2) voluntary medical male circumcision (VMMC) for men 15-29 years of age; and (3) Option B+. PEPFAR 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 will work with civil society and GRN to foster stigma-free access to comprehensive HIV services for key populations. At national and regional levels, PEPFAR will improve systems that support epidemic control, in particular quality assurance/quality improvement (QA/QI), HIV supply chain, human resources for health (HRH), domestic resource mobilization and strategic allocation. PEPFAR will strengthen capacity to institutionalize HIV data availability, analysis and use.

PEPFAR efforts to expand ART coverage to 80% in priority regions will require intensification of USG, GRN and multilateral co-investments. This SDS is supplemented with a "Proposal to Accelerate ART

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<sup>1</sup> This is comparable to the NSF's goal of 95% coverage for ART of eligible PLHIV by 2017.

Scale-up to Attain 80% Coverage in Priority Regions and Hotspots of Namibia.” The two documents are integrally related and ART targets in the SDS are dependent on the Proposal being approved.

## 1.0 Epidemic, Response, and Program Context

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

Namibia is a sparsely-populated desert country of 2.28 million people 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.

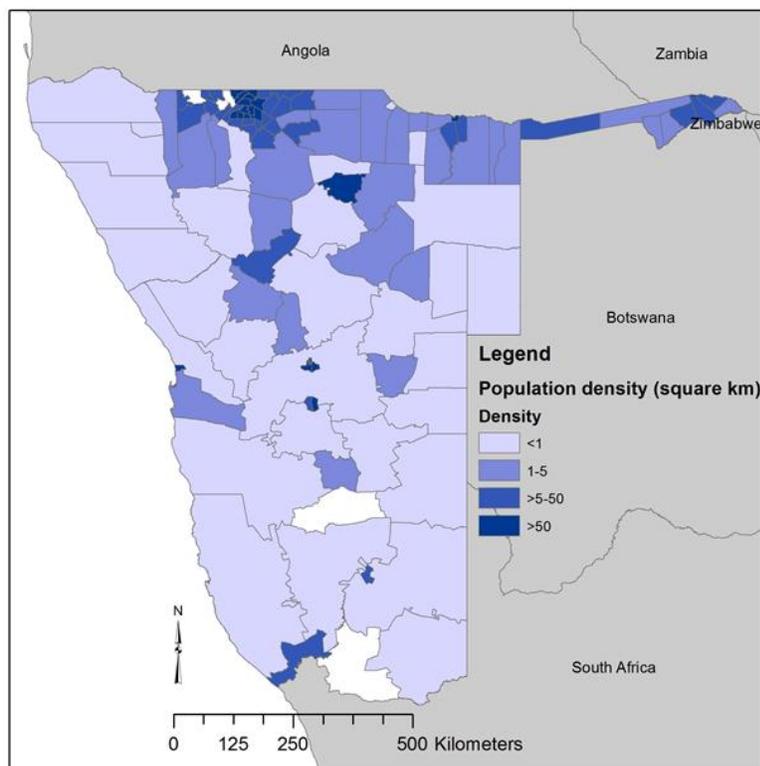


FIGURE 1.1.1: POPULATION DENSITY IN NAMIBIA

Namibia is an upper-middle income country with GNI per capita of USD 8,890 (World Bank, 2012) but starkly unequal income distribution. Namibia’s Gini coefficient is 0.5971, sixth-highest in the world (CIA Fact Book 2011). 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. Impressive results in immunization and nutrition of children have been achieved ringing down under 5 deaths from 4,200

per year in 1990 to less than 3,000 in 2013.

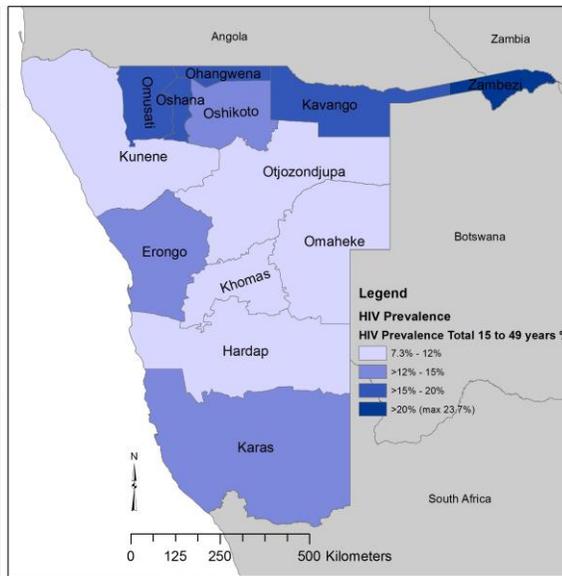
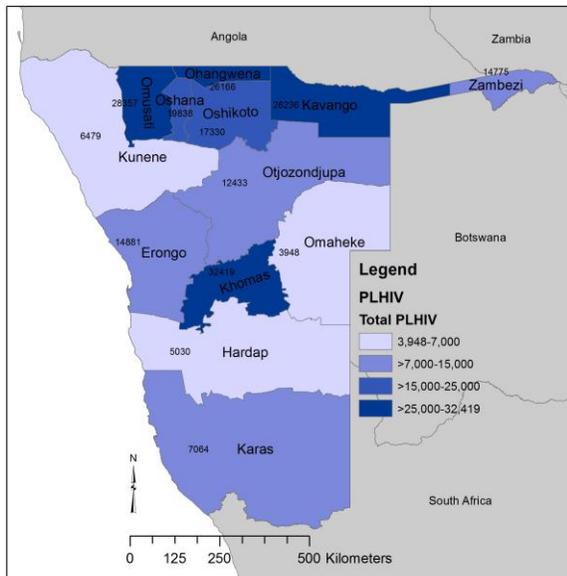
The GRN’s strong political, administrative, and financial leadership has resulted in Namibia having impressively high coverage levels for treatment and prevention of mother-to child transmission (PMTCT), rapidly adopting new international guidelines and best practices, and increasing domestic financing for HIV programming. As a result of the progress made in the fight against HIV/AIDS, new HIV infections were halved since 2004 and life expectancy rose from 56 in 2005 to 64 in 2012 (World Bank).

Nationally, Namibia has a generalized HIV epidemic with 14% of the 15- 49 year old population (214,956 people) living with HIV (NDHS, 2013). HIV/AIDS was

Table 1.1.A: Top 10 Causes of Death in Namibia	
1. HIV 23%	6. Tuberculosis 5%
2. Cancer 8%	7. Ischemic Heart Disease 4%
3. Stroke 7%	8. Diabetes 3%
4. Lower Respiratory Infections 5%	9. Interpersonal Violence 3%
5. Diarrheal Diseases 5%	10. Malaria 3%
Source: GBD Compare ( <a href="http://viz.healthmetricsandevaluation.org/gbd-compare/">http://viz.healthmetricsandevaluation.org/gbd-compare/</a> ), 2010	

responsible for 3,610 deaths in 2014 and is still the leading cause of death among adults and sixth leading cause among children under 5 years of age (MOH Child Survival Strategy, 2014). Among adults (>15 years) women bear a disproportionate burden of the HIV epidemic with a prevalence of 16.9% compared to 10.9% for men. An estimated 2.6% of children <15 years of age are HIV+. No data are available on positivity rates between genders for children.

The incidence rate for Namibia is 0.7% (Spectrum 2104), equal to 7,958 new infections in 2014. The highest incidence and prevalence burden is in areas of highest population density: Khomas region, which includes the capital, Windhoek, and six northern regions. These seven areas are in crisis.



**FIGURE 1.1.2: PLHIV BY REGION**

**FIGURE 1.1.3: HIV PREVALENCE BY REGION**

The national decrease in incidence to date has been predominantly due to a reduction in incidence among infants from scale up of PMTCT. Spectrum (2014) estimates that the decline is not expected to continue if current treatment coverage levels remain unchanged. The northern regions, home to the majority of the population, adjoin the borders of 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 2013). TB/HIV co-infection is high among adults > 15 years of age (49% for women and 41% for men) and 17% among children <15 years of age. While TB/HIV co-infection declined from 58% in 2009 to 44% in 2014 and ART coverage for co-infected persons increased from 80% in 2013 to 84% in 2014, this is still below the GRN target of 100% (NTLP, 2014).

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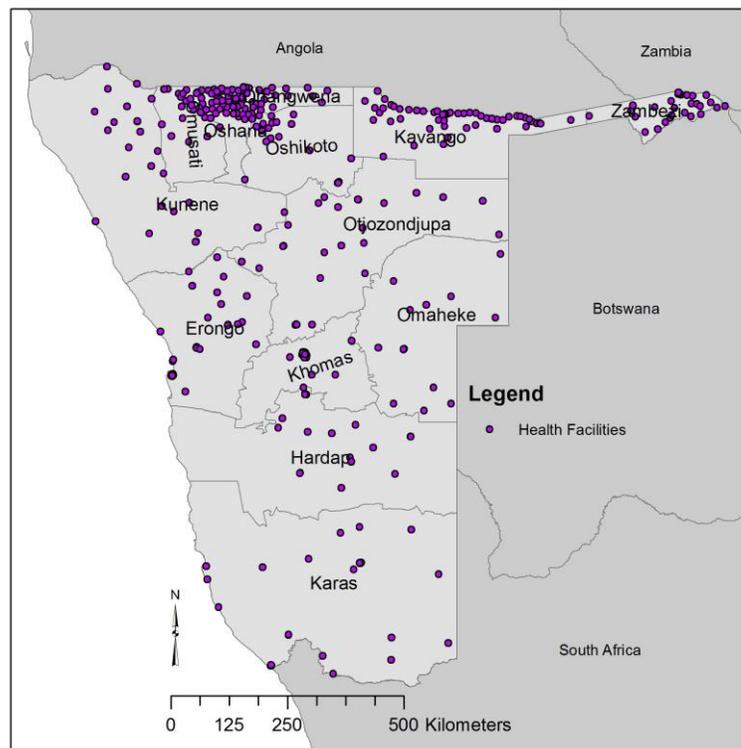
HTC sites in Namibia are widespread. Overall, 79.6% of women and 62.6% of men over 15 years of age report having ever been tested and 49.4% of women and 38.8% of men reported being tested in the last year (NDHS 2013). Reaching men has been and continues to be a challenge. While, the self-reported circumcision rate is 25.5% (NDHS, 2013), Namibia struggles to roll out VMMC for men aged 15-29. Between 2010 and 2014, PEPFAR performed 13,531 VMMCs.

Since ART was introduced in 2003, the number of HIV+ adults on ART has increased annually, rising from 75,681 in 2010 to 131,721 in 2014. This translates to a 74% increase in ART enrollment over five years and 61.3% of all PLHIV on treatment by the end of 2014. In 2014, national guidelines changed eligibility for ART to: children <15, TB/HIV co-infected patients, pregnant women, discordant couples, and patients  $\geq 15$  years of age with a CD4 count of  $\leq 500$ . These and other changes have resulted in a continued rise in number of people eligible for treatment.

The majority of the population receives ART from the public sector. The MOHSS reports that the private sector provided ART to 14,600 PLHIV in 2014.

The current national treatment gap is estimated to be 27,793 HIV+ individuals who are eligible for but not currently on treatment (see Table 4.1A). The gap is greatest in Khomas and Kavango regions. Because of Zambezi region's small population, the ART gap appears small in absolute numbers. However, Zambezi - a major trucking route and trade corridor bordering three countries - is the region with the highest overall HIV prevalence (23.7%) and the highest prevalence among pregnant women at ANC (37.7%).

Testing among pregnant women is high. More than 95% of pregnant women know their status or are tested during ANC visits or at delivery (GUHRS, 2014). ANC coverage (at least one visit) is 96.6% and delivery in a health center is greater than 87%. Namibia has made significant progress in PMTCT and 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. Over 224 health facilities collect Dried Blood Spot 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 north and north-east part of the country bearing the greatest burden.



**FIGURE 1.1.4: HEALTH FACILITIES IN NAMIBIA**

In 2013, GRN adopted Option B+, which includes lifelong ART for all HIV+ pregnant women. Option B+ implementation began in the second quarter of 2014. Current coverage of ART under Option B+ is at 45.3% (national program data, 2014). Because pregnant women are in contact with the health system, enrollment and retention on ART is possible if access to quality care and treatment could be ensured at all ANC centers (NDHS 2013). About 50% of all ANC sites initiate option B+ on site, while the other 50% refer to the nearest ART site for initiation.

Identifying HIV+ children through EID and active mother baby follow-up, including retesting for the first 18 months of life, is a Namibian policy, but execution remains challenging. Coverage of EID (i.e. testing of infants born to an HIV+ woman) in 2013 was only 56% (Global Progress Report 2014). In 2013, GRN adopted a universal ART coverage policy for children <15, irrespective of CD4 count. Catch-up enrollment of children living with HIV, beyond those identified through EID, remains a challenge. ART coverage among children is 49% (Spectrum, 2014), substantially less than for adults. An opportunity exists for targeted interventions to identify 10,811 HIV+ children who are currently not on treatment and eligible for treatment.

The HIV epidemic in Namibia has generated a large population of OVC, estimated at 93,226 (Spectrum, 2014). National-level data are limited for differentiating the number of AIDS affected or infected OVC, among those who are HIV+, have at least one parent living with HIV or have one or both parents deceased from HIV/AIDS.



**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	2,280,716		411,852	18.1%	418,212	18.3%	760,588	33.3%	690,064	30.3%	Namibia Population Projections 2011-2014
Prevalence (%)		14.0%		2.6%		2.6%		16.9%		10.9%	HIV prevalence is for 15 - 49 year olds, NDHS 2013; Total PLHIV population estimates (2011 census projections) against NDHS 2013 HIV prevalence and Spectrum (2014) for pediatrics
AIDS deaths (per year)	3,610		NA		NA		NA		NA		Spectrum (2014)
PLHIV	214,956		10,708		10,874		101,387		91,987		HIV prevalence is for 15 - 49 year olds, NDHS 2013; Total PLHIV population estimates (2011 census projections) against NDHS 2013 HIV prevalence and Spectrum (2014) for pediatrics
Incidence Rate (Yr.)		0.7%		NA		NA		NA		NA	Spectrum (2014)
New Infections (Yr.)	7,958										Spectrum (2014)
Annual Births	55,000	3.6 TFR									NDHS (2013)
%>=1 ANC visit	66,323	96.6%									NDHS (2013)
Pregnant women needing ARVs	9,940	12.5%									National program data and Spectrum (both 2014)
Orphans (maternal, paternal, double)	150,589		NA		NA		NA		NA		Census (2011)

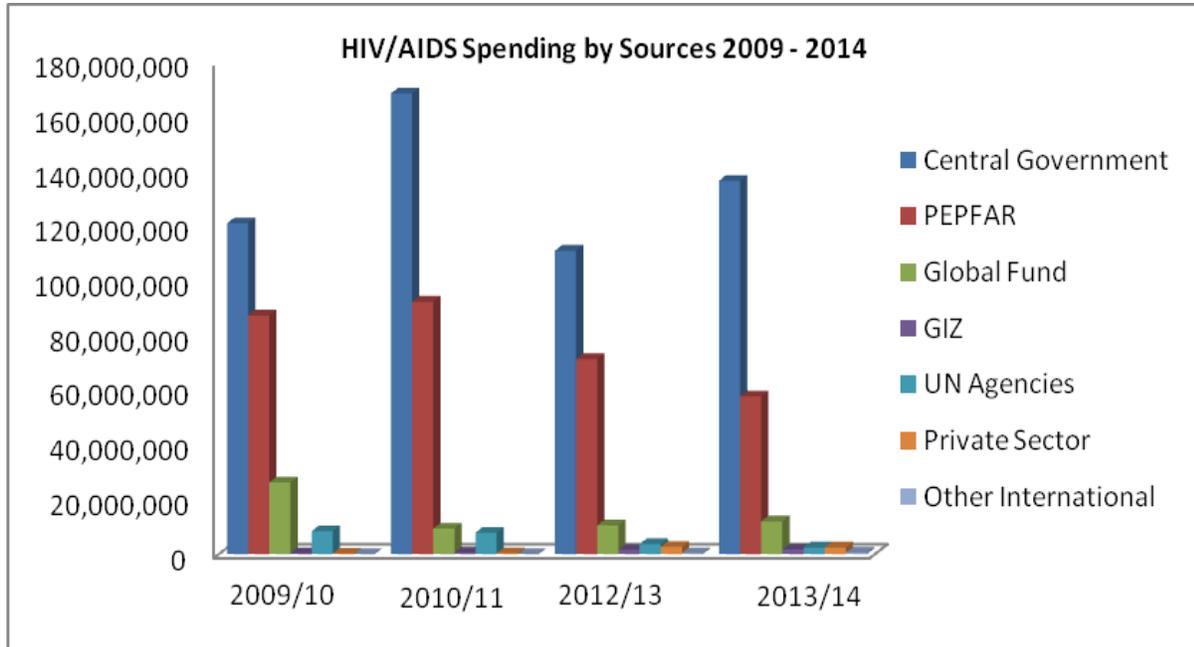
TB cases (Yr.)	9,882		459		483		3,634		5,399		National TB program data (2014, unpublished)
TB/HIV co-infection	3,993	44.0%	75	18.0%	68	16.0%	1,723	49.0%	2,129	41.0%	Electronic TB Register (2014) and paper-based data collection
Military Subpopulation	17,000		NA	NA	NA	NA	3,400	20.0%	13,600	80.0%	NDF (2013)
Military Prevalence (%)		NA		NA		NA		NA		NA	No prevalence study has been done to date
Males Circumcised	1,335	3.2%			0	0%			1,335	3.2%	National program data of men circumcised through VMMC 15 - 29 years old (2014)
Key Populations	[REDACTED]	NA	NA	NA	NA	NA	[REDACTED]	NA	[REDACTED]	NA	[REDACTED]
Total MSM	[REDACTED]	NA									[REDACTED]
MSM HIV prevalence		[REDACTED]									[REDACTED]
Total FSW	[REDACTED]	NA									[REDACTED]
FSW HIV prevalence		[REDACTED]									[REDACTED]
Total PWID HIV Prevalence	NA	NA									Data Unavailable
Total Transgendered Women HIV Prevalence	NA	NA									Data Unavailable

**Table 1.1.2 Cascade of HIV Diagnosis, Care and Treatment (12 months)**

Table 1.1.2 Cascade of HIV Diagnosis, Care and Treatment (12 months)											
				HIV Care and Treatment				HIV Testing and Linkage to ART			
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV+ (#)	Initiated on ART (#)	Source, Year
Total Population	2,280,716	14.0%	214,956	NA	131,721	84.0%	86.0%	264,698	18,729	NA	HIV prevalence is for 15 - 49 year olds, NDHS 2013; Total PLHIV population estimates (2011 census projections) against NDHS 2013 HIV prevalence and Spectrum (2014) for pediatrics
Population less than 15 years	830,064	2.6%	21,386	NA	10,575	83.0%	69.0%	NA	NA	NA	Spectrum (2014) and MOHSS program data
Pregnant Women	55,000	16.70%	9,940	NA	NA	NA	NA	58,350	9,667	4,380	Total PLHIV is modeled on ANC Sentinel Surveillance Report (2014) prevalence against modeled population estimates based on 2015 census projections (2011 - 2041)
Military subpopulation	NA	NA	2,380	15	316	100%	5	12,962	935	316	Site report from MoD
MSM	[REDACTED]	[REDACTED]	[REDACTED]	NA	NA	NA	NA	NA	NA	NA	[REDACTED]
FSW	[REDACTED]	[REDACTED]	[REDACTED]	NA	NA	NA	NA	NA	NA	NA	[REDACTED]
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	

## 1.2 Investment Profile

Namibia recently 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 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 adopted the new WHO treatment guidelines in 2014, which will result in an increase in the number of people eligible for and initiated on treatment. In 2014, Namibia revised its testing strategy to move toward universal knowledge of HIV status. Additionally, GRN is developing a new ART operational plan to meet the ambitious NSF targets of initiating 95% of HIV eligible positive people on ART. A new first line regimen using fixed-dosed combination of FTC/3TC/EFC was introduced in 2014. It has higher treatment costs than the previous regimen of AZT/3TC/EFV. As a result, additional spending on or budget for ARV drugs and laboratory services will be required.

UN agencies are developing an Investment Case for Namibia, which will present an opportunity to assess various programmatic choices, model their impact and relative costs, and make decisions about the optimal investment of resources for HIV based on actual needs. Data analyses indicate that if the current trajectory of ART enrollment is maintained, HIV incidence will increase and the cost of covering an increasing number of PLHIV on ART will become unaffordable for the GRN and international development partners. PEPFAR will be working in tandem with the UN on recommendations for the Investment Case.

Inadequate human resources (absolute numbers and geographic mal-distribution) pose a major challenge for achieving targets. Namibia is faced with one of the most severe public-health workforce shortages in the world. Eighty 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, 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 Polytechnic of Namibia's Bachelor degree programs in biomedical sciences and logistics. This is in addition to the nursing and public health trainings at the 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.

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

<b>Program Area</b>	<b>Total Expenditure (USD)</b>	<b>PEPFAR</b>	<b>GF</b>	<b>GRN</b>	<b>Other</b>
ARVs	15,359,215		29%	71%	
Rapid test kits	2,181,039			100%	
Other drugs	24,907,856			100%	
Lab services	11,114,344 <sup>5</sup>	30%		70%	
Condoms	1,996,565			100%	
Other commodities	9,902,602	22%		78%	
<b>Total</b>	<b>65,461,621</b>	<b>8%</b>	<b>7%</b>	<b>85%</b>	<b>0%</b>

<sup>2</sup> Namibia National AIDS Spending Assessment (NASA) 2013/2014

<sup>3</sup> This is the only lab line item listed in the NASA. Other lab costs are captured under treatment and care activities. There is no way of knowing how much the other lab costs are from the available data.

<sup>4</sup> 2013/14 spend data from SCMS

<sup>5</sup> Note that the amount is what is paid for laboratory services and not just lab reagents.

**Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives (2014)**

<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	----	----	----	----	NA
USAID TB	----	----	----	----	NA
USAID Malaria	----	----	----	----	NA
Family Planning	----	----	----	----	NA
NIH	----	----	----	----	NA
CDC NCD	----	----	----	----	NA
Peace Corps	----	----	----	----	NA
DOD Ebola	----	----	----	----	NA
MCC	----	----	----	----	NA
Private Sector	----	----	----	----	NA
PEPFAR Central Initiatives	\$10,596,681	\$10,596,681	13	\$21,749,876	Strengthen partner country: SI capacity; TB/HIV collaboration in selected districts; GF-related coordination capacity; private partnerships for mobile HIV services
<b>Total</b>	<b>\$10,596,681</b>	<b>\$10,596,681</b>	<b>13</b>	<b>\$21,749,876</b>	

Source: USAID 2015, CDC 2015

### 1.3 National Sustainability Profile

Results from an assessment conducted jointly with the GRN are mixed, but overall the country is moving toward sustainability. Four elements are the most promising: performance data, access and demand, quality management and resource generation. Eleven elements are in the middle of the spectrum. No elements were found to be at the low end of the spectrum.

The assessment indicates Namibia is still dependent on external support for collecting and analyzing HIV/AIDS epidemiological data. Additionally, the government is not systematically tracking HIV/AIDS financial and expenditure data. The GRN has not institutionalized data on HIV incidence and key populations, which also negatively impacted the score.

In the domestic program and service delivery domain, Namibia scored lowest in two areas: supply chain and HRH. The lack of a supply chain plan and standard operating procedures contributed to the low score. Additionally, a Namibian National Supply Chain Assessment (SCMS, 2013) gave Namibia a score below 80%. Assessment results indicated average levels of capability of key supply chain functions such as forecasting, procurement, warehousing and transportation and high for order fill rate, on-time delivery, expiry and facility reporting rates completeness.

Inadequate HRH remains one of the most serious sustainability challenges facing Namibia. The number of staff is insufficient and they are not distributed strategically to meet demand. For instance, a greater number of personnel are located at the district and intermediary hospitals than at rural health centers and dispensaries. PEPFAR Namibia previously supported pre-service and in-service trainings for clinical and support staff and will continue to collaborate with GRN to build the capacity and increase the numbers of health personnel in priority regions, where the HIV burden is the highest.

In the health financing and strategic investment domain, Namibia scored in the low-middle of the sustainability spectrum despite GRN funding 64% of the HIV response. One of the challenges in domestic financing included no specific budget allocation for interventions targeting key populations. Additionally, GRN's net lending/borrowing as a percent of GDP averaged 4.2% from 2011 to 2013, greater than the 3.1% threshold in the MCC scorecard for fiscal policy. As of 2015, GRN budget allocation for health is 10% of the general GRN budget (National Budget Speech, PWC, 2015), well below the 15% target set by the Abuja Declaration.

Namibia has one of the highest per PLHIV expenditure rates in Southern Africa. Many of these expenditures are for procurement of ARVs, which are double the price of those purchased in neighboring South Africa. Namibia does not participate in the pooled ARV procurement system used by other countries in the region. 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 assessment indicates that Namibia should increase transparency in working to achieve HIV/AIDS program targets and improve stewardship of HIV/AIDS finances. While the national HIV/AIDS program does produce annual progress reports, they are not disseminated beyond print reports and presentations and, thus, are not available to the majority of Namibians. Also, the GRN does not yet 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 demonstrates that Namibia could take further action to create policy and legal environments that remove obstacles to HIV prevention, treatment, care, and support and reduce 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 the CSOs engaged in the national response. While engagement exists between CSOs and GRN, the GRN does not track and map all CSOs HIV/AIDS activities. GRN engagement with the private sector is similar. Active coordination by GRN with these two other sectors could improve the HIV/AIDS response, fill service delivery gaps and avoid unnecessary duplication of efforts.

#### **1.4 Alignment of PEPFAR Investments Geographically to Disease Burden**

PEPFAR Namibia is categorized as a co-financing, targeted assistance program. Until FY14, PEPFAR Namibia was focused on transitioning components of support to the GRN and spent the majority of funding on strengthening capacity to increase a country-led, managed, implemented and financed response. Historic EA data demonstrates the shift away from technical assistance focus at the national level with 52% in FY13 and a decline to 33% in FY14 of total PEPFAR expenditures. It is expected that

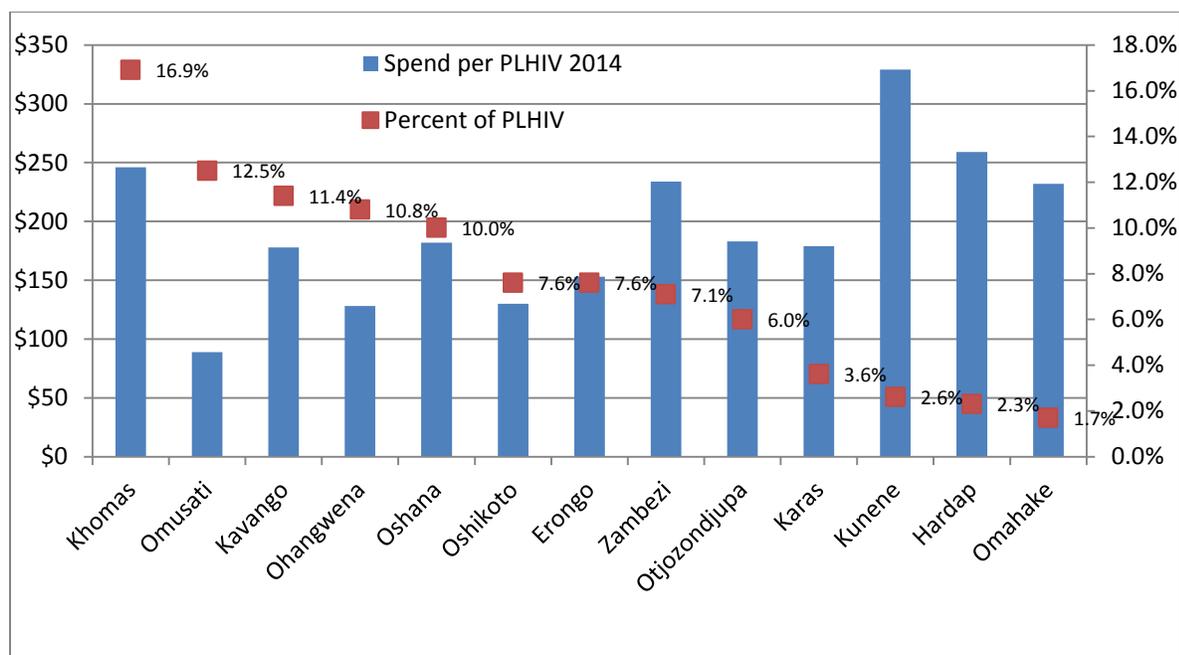
with the pivot to priority regions during COP14/FY15 period, the decrease will continue in above site and national level expenditures and there will be an increase in expenditures at the site level in priority regions.

COP14 represented a pivot in geographic focus and in the focus of expenditures on interventions to achieve epidemic control. For COP15, PEPFAR will further increase spending at the site-level in priority regions to achieve saturation and improve the continuum of care cascade. The targets and activities of PEPFAR Namibia’s Proposal to Accelerate the Scale-Up of HIV Treatment in Namibia to Achieve 80% Coverage by 2017 have been incorporated within COP15.

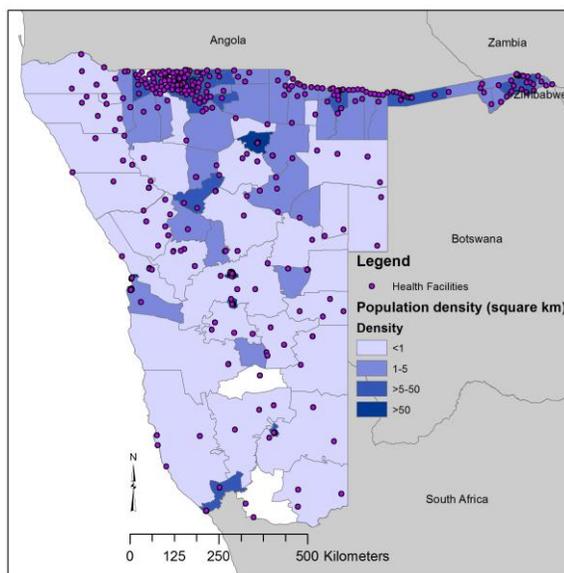
Figure 1.4.1 represents FY14 PEPFAR Namibia expenditures per PLHIV by region in comparison to the regional PLHIV burden. The figure represents SNU1 (regional level) EA data, since Namibia is a TA country and EA data are not available for SNU2 (district level). The spend represents all PEPFAR implementing partner project expenditures at the regional level divided by the total number of PLHIV per region. The percentage of PLHIV represents the proportion of each region to the total number of PLHIV in Namibia. This chart indicates that the level of PEPFAR spending per PLHIV was not well aligned with the proportion of PLHIV in each region.

For the FY15 EA, PEPFAR Namibia will demonstrate a significant decrease in total PLHIV expenditures in non-priority regions and increased spending in priority regions where there is the highest PLHIV burden and greatest unmet need for ART. To increase economies of scale, the amount to be spent per PLHIV in priority regions will necessitate ongoing analysis and interpretation.

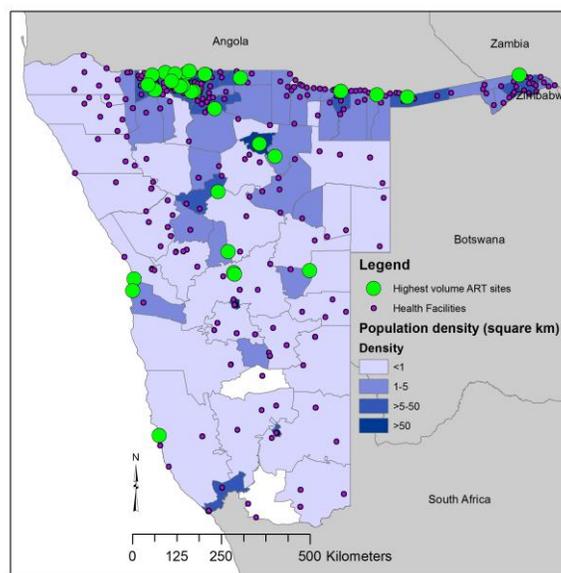
**FIGURE 1.4.1 PERCENT OF PLHIV BY REGION AND PEPFAR, FY14**



**Source: 2014 PEPFAR Namibia Expenditure**



**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 CHP country. In July 2014, the GRN and USG signed a Letter of Intent with four objectives:

1. Jointly develop a plan to enhance coordination and improve effectiveness of USG contributions
2. Develop an effective strategy for program monitoring and data use for evidence-based decision making
3. Jointly examine and refine USG operating procedures to ensure greater transparency of budgeting and financial monitoring of USG HIV/AIDS resources without compromising procurement integrity
4. Jointly develop more effective strategies for local civil society and the private sector to partner with GRN in expanding access to and delivery of HIV prevention, care and treatment services

As an initial step after COP14 approval, the USG, in partnership with the GRN's NPC, convened a PEPFAR stakeholders meeting in November 2014 to present PEPFAR 3.0 and the implications for Namibia. Meeting participants included government, civil society and development partners. Presentations and discussions focused on epidemic data, strategic direction, and program shifts from national technical assistance to support that aligns with the epidemic. The jointly conducted sustainability assessment was presented and discussed in small groups, allowing for stakeholder feedback and input.

Since that time, the USG and GRN have had numerous engagements on the development of COP15. On February 12, 2015, the Chief of Mission met with the co-signatories of the CHP Letter of Intent - the Director General of the NPC and the Minister of Health - to request GRN staff participation in the COP15 planning process, confirm commitments to the development of the CHP, and share the jointly completed SID. On March 4, the USG and the NPC co-convened a consultation to co-present data on the epidemic and to obtain initial input in the development of the COP. Meeting participants included representatives from a range of government sectors, including health, gender and child welfare, and the Office of the Prime Minister. The purpose of this meeting was to align interventions to the geographic burden of the disease in order to achieve epidemic control and inform work plans and M&E strategies.

To enrich technical collaboration for COP development, senior LES met with DSP in the MOHSS to establish a process for increased joint planning. On March 16, the DSP called a meeting of all technical staff and the PEPFAR Namibia country team to map out a plan for joint technical planning. On March 17, PEPFAR technical staff participated in the Combination Prevention Strategy TAC Meeting. On March 26, an interagency PEPFAR group visited the MGECW to discuss collaboration related to OVC. This was a very fruitful dialog, as the new Child Care and Protection Act had recently passed, reducing the age of consent for HIV testing and introducing universal access to lifelong ART for all HIV+ children. The PEPFAR team presented epidemiological data and the need for geographic focus, producing agreement that PEPFAR OVC work would focus in the priority regions. Several requests for technical support related to counseling and testing and linkages with treatment for OVC came out of that meeting and have been incorporated into COP 15. On March 30, PEPFAR technical staff met with the DSP's Community Based Health Care subdivision for joint planning. The meeting mapped out gaps, described bottlenecks and recommended solutions that could be supported by the GRN and PEPFAR.

After a few weeks of informal meetings between the PEPFAR ITTs and DSP technical leads, the DSP organized a MOHSS-PEPFAR meeting on April 8-9, 2015 for Regional Officers from the seven priority regions to determine what was needed to accelerate the achievement of ART targets and scale up to saturation. During this meeting, regional teams mapped out gaps, described bottlenecks and recommended solutions that could be supported by the GRN and PEPFAR. Selected site-level recommendations that came out of this process were incorporated into the COP. After incorporating inputs from stakeholders, PEPFAR Namibia shared a draft of the SDS with the GRN and elicited written feedback.

The results of these engagements and the subsequent SDS and proposed ART acceleration plan became the basis for discussions on co-investments with the GRN. Applying Global Health Diplomacy, the Chief of Mission met to discuss the COP15 with the Director General of the NPC and the Minister of Health. During those meetings, the Chief of Mission initiated a dialog on co-investments to scale up to saturation and achieve epidemic control and discussed the development, over the next few months, of a written arrangement related to the ART Acceleration Proposal under the CHP.

On May 11, the NPC, MOHSS and the U.S. Embassy co-convened a high-level meeting to jointly present the COP15 to USG and GRN leadership. PEPFAR and GRN jointly presented the geographic prioritization of regions with highest HIV prevalence/HIV burden and urban hot spots, and proposed key activities, COP15 funding levels by technical area, and targets. Participants agreed to the methodology and the proposed plan for PEPFAR's role in accelerating progress towards epidemic control in Namibia.

#### *Multilateral Partners*

Engagement with multilateral partners is routine and ongoing. UNAIDS, UNICEF, and WHO participated in the stakeholder meetings described above. The PEPFAR Namibia team collaborates closely with the GF, and recently held a meeting with the newly appointed Fund Portfolio Manager for Southern and Eastern Africa. The USG has representatives on the CCM and engages in joint planning. PEPFAR agency leads and the coordinator attend monthly health development partners (HDP) meetings convened by WHO. At the April HDP meeting, PEPFAR presented the highlights of COP15. Additionally, the PEPFAR Coordinator's Office met with UNAIDS as part of COP15 planning to discuss matters of mutual interest, including the recently completed legal environment assessment, their plans for conducting a national stigma index and the Investment Case (still in development). UNAIDS requested PEPFAR's

technical support in conducting the stigma index. At the May 11 stakeholder meeting, UNAIDS presented their remarks on the COP15 proposal.

PEPFAR Namibia views civil society as a critical partner for achieving and sustaining epidemic control. PEPFAR strengthens CSOs through capacity building and bilateral or sub-agreements. Local CSOs are engaged through PEPFAR and, in FY 2014, CSOs received \$3,625,010, or 16.2% of PEPFAR FY14 funding. CSOs participated in a number of COP15 development meetings held in November, March and the May.

On March 5, PEPFAR convened a COP15 planning meeting for CSOs separately from the GRN meeting, to allow for free discussion. The meeting included 40 participants from a wide range of CSOs including those that serve the geographic areas with the highest HIV burden. Participants included those representing key affected populations, umbrella network groups, NGOs, activist and advocacy groups, women's organizations, and LGBTI populations. At this meeting, the PEPFAR team presented an overview of the HIV epidemic in Namibia. Small breakout groups were formed on thematic areas including targeting and geographic prioritization, identifying gaps and challenges to Namibia achieving epidemic control, improving civil society and PLHIV engagement in the response, and increasing CSO involvement to provide input to the implementation of PEPFAR activities. PEPFAR also participated in the UNAIDS/Namibia meeting on accelerating to achieve 90-90-90 and interacted with CSOs during group exercises.

Immediately following the May 11 meeting with GRN, PEPFAR held a meeting with representatives from civil society and multilateral partners. Following the COP15 presentation, there was a lively discussion and question and answer period. Civil society aired their concerns about what some considered an overemphasis on treatment and the reduced support for traditional prevention approaches. Others were concerned with the emphasis on the biomedical model and lack of attention to social and structural factors that create vulnerability to HIV infection. Details of the discussion are documented in the supplementary civil society engagement plan.

CSOs agreed that PEPFAR needs to target regions with high burden and prevalence and that key populations (MSM and FSW) and priority groups, such as AGYW and PLHIV, should receive special attention. At the district and site level, it was noted that civil society can drive advocacy, should be included in the design and implementation of programs targeted at key populations and priority populations, and that health care workers need sensitivity training to reduce stigma and discrimination. Gaps identified included the lack of decentralized ART services closer to clients, weak linkages and referrals between service delivery and communities, limited services for adolescents, and decreasing donor funding.

Human rights issues are a critical component of sustained epidemic control in Namibia. CSO representatives asked PEPFAR to avoid an abrupt end to services in non-priority regions and stated that more needs to be done around access, quality, retention and coordination.

Greater partnership is needed between GRN and CSOs to improve efficiencies, expand access to HIV services, and improve retention and adherence in the poorer performing regions. 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. 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 engaged with the private sector during the COP15 planning through a private sector umbrella organization. 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.

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

In COP14, PEPFAR Namibia conducted its first core/near-core/non-core exercise to pivot the program and address the HIV epidemic in the right places with the most impactful activities. For COP15, the team built on this exercise in three ways:

1. Completing an in-depth and extensive analysis using the latest data available
2. Discussing prioritization and data with an expanded group of stakeholders
3. Intensifying co-planning with GRN counterparts at both the national and regional level for a more granular gap analysis and plan.

This deep dive into data led to further refinement of geographic prioritization and pivoting from a regional technical assistance focus to an intensified site-specific program. COP15 is based on implementing activities most essential to achieving epidemic control and relieving the bottlenecks that preclude scale-up to saturation.

Core activities will focus on accelerating the identification and diagnosis of HIV+ people through intensified and expanded HTC, initiating these individuals in treatment, and strengthening the care and treatment/continuum of care cascade among priority and key populations in targeted districts. Priority areas of intervention for core PEPFAR-funded activities include decentralization and scale-up of ART services to saturation, accelerated implementation of Option B+ and EID, increased VMMC coverage, implementation of evidence-based prevention strategies for key populations, improved targeting and focus of OVC programming, and strengthened linkages between clinical and community-based services to improve adherence and retention.

Near-core activities will include time-limited technical assistance to the GRN, targeting program support that catalyzes epidemic control. Near core activities will institutionalize a quality improvement approach and strengthen health systems at sub-national levels, in particular the HIV-related components of the health supply chain, HRH at service delivery sites, and laboratory systems.

While important to the national HIV response, activities identified as non-core will no longer be supported by PEPFAR. These include procurement of commodities and lab consumables, national lab standards development and accreditation, condoms for the military and HRH support in non-priority regions. Centrally supported sites (transition) planning for non-core activities has been developed and is being operationalized. Savings, as a result of discontinuing non-core activities, are estimated at \$14,690,640. These resources are being redirected to support ART scale-up to saturation and other core activities in COP15.

### 3.0 Geographic and Population Prioritization

HIV prevalence, PLHIV burden and unmet need for ART vary across Namibia. Based on Namibia’s HIV epidemiologic data, seven out of 13 regions represent approximately 80% of the disease burden (see Table 3.1). In COP15, Namibia is pivoting from regional TA to a site-based approach. PEPFAR will support treatment scale up and other HIV services in all of the 144 ART facilities in priority locations, breaking down to 63 DSD and 81 TA sites<sup>6</sup>.

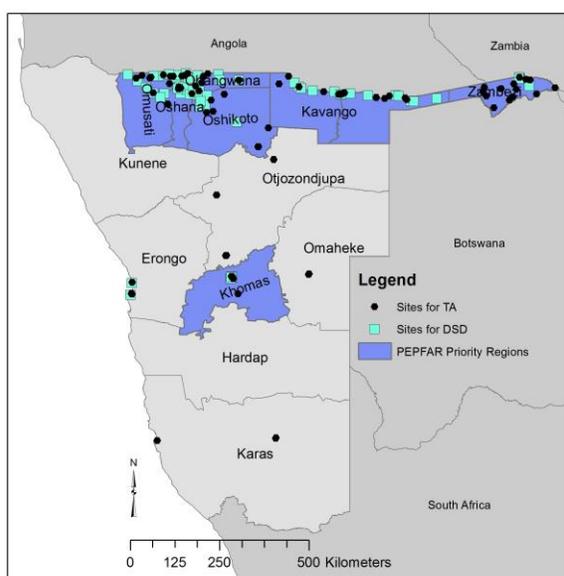
Namibia has eight urban hotspots outside the seven regions with disproportionately higher than national HIV prevalence (see Table 3.1). These hotspots have high concentrations of key populations, large ART sites (1,200+ patients), and military personnel. There are also high TB case rates and/or MDR TB burden in some urban hotspots in the south and west. While the military has installations in many parts of the country, it operates only one ART clinic in the country. Special focus is needed to target these urban hotspots and ensure a continuum of prevention, care and treatment services to achieve ART saturation.

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 as identified for the COP16 implementation period.

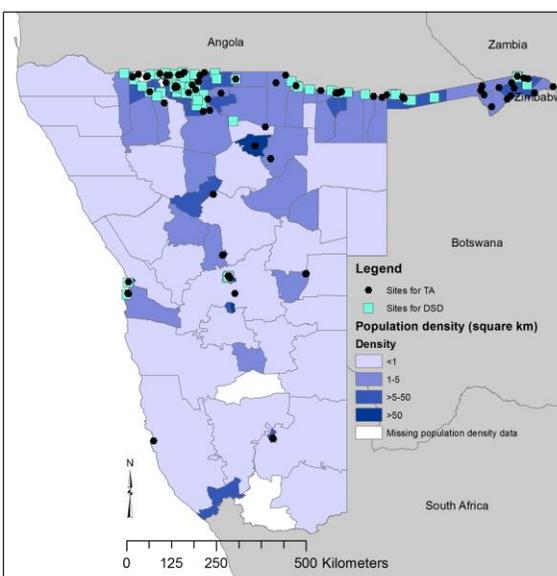
<b>Table 3.1: Priority Regions and Hotspots for COP15</b>	
<b>Priority Regions (7)</b>	<b>Urban Hotspots (8)</b>
Kavango	Gobabis
Khomas	Grootfontein
Ohangwena	Keetmanshoop
Omusati	Luderitz
Oshana	Okahandja
Oshikoto	Otjiwarongo
Zambezi	Swakopmund
	Walvis Bay

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<sup>6</sup> The level of support may vary per site once a comprehensive facility assessment is completed.



**FIGURE 3.1: TA AND DSD SITES FOR COP15 IN PRIORITY REGIONS AND HOTSPOTS**



**FIGURE 3.2: TA AND DSD SITES OVER POPULATION DENSITY**

**TABLE 3.2: SUMMARY OF COP15 TARGETS BY REGION**

Priority Regions /Hotspots	Newly Enrolled on ART	PMTCT	OVC	HTC	VMMC	TB/HIV
<b>Priority Regions</b>						
Kavango	2,979	1,309	3,669	47,748		335
Khomas	2,341	1,590	5,112	43,059	6,500 (private sector)	210
Ohangwena	2,890	1,252	2,638	49,250		412
Omusati	1,782	1,261	3,525	37,088		253
Oshana	414	936	1,886	49,934	9,000 (8,000 public and 1,000 private)	202
Oshikoto	1,664	905	1,545	35,637		253
Zambezi	1,405	889	2,521	21,277	6,000 (public sector)	174
<b>Urban Hotspots</b>						
Gobabis	77	157		3,436		97
Grootfontein	300	122		3,335		50
Keetmanshoop	217	55		4,899		160
Luderitz	100	78		2,927		41
Okahandja	300	240		3,341		68
Otjiwarongo	300	182		4,582		114
Swakopmund	500	164		5,220		109
Walvis Bay	977	487		8,264		220
Military					2,700	

## 4.0 Program Activities for Epidemic Control in Priority Locations and Populations

### 4.1. Targets for Priority Locations and Populations

#### *ART Targets Process and Assumptions*

The total number of PLHIV in Namibia is estimated at 214,956. The target for ART is 81% of this total population, or 174,114. Currently, there are 146,321 PLHIV on ART in Namibia. Of those, 111,639, or 76% (including estimate from private sector<sup>7</sup>) are located within the seven priority regions with more in the eight hotspots.

Adding the public and private sector ART numbers, the national ART gap is estimated at 27,793. The seven priority regions and eight hotspots account for approximately 80% of ART need (24,603<sup>8</sup>) to achieve saturation, adjusted upward by 15% to 38,615 to account for new infections, loss-to-follow-up, and unknown numbers of patients crossing into Namibia for ART over the next two years.

PEPFAR will provide targeted support (both technical assistance and DSD) to national and sub-national GRN entities to scale-up ART to saturation. PEPFAR is using a 40/60% approach: 16,246 people newly enrolled in COP15 and 22,369 newly enrolled in COP16.

During COP15, PEPFAR sites will support 8,982 newly enrolled on ART through site-level technical assistance and 7,264 through site-level DSD. PEPFAR will support 144 sites in the seven regions and eight hotspots for ART scale up. PEPFAR Namibia will focus technical assistance on 31 existing high-volume ART sites accounting for >80% ART patients and 32 functioning IMAI sites. PEPFAR will provide DSD support to decentralize ART expansion in 81 sites.

**Table 4.1A: ART Target Summary Table**

<b>In Namibia</b>	<b>Number</b>	<b>Notes/Sources</b>
Total PLHIV	214,956	NDHS (2013) Namibia Population Projections 2011-2041 (2014)
Target for ART	174,114	81% of total PLHIV in Namibia (90% x 90%)
Currently using ART (public and private)	146,321	EDT, 2014; SHOPS/MOHSS (68.1% ART coverage)
National Treatment Gap	27,793	80% PLHIV minus current on ART
<b>In Priority Regions</b>		
<b>In Priority Regions</b>	<b>Number</b>	<b>Notes/Sources</b>
Total PLHIV	165,121	Namibia Population Projections 2011-2014 (2014)
Target for ART	133,748	81% of Total PLHIV in priority regions (90% x 90%)
Currently using ART	111,639	National program data (2014)
Treatment Gap	22,109	Target minus current
Target for ART for 8 urban hotspots	2,494	
Net Target	24,603	
Adjustments	14,012	LTFO, non-residents, new infections
Adjusted target to achieve saturation	38,615	

<sup>7</sup> Based on data analysis from private sector providers, approximately 14,600 people are prescribed ART through the private sector.

<sup>8</sup> Includes 617 newly enrolled on ART among military personnel.

<b>Table 4.1.1 ART Targets in Priority Sub-national Units for Epidemic Control</b>					
<b>SNU</b>	<b>Total PLHIV</b>	<b>Expected current on ART (2015)</b>	<b>Additional patients required for 80% ART coverage</b>	<b>Target current on ART (FY16) TX_CURR</b>	<b>Newly initiated in FY15 TX_NEW</b>
Kavango	26,236	13,390	7,599	16,369	2,979
Khomas	32,419	17,954	7,981	20,295	2,341
Ohangwena	26,166	16,449	4,484	18,652	3,168
Omusati	28,357	19,527	3,159	22,361	1,869
Oshana	19,838	15,632	238	16,046	414
Oshikoto	17,330	11,749	2,115	13,329	1,577
Zambezi	14,775	8,178	3,642	9,583	1,405
Total	165,121	86,430	29,218	116,635	13,753

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

To reach the enrollment goal of 38,615, 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, and HIV+ patients identified among priority and key populations.

HTC 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 HTC sites in the country, 166 are in priority regions and account for 85% of the HTC volume and approximately 90% of the HIV+ in 2014. During COP15 and COP16, additional volume will be achieved by supporting MOHSS to scale up in-patient PITC at high-volume district hospitals (10 in 2015 and 21 additional in 2016). In addition, there will be 79 community-based HTC sites (stand-alone VCT sites, outreach sites, home-based targeted testing sites and the health extension workers) that will target key populations, partners of index patients and OVC. These approaches will increase the volume of HTC and achieve increased yield and volume of HIV+ newly identified.

Based on the different HTC modalities, PEPFAR estimates that that 321,179 people will need to be tested during COP15 to achieve the goal of 16,246 newly enrolled on treatment. Note that a 20% downward adjustment on the number of HIV+ individuals identified has been made due to repeat testing and double counting for all modalities. The same assumption applies to COP16 targets as well.

Similarly, during COP16, PEPFAR will need to identify 27,416 HIV+ people to achieve the ART saturation goal of 22,369. These numbers account for those not linked into care, repeat testing and other structural issues.

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 10,000 HIV+ patients will be identified through PMTCT during COP15. Historical data indicates that approximately 50% of

HIV+ pregnant women will already be receiving ART. PEPFAR 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 will enroll 80% of newly identified TB/HIV co-infected patients on ART. The national ART program does not routinely collect data on the number of PLHIV on pre-ART; however, it is estimated that they constitute approximately 5% of the current number of patients on ART in the priority regions. PEPFAR will target to reach 50% of these during COP15.

The remaining stream of entry to ART comprises PLHIV and other priority populations identified through different HTC modalities. PEPFAR will enroll 5,800 of these newly identified PLHIV on ART during COP15. Of these, 4,800 will be identified through facility and community-based HTC provided to 200,000 adult clients.

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 HTC 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 9,134 infants born to HIV+ mothers will be tested during COP15. Of these, 4% are expected to be HIV+ and will lead to approximately 362 infants <1 year of age initiated on ART. These HEI will make up 40% of the OVC to be tested during COP15. In total, PEPFAR expects to enroll about 1,000 HIV positive OVC on ART during COP15.

<b>Entry Streams</b>	<b>Tested for HIV (in FY16)</b>	<b>Identified Positive (in FY16)</b>	<b>Enrolled on ART (in FY16)</b>
Clinical care patients not on ART (pre-ART)	NA	NA	2,554
TB-HIV patients not on ART	7,905	3,162	2,592
HIV-positive pregnant women	55,307	5,183 <sup>9</sup>	4,665
Other priority and key populations	5,700	723	615
HTC (PITC, OVC, EID)	252,267	7,205	5,820
<b>Total</b>	<b>321,179</b>	<b>16,273</b>	<b>16,246</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 will support DSD of VMMC to reach 80% MC coverage by 2017 in three of the seven priority regions (Khomas, Oshana and Zambezi) and through the military. For COP15, VMMC targets 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 priority regions (Zambezi 14%, Oshana 18% and Khomas 31%). To meet the 80%

<sup>9</sup> Excludes known positives already on ART

MMC strategic coverage goal by 2017, the projected APR16 coverages for each of the regions (Zambezi 55%, Oshana 50% and Khomas 42%) were used to calculate the number of VMMC procedures required. Based on these calculations, in COP15 PEPFAR will target 14,000 VMMC in the public sector, 7,500 (6,500 in Khomas and 1,000 in Oshana) by private health practitioners and 2,700 through the NDF/MOD.

Target populations (Males, 15 – 29 years)	Population size estimate <sup>10</sup> (priority SNU(s))	Current coverage estimate of males 15 – 49 years <sup>11</sup>	COP 15 target	Expected coverage COP 15, Males 15 - 49 years
Kavango	33,255	33%	NA	33%
Khomas	61,996	31%	6,500	42%
Ohangwena	37,591	12%	NA	12%
Omusati	36,235	16%	NA	16%
Oshana	28,231	18%	9,000	50%
Oshikoto	29,639	16%	NA	16%
Zambezi	14,514	14%	6,000	55%
Military	NA	NA	2,700	NA
<b>Total</b>	<b>241,461</b>	<b>26%</b>	<b>24,200</b>	<b>36%</b>

*Key and Priority Populations Target Setting Process and Assumptions*

No country specific data are available for FSW, MSM, transgendered women or 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).

PEPFAR defines AGYW as a priority population. AGYW size estimates are based on population projection estimates for 2015, using the 2011 census published by the NSA. Only priority regions are included. A national coverage target is defined in the NSF, 2010/11 – 2015/16 as 90%. PEPFAR recognizes the target and contributes approximately 45% of activities through multiple implementing mechanisms.

Target populations	Population Size Estimate (priority SNU(s))	National Coverage Goal 2016/17	FY 2016 Target
Female Sex Worker (FSW)	8,082	90%	5,320
Men who have Sex with Men (MSM)	6,538	90%	3,825
Adolescent Girls & Young Women (AGYW)	174,858	90%	96,000

<sup>10</sup> Source: Namibia Population and Projections 2011-2041, NSA 2014

<sup>11</sup> Source: Namibia Demographic and Health Survey, 2014

<sup>12</sup> Sources: Census 2011 Population Projection for 2015

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

OVC targets include CLHIV age 0-15 and HIV-affected children (e.g. children of PLHIV including HEI or AIDS orphans). The target for OVC served is based on the number of PLHIV <15 estimated from Spectrum (2014) and the number of orphans enumerated in the 2011 census. Based on SIMS OVC program data, it is estimated that 65% of OVC being served have unknown or undocumented HIV status. As a result of these findings, PEPFAR set a target of 80% OVC served to be referred and linked to HTC.

OVC access is a subset of OVC served. An anticipated 80% of OVC served will need specific HIV-based services within facilities and communities. These services include HIV testing and counseling, 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. Of children newly diagnosed with HIV, 100% will be linked to care and treatment services.

<b>Table 4.1.5 Targets for OVC and Pediatric HIV Testing, Care and Treatment</b>						
<b>SNU 1</b>	<b>Estimated # of OVC</b>	<b>Estimated # of Children PLHIV (&lt;15)</b>	<b>Target # of active OVC (FY16 Target) OVC_SERV</b>	<b>Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target) OVC_ACC</b>	<b>Target # of children tested (FY16 Target)</b>	<b>Target # of children on ART</b>
Kavango	11,358	1,649	3,669	2,934	2,934	295
Khomas	17,041	3,753	5,112	4,090	3,272	161
Oshana	12,526	2,376	2,638	2,102	2,102	301
Omusati	13,099	2,330	3,525	2,820	2,256	187
Oshana	12,294	1,750	1,886	1,509	1,509	41
Oshikoto	10,367	1,805	1,545	1,236	1,236	113
Zambezi	5906	911	2,521	2,017	2,017	141
<b>Total</b>	<b>82,591</b>	<b>14,574</b>	<b>20,896</b>	<b>16,708</b>	<b>15,326</b>	<b>1,239</b>

#### **4.2. Priority Population Prevention**

PEPFAR Namibia defines priority populations as AGYW. HIV prevalence among AGYW in priority regions ranges from 2.7% in Oshana to 19.2% in Zambezi. Women aged 15 - 24 reported an average of 2.8 sexual partners during the past 12 months. In Oshana, the ratio of HIV+ AGYW to HIV+ young men is 6.2.

*[REDACTED]*

MOHSS issued a Combination Prevention Strategy focused on reducing new HIV infections by coordinating essential interventions (PMTCT, ART, VMMC, and condoms) and complementary interventions (advocacy, social mobilization and communication) to achieve and sustain population coverage. In COP14, PEPFAR Namibia closed stand-alone general population, community-level behavioral change activities and will continue its focus on the evidence-based combination prevention essential interventions.

In COP15, community-based prevention interventions will be aligned to highest disease burden areas and to both priority and key populations. Activities for AGYW will be conducted in priority regions. Activities for key populations will be conducted in seven urban areas: Windhoek, Walvis Bay, Swakopmund, Keetmanshoop, Oshikango, Katima Mulilo and Oshakati.

HIV prevention interventions will accelerate epidemic control among AGYW and increase coverage among FSW and MSM. PEPFAR will deliver targeted risk reduction counseling, condom distribution, GBV activities and mobilization to increase uptake of PMTCT, HTC and VMMC. PEPFAR will test innovative models to deliver PrEP and HIV care and treatment services to high-risk young women and key populations through SRH/HIV clinics and communities, in partnership with MOHSS. PEPFAR will assist MOHSS to integrate HIV services into domestically-financed, community-health platforms in high-priority regions. Appendix A2 lists detailed activities.

#### **4.3 Voluntary Medical Male Circumcision**

VMMC is a core component of PEPFAR's HIV prevention portfolio in COP15. Only 25.5% of the male population aged 15 – 49 self-report being circumcised. EIMC and MMC are not routinely offered in most health facilities.

The national VMMC strategy focuses on rapid scale-up in seven priority regions targeting 330,000 males aged 10 – 49 years. Program challenges include uncertain demand, barriers to care and HCW shortages. MOHSS conducts demand creation and service delivery through fixed facilities, outreach, mobile services and private clinics. The GRN has also approved task-shifting for nurses and deployed dedicated VMMC teams.

The PEPFAR VMMC program restarted in FY15. The VMMC program uses a mix of fixed and mobile sites. PEPFAR and GF support seven priority regions to rapidly scale-up VMMC services and integrate EIMC into newborn care services. About 204,000 MMC are required to achieve saturation among males aged 15 – 29 in these locations.

PEPFAR will support DSD (including health care worker salaries and training, commodity procurement and M&E) of VMMC focusing on males aged 15 – 29. PEPFAR will work in three priority regions (Khomas, Oshana and Zambezi) and military bases to achieve 14,000 MMC in the public sector and 7,500 MMC by private health practitioners. The military comprises 2,700 MMC (19%) of the country total. Military personnel, families, and members of communities near bases will be the focus of the VMMC program.

Technical assistance will support demand creation, quality assurance, supply chain and M&E activities. PEPFAR will fund a contingency stock of VMMC surgical kits to accommodate VMMC scale-up in Namibia. Appendix A2 lists detailed activities.

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

PEPFAR has been supporting the GRN to scale up PMTCT, update its guidelines and develop an eMTCT action plan to reduce MTCT to less than 5% and increase EID to 95% by 2015/16. However, there is shortage of trained staff, weak mentorship, inconsistencies in quality of Option B+ and EID service

delivery, lack of real time data capture and reporting tools, and weak linkages between facilities and communities for active post-natal mother/baby follow-up.

In COP15, PEPFAR will focus its PMTCT/EID technical assistance to 31 high-volume ART sites in priority regions and three urban hot-spots to ensure 95% of pregnant women know their HIV status, 95% of HIV+ pregnant women have access to immediate initiation of ART, and 95% of HEIs are tested for HIV and linked to care.

PEPFAR will support:

1. Early identification and initiation of treatment for all HIV+ pregnant and breastfeeding women
2. Active follow-up and tracing using facility based and community cadres and mHealth tools
3. Robust mentorship and supervisory systems including QA/QI program
4. Linkage between PMTCT and ART programs
5. Standardized mother-baby follow-up care for HEI and EID
6. Monitoring, evaluation and data systems for PMTCT and EID

Of the selected 144 facilities, 58 sites (34 outreach for ART and 24 without ART services) do not have Option B+ on site. In COP15, PEPFAR will provide support to these sites to initiate life-long ART. Appendix A2 lists detailed activities.

#### **4.5 HIV Testing and Counseling (HTC)**

In Namibia, HTC services are provided through health facility-based self-referral, ANC and TB programs, stand-alone VCT, private health facilities and mobile/community-based programs. As of 2013, 75.8% of individuals aged 15–49 reported being tested at least once for HIV. In 2014, PEPFAR Namibia HTC served 264,026 clients nationally in 335 HTC sites. A yield analysis indicated that 29% of HTC sites contributed 80% of reactive tests. Out of the 335 high-volume and high-yield sites in the country, 144 are located in regions and hotspots prioritized for COP15.

Namibia experiences gender and age disparity in HTC services. Facility HTC is poorly accessed by OVC, adolescents, men, couples and key populations. PITC implementation is limited. Two national shortages of HTC commodities have impacted testing in the last 12 months. Specific priority locations have unmet need for HTC. In 2014, PEPFAR transitioned 550 HTC counsellors to the MOHSS budget. Community-based HTC remains dependent on external assistance.

In COP15, PEPFAR Namibia will help increase HTC uptake, yield and linkage to ART in priority locations and populations. This support includes supporting a mix of DSD and technical assistance to national (guidelines and M&E), district (QA, M&E) and facility/community site-level. PEPFAR Namibia will prioritize assistance to scale-up PITC in public and private health facilities, support targeted community-based HTC, partner notification services and linkage to HIV care and treatment services. Technical assistance will initiate a multi-year transition of community-based HTC to the Health Extension Program. Appendix A2 lists detailed activities.

#### **4.6 Facility and Community-Based Care and Support**

The number of HIV+ clients either 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 priority regions and facilities to increase ART enrollment of patients already registered in care and now eligible for ART under new national guidelines to initiate all PLHIV with CD4<500.

PEPFAR will focus technical assistance to:

1. Dispense cotrimoxazole and INH prophylaxis to eligible clients
2. Improve TB/HIV care cascade
3. Strengthen adherence and retention of patients in care and treatment – including piloting innovative models
4. Validate the current pre-ART patient data registered in ePMS

At the community level, PEPFAR will provide TA to deliver child-focused OVC services and nutrition care for malnourished HIV positive adults and children. PEPFAR will also provide targeted technical support to improve pediatric care and support by:

1. Expanding the EID system and POC testing
2. Strengthening PMTCT-ART-care linkages and follow-up of mother-baby pairs to improve retention of HIV-infected children in care
3. Strengthening health system areas such as quality assurance, supply chain, and in-service training for staff at existing and new ART and/or NIMART sites
4. Continuing to support community adherence support and tracking of patients who are lost to follow-up

Appendix A2 lists detailed activities.

#### **4.7 TB/HIV**

Namibia had the fifth highest TB incidence (651 per 100,000 population) in 2013 (WHO). The estimated MDR prevalence is 3.8% among new TB patients and 16.4% among previously treated TB patients (Namibia TB drug resistance survey, 2008/09).

The TB/HIV burden remains high, with 44% HIV prevalence among TB patients with known HIV status (NTLP, 2014). HTC coverage among TB patients is high (92%) but remains below the 100% target. ART coverage for HIV+ TB patients increased to 84% in 2014 but remains below the 100% target. Data on TB screening/ICF, TB IPT and TBIC are limited. HIVQUAL indicates high TB screening rates among PLHIV in HIV care and treatment (~95%). However, no data are available on how TB screening is conducted, results of TB screening (proportion positive), outcomes of follow-up diagnostic evaluations, TB diagnosis among PLHIV in care and treatment settings and linkage to TB treatment. Based on HIVQUAL data, IPT uptake remains low (<30%). No data are available on IPT completion rates. TBIC implementation data are limited and no data on TB among healthcare workers are available routinely. Gaps remain in addressing TB/HIV among children/adolescents.

PEPFAR Namibia will support activities to:

1. Ensure patients with presumptive TB or TB disease receive HIV testing and immediate access to ART to achieve universal (100%) ART coverage through clinical mentorship, targeted training and QI
2. Support integration of TB/HIV care and treatment to ensure linkage and retention through expansion of TB/HIV clinical service delivery model, TB/HIV collaborative activities into ANC/PMTCT/MCH settings, and TB ICF/IPT and TB diagnostic testing into existing outreach and mobile testing platforms
3. Support TBIC to prevent transmission in healthcare and community settings through accelerating implementation and M&E of revised national guidelines, including the FAST strategy (**F**ind TB cases, **A**ctively, **S**eparating safely, and **T**reating effectively) and development of a system for prevention, screening, diagnosis and treatment among HCWs
4. Expand interventions, including Xpert MTB/RIF assay, to improve early diagnosis and effective treatment of TB among PLHIV by expanding access to rapid TB diagnostics and strengthening linkage to facility and community-based TB screening/ICF; and through support for high quality TB treatment and comprehensive DR-TB management
5. Strengthen TB/HIV program M&E through improved TB/HIV data collection, reporting and analysis/utilization including improving recording, reporting and outcomes analysis for pediatric and adolescent populations
6. Ensure that children and adolescents, pregnant women, and other vulnerable populations (people in prisons, mines, and fisheries) are included in all TB/HIV program activities

Appendix A2 lists detailed activities.

#### **4.8 Adult Treatment**

PEPFAR will support the GRN's implementation of new adult treatment guidelines by:

1. Increasing the number of adults linked and newly initiated on ART in priority regions
2. Promoting adherence and retention in care
3. Improving access to lab services, especially VL testing, for care and treatment.

PEPFAR will contribute to the saturation of ART in priority areas through decentralization of services from over-burdened, high-volume sites to lower-level facilities through task shifting, NIMART, and IMAI. PEPFAR will help build 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 ART Acceleration Proposal, PEPFAR will provide 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 will also provide time-limited technical assistance to build HCW capacity in CQI to ensure quality of care and improve operational efficiency. Promotion of adherence and retention in care will be supported through technical assistance for supply chain management systems strengthening (ARV selection, quantification and forecasting) and other evidence-based interventions. The EDT will enable more ART facilities to dispense ARVs. In COP15, laboratory access will be expanded at the point of care

(e.g. CD4 POC testing) and central laboratory capacity for VL testing will be further strengthened, facilitating linkage to care, early ART initiation and timely monitoring of ART clinical outcomes.

Appendix A2 lists detailed activities.

#### **4.9 Pediatric Treatment**

PEPFAR supported 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. While the change in guidelines is welcome, challenges in the pediatric treatment program remain. These include weak documentation of CLHIV services and clinical outcomes, sub-optimal quality of service delivery, and weak linkage of pediatric treatment program with OVC and PMTCT/EID services. Additionally, the VL suppression rate among children/adolescents on treatment is lower than adults and active loss-to-follow-up tracing of children and adolescents on treatment is weak.

In COP15, PEPFAR will continue its technical assistance to priority regions and sites in Namibia to improve pediatric treatment services by:

1. Ensuring linkages to HIV care and treatment for all CLHIV through decentralization of ART services
2. Promoting pediatric case finding and expanding clinical laboratory monitoring of children and adolescents on treatment
3. 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
4. Delivering in-service training to providers on the monitoring, supervision, documenting and provision of pediatric HIV services
5. Supporting clinical mentorship, mHealth and community volunteers to improve adherence and retention in treatment
6. Engaging HIV+ adolescents to better understand their challenges and unique needs in order to improve treatment support

Appendix A2 lists detailed activities.

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

Spectrum (2014) estimates 110,000 OVC are a result of HIV. PEPFAR Namibia's current OVC activities support 19,307 OVC in all 13 regions of Namibia. In COP14, pivots were made to align activities to priority regions based on epidemiological data, shifting focus to high-burden/high-volume sites. Some activities in non-priority regions were transitioned, while others will be transitioned to GRN as awards end in FY15.

PEPFAR will provide care and support to OVC through three approaches:

1. Support a case management demonstration project that will ensure enrolled children and families are followed longitudinally and provided services, as determined by assessments.
2. Ensure HIV testing for children and caregivers by strengthening linkages to child health services, including for those under five.
3. Increase access to ART services and support adherence and care retention for HIV+ children and adolescents.

For OVC and caregivers who qualify after a household assessment, PEPFAR will strengthen linkages to socio-economic support to mitigate the effects of HIV and build resilience of OVC and families, e.g. household savings schemes and cash transfers, and targeted support to keep at-risk AGYW and OVC in school. PEPFAR will implement prevention activities for HIV negative AYGW and OVC. For HIV+ AGYW and OVC, PEPFAR will support activities to improve health and well-being, including psychosocial support. For at-risk and or HIV+AYGW and OVC, PEPFAR will support adolescent-friendly sexual and reproductive health services. At the community, PEPFAR will support interventions to reduce violence, raise the status of AGYW, and increase assets of girls and their families, such as saving schemes, cash transfers and parenting programs.

PEPFAR will provide national-level technical assistance to GRN to:

1. Integrate case management and implement family-centered services into existing OVC programs
2. Infuse lessons learned from the demonstration project into the national OVC program
3. Operationalize OVC policies to align with HIV guidelines for testing, counseling, treatment and disclosure
4. Support the development of job aids and training for HIV disclosure, HIV testing and access to treatment for OVC
5. Provide capacity building to GRN and CSO around OVC
6. Improve the M&E system to increase the availability of OVC data, including conducting the OVC MER 1.5 essential survey.

Appendix A2 lists detailed activities.

#### **4.11 Peace Corps**

Peace Corps will shift from facilities-based placements to community-based placements. This shift will position Volunteers to target youth 15-19 years of age with testing, adherence support, VMMC mobilization, and links to care and PMTCT services for the demographic. Peace Corps will enhance behavior change and social mobilization training for Volunteers. Volunteers will employ those skills with the narrowed focus of 15-19 year olds, leveraging close working relationships Volunteers have proven to foster with youth. PC will roll out adherence group development and support using the MoHSS methodology and best practices from Peace Corps Mozambique and Botswana.

## **5.0 Program Activities to Maintain Support for Other Locations and Populations**

### **5.1. Maintenance Package of Services in Other Locations and Populations**

As a result of geographic prioritization, PEPFAR's technical assistance for St. Mary's Hospital in Rehoboth, Hardap Region is being discontinued. Discussions with the GRN and Catholic Health Services (CHS) indicated that services at the site will not be negatively impacted. In its place, PEPFAR will provide technical assistance (central support) to a high-volume site in one of the priority regions. PEPFAR support being transitioned includes salary support for community counsellors and data clerks by September 2016. In COP15, PEPFAR Namibia will provide a maintenance package of services through above site-level technical support (central support) to build the capacity of the hospital and district in HIV

prevention, care, and treatment services, M&E, and data quality and management systems with MOHSS policy and guidelines.

<b>Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Non-priority Districts</b>				
<b>Maintenance Volume by Group</b>		<b>Expected result APR 15</b>	<b>Expected result APR 16</b>	<b>Percent increase (decrease)</b>
HIV testing in PMTCT sites (percentage)	PMTCT_STAT	88	92	4%
HTC (only maintenance ART sites in FY16)	HTC_TST	1,048	1,200	13%
Current on care (not yet initiated on ART)	CARE_CURR-TX_CURR	3,800	3,000	(21%)
Current on ART	TX_CURR	1,050	1,210	15%
OVC	OVC_SERV	3,447	3,447	0%

Source: PMTCT, HCT and ART projections from one site supported by USAID/IntraHealth in FY15 Q1

Sustained support (a maintenance package) will be provided with core and near-core OVC services in the non-priority regions and districts to 7,060 OVC. The maintenance package will include comprehensive and integrated OVC care and support, and linkage with HIV prevention, care and treatment activities. PEPFAR will support a maintenance package of services to OVC in non-priority regions/districts as four projects in non-priority areas transition/come to an end and as OVC transition or graduate from the program to GRN system or private sector due to age.

During COP15, PEPFAR support for the NDF will discontinue for HIV prevention, HIV testing and counseling, care, lab, health systems strengthening and HIV/TB. A maintenance package will be provided of above site-level TA to build capacity of military health officials in HIV prevention, care and treatment services, as well as monitoring and evaluation.

## **5.2 Transition (Central Support) Plans for Redirecting PEPFAR Support to Priority Locations and Populations**

Over the next year, PEPFAR support for sustaining laboratory commodities, laboratory accreditation (including SLMTA) support for establishment of National Public Health Laboratories, and general in-service training at non-priority regions will be transitioned to respective regional health directorates. Resources will be redirected to priority regions. Discussions have started with the GRN and CHS to transition St. Mary's Hospital in Rehoboth by mid-2016.

PEPFAR through central support will transition routine supervisory support visits, district data review meetings, in-service trainings and lab consumables procurement to the Regional Health Directorate and District Health Management teams. PEPFAR support in non-priority sites will be reduced and central support for OVC in nine districts in the non-priority regions transitioned to GRN by September 2016. PEPFAR will work closely with the MGECW and relevant stakeholders (e.g. UNICEF and GF) to refine OVC transition plans to support the GRN in the management and coordination of activities during the transition period. The expected number of OVC to be affected by this transition out of non-priority districts is 7,060.

## 6.0 Program Support Necessary to Achieve Sustained Epidemic Control

### 6.1 Laboratory Strengthening

PEPFAR currently supports basic laboratory infrastructure in 40 laboratories, HIV rapid testing quality assurance in 363 testing sites, 8 regional laboratories for accreditation and SLMTA implementation in 16 laboratories. In COP15, PEPFAR will focus on 26 laboratories, 145 RT sites, and 70 CD4 POC sites and expand POC testing to 50 new sites. Testing sites and laboratories outside the priority regions will be transitioned to GRN over the next year.

The following laboratory bottlenecks to scaling up ART services in the priority regions have been identified: 1) limited capacity for routine VL testing to assess adherence and effectiveness of ART, 2) inadequate quality of HIV and CD4 testing, and 3) limited access to EID, CD4 and other essential bio-clinical monitoring testing for ART initiation.

In order to address these gaps, PEPFAR Namibia will support the GRN's core laboratory activities by:

1. Implementing continuous quality improvement for HIV RT, CD4 POC and other bio clinical monitoring tests
2. Increasing HIV viral load testing capacity
3. Supporting the specimens transport to VL testing hubs and result return to health facilities
4. Expanding POC testing for CD4 and other essential bio clinical monitoring testing
5. Auditing laboratories and providing support visits to testing sites

1. Brief Activity Description	Deliverables		Budget codes and allocation (US\$)		7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016		8. HIV Testing	9. LTC - Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Provide QA for all clinical laboratory testing: RT, EID, VL and CD4 POC	Development of QA system for all RT sites, VL and EID laboratory hubs, and CD4 POC testing sites	Implementation and expansion of sites for the QA system	HLAB 423,783	HLAB 523,783		X	X			

Auditing of laboratories and testing sites to assess implementation of continuous QA	Continuous quality improvement implemented in 16 laboratory hubs	Continuous quality improvement implemented at 10 additional (26 in total) laboratory hubs	HLAB 133,306	HLAB 133,306		X					
Increase laboratory capacity for HIV VL testing	HIV VL testing available at 16 laboratory hubs	HIV VL testing available at 10 additional (26 in total) laboratory hubs	HLAB 1,126,671	HLAB 1,126,671							X
Support specimens referral system	Specimens referral system to viral testing hubs in place for 144 health facilities in priority regions and hot spots		HTX 410,050	-----							X
Expansion of POC testing to sites	Point of care testing machines and devices for required tests for ART initiation Such as serum creatinine and Hepatitis B s Ag available at 144 sites in priority regions and hot spots as required by Namibia national guidelines	-----	HLAB 194,800	-----				X	X		

Expand SMS printers to priority sites	SMS printers available at all sites in priority regions and hot spots	-----	HLAB 136,800	-----			X	X		X
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## 6.2 Strategic Information (SI)

In general, SI systems in Namibia function effectively. However, a number of gaps limit the effectiveness of national and sub-national systems in achieving sustained epidemic control. The most critical SI issues include:

1. Absence of ongoing tracking of the HIV epidemic through biomarkers
2. Lack of integration and interoperability among various HIS
3. Need for enhanced routine data dissemination and data use for planning and implementing
4. Shortage of GRN M&E staff to implement monitoring systems.

While Namibia has conducted integrated bio-behavioral surveys among both the general population and key/vulnerable populations in 2013, additional population-based data are needed. PEPFAR will support GRN with proposed HIA with an integrated VACS component and a National Orphans and Vulnerable Children Outcome Assessment. Nationally representative survey (including HIV biomarker) will provide data points for HIV testing and uptake amongst adolescents. These surveys will assist GRN and stakeholders in planning interventions for epidemic control.

A part of the Combination Prevention strategy, PEPFAR will implement two PrEP demonstration activities, one for AGYW and one for key populations. All enrolled clients in PrEP uptake will be routinely testing for HIV.

The GRN operates more than 60 stand-alone HIS at the national and sub-national levels (2012 HIS Inventory). During COP15/16, PEPFAR will assist the GRN to develop enterprise architecture that will allow interoperability between the most critical HIS and support deployment of the newly developed DHIS 2.0. These systems will be linked through a HIE interoperability layer and a unique HIV/ART unique patient ID code system to allow for real-time monitoring of patient outcomes, including VL suppression. HIE/inter-operability later will allow for linkages between key HIV patient level systems and enable GRN to track patients from entry point at HTC throughout the HIV continuum of services, including ART patient outcome and VL monitoring.

The development and implementation of a comprehensive HIV logistics management information system ensures through enhanced logistics management systems that no stock-outs occur at health facilities when ART and other essential medicines are available at district and regional medical stores.

PEPFAR will conduct a study to refine protocols and procedures to use routine PMTCT data for nationalize HIV surveillance and integrate best practices and lessons into the GRN data systems. This will ensure the testing, early initiation onto ART, and monitoring of the proportion of HIV+ identified pregnant women that enroll in lifetime ART.

Ongoing/real time monitoring of HIV outcome data at sub-national levels (including HIV testing) will allow for program evaluation and resource changes necessary to achieve epidemic control. Ensuring that GRN staff members are able to utilize HIS data for performance monitoring and planning is a remaining need. PEPFAR will work with GRN counterparts to ensure institutionalization of routine and national survey HIV data collection, analysis, dissemination and use.

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016		7. HIV Testing	8. Linkage to Care (LTC)	9. ART uptake	10.*Other Combination prevention	11. Viral suppression
Develop and implement health Information Exchange	Key patient level systems assessed for interoperability points. HIE enterprise system developed and deployed. ePMS, EDT, MediTech and DHIS to be connected	Continued deployment of HIE and monitoring of system. Additional systems to be interconnected	Funded under SI CI	-----	Element: 1 Score: 15	X	X	X	X	X
Hire 32 data entry clerks on time-limited basis to assist with the shortage of SI human resources at sub-national levels in the collection of HIV program data (ART acceleration)	Recruit, hire and train site-level data entry clerks for enhanced data monitoring, quality and reporting for real-time epidemic analysis and decision making	Maintain site-level data entry clerks for enhanced data monitoring, quality and reporting for real-time epidemic analysis and decision making	HVSI 10,000 x 32 data clerks = 320,000	HVSI 10,000 x 32 data clerks = 320,000	Element: 7 Score: 13.5	X	X	X	X	X

plan)										
Design and implement a comprehensive HIV logistics management information system (LMIS)	Rapid assessment of regional and medical stores. Development and implementation of HIV essential medicine registers. Development of dashboard for monitoring of system	Ongoing monitoring of system. Strengthening MoHSS staff capacity to utilize system	HVSI – total cost 200,000 (and additional 500,000 from CI)	HVSI 150,000 for maintenance	Element: 6 Score: 9			X		
Operationalize use of routine PMTCT data for sentinel surveillance	Conduct study to refine protocol and procedures to use routine PMTCT data for nationalize HIV surveillance	Consolidate best practices and lessons and implement PMTCT service delivery data for national surveillance	PMTCT – 100,000	PMTCT – 100,000	Element: 3 Score: 15	X	X	X		
HIV Impact Assessment (HIA)	Develop HIA methodology, protocol approval and finalization of instruments. Begin ToT training for field supervisors. Recruit and train field staff. Begin data collection.	Continue HIA data collection. Finalize data collection. Release data analysis and results.	CDC HQ	CDC HQ	Element: 3 Score: 15	X		X		
Implement Violence Against Children Survey (VACS) (with HIV prevalence measurement)	Design methodology for VACS implementation national survey. Begin data collection	Continue VACS data collection. Finalize data collection. Release data analysis and results.	HVSI 150,000 - with co-funding with	HVSI 30,000	Element: 3 Score: 15	X		X		

			Global Fund							
Strengthen GRN national and sub-national data use, management, quality, and dissemination using the PRISM tool, allowing GRN to monitor and respond to HIV epidemic trends in real time	Ensure capacity of GRN staff to conduct ongoing trainings and support data use through ongoing HIV program data (national and sub-national) dissemination and use training.	Conduct data use sessions in all priority regions and districts	HVSI 200,000 Some funding already in place through SI CI	HVSI 200,000 Some funding already in place through SI CI	Element: 3 Score: 15	X		X		X
Support the completion of the first SISTER (Sentinel Incidence Survey To Evaluate the Response) in Zambezi Region.	Begin expansion of study in selected high prevalence regions.	Conduct ongoing monitoring of incidence surveillance activities	HVSI/H TX 100,000 20,000	HVSI/H TX 100,000	Element: 1 Score: 13.3	X	X	X	X	
Develop and implement systems to capture private sector patient-level HIV data	Work with private sector to develop and implement system for capturing HIV patient care and VMMC data at point of service.	Continue to work with private sector to develop and implement system for capturing HIV patient care and VMMC data at point of service.	-----	-----	Element: 1 Score: 13.3			X		X

Conduct HIV data triangulation	Design and implement data triangulation activity. Develop findings report and disseminate to relevant stakeholders	N/A	HVSI 120,000	-----	Element: 1 Score: 13.3	X	X	X	X	X
Implement HIV drug resistance surveillance systems	Support MOHSS to implement drug resistance surveillance data findings at national and sub-national levels for ongoing program planning, and epidemic control	Support MOHSS to conduct acquired HIV drug resistance survey	HVSI 20,000	HVSI 20,000	Element: 3 Score: 15					X
Strengthen capacity of GRN and stakeholder personnel to use mathematical modelling systems	Provide instruction, mentorship and guidance on using existing data to model impact in order to improve program design	Run 2016 Spectrum estimates in-country	HVMS2 0,000	HVMS 20,000	Element: 1 Score: 13.3	X	X	X	X	X
Revise and implement enhanced EPMS system to allow for provider-initiated data capture of real-time patient-level clinical outcome monitoring	Finalize demonstration and disseminate and analyze data findings	-----	HVSI 170,000	-----	Element: 1 Score: 13.3	X	X	X		

Design m-technology application and deploy to selected HEP sites	Purchase and deploy m-technology systems to ensure health extension workers have appropriate monitoring tools to capture key HIV community program indicators	-----	HVSI 150,000	-----	Element: 1 Score: 13.3		X	X	X		
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### 6.3 Health System Strengthening (HSS)

Based on gap analyses and the findings from an assessment conducted jointly with the GRN, PEPFAR has identified health systems that require strengthening to enable accelerated scale-up of HTC and ART in priority regions. PEPFAR will support targeted HSS efforts to improve access and uptake of HTC and ART. HSS activities will support the decentralization and expansion of service delivery, address human resource gaps and bottlenecks, explore effective health financing strategies, ensure a reliable supply chain, and improve the quality of services through increased efficiency in workflow and institution of QA/QI at site level.

The current inadequate numbers of staff in priority regions presents a serious challenge to scaling up HTC, ART and VMMC. The vast majority of health staff work in overburdened hospitals. In contrast, significant shortages of health personnel exist at health centers and dispensaries.

The HRH WISN Assessment found that the GRN has made minimal progress in task-shifting ART to nurses to ease HRH shortages. The MOHSS is in the process of restructuring health sector staffing to address these gaps, although the implementation of this plan is expected to take time. PEPFAR Namibia will assist the GRN to operationalize task-shifting by training and mentoring nurses at lower level health facilities and will, on a time-limited basis, assist the GRN in filling vacant posts critical to ART and HTC.

In COP15, PEPFAR will conduct HRH assessments in priority regions and assist regions in identifying and testing sustainable local solutions. At the national level, PEPFAR will provide technical assistance for the revision and implementation of the HRH strategy.

QI at the facility level is weak. Workflow processes at health facilities are inefficient and lead to congestion and long waiting times. PEPFAR will provide technical assistance to improve QI efforts at regional/district levels, in addition to workflow analysis and revision at select high-volume facilities.

The jointly conducted sustainability assessment highlighted weaknesses in allocative efficiency and technical efficiency. Namibia has a high expenditure per PLHIV (\$877), some two to three times higher than other Southern African countries (e.g. South Africa -\$285; Swaziland - \$376). Expenditure data are neither available for the subnational levels nor used in decision making. Namibia has not conducted cost-effectiveness nor cost-benefit analyses of ART options and approaches, and there has not been a detailed costing analysis for the revised treatment guidelines. PEPFAR will provide technical assistance to the MOHSS to design and conduct cost-effectiveness studies and cost-benefit analyses of ART service delivery models, testing and counseling services, and Option B+ roll-out. Additionally, PEPFAR will provide technical assistance for costing the HIV response in line with new treatment guidelines.

A 2013 assessment of the national supply chain system revealed potential risk for declining performance, most notably warehousing and procurement, high staff turnover rates with limited training for new staff, and fundamental changes to procurement processes. PEPFAR will provide TA to strengthen the supply chain at the national and subnational levels in priority regions.

Leadership and coordination of the HIV response at subnational levels are weak. An assessment found minimal understanding of the epidemiological profile at the regional and district level and that data are not routinely used for decision making (Source - NIS/Pact Assessment). PEPFAR Namibia will support activities in priority regions to help leadership use data to better understand the HIV epidemic, identify gaps and bottlenecks facing their region, and develop local solutions.

While a legal environment analysis has not been conducted in Namibia, civil society has noted two things: stigma and discrimination are barriers to service access and the voice of PLHIV in the HIV response is not heard. PEPFAR will strengthen the capacity for local PLHIV networks and organizations to enable active engagement in the HIV response. PEPFAR will also provide technical assistance in the analysis of data resulting from the Legal Environmental Assessment and the Stigma Index, both to be implemented by UNAIDS in 2015.

The Chief of Mission will apply health diplomacy to negotiate co-investments with the GRN in HRH, ARVs and commodities, and decentralized infrastructure.

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016		7. HIV Testing	8. Linkage to Care (LTC)	9. ART uptake	10.*Other Combination prevention	11. Viral suppression
Health Finance – support for improved allocative & technical efficiencies	Assist MOHSS to develop and implement pilot HIV expenditure tracking and analysis system at the facility level in	-----	OHSS 300,000	-----	Element: 2 Score:12 Elements: 8,9,10,11 Scores: 14, 7, 9, 10.8	X		X		

	priority regions. This system will assist GRN in determining actual costs and identifying efficiencies for HIV services (e.g. HCT, ART, etc.)									
Conduct technical assistance to MOHSS in support of gaining technical efficiencies in procurement, warehousing and logistics for domestic HIV supply chain management services.	HIV commodity security and procurement and logistics efficiencies	-----	OHSS 100,000	-----	Element: 6 Score: 10	X		X		X
HRH: support to inform MOHSS and USG of health care worker staffing requirements	Data collection and modeling of health care worker requirements to support HIV epidemic control in priority locations; Limited assistance to MOHSS and Health Professional Counsel of Namibia to revise the Nursing Scope of Practice to support ART initiation and related HIV-pharmacy services.	-----	OHSS 250,000	-----	Element:5 Score: 11.8			X		

	Technical support to the revision and finalization of the national HRH strategy (restructuring)									
Costing of laboratory and diagnostic services	Costing of laboratory and diagnostic services report available and used for decision making	----	OHSS 75,000	-----	Element: 2 Score:12 Elements: 8,9,10,11 Scores: 14, 7, 9, 10.8				X	
Adaptation of WHO HIV confirmation testing policy	Develop HIV confirmation testing policy	Implement HIV confirmation testing policy	OHSS 50,000	OHSS 50,000		X			X	X
Updating of HIV/AIDS and TB curriculum for UNAM School of Medicine to align with new national guidelines	Curriculum including HIV AIDS elements updated and in use for UNAM medical students	----	HSS 50,000	-----	Element:5 Score:11.8	X	X	X	X	X
Capacity building for MOHSS in epidemiology and data analysis to improve allocative efficiency, understanding and responding to the epidemic to support the transition of	MOHSS staff capacitated in epidemiology and data analysis; improved data use for decision making and resource allocation (based on 90/90/90)	----	HSS \$410,000	-----	Element:5 Score:11.8				X	

FELTP										
Continue to support dedicated time-limited national, regional and district RM&E staff	Adequate RM&E staff at national and regional at above site level to support the site level data clerks	-----	HSS \$427,938	-----	Element:5 Score:11.8	X	X	X	X	X

## 7.0 Staffing Plan

### 7.1 Analysis of Team in Context of Pivot

As a result of the strategic pivots and an increased emphasis on data analysis and use during COP14, PEPFAR Namibia determined that a regional-based interagency technical presence was necessary to provide direct, real-time support of HIV epidemic control, including QA/QI support and SIMS implementation. Three staff at USAID and two at CDC were added to meet this need.

A major shift in staffing occurred during the COP14 pivot. Previous to COP14, technical assistance provided directly by USG agency staff was mostly at the national level and was usually charged to M&O. The COP14 pivot to site-level support in priority regions led to decreased M&O FTE and increased staff level of effort for specific technical areas.

Other changes in staffing include:

- Peace Corps FTE has been realigned to match the level of effort spent on PEPFAR. Two M&O positions shifted to other funding. Peace Corps is decreasing the number of staff fully funded by PEPFAR from nine to six. In total, Peace Corps will have 6 FTE. In addition, Peace Corps will support 57 PEPFAR-funded Peace Corps Volunteers.
- The PEPFAR Coordinator's Office, through State Department, is changing the number of FTE from two part-time FTEs and three full-time FTEs to four FTEs (the PEPFAR Coordinator, a Deputy Coordinator, a Health Assistant, and a Communications/Small Grants Officer). The PEPFAR Coordinator will continue to be funded through USAID.
- CDC is shifting two international contractors to local staff in COP14 and will transition two others in COP15. CDC will reduce the number of fellows by three. In total, CDC will have 45 FTE.
- USAID is repurposing positions for QA/QI and care and treatment. In total, USAID will have 32 FTE. USAID is shifting funding sources for four existing positions to PEPFAR: Program Development Specialist, Accountant, C&R/Receptionist, and HR/Travel Assistant.
- DOD will not replace the locally-employed staff position which is currently vacant.

To better align with core/near core activities, the PEPFAR Namibia team will:

- Eliminate CDC's medical epidemiologist position as FELTP was moved to non-core
- Repurpose USAID's Health Economist position to align with priorities to QA/QI Advisor
- Repurpose USAID's Senior Policy and Strategy Advisor to the Continuum of Care Team Lead.

PEPFAR plans to change the CODB in the next cycle by filling several positions with LE Staff, if qualified local applicants can be recruited. Our staffing principles commit PEPFAR first to advertise all positions locally but major challenges in finding qualified applicants have been encountered. Only 10% of the population 15 - 49 has post-secondary education (NDHS 2013). Even when qualified candidates are identified, PEPFAR agencies face serious challenges in recruitment due to the low local compensation package.

In order to meet SIMS requirements, all technical staff will participate in SIMS. The PEPFAR Team is in the process of establishing three field offices to secure an interagency presence in the priority regions to save resources, increase oversight, and improve efficiency.

The scope of unfilled positions has been modified to align with the new directions of COP15. For vacancies in COP14:

- CDC has filled two vacancies, two remain for the north field officer positions, and the Deputy Director for policy and communications has been repurposed to Deputy Director for programs;
- USAID has repurposed its unfilled positions from COP14 for the north. The field officer positions and three vacancies (OVC recruited: Data Analyst, QA Advisors, PDS budget) are in process.

Staff time dedicated to technical assistance through USG rather than partner support will continue. As a result of the pivot, PEPFAR USG staff shifted from generally providing technical assistance at the national level to providing technical assistance in priority regions and sites with the goal of increasing identification, enrollment, and treatment to achieve epidemic control. New field officers will provide site-level quality improvement/assurance support. PEPFAR 3.0 ongoing and new initiatives require staff and the intensification of data collection and analysis intensified as essential. SIMS, in particular, will impact not only on the number of staff required but will also require increased logistics and travel management.

At the national level, USG staff will continue to provide technical assistance to address: system strengthening; development of GRN policies, guidelines, and SOPs essential for epidemic control; assistance with monitoring quality implementation at the sites; and training and capacity building at the local level in priority regions.

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

**Table A.1 Goals per Program Core, Near-Core, and Non-Core Activities for COP 15**

Level of Implementation	Core Activities	Near-Core Activities	Non-Core Activities
<p><b>Site level</b></p>	<p>Pivot assistance to high burden regions and sites to increase HTC yield and ART enrollment to achieve 80% coverage</p> <p>Accelerate identification and diagnosis of HIV+ people through intensified and expanded HTC modalities</p> <p>Ensure immediate and lifelong ART for TB/HIV co-infected patients, discordant couples, and HIV+ children under 15, HIV+ pregnant women, and PLHIV with CD4 &lt;500</p> <p>Improve HIV continuum of care and treatment cascade among priority and key populations, including OVC</p> <p>Achieve viral suppression among 90% of pediatric and adult clients on treatment</p> <p>Strengthen linkages between clinical and community-based services for improved adherence and retention</p> <p>Support acceleration of Option B+ roll out, including EID</p> <p>Increase VMMC in priority regions</p>	<p>Target assistance for AGYW to receive integrated clinical HIV prevention, care and treatment services in high priority districts</p> <p>Provide TA to integrate case management into the existing government and CSO OVC programs</p> <p>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</p> <p>Strengthen capacity to institutionalize and improve service data quality, use and reporting</p>	<p>Support procurement of military condoms</p> <p>Conduct school-based OVC activities</p> <p>TB/HIV emergency commodity procurement</p> <p>Routine supervisory support visits</p> <p>Lab consumables procurement</p>

	<p>Support innovative models to deliver ARV-based prevention services, including pre-exposure prophylaxis and post-exposure prophylaxis, to high risk young women and key populations.</p> <p>Align OVC programming with other HIV services in priority regions 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>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 engagement/enrollment, adherence and retention, including gender inequality, GBV, stigma and discrimination</p> <p>Technical assistance to regional leadership</p>	<p>Conduct stand-alone general population prevention activities</p> <p>Support blood safety</p> <p>Conduct renovations in non-priority regions</p> <p>Hold routine data review meetings</p> <p>Conduct routine trainings</p>

		<p>to use data to better understand their HIV epidemic, identify gaps and develop local solutions</p> <p>HRH assessments to determine gap between needs and available staff and help develop localized 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 ART expansion in priority regions 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 QI (PDSA, measurement, monitoring) to improve linkage of OVC programs to HIV care and treatment services</p> <p>Improve ART data/measurement</p> <p>Provide TA to strengthen Namibia's supply chain ensuring availability of adequate HIV commodities</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>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>Provide TA to streamline registration and licensing of pharmacy personnel</p> <p>Provide TA for improving routine expenditure tracking from site level</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 15 (\*\* indicate 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 six urban hotspots to increase HTC uptake, support GBV activities, distribute condoms and expand access to PrEP and PEP for sex workers and gender/sexual minorities</p> <p>Conduct pilot project to introduce PrEP among sero-discordant couples and high-risk young women 19-29 years of age living in a sample of sites in high prevalence regions</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 priority regions</p> <p>Community-based social mobilization, risk reduction counseling, condom promotion, HTC and onward linkage in selected communities in high priority regions</p> <p>Provide technical assistance to selected</p>	<p>Provide support to general population HIV prevention utilizing stand-alone social and behavior change communications</p> <p>Procurement of condoms for the NDF</p>

		<p>high priority regions to integrate HIV services into the Health Extension Program</p> <p>Technical assistance to HIV-specific health information systems and selected studies to generate information on adolescent girls and young women, men, and key populations</p>	
<b>VMMC</b>	<p>Provide targeted assistance to MOHSS and MOD in priority regions 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 priority regions</p>		<p>Provide technical assistance on national VMMC planning and advocacy activities (refocused to service delivery in high priority regions)</p> <p>Technical assistance for impact modeling of VMMC (refocused to service delivery in high priority regions)</p> <p>Provide targeted assistance to The GF supported priority regions for VMMC service delivery (refocused to service delivery in high priority regions)</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 priority regions</p> <p>Recruit additional time-limited health care workers and data clerks to fill gaps in service delivery in priority regions**</p> <p>Support site-level physician and nursing mentorship at health facilities in high priority regions</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 priority regions</p> <p>Provide TA to HIV-specific health</p>	<p>Support male involvement activities (refocused to Option B+ service delivery) to support the Namibia First Lady's campaign</p> <p>Support health communications on PMTCT services (refocused to quality assurance activities)</p> <p>Conduct renovations in non-priority regions (refocused to Option B+ service delivery)</p>

	<p>Implement technical assistance to integrate FP/HTC services including linkage to care and confirmation retesting into ANC, L&amp;D, maternity and PNC settings in high priority regions</p> <p>Support scale-up of EID and mother-baby follow-up care, including breast feeding support in health facilities in high priority regions</p>	<p>information systems to support Option B+ implementation and HEI services</p>	<p>Procure laboratory reagents and commodities for EID (refocused to technical assistance on PMTCT SOPs)</p> <p>Conduct PMTCT impact evaluation study (refocused on EID service delivery)</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 priority regions</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 priority regions**</p> <p>Support increased uptake of HTC and linkage to HIV care and treatment among key populations in high priority regions 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 priority regions through health facility and community-based HTC models **</p> <p>Support HTC quality assurance activities at service delivery points in high priority regions</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>Salary support for HTC counselors in non-priority regions and low volume sites (refocused to PITC implementation in high priority regions)</p> <p>Transition service delivery of HTC targeting low yield rural communities and schools (refocused to targeted community HTC in high priority regions)</p> <p>Support to implementation of unique ID system for health services (refocused to quality assurance activities in high priority regions)</p> <p>Salary support for HTC-focused National M&amp;E Office (refocused to increasing HTC uptake in key populations)</p>
<b>TB/HIV</b>	<p>Improve early TB/HIV diagnosis</p> <ul style="list-style-type: none"> <li>Scale up of PITC to increase identification of HIV in suspects and</li> </ul>	<p>Conduct baseline assessment to determine magnitude of TB/HIV in the mining sector (implementation of SADC Declaration of</p>	<p>Emergency commodity procurement</p> <p>Routine supervisory support visits</p>

	<p>confirmed cases of TB</p> <ul style="list-style-type: none"> <li>Expand use of Gene Xpert for TB diagnosis in PLHIV, children and DR TB</li> </ul> <p>Strengthen early TB and ART treatment, retention and adherence through linkages and referral in clinical and community settings</p> <ul style="list-style-type: none"> <li>Provide ART to all TB/HIV co-infected patients within 2-8 weeks of beginning TB treatment</li> <li>Train existing cadres (field promoters, HEW and community counselors) on TB/HIV and TB infection control measures</li> <li>Expand service integration model for ART in TB settings</li> <li>Conduct mentoring sessions to health care workers to improve TB screening among PLHIV</li> </ul> <p>Support increased IPT uptake through quality-assured TB screening, patient awareness and education and documentation of IPT clients completion</p> <p>Integration of TB/HIV, management of DR TB into clinical mentorship support to clinicians</p> <p>Establish clinical and community-based adherence support interventions to improve treatment completion rates among PLHIV</p> <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>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-limited 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> <p>Lab consumables procurement</p>
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	<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>Support TB infection control (TB IC) measures to prevent transmission of TB in healthcare and community settings</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>Demonstration site for improved case management</p> <ul style="list-style-type: none"> <li>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</li> </ul> <p>Improve linkages</p> <ul style="list-style-type: none"> <li>Support linkages and facilitate access to community-based and facility-based HIV services including HTC, prevention, pediatric care, EID, routine child health services, such</li> </ul>	<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>Develop and implement guidelines/ SOPs on HIV disclosure and the provision of PEP for sexually assaulted children</p>	<p>Support school-based prevention and social protection activities</p> <p>Support school-based psychosocial support and safety from violence</p> <p>Support for vocational training components</p> <p>Support to ECD centers</p> <p>Support for community and national level child protection/GBV prevention and response activities</p>

	<p>as immunizations, treatment and prevention services</p> <ul style="list-style-type: none"> <li>• Refer to prevention programs for HIV negative OVC, especially AGYW</li> </ul> <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 socio-economic and household economic strengthening interventions</li> </ul>	<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> <li>• Facilitate referrals for birth registrations of OVC and caregivers</li> <li>• Provide technical assistance to CSO and GRN to improve OVC data systems for PEPFAR funded programs</li> <li>• Conduct OVC MER Essential Indicators Survey</li> <li>• Provide TA for OVC Curriculum development for Health Care Workers</li> <li>• Provide funding to continue support to the 611 counselling line to reach and help children</li> <li>• Provide targeted educational support such as cash transfers to facilitate school enrollment, progression and completion of OVC</li> </ul>	<p>National level GBV activities</p> <p>Support for residential care including foster parenting services</p> <p>Radio programs for children</p> <p>Child Rights Advocacy activities</p> <p>Technical assistance to transition ECD from MGECW to the Ministry of Education</p>
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		<p>Improve sub-national coordination of OVC programs</p> <ul style="list-style-type: none"> <li>• Provide TA to MGECW National and Sub national level structures (priority regions) 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 priority sites and district MOHSS offices to operationalize use of routine PMTCT data for ANC 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 Systems</b>	Support HIV care and treatment sites in linking ART patient VL tests to their HIV care and treatment files through linking the unique ART number to the lab information system	Provide targeted assistance to high-volume, priority ART sites for implementation of Logistics Management Information System (LMIS)	

		<p>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</p> <p>Create interoperability and integration of HIV patient level data systems through development of a Health Information Exchange</p> <p>Support Directorate of Pharmaceutical services to implement LMIS in priority regions</p>	
<b>Monitoring and Evaluation</b>	Implement and demonstrate proof of concept of a PrEP intervention in priority site(s) for AGYW	<p>Coordinate with regional level MGECW offices to implement MER OVC outcomes survey</p> <p>Build capacity of national and sub-national staff in priority regions to conduct HIV mathematical modeling activities</p> <p>Provide HRH support to high-volume priority sites through hiring of 32 data clerks to allow for continued high-quality data collection and reporting</p>	
<b>HRH</b>	<p>Support HRH assessments in priority regions to determine gap between available staff and required staff. Help regional leadership develop localized solutions</p> <p>Improve the performance of existing health care workers by providing NIMART training in the</p>	<p>Technical assistance on HRH at the MOHSS</p> <ul style="list-style-type: none"> <li>Support the revision and implementation of the MOHSS HRH strategy</li> </ul>	<p>Transition salary support for faculty positions at UNAM as part of pre service training</p> <p>Transition HRH capacity building support to Polytechnic</p>

	<p>seven priority regions 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>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 priority regions 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 program efficiencies</p> <p>Build capacity of GRN for expenditure analysis and unit cost estimation to inform</p>	

		budgeting and planning	
<b>Leadership &amp; Governance</b>		<p>Provide TA for analysis of data from the Legal Environmental Assessment and the Stigma Index, both to be implemented by UNAIDS in 2015</p> <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 in priority regions to IMAI/NIMART sites**</p> <p>Promote adherence and retention through the m-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 clients with</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 priority regions</p>	<p>Support implementation of the PMTCT Impact Evaluation</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>Pay for Early Infant Diagnostics (EID) testing</p>

	<p>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>Strengthen data use for 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>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>Audit labs and testing sites to assess implementation of continuous QA</p>
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Table A.3 Transition (Central Support) Plans for Non-Core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# 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
Coordination for implementation of activities toward lab accreditation including SLMTA	Non-core	-----	-----	1		Transitioned to NIP
Support for establishment of National Public Health Laboratory	Non-core	-----	-----	1		Transitioned to GRN/MOHSS
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	Non-core	-----	-----	1		

visitation components of community home-based care						
Household Economic Strengthening for PLHIV	Non-core	-----	-----	1		
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		
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	\$410,000	-----	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	\$427,938	-----	1	Sept 2016	
OVC Support for national level child protection/GBV prevention and response activities	Government/ MGECW transition	-----	-----		September 2016	Activities are funded by MGECW

Child rights advocacy activities	Government/ MGEWC transition	-----	-----		September 2016	Children's rights work is supported by UNICEF and Legal Assistance Centre.
School-based prevention, social protection psychosocial support and safety from violence activities	Activities will be transitioned to Ministry of Education (MOE) at the end of the project.	\$200,000	-----	1	September 2016	Life skills covering prevention, social protection psychosocial support and safety from violence activities integrated into MOE curriculum. MOE employs fulltime school counsellors to deal with school based PSS issue, counselling and referrals to social services
Support for residential care including foster parenting services	MGEWC	-----	-----		September 2016	Residential care financial support transitioned to MGEWC and foster parents receiving subsidies through GRN social grants
TA to assist with the transition of ECD program from MGEWC to the MoE	MGEWC	-----	-----		September 2016	The European Union is supporting GRN on ECD transitioning
Radio programs for children	Radio programs will be made available to stakeholders at end of project.	\$300,000	-----	1	June 2016	Radio program institutionalized into the organization and will continue post grant
Training, mentoring and supervision for NDF ART site	Transition to NDF	\$70,000	-----	1	September 2016	
<b>Totals</b>		<b>\$1,407,938</b>				

## APPENDIX B: Planned Spending

### B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
US\$ 27,792,447	US\$ 18,126,775	US\$ 45,919,222

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$606,727
HVAB	Abstinence/Be Faithful Prevention	-----
HVOP	Other Sexual Prevention	\$ 57,426
IDUP	Injecting and Non-Injecting Drug Use	-----
HMBL	Blood Safety	-----
HMIN	Injection Safety	-----
CIRC	Male Circumcision	\$2,856,596
HVCT	Counseling and Testing	\$38,818
HBHC	Adult Care and Support	\$551,930
PDCS	Pediatric Care and Support	\$1,015,336
HKID	Orphans and Vulnerable Children	\$2,560,655
HTXS	Adult Treatment	\$6,227,502
HTXD	ARV Drugs	-----
PDTX	Pediatric Treatment	\$678,022
HVTB	TB/HIV Care	\$688,248
HLAB	Lab	\$ 48,504
HVSI	Strategic Information	\$344,221
OHSS	Health Systems Strengthening	\$207,867
HVMS	Management and Operations	\$2,244,923
TOTAL		\$18,126,775

## **B.2 Resource Projections**

**Epidemiological and Program Data Analysis:** The PEPFAR SI and technical working groups started the process with an in-depth analysis of epidemiological and programmatic data to identify regional geographic priority areas based on disease burden and ART unmet need. These data and service delivery data from the MOHSS were further analyzed in terms of which had the greatest potential for rapid acceleration of ART (had high volume TB/HIV clinics, needed to roll out Option B+, had high HTC 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 HTC, PMTCT, OVC, and key population interventions.

**Gap Analysis:** During the COP process, PEPFAR worked closely with GRN to identify gaps. In particular, PEPFAR worked with seven Regional Health Directorates to identify gaps and bottlenecks and recommend solutions to address these gaps. At this point, during the COP15 planning, a fully accurate gap analysis for the GRN to meet its HIV National Strategic Framework goals is not available due to a lack of data. While there is an understanding of specific needs in regions based on gaps in the continuum of HIV services, no actual financial data are available. PEPFAR is working closely with the GRN, with support from OGAC and agency headquarters, to develop a methodology for quantifying this gap.

**PBAC:** Using limited Namibia EA data and costing data from neighboring countries, PEPFAR establish the unit costs needed to complete the PBAC. PBAC development was an iterative process allowing PEPFAR to reach earmarks and targets for achieve epidemic control. Priority geographic regions, sites and technical activities were then divided by IMs to ensure greatest efficiency.

**Outlier Analysis:** PEPFAR Namibia performed an outlier analysis of unit expenditures by active implementing partners during COP15 development. 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. In cases where there are demonstrated outliers a number of decisions were made as part of the COP14 review and the subsequent pivot to achieve epidemic control in Namibia during COP14 implementation and COP15 planning. These decisions included: transition to ending agreements of outlying partners that are not achieving contributing to core activities and; working closely with partners (i.e. Key Population Partner, Society for Family Health, Community Support and Testing partner - DAPP) to re-position 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.

### Namibia COP15 Targets by Health District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Andara	8,279	-	-	557	3,242
Aranos	-	-	-	-	-
Eenhana	9,803	-	-	1,080	3,198
Engela	33,402	-	-	1,489	11,513
Gobabis	-	-	-	77	1,350
Grootfontein	-	-	-	300	1,964
Karasburg	-	-	-	-	-
Katima Mulilo	21,319	-	-	1,416	8,147
Keetmanshoop	4,500	-	-	100	1,221
Khorixas	-	-	-	-	-
Luderitz	2,927	-	-	100	1,320
Mariental	-	-	-	-	-
Nankudu	3,707	-	-	314	1,392
Nkurenkuru	-	-	-	-	-
Nyangana	6,469	-	-	496	1,377
Okahandja	-	-	-	300	2,024
Okahao	6,663	-	-	230	3,817
Okakarara	-	-	-	-	-
Okongo	1,220	-	-	343	618
Omaruru	-	-	-	-	-
Omuhiya	-	-	-	-	-
Onandjokwe	32,996	-	-	1,127	15,037
Opuwo	-	-	-	-	-
Oshakati	49,935	-	-	422	11,120
Oshikuku	14,037	-	-	781	5,805
Otjiwarongo	3,151	-	-	300	2,249
Outapi	12,221	-	-	474	7,937
Outjo	-	-	-	-	-
Rehoboth	-	-	-	-	-
Rundu	18,389	-	-	1,317	5,585
Swakopmund	4,720	-	-	500	3,325
Tsandi	2,096	-	-	232	2,756
Tsumeb	5,978	-	-	537	2,981
Usakos	-	-	-	-	-
Walvis Bay	8,264	-	-	779	5,056
Windhoek	38,246	-	-	2,504	14,397
Other_ Namibia	-	-	-	-	-
<b>Total</b>	<b>288,322</b>	<b>-</b>	<b>-</b>	<b>15,775</b>	<b>117,431</b>

**Namibia COP 15 Targets by Health District: Key, Priority,  
Orphan and Vulnerable Children Indicators**

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Andara	14,580	-	889
Aranos	146	-	122
Eenhana	129	-	904
Engela	5,000	2,000	1,055
Gobabis	162	-	155
Grootfontein	131	-	114
Karasburg	-	-	-
Katima Mulilo	34,836	750	2,607
Keetmanshoop	150	-	106
Khorixas	223	-	115
Luderitz	169	-	121
Mariental	178	-	133
Nankudu	9,162	-	733
Nkurenkuru	151	-	139
Nyangana	12,853	-	864
Okahandja	131	-	158
Okahao	3,274	-	705
Okakarara	187	-	133
Okongo	-	-	792
Omaruru	126	-	86
Omuthiya	-	-	-
Onandjokwe	167	-	1,054
Opuwo	153	-	125
Oshakati	18,076	750	1,978
Oshikuku	3,318	-	757
Otjiwarongo	-	-	-
Outapi	6,587	-	1,057
Outjo	149	-	107
Rehoboth	143	-	118
Rundu	28,439	1,000	1,628
Swakopmund	92	-	65
Tsandi	2,949	-	705
Tsumeb	-	-	618
Usakos	119	-	104
Walvis Bay	-	2,000	-
Windhoek	50,919	-	5,112
Other_ Namibia	-	-	-
<b>Total</b>	<b>192,699</b>	<b>6,500</b>	<b>23,359</b>

**Namibia COP15 Targets by Health District:  
Breastfeeding and Pregnant Women**

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Andara	776	203
Aranos	-	-
Eenhana	3,252	499
Engela	3,690	645
Gobabis	1,230	157
Grootfontein	1,111	122
Karasburg	-	-
Katima Mulilo	2,908	864
Keetmanshoop	384	55
Khorixas	-	-
Luderitz	433	78
Mariental	-	-
Nankudu	1,636	243
Nkurenkuru	-	-
Nyangana	686	186
Okahandja	1,052	240
Okahao	700	134
Okakarara	-	-
Okongo	611	107
Omaruru	-	-
Omuthiya	-	-
Onandjokwe	4,148	731
Opuwo	-	-
Oshakati	4,959	935
Oshikuku	1,668	391
Otjiwarongo	1,341	182
Outapi	3,424	539
Outjo	-	-
Rehoboth	-	-
Rundu	4,768	772
Swakopmund	1,364	164
Tsandi	612	152
Tsumeb	1,207	173
Usakos	-	-
Walvis Bay	2,633	487
Windhoek	11,233	1,590
Other_ Namibia	-	-
<b>Total</b>	<b>55,826</b>	<b>9,649</b>

**Namibia COP15 Targets by Health District:  
Tuberculosis (TB)**

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Andara	-	-
Aranos	-	-
Eenhana	-	-
Engela	1,000	250
Gobabis	-	-
Grootfontein	-	-
Karasburg	-	-
Katima Mulilo	-	-
Keetmanshoop	-	-
Khorixas	-	-
Luderitz	-	-
Mariental	-	-
Nankudu	-	-
Nkurenkuru	-	-
Nyangana	-	-
Okahandja	-	-
Okahao	-	-
Okakarara	-	-
Okongo	-	-
Omaruru	-	-
Omuthiya	-	-
Onandjokwe	522	150
Opuwo	-	-
Oshakati	-	-
Oshikuku	1,500	400
Otjiwarongo	-	-
Outapi	-	-
Outjo	-	-
Rehoboth	-	-
Rundu	-	-
Swakopmund	600	250
Tsandi	-	-
Tsumeb	-	-
Usakos	-	-
Walvis Bay	1,300	325
Windhoek	4,000	1,500
Other_ Namibia	-	-
<b>Total</b>	<b>8,922</b>	<b>2,875</b>

**Namibia COP15 Targets by Health District: Voluntary  
Male Medical Circumcision (VMMC)**

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Andara	-
Aranos	-
Eenhana	-
Engela	-
Gobabis	-
Grootfontein	-
Karasburg	-
Katima Mulilo	6,001
Keetmanshoop	-
Khorixas	-
Luderitz	-
Mariental	-
Nankudu	-
Nkurenkuru	-
Nyangana	-
Okahandja	-
Okahao	-
Okakarara	-
Okongo	-
Omaruru	-
Omuthiya	-
Onandjokwe	-
Opuwo	-
Oshakati	8,001
Oshikuku	-
Otjiwarongo	-
Outapi	-
Outjo	-
Rehoboth	-
Rundu	-
Swakopmund	-
Tsandi	-
Tsumeb	-
Usakos	-
Walvis Bay	-
Windhoek	-
Other_ Namibia	2,500
<b>Total</b>	<b>16,502</b>