Namibia
Country Operational Plan (COP) 2021
Strategic Direction Summary
15 April 2021

Table of Contents

Abbreviations and Acronyms

AGYW	Adolescent Girls and Young Women (aged 15-24)
ANC	Antenatal Clinic
APR	Annual Progress Report
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
CAC	Client-led Community Adherence Clubs
CADRE	Cyclical Acquired Drug Resistance Patient Monitoring
CCBHS	Comprehensive Community Based Health Services
CDC	Centers for Disease Control and Prevention
CLHIV	Children Living with HIV
CMS	Central Medical Stores
CODB	Cost of Doing Business
COP	Country Operational Plan
CSO	Civil Society Organization
CXCA	Cervical Cancer
DMPPT	Decision Makers Program Planning Tool
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe Women
EDT	Electronic Dispensing Tool
EID	Early Infant Diagnosis
ePMS	electronic Patient Management System
EPOA	Enhanced Peer Outreach Approach
EQA	External Quality Assurance
FAST	Funding Allocation to Strategy Tool
FELTP	Field Epidemiology and Laboratory Training Program
FSW	Female Sex Worker
FY	Fiscal Year
G2G	Government to Government
GBV	Gender-based Violence
GF	Global Fund
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	Gross National Income
GRN	Government of the Republic of Namibia
HCMS	Human Capital Management System
HCW	Health Care Worker
HEI	HIV-exposed Infant
HIVST	HIV Self -Testing
HR	Human Resources
HRH	Human Resources for Health
HTS	HIV Testing Services
HSS	Health Systems Strengthening
IBBS	Integrated Biological and Behavioral Surveillance Survey
ICD	International Classification of Diseases
IEC	Information, Education, and Communication
IHME	Institute of Health Metrics and Evaluation
IM	Implementing Mechanism

IPV	Intimate Partner Violence
ISME	Implementation Subject Matter Expert
KP	Key Population
LES	Locally employed staff
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDR	Multiple Drug Resistant
MDG	Millennium Development Goal
MER	Monitoring, Evaluation and Reporting
MGEPESW	Ministry of Gender Equality, Poverty Eradication and Social Welfare
MOHSS	Ministry of Health and Social Services
MSM	Men who have Sex with Men
MSYNS	Ministry of Sports, Youth and National Services
MTCT	Mother-To-Child Transmission
NAD	Namibian Dollar
NAMPHIA	Namibia Population-Based HIV Impact Assessment
NASA	National AIDS Spending Assessment
NDHS	Namibia Demographic and Health Survey
NEC	New Embassy Compound
NHFA	National Health Force Accounts
NIMART	Nurse-Initiated and Managed ART
NIPH	National Institute of Public Health
NSF	National Strategic Framework
OGAC	Office of the U.S. Global AIDS Coordinator
OPD	Outpatient Department
OVC	Orphans and Vulnerable Children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counseling
PLACE	Priorities for Local AIDS Control Efforts
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
POC	Point-of-Care
PrEP	Pre-Exposure Prophylaxis
QA	Quality Assurance
QM	Quality Management
RTK	Rapid Test Kit
SDS	Strategic Direction Summary
SID	Sustainability Index Dashboard
SI	Strategic Information
SIMS	Site Improvement through Monitoring System
SNU	Sub-National Unit
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis

TG	Transgender
TGW	Transgender women
TLD	Tenofovir/Lamivudine/Dolutegravir
TPT	TB Preventive Therapy
TWG	Technical Working Group
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development
USD	United States Dollar
USG	United States Government
VACS	Violence against Children Survey
VIA	Visualization with Acetic Acid
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

1.0 Goal Statement

Namibia is estimated to be at 90-98-91 as defined by the UNAIDS 95-95-95 treatment cascade, one of the first high burden countries to approach epidemic control. COP21 utilizes Namibia's unified PEPFAR program built around structural sustainability, to push for success in testing the remaining ten percent of people with unknown status, preventing new infections, and retaining more than 186,000 people on treatment.

Primary gaps exist most prominently among children aged less than 9 years old, and males aged 20-34 years being unaware of their HIV-positive status and not on treatment. The gap of people living with HIV (PLHIV) not on antiretroviral treatment (ART) may be concentrated in the larger urban areas in the capital and on the coast. However, the perceived gap may be due to a huge number of PLHIV receiving their ART in the private sector in these urban areas. Prevention measures need to be considered holistically, with particular focus on pregnant and breastfeeding women and their babies, and adolescent girls and young women.

PEPFAR Namibia's program areas form an integrated cascade across the three 95s, with the community, facility, and health system partners successfully providing comprehensive services. This extends to a comprehensive and integrated prevention approach as well, tailored to reach unreached populations or those at highest risk. This structural sustainability model further refined in COP21 is expected to increase domestic ownership, financial responsibility, and quality of care with successful outcomes. This unified program presents Namibia's vision of streamlined, efficient partners, coordinated as one portfolio by the Ministry of Health and Social Services.

Innovative program highlights to address the needs in COP21 include:

- Applying key continuity of care interventions along the cascade, in those diagnosed, on treatment, who have missed appointments, or had interruption in treatment;
- Identifying reasons for interruption in treatment and ensuring over 98% are re-engaged and confirmed active;
- Providing post tracing services to ensure a warm client-centered welcome back into care that addresses individual client reasons that led to prior treatment interruption;
- Providing decentralized drug dispensing through PeleBox, ART Home delivery, Comprehensive Community Based Health Services including at border areas;
- Ensuring high quality of care through implementation of Quality Improvement Collaborative approaches;
- Ensuring priority populations in correctional facilities and police holding cells receive high quality HIV testing, care and treatment services;
- Optimizing laboratory instrument utilization, workflow and specimen transport to fill testing gaps
- Improving TLD adherence monitoring and viral re-suppression through point-of-care urine TDF screening;
- Focusing on pregnant women, a group most at risk of seroconversion including referrals from ANC to DREAMS and OVC programs
- Saturate existing nine DREAMs districts;
- Work closely with Global Fund and relevant ministries to deliver elements of the DREAMS program to AGYW and their male partners;

- Accelerate and expand community based viral load monitoring interventions under the Differentiated Service Delivery (DSD) model including pediatrics and adolescents;
- Scale up community maternal and infant tracing;
- Use IBBS data to address and improve significant gaps within the KP cascade;
- Scale up PrEP provision among PBFW, women involved in IPV and in partners of index clients and support the MOHSS in developing tools that could disaggregate screening and data collection for these populations;
- Advance the reduction of the cervical (CXCA) re-screening and post treatment intervals, to prevent delays in screening and possible disease progression and scale up screening and close treatment gaps;

The goal of COP21 is evident: retain PLHIV on treatment and prevent new infections through PEPFAR Namibia's unified, comprehensive approach using both proven and innovative ways to identify and address populations most at risk. By the end of COP21, PEPFAR Namibia will put an additional 7,994 PLHIV on treatment and ensure 198,354 of the total expected 206,980 PLHIV on treatment will be virally suppressed reaffirming that Namibia is on a truly successful path to sustainability.

2.0 Epidemic, Response, and Program Context

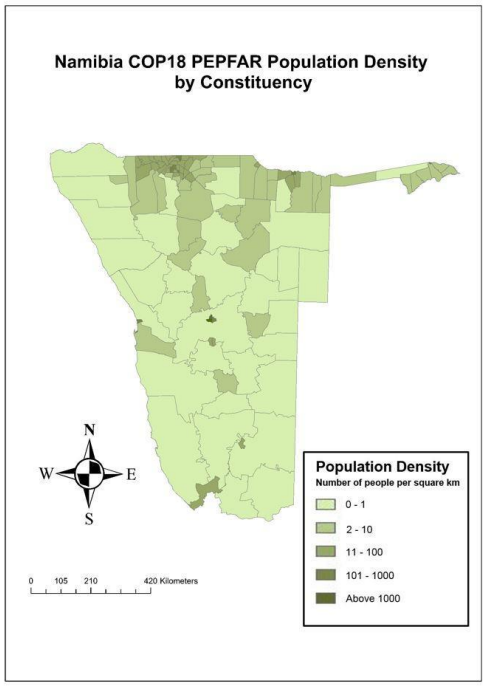
2.1 Summary statistics, disease burden and country profile

Namibia is a sparsely populated desert country of 2.5 million people (Namibia Statistics Agency (NSA), Population Projections 2011-2041) with an area more than twice the size of Germany. The population is concentrated in small urban areas scattered throughout the country, particularly in the north near the border with Angola (see Figure 2.1.1). Urbanization continues to increase rapidly at a rate of 3.63% (CIA Factbook 2017), and urban population was projected to surpass the rural population for the first time ever in 2019.

Namibia is an upper-middle income country with a gross national income (GNI) per capita of $ 9,780 (World Bank, 2019), but with starkly unequal income distribution. Namibia's Gini coefficient is 0.59, while its Palma Ratio at 5.8, both near the highest in the world (UNDP HDR statistical update 2020). According to a 2012 assessment of poverty dynamics in Namibia, approximately 29% of people in Namibia are poor (living on less than 30/day Namibian Dollars

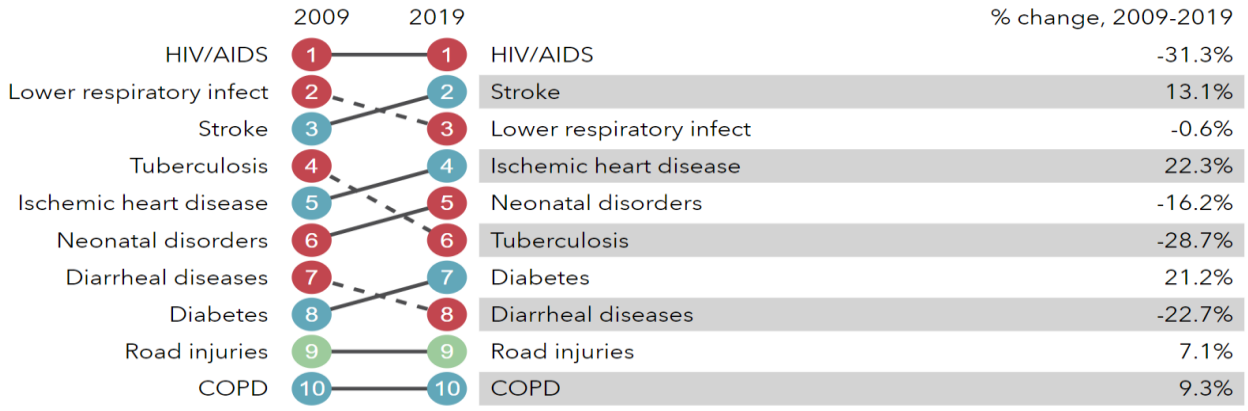
(NAD) and more than 15% are severely poor (living on less than NAD 22/day). Unemployment is estimated at 33.4%, down from 34% two years earlier (NSA Labor Force Survey 2018).

The country made great strides in attaining the Millennium Development Goals (MDGs) related to access to education, gender parity in education, and health. Impressive results in immunization and nutrition of children have also been achieved, bringing down under-five deaths from 4,200 per year in 1990 to less than 3,000 in 2013: child mortality rates are 45.2 deaths per thousand live births (UN Inter-Agency Group for Child Mortality, 2016). Namibia launched the Sustainable Development Goals agenda in 2016, which builds on the MDGs and goes further in addressing the root causes of poverty and the universal need for development that works for all people.



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

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



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

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

Namibia has been accelerating progress towards HIV epidemic control, and at the end of fiscal year (FY) 20, over 98% of the estimated 206,736 PLHIV in Namibia will be on ART. New HIV infections have halved since 2004, and life expectancy increased by eight years from 56 in 2005 to 64 in 2016 (World Bank). The Government of the Republic of Namibia's (GRN) leadership has also resulted in Namibia achieving high HIV treatment and prevention of mother-to child transmission (PMTCT) coverage levels, and rapidly adopting new international guidelines and best practices. Of note, given the high TB/HIV co-infection rate (32%) in the country, Figure 2.1.2 may underestimate deaths due to TB because when an HIV-positive person dies from TB disease, the underlying cause of death is classified as HIV in the International Classification of Diseases

system (ICD-10). ICD-11 coding training has been conducted regionally but a significant backlog of uncertified deaths remain in the e-death data system.

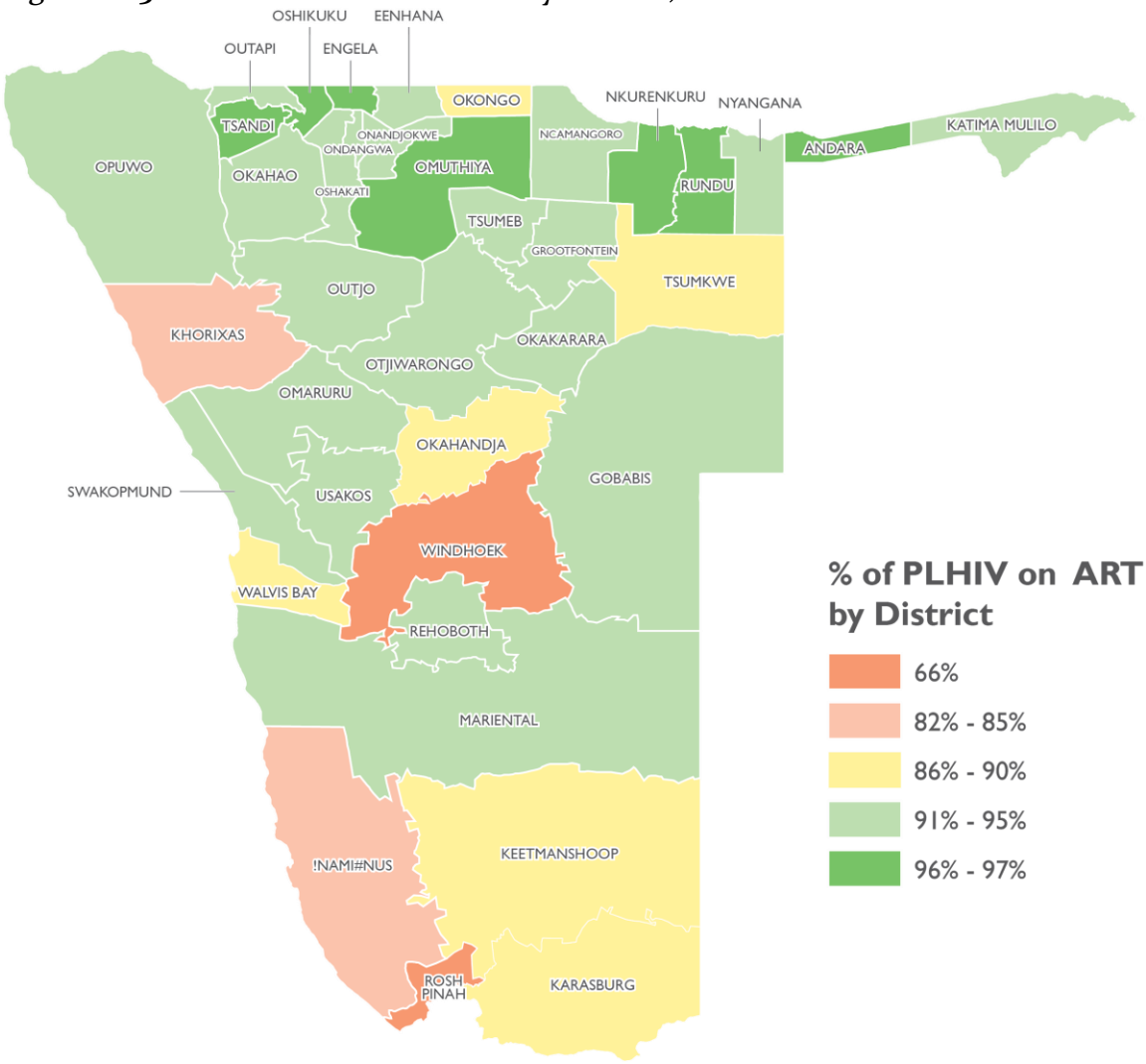
HIV Prevalence and Incidence

Namibia has a generalized HIV epidemic, with 8.2% of the general population living with HIV (2021 Spectrum Model). HIV/AIDS will be responsible for an estimated 2,870 deaths in 2021 (see Table 2.1.1), and the disease remains the leading cause of death among adults and the leading cause among children under five years of age (Republic of Namibia Report on Mortality and Causes of Death, 2016-2017 Edition 1). Among adults (>25 years of age), women bear a disproportionate burden of the HIV epidemic, with a prevalence of 19.1% compared to 11.8% for men (see Table 2.1.1). Although data are only now becoming available on sex-specific positivity rates among children, an estimated 0.78% of female children under 15 years of age are HIV infected while a similar statistic for male children is 0.79%. According to the 2021 Spectrum Model, the highest proportion of estimated new infections is among women older than 25 years, accounting for 38.8% of new infections. Men older than 25 years old are estimated to account for 23.1% of the new infections, coming in a close third, just behind women 15-24 years who account for 23.6% of new infections (2021 Spectrum Model).

Treatment Coverage

The results from the Namibia Population-Based HIV Impact Assessment (NAMPHIA) survey indicate that most people who test positive for HIV start treatment and generally remain on treatment. 96% of people aware of their HIV-positive status were on ART. That is further supported by NAMPHIA laboratory data that show that 91% of people who report being on ART are confirmed to be virally suppressed. Since the introduction of ART in 2003, the number of PLHIV on ART has increased annually, rising from 75,681 in 2010 to approximately 186, 234 in 2021 (see Table 2.1.2). Disaggregated data by age and sex illustrate that the proportional treatment gap is highest among young men 15-24 and older men 25+ years. Namibia has made incredible strides in its HIV/AIDS response, with a treatment coverage of 98% among PLHIV knowing their status by December 2020 (including private sector on treatment). However, treatment coverage variations exist by district. While almost all districts now have estimated ART coverage exceeding 80%, there are a few districts such as Windhoek and Rosh Pinah which lag significantly behind others.

Figure 2.1.3. Percent of PLHIV on ART by District, December 2020



Prevention of Mother-to-Child Transmission (PMTCT)

In the latest UNAIDS report published in July 2020, the PMTCT program continues to show achievement with declining new HIV infections among young women. There is a high ART coverage in HIV positive pregnant women, declining 6-week and final HIV transmission rates. ANC1 attendance is high at 98% as well as increased coverage rates for EID testing (Figure 2.1.3). Even with COVID19 related impacts of increased pregnancies and interruptions to ART services, ANC1 clients knowing their HIV status (99% as of FY20 Q4) and ART coverage (98% as of FY20Q4) remained high. However, over the course of FY20, a total 276 women were newly diagnosed HIV positive either late in pregnancy or at labor and delivery. This is of major concern, as these mothers are at substantially higher risk of transmitting HIV to their infants. Increased

efforts are needed in diagnosing pregnant women earlier, to start ART with enough time to reach viral suppression before delivery. Namibia is however close to achieving <250 cases of MTCT per 100,000 live births by 2024. Based on the 2013 Demographic Health Survey, the percentage of pregnant women with four or more antenatal care is just 63%, but delivery in a health center is higher at 87%. PMTCT and early infant diagnosis (EID) services are integrated in all public health sites.

According to the 2016 HIV sentinel surveillance:

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

Infant HIV case identification through EID is a Namibian policy, but execution remains a challenge. Documentation of outcome status is poor with only 24% of infants with this documented status. In FY20, PEPFAR Namibia supported 284 sites, addressing >90% of national PMTCT and EID needs.

Fig. 2.1.4. UNAIDS 2020 Report, published July 2020

TB/HIV

Namibia has one of the highest per capita burden in the world and is ranked by the World Health Organization (WHO) among the top 30 high TB burden countries in the world. In 2019, the country recorded 8,016 TB cases (57% male, 34% female, and 9% children), translating to a case notification rate (CNR) of 314/100,000. Most of the cases were aged 25-34 years. The high case load is attributed mainly to the HIV epidemic as reflected by an HIV prevalence of 17.2% among ante-natal clinic attendees in 2016 and an HIV prevalence rate of 32% among TB patients in 2020.

In FY20 the rate of TB patients with known HIV status was 100% with 97% ART initiation among those who tested positive.

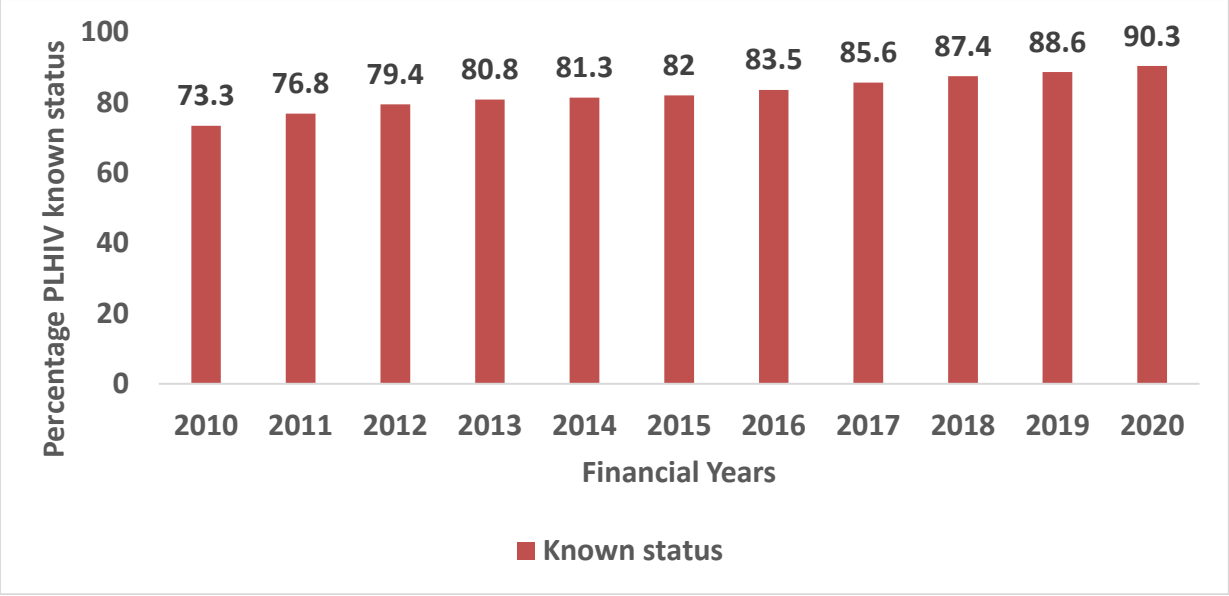
Drug-resistant TB is one of the greatest threats to ending TB in Namibia. The 2015/6 anti-TB drug resistance survey (DRS) showed MDR-TB prevalence of 3.9% and 8.7% among new and previously treated patients respectively. In 2019, 293 patients with drug resistant TB were notified.

The 2018 TB Disease Prevalence Survey (DPS) confirmed Namibia's position among the top high TB burden countries reporting the rate of bacteriologically confirmed TB as 465/100,000 (95% CI: 340-590). TB among males was significantly higher (60%) than females. HIV-positive rate was 13.5% among participants who knew their HIV status at the end of the survey (83.5%). HIV positivity rate among DR-TB patients was 42% and ART was initiated among 89% of these.

HIV Testing Services (HTS)

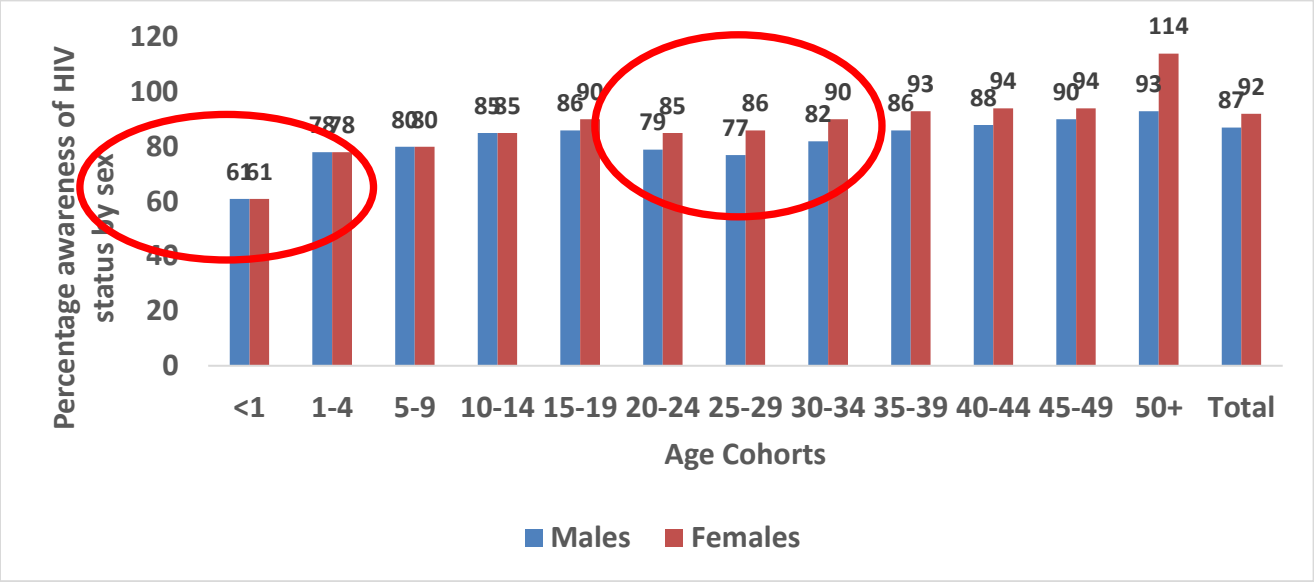
Namibia has made significant progress in scaling up targeted case finding strategies to all parts of the country and population groups. According to data from NAMPHIA, 86% of adults between the age of 15 and 64 years (79.6% for men and 89.5% for women) who are living with HIV know their status. This shows an improvement from the 75.6% (62.6% for men and 79.6% for women) reported from the 2013 Namibia Demographic and Health Survey (NDHS). According to the latest Spectrum estimates, Namibia identified 90% of PLHIV who know their status in FY 2020. Figure 2.1.5 below shows the percentage of PLHIV aware of their status as a trend from 2010 to 2020.

Fig 2.1.5. Percentage known status annual trends: Spectrum estimates/ Shiny 90 file



According to Spectrum/Shiny90 file, prominent case finding gaps are among children aged <1-9 years as well as males aged 20-34 years as illustrated below in figure 2.1.6.

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



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

Fig 2.1.7. Percent of PLHIV on ART by health district

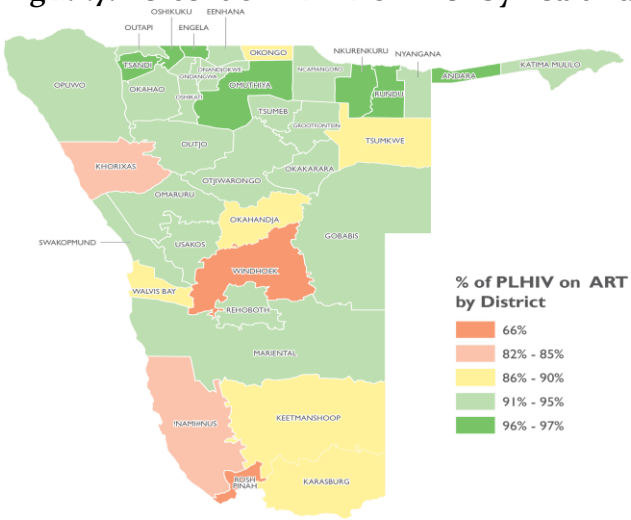
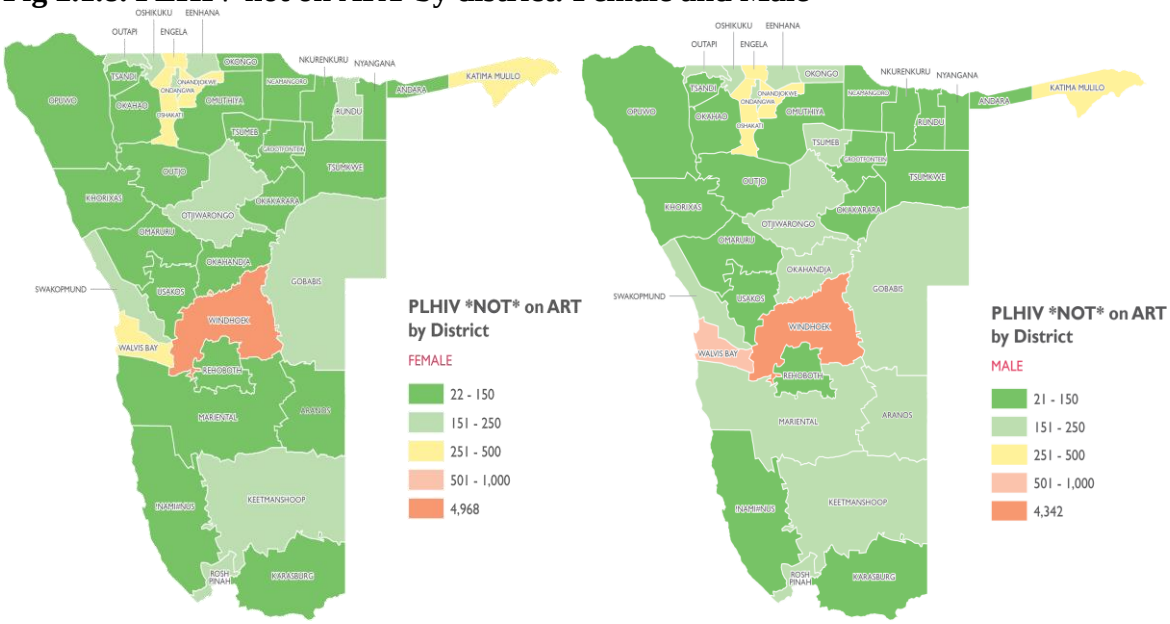
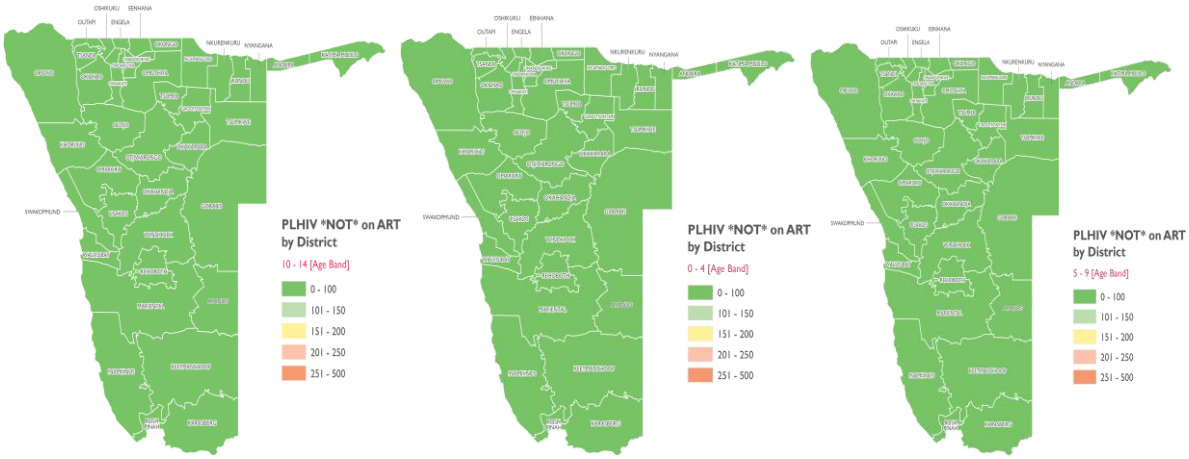


Fig 2.1.8. PLHIV not on ART by district: Female and Male



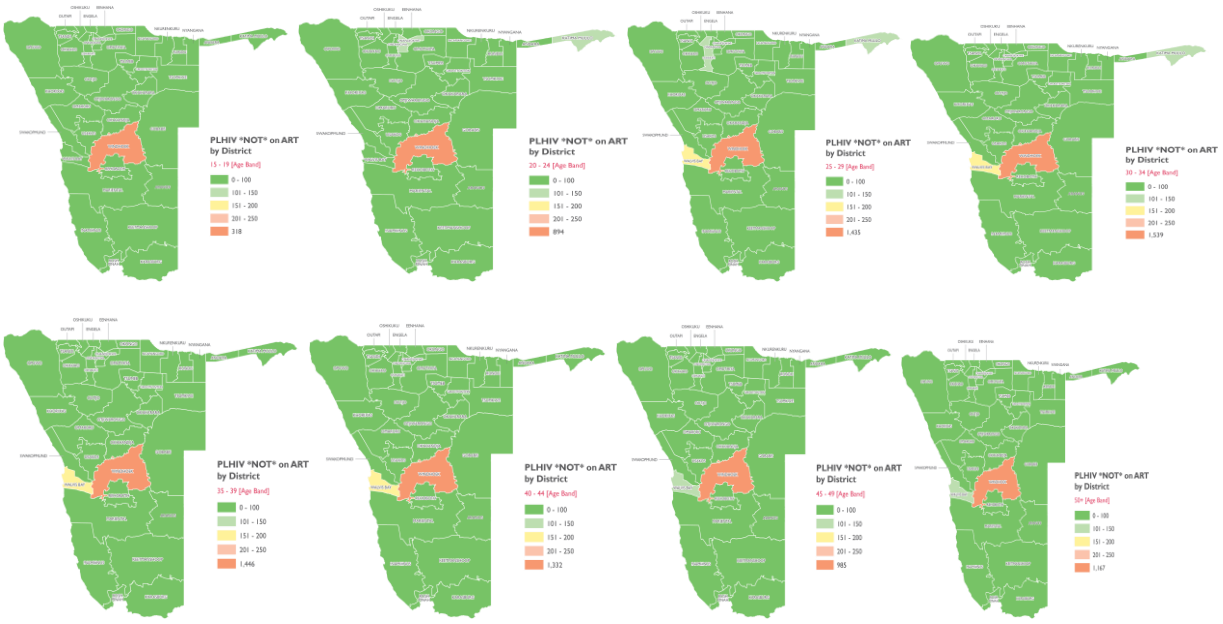
The maps above show the PLHIV not on ART by district and sex (females on the left and males on the right). Prominent gaps for both females and males are observed in Windhoek and Walvis Bay districts and smaller gaps in Katima Mulilo, Engela, Onandjokwe, Ondangwa and Oshakati districts. Low prevalence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

Fig 2.1.9. PLHIV not on ART by district: Children <15 years of age



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

Fig 2.1.10. PLHIV not on ART

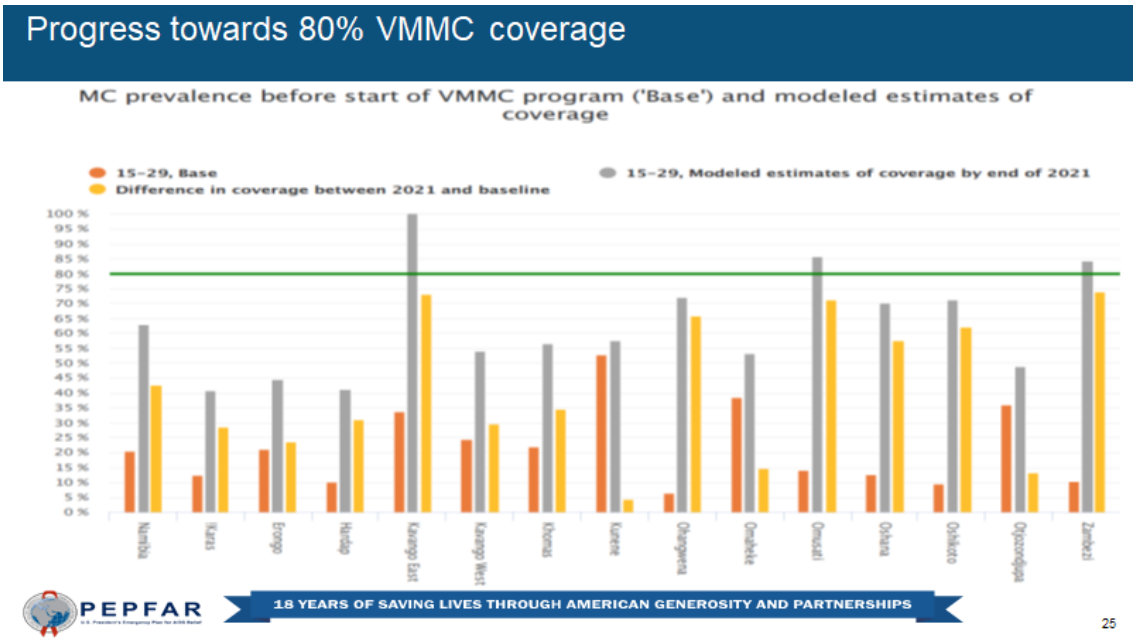


The maps above show PLHIV not on ART by age above 15 years. As seen before, prominent gaps across most of the age cohorts are in Windhoek and Walvis Bay districts, with a very small absolute gap observed in all regions across all age cohorts.

Voluntary Medical Male Circumcision (VMMC)

Data validation and modeled national coverage for VMMC among priority age groups of 15-29 years old is 63% (Data validation Decision Makers Program Planning Tool, DMPPT-2020/2021), which is less than the recommended 80% target to achieve a population level impact in epidemic control (see Figure 2.1.11 below).

Fig 2.1.11. Progress towards 80% VMMC coverage

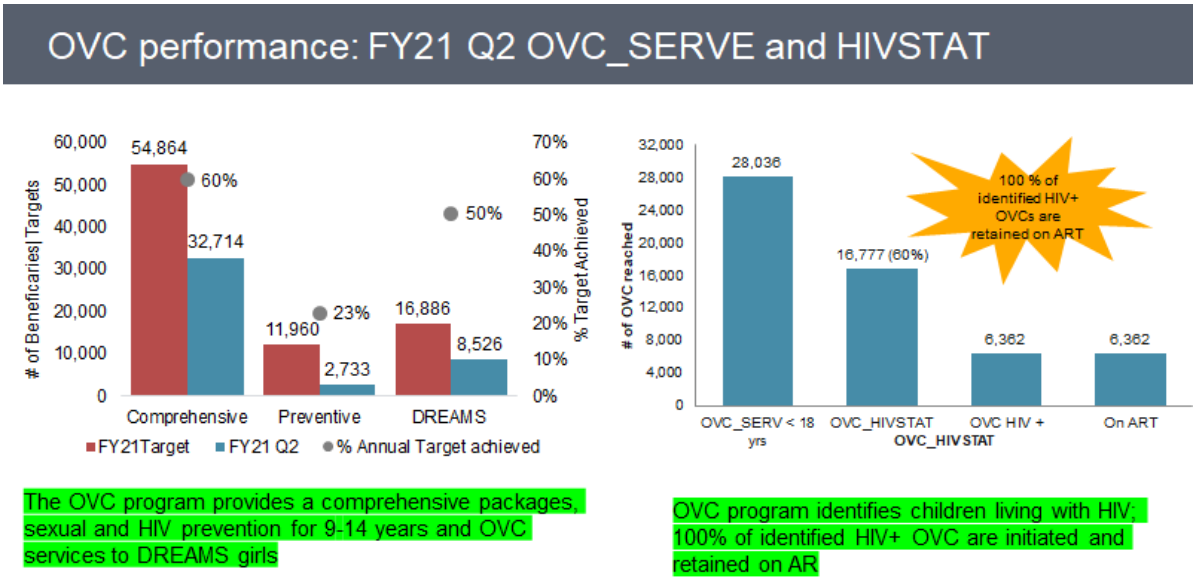


The Ministry of Health and Social Services (MOHSS) scaled up the implementation of an extensive VMMC demand creation campaign. As part of this campaign, PEPFAR Namibia, in collaboration with MOHSS, worked with a popular Namibian musician to promote the benefits of VMMC and increase uptake among young people aged 15-29 years. Promotional concerts and online based social media demand creation activities were conducted during the high VMMC season from May to September. Due to expansion of service access and demand generation efforts, the PEPFAR VMMC program has seen 15% increase in VMMC coverage. At the end of FY20, the PEPFAR program reported a high number of circumcisions: 26,723 men (73.5% above 15 years of age), (Annual Progress Report [APR] 2020). PEPFAR Namibia's COP21 target will rapidly saturate VMMC services among priority age bands (15-29) in six regions (Khomas, Ohangwena, Oshikoto, Oshana, Erongo, and Kavango West) to 75-80% coverage of VMMC.

Orphans and Vulnerable Children (OVC)

The HIV epidemic in Namibia has generated a large population of orphans and vulnerable children. Approximately 250,000 children in Namibia are considered vulnerable (NAC 2018-2022). According to the UNAIDS Spectrum 2020 estimates, Namibia has roughly 11,000 children under the age of 15 living with HIV. Spectrum 2020 estimates the number of orphans to be 45,711. Among those who are between 15-19 years old, 56.6% girls and 74.2% boys had never been tested for HIV (NDHS, 2013). With increased ART coverage, children are living longer, requiring sufficient HIV care and support services including sexual violence prevention. In Q2 FY21, there were 10,820 children 0-18 years on ART, of which 54% (5,883) were enrolled in the comprehensive OVC program. This leaves an OVC coverage gap of 4,937 HIV+ children on ART that will be targeted for enrollment in the OVC program in COP20/21. In Q2FY21, the number CLHIV on ART and enrolled to OVC program increased by 479, reaching 6,3,62. Approximately 32,714 (60% of the FY21 target) were provided with the comprehensive package of OVC services (see the graph below).

Fig.2.1.12. Number of OVC performance: FY21 Q2 OVC_SERVE and HIVSTAT



According to the World Bank, Namibia is one of the most unequal countries in the world and this slows the pace of poverty reduction. Unemployment has remained stubbornly high at 34.0% of the working population in 2016 and is higher among women (38.3%) and the youth (43.4%). Children and women are disproportionately disadvantaged by poverty, with up to 56 % of children either living in poverty or at risk of becoming poor. Simultaneously, according to the National Statistical Agency of Namibia, 204,162 children were on social grants in 2016 and 58% of those eligible are not receiving grants. More than half of Namibia's children do not complete primary school. Child grants and universal pensions are important social protection mechanisms in Namibia. Household economic strengthening activities implemented through USG-funded partners are complementary, leveraging government resources with support for money management, additional savings, nutritional information and food security initiatives.

Gender Inequalities

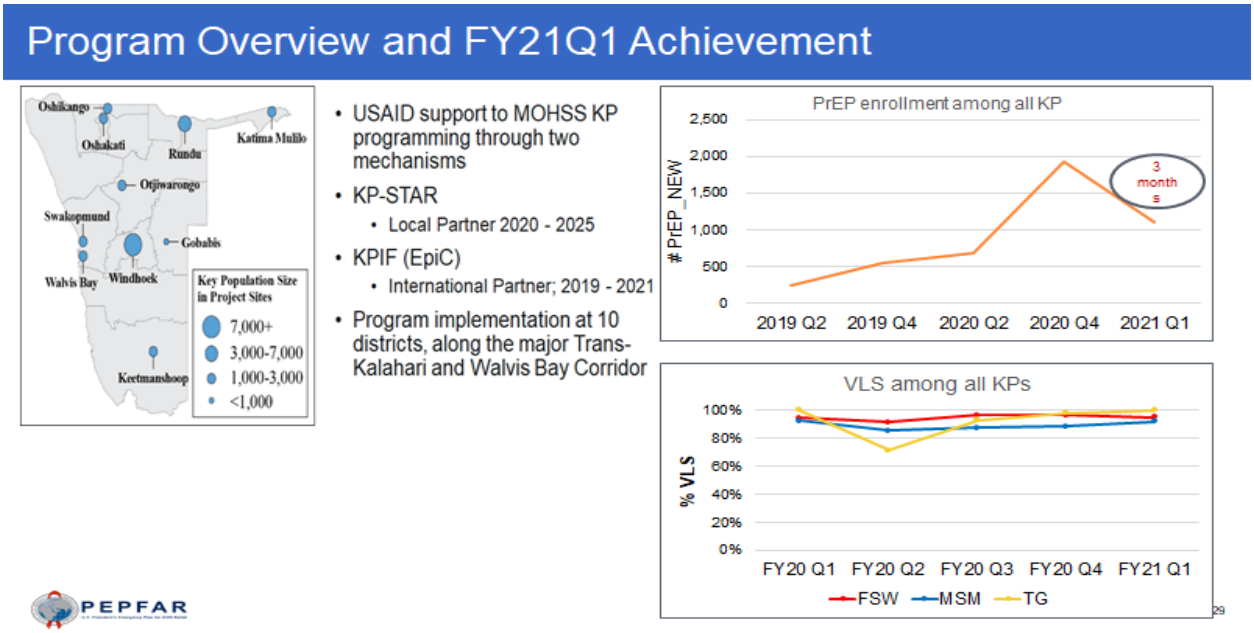
In Namibia, gender norms and gender-specific roles are deeply entrenched. Due to cultural and economic gender inequalities, women and girls are the most affected by the HIV epidemic, with some unable to protect themselves from HIV. Cultural norms that inhibit health seeking behaviors in men and boys also contribute to HIV risk. According to the 2013 DHS, one in three (32%) women aged 15-49 has experienced physical violence since age 15, and 14% of women in this age group experienced physical violence in the 12 months prior to the survey. Seven percent of women aged 15-49 experienced sexual violence since age 15, and four percent experienced physical violence in the 12 months prior to the survey. Women, who are not employed or are less educated, are more likely to have experienced sexual violence. While the GRN has approved various progressive laws and policies to address inequalities between men and women, full implementation is difficult due to limited allocation of financial and human resources.

In addition, the Violence against Children Survey (VACS) final report will be released by the MGECW in FY21, and will provide recommendations to relevant Namibian ministries, and international and national non-governmental organizations on developing, improving, and enhancing prevention and response strategies to address violence against children as part of a larger, comprehensive, multi-sectoral approach.

Key Populations

Key populations (KP) in Namibia, especially men who have sex with men (MSM), female sex workers (FSW), and transgender women (TGW) are at high risk of HIV. Based on the Namibia Integrated Biological and Behavioral Survey (NAM-IBBS) conducted in 2019, HIV prevalence was high among FSW: 21.3% in Windhoek, 20.3% in Walvis Bay and 44.2% in Katima Mulilo. HIV prevalence among MSM was relatively consistent with that of adult men in the general populations of their respective regions as estimated in NAMPHIA: 8.4% vs.7.2% in Khomas (Windhoek) and 9.7% vs. 7.5% in Erongo (Walvis Bay/Swakopmund), respectively. Approximately 60% of MSM testing positive for syphilis were also HIV-positive. Coverage of ART among KPs who had known HIV status was comparable to estimates from NAMPHIA but viral load suppression rates were low. Among FSW, viral load suppression was 52.0% in Windhoek, 30.1% in Walvis Bay and 75.8% in Katima Mulilo. Viral load suppression among MSM was 76.1% in Windhoek and 55.8% in Walvis Bay(see Figure2.1.12 below)

Fig 2.1.13 Program Overview and FY21 Q1 Achievement



The NAM-IBBS findings differ from programmatic results. In FY19, programmatic data showed a strong linkage to treatment and high viral load suppression rates. In FY20, PEPFAR supported programs showed 96% linkage to treatment among diagnosed KPs and 94% viral load suppression rate. By the end of Q1 Fy21, linkage to treatment improved to 99% and viral load suppression remained strong at 93% among KPs. The NAM-IBBS provided additional information on population size estimates for all three study sites for FSW, MSM and TG people, meaning that the

high rates of successful outcomes for those reached through KP programs are only representing a small portion of those populations. In FY22, PEPFAR Namibia will continue to use the findings from the NAM-IBBS and lessons learned from program implementations in FY21 to further expand and reach new hidden groups, improve case finding and linkage to treatment strategies for KP in Namibia.

Pre-Exposure Prophylaxis (PrEP)

Namibia included PrEP in its National Strategic Framework for HIV (2017/2018-2021/2022) and granted regulatory approval for tenofovir disoproxil fumarate (Ricovir-M) in May 2017. PEPFAR Namibia provided technical assistance to support the adoption of PrEP in the national guidelines in 2016 and a scale up of coverage in 2017. In FY18 a major PrEP program scale-up focusing on Adolescent Girls and Young Women (AGYW), KPs, and serodiscordant couples resulted in 4,702 people initiated on PrEP; and FY20 saw an additional increase with 11,654 people accessing PrEP. The increase is attributed to innovative and targeted demand creation through peer-to-peer engagement and using virtual platforms, as well as active screening and peer referrals. COP20 added prioritizing PrEP scale up among high-risk HIV negative pregnant and breastfeeding women, after an increased incident infection among this population showed a high seroconversion rate.

Programmatic and Systemic Gaps

The data from NAMPHIA show that Namibia is close to reaching epidemic control, but there are several systemic and programmatic challenges that create significant barriers to achieving sustainable epidemic control. The Sustainability Index and Dashboard (2019) highlighted human resources for health (HRH) as a primary vulnerability, and noted that Namibia requires implementation of a human resource staffing structure for the MOHSS that is responsive to the demands of the epidemic. The government was hampered by the fact that there was a hiring freeze meaning that adding positions was not possible. While the overall cost of maintaining the civil service is extensive, this is not reflected at the facility level where the necessary HRH are often not available. Policy and operational interventions are required. Other health system components that require strengthening are health financing and spending efficiency, private sector and civil society engagement, supply chain systems, and health information and surveillance systems.

Table 2.1.1 Host Country Government Results

	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	2,535,093	100%	466,202	18.4%	466,106	18.4%	243,995	9.6%	240,305	9.5%	592,833	23.4 %	525,652	20.7 %	Population Projections 2011-2041. Namibia Statistics Agency
HIV Prevalence (%)		8.15%		0.78%		0.79%		5.60%		3.30 %		19.10 %		11.80 %	Spectrum/Naomi est. for 9/21
AIDS Deaths (per year)	2,870		111		112		169		147		1,196		1135		Spectrum/Naomi est. for 9/21
# PLHIV	206,694	100%	3,684	1.8%	3,695	1.8%	13,736	6.6%	7,824	3.8%	114,721	55.5 %	63,033	30.5 %	Spectrum/Naomi est. for 9/21
Incidence Rate (Yr)		0.21%						0.50%		0.16 %					Spectrum/Naomi est. for 9/21; NAMPHIA 2017*
New Infections (Yr)	4,916		163		164		1,160		383		1,909		1,137		Spectrum/Naomi est. for 9/21
Annual births	85,946	100													Estimated from annual birth rate and population projection
% of Pregnant Women with at least one ANC visit	103,330	120%													Namibia Program Data
Pregnant women needing ARVs	14,951	14.5%													Namibia Program Data

Orphans (maternal, paternal, double)	**49,330**														
Notified TB cases (Yr)	**7,770**														**National Tuberculosis and Leprosy Program (NTLP) 2019 Annual Report**
% of TB cases that are HIV infected	**2,536**	**32.64%**													
% of Males Circumcised	**422,388**	**34.0%**			**62,295**	**13.3%**			**146,965**	**61.1 %**			**213,128**	**40.1 %**	**Namibia Program Data**
Estimated Population Size of MSM*	**2,210 (Windhoek) 670 (Walvis Bay/Swakopmund)**														**IBBS, 2019**
MSM HIV Prevalence		**8.4% (Windhoek) 9.7% (Walvis Bay/Swakopmund)**													**IBBS, 2019**
Estimated Population Size of FSW	**2,440 (Windhoek) 970 (Walvis Bay/Swakopmund) 890 (Katima Mulilo)**														**IBBS, 2019**
FSW HIV Prevalence		**20.9% (Windhoek) 21.2% (Walvis Bay/Swakopmund) 43.6% (Katima Mulilo)**													**IBBS, 2019**
Estimated Population Size of PWID	**N/A**														
PWID HIV Prevalence	**N/A**														

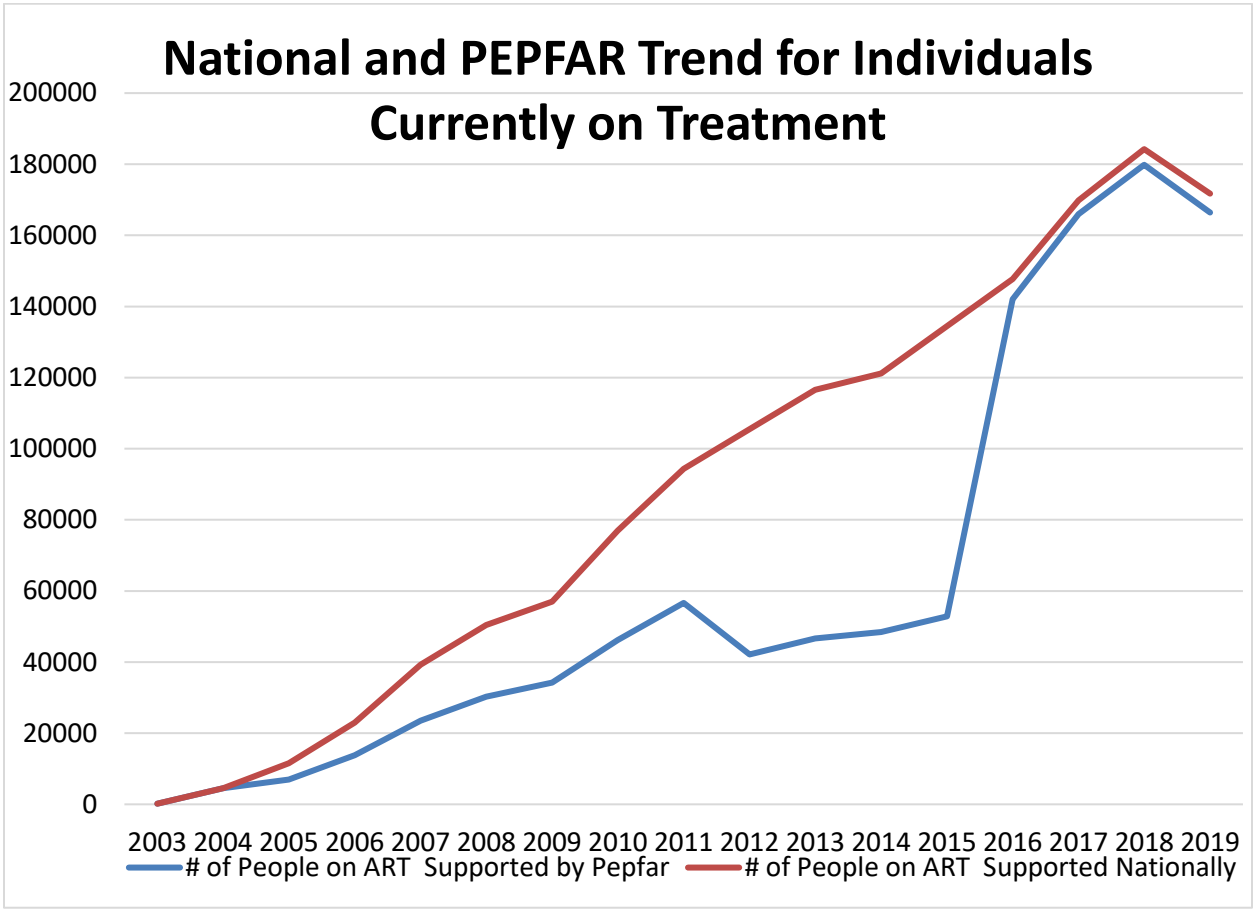
Estimated Size of Priority Populations (specify)	**N/A**														
Estimated Size of Priority Populations Prevalence (specify)	**N/A**														

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

Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate* (#)	**HIV Prevalence** (%)	**Estimated Total PLHIV*** (#)	**PLHIV diagnosed**** (#)	**On ART***** (#)	**ART Coverage (%)**	**Viral Suppression (%)*****	**Tested for HIV***** (#)	**Diagnosed HIV Positive***** (#)	**Initiated on ART***** (#)
Total population	**2,522,659**	8.2%	**206,694**	189,718	186,234	98.2%	91.2%	350,383	10,363	11,599
Population <15 years	**929,430**	0.9%	**8,008**	6,615	6,578	99.4%	80.0%	11,505	269	428
Men 15-24 years	**239,304**	3.4%	**8,065**	6,846	6,622	96.7%	73.5%	17,650	313	323
Men 25+ years	**521,376**	12.1%	**62,944**	57,922	55,201	95.3%	90.0%	81,204	3,960	3,772
Women 15-24 years	**242,898**	6.0%	**14,553**	12,693	12,657	99.7%	83.2%	46,671	1,293	1,831
Women 25+ years	**589,651**	19.2%	**113,122**	105,642	105,176	99.6%	93.9%	193,353	4,528	5,245
MSM	2,210** (Windhoek) 670** (Walvis Bay/Swakopmund)	8.4%** (Windhoek) 9.7%** (Walvis Bay/Swakopmund)	186** (Windhoek) 65** (Walvis Bay/Swakopmund)	119** (Windhoek) 32** (Walvis Bay/Swakopmund)	97** (Windhoek) 27** (Walvis Bay/Swakopmund)	81.9% (Windhoek) 84.0% (Walvis Bay/Swakopmund)	76.1% (Windhoek) 55.8% (Walvis Bay/Swakopmund)	2495	198	191
FSW	2,440** (Windhoek) 970** (Walvis Bay/Swakopmund) 890** (Katima Mulilo)	20.9%** (Windhoek) 21.2%** (Walvis Bay/Swakopmund) 43.6%** (Katima Mulilo)	510**(Windhoek) 206** (Walvis Bay/Swakopmund) 388** (Katima Mulilo)	251** (Windhoek) 106** (Walvis Bay/Swakopmund) 100** (Katima Mulilo)	183** (Windhoek) 95** (Walvis Bay/Swakopmund) 97** (Katima Mulilo)	72.9%** (Windhoek) 89.8% (Walvis Bay/Swakopmund) 96.7% (Katima Mulilo)	52.4% (Windhoek) 31.2% (Walvis Bay/Swakopmund) 75.5% (Katima Mulilo)	8502	614	603
PWID	N/A									
Priority Pop (specify)	N/A									

* UNAIDS 2021 Naomi District Estimates, 8 April 2021 version for Dec 2020
**IBBS, 2019
*** MOHSS Program Data incl NIP

Figure 2.1.14 Trend for Individuals currently on Treatment



2.2. New Activities and Areas of Focus for COP21, Including Focus on Client Retention

PEPFAR Namibia's focus for COP21 is reaching and maintaining epidemic control through a unified and integrated clinical cascade, primed to identify and address recent infections, ensure that all HIV positive people are put on treatment, remain on treatment, and are virally suppressed. This is an approach that termed "structural sustainability", as it entrenches the whole response within the public health approach of the Ministry of Health and Social Services, regardless of whether interventions are at the facility level or community level or whether they are being implemented by the government or private and civil society partners. New in COP20, though implementation was delayed due to COVID 19, is the interventions for integrated approaches to the clinical cascade, the "Fiver System of Integrated Community Care", where small integrated teams of five, called "fivers," are embedded in each district. Within the teams, individual field staff manage index partner testing and linkage, while others perform ART and ANC client tracing and managing community adherence groups. Fiver teams will be able to respond nimbly to the epidemiology and needs of each area, shifting from case finding to tracing in saturated areas and back to index testing where gaps are found, nationally. Namibia's retention interventions span the clinical cascade from the point that an individual is diagnosed, and are designed to be both preventive of loss, and responsive to times when patients miss their appointments or leave the treatment cascade. A new responsive intervention that will be introduced in COP21 is a post-tracing

services algorithm that provides guidance on how to support clients who are re-engaged in care. This includes identifying the barriers to continuity in care and providing differentiated services to address them.

In 2019, Namibia updated their ANC guidelines, with an emphasis on maternal retesting at 36 weeks gestation, at labor and delivery, and every 3 months throughout the breastfeeding period. Despite the updated guidelines, maternal retesting lags in most regions (12% - 88%). Even with low retesting rates (2,613 tests in FY20), a total 276 women were newly diagnosed HIV positive either late in pregnancy, after a previous HIV negative result at their first ANC visit, or newly diagnosed at labor and delivery or during the breastfeeding period. This data supports the need for urgent implementation and targeted scale up of PrEP in ANC settings, prioritizing regions with the highest yield as well as providing additional support to HIV negative women, either from our community partners or linkage to current OVC and DREAMS programs.

Namibia piloted a community-based maternal tracking program that identified pregnant women who had not enrolled into ANC care with unknown HIV status and had promising results. This program also tracked HIV positive breastfeeding mother-baby pairs, making sure mothers were retained on ART and virally suppressed. Although limited in geographic scope, the pilot achieved 100% maternal retention and 0% of infants positive at 18 months. COP20 formalized this program, adding HIV-positive pregnant women for ART and VL tracking and infants to receive timely EID services and documented final-outcome status. This program currently exists in six regions. COP21 will build on this program and address these urgent gaps, expanding the geographic coverage to 10 regions. The program will enroll HIV negative pregnant and breastfeeding women, linking them to PrEP services, 3-month retesting services, ensuring adherence to PrEP during their high-risk period, and that re-testing results are documented.

The goal for COP21 continues to be eliminating mother-to-child transmission. This will be achieved through community tracking of pregnant and breastfeeding women, as well as other structural and programmatic quality initiatives.

In COP21, PEPFAR Namibia will continue to optimize the laboratory diagnostic network and work to close the coverage gaps for early infant diagnosis (EID), viral load (VL) and TB testing. This will be done by decentralizing infant testing to molecular laboratories and priority GeneXpert sites. PEPFAR Namibia will also work to address the poor EID final status documentation that has plagued the program. Secondly, an integrated national sample referral system will be developed to enhance sample integrity, track turnaround times, and ensure results are returned to the facility and the client, with the hope to reduce turnaround time. Currently, over 40% of health facilities have viral load suppression of at least 95%, and through site level analysis and an understanding of viral load testing coverage, PEPFAR Namibia has identified several high-volume sites to target for improvement of VL coverage and improved VL suppression outcomes.

In COP21, the OVC program will strengthen linkages with the Pediatric and PMTCT program to link HIV positive mothers, their children and all HIV-exposed infants to OVC services.

In COP 21, three of the nine DREAMS Districts will have reached saturation for the lower age bands 10-19. These districts will implement their maintenance plan for those age bands and increase targets for those aged 20-24. The four districts new in COP20 will be scaling up the DREAMS package including PrEP, economic strengthening and HIV and violence prevention in every age band. The government-to-government agreement with the Ministry of Sport, Youth and National Service will offer economic strengthening, comprehensive sexuality education and gender-based violence prevention in support of the National Strategic Framework.

For COP21, Namibia will strengthen community ART monitoring mechanisms through emphasis on the quality of care in Community Adherence Groups (CAGs); providing adherence counseling, promoting treatment literacy, community level TB screening and referrals for stable patients differentiated services delivery.

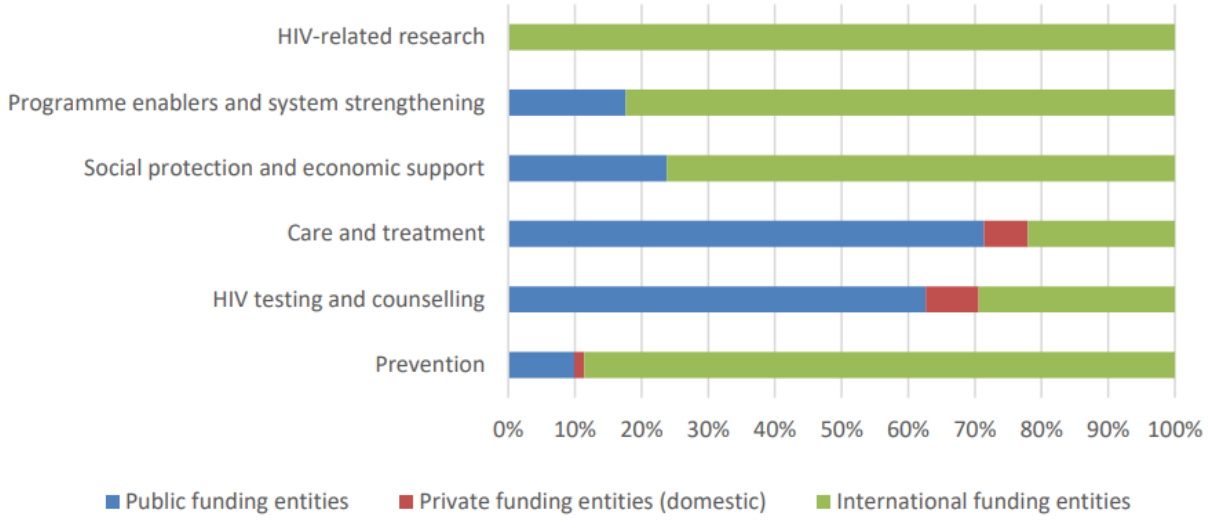
2.3 Investment Profile

The Namibian government continues to assume the largest burden of funding the HIV response, accounting for 61% in the most recent estimate with gradual year-to-year increases. Bilateral donors contributed 23% to the total HIV expenditure, almost all of which came from the USG. Multilateral donors and development partners' contributions made up 10 % of the total HIV spending, of which 9 % came from the Global Fund. Domestic corporations and households accounted for the rest.

The Namibian government also procures most of all commodities, including commodities for HIV. Over the past few years, donors, namely PEPFAR and the Global Fund, have assisted with the procurement of some commodities to fill funding gaps resulting from Namibia's multi-year recession. Donors have supported the procurement of commodities that the MOHSS has struggled to obtain, such as low consumption ARVs like those for pediatric clients. The role of donors is significant in funding Human Resources for Health, with nearly 1700 workers supported across the country in 2020. About half of these are lay workers, such as health assistants and data clerks, but critical clinical staff, like doctors and nurses, make up more than 15% of all donor-funded HRH.

As shown in Figure 2.3.1, the Government of Namibia was the largest funder of care and treatment and HTC in the most recent estimates, at 71% and 63% respectively. International entities dominated the other categories, accounting for 89% of prevention activities, 76% of social protection, and 82% of program enablers and systems strengthening. The country has remained reliant on donors for funding all HIV related research.

Figure 2.3.1. HIV programmatic areas by funding entity, 2017/18



In recent years, PEPFAR Namibia executed a stepwise approach to prepare for eventual sustained epidemic control. This included supporting the MOHSS in developing the Sustainability Framework for HIV. The now finalized framework serves as an umbrella document for the response, with key milestones and actions to reach sustainability. PEPFAR also assisted with the development of a minimum package of services for HIV, establishing a list of services essential to sustain epidemic control. PEPFAR Namibia continues to work with the Namibian Government to advocate for and implement initiatives that address inefficiencies in the HIV response. With public spending for health at the Abuja standard of 15% of government expenditures, the sector needs to spend more efficiently to achieve better results with the resources it has. Greater coordination with and utilization of the private sector and civil society organizations are options worthy of consideration.

PEPFAR Namibia will support the MOHSS in optimizing existing HRH planning to meet the demands of an ever-evolving epidemic. In COP20, PEPFAR Namibia initiated support for the development of a Human Resources Information System (HRIS), a system that will remove one of the final barriers to efforts at HRH rationalization and sustainability planning for the future of the response. The HRIS will allow for a more strategically deployed and maintained workforce to serve and retain the treatment cohort and this work continues in COP21. This investment is part of a broader sustainability planning approach to first, to identify the essential functions and HRH gaps to achieve and maintain epidemic control second, to ensure stable public investment in HRH, and third, to engage complementary domestic entities, like the private sector and civil society, in addressing the remaining gaps. PEPFAR Namibia's interventions will be focused on supporting the MOHSS in optimizing the health workforce going forward, ensuring the appropriateness of the country's HRH and the delivery of client-centered services.

To improve the health supply chain in Namibia and to reduce the number of emergency procurement requests directed at donors, PEPFAR Namibia will support the government streamlining and strengthening in-country procurement and tender management systems, facilitating framework contracts and pooled procurement. PEPFAR Namibia will also continue to support the roll-out of multi-month dispensing of ARVs to reduce the burden on the supply chain and to decongest health facilities by reducing the frequency of patient visits for pill pick-ups.

From 2018-20, donors supported limited procurements upon request from the government, including adult ARVs (by GF), and pediatric ARVs and anti-TB medicines (by PEPFAR). Given the ongoing recession in Namibia and corresponding fiscal constraints, PEPFAR Namibia will continue to support emergency procurements on a limited basis. This includes TLD, anti-TB medicines, and small batch items that are difficult to procure, like pediatric ARVs. Additionally, PEPFAR will procure drugs and test kits in COP21 to support PrEP expansion.

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

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

Table 2.3.2. Annual Procurement Profile for Key Commodities, Apr 2019-March 2020

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

Table 2.3.3. is intentionally left blank, as PEPFAR Namibia does not receive any non-PEPFAR funding or co-funding.

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

2.4 National Sustainability Profile Update

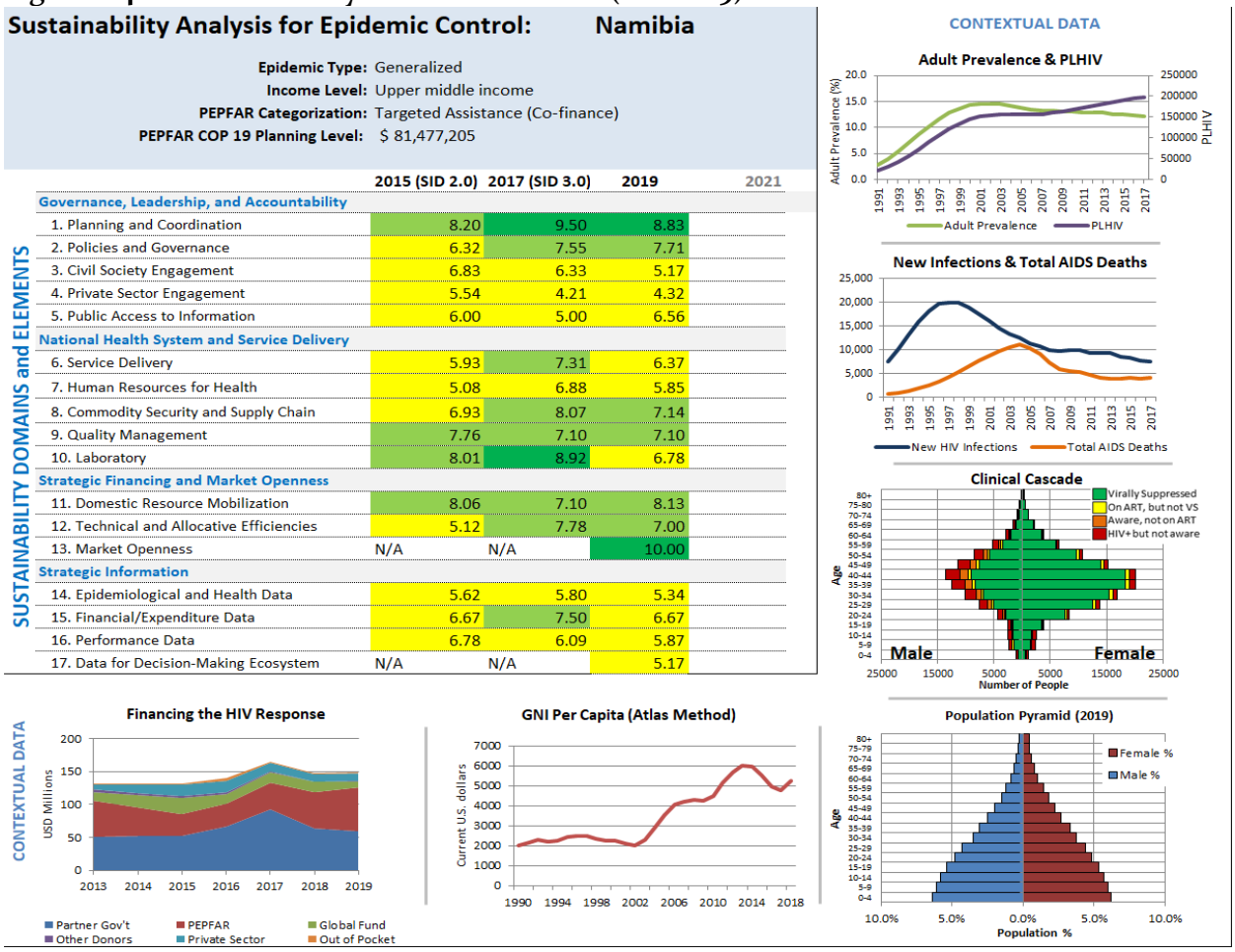
The 2019 Sustainability Index and Dashboard (SID) was completed using a highly participatory approach in collaboration with the Joint United Nations Program on HIV/AIDS (UNAIDS). PEPFAR Namibia held a national stakeholder meeting to validate the SID, where 60 multi sectoral stakeholders from government,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

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

Certain categories and localities of HRH rely heavily on donor funding and expatriates to fill positions. Key HRH weaknesses in the SID 4.0 included: inadequate distribution of health workers across all facilities, the public and private sector, and urban and rural locales; the lack of a plan to account for a decline in funding for donor-supported HRH; and limited use of data for HRH planning and management. Several health professionals hired by donors as part of PEPFAR's "Treatment Acceleration Plan" are not included in the MOHSS' approved staffing structure and a significant number of GF HRH positions ceased to be funded on December 31, 2017, with PEPFAR filling the gap by supporting several critical positions. Moreover, the public health sector's HRH structure merits an update for it to be more responsive to both the needs of the country's HIV/AIDS response and the broader health sector.

In 2018 and 2020, PEPFAR Namibia conducted an inventory of donor supported HRH, and is supporting the government in developing optimization options for its HRH, including the development and rollout of an HRIS in COP20 and COP21. The compensation levels of PEPFAR-supported HRH map well to equivalent government cadres, indicating that drastic differences in compensation may not pose as significant an obstacle in Namibia as in many other PEPFAR countries.

Figure 2.4.1. Sustainability Index Dashboard (SID 2019)



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

The SID identified several weaknesses in the supply chain, most notably stock outs and low stock for critical commodities and medicines however minimal but including condoms. The Namibian government must be acknowledged for its efforts to ensure HIV commodity security, including procurement of greater than 95% of the ARVs in 2019. Their commitment is evident by the result of no national stockouts of first-line adult ARVs in over 10 years. PEPFAR Namibia and Global Fund have played an important role in filling gaps for stock outs of other HIV commodities when needed. With technical assistance from PEPFAR, MOHSS finalized a pooled procurement of vaccines from UNICEF in 2019 at a savings of almost 1 million US dollars. If these mechanisms were fully maximized, the Ministry would stand to achieve significant savings of over US $7 million in the future. In COP21, PEPFAR Namibia will continue to support the government in accelerating the implementation of multi-month dispensing of ARVs.

The SID 4.0 assessment revealed that while the framework exists for the engagement of both civil society and the private sector, there are missed opportunities in actualizing the multisectoral response. Stakeholders voiced concern that civil society coordination was not comprehensive, and that engagement, particularly at the subnational level, could be improved to be more inclusive of key and vulnerable populations. PEPFAR is working with the UN in supporting the MOHSS in developing a social contracting framework, as in COP20 MOHSS will be sub-awarding resources from its cooperative agreement with PEPFAR to local partners in COP21, creating a model for future private sector and civil society engagement and partnership. In COP19, PEPFAR Namibia supported GRN in laying the groundwork for sustainable epidemic control, including defining a minimum package of HIV services. In COP19 PEPFAR Namibia supported GRN to lay the groundwork for sustainable epidemic control, including defining and costing a minimum package of services, and will be undertaking a broader activity-based costing exercise in COP21, that will provide site-level and above-site costs for delivering HIV services. Improved cost data will provide a strong framework for the MOHSS to engage with other health partners on sustainable health financing, such as the Global Fund's new Payment for Results approach.

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

Through its stakeholder engagement and sustainability interagency technical teams (ITTs), PEPFAR Namibia has held several stakeholder engagements meetings in COP19, including additional engagements on the portfolio realignment process, and with organizations representing key Populations; the Medical Association of Namibia, representing medical practitioners; and the Namibia Association of Medical Aid Funds (NAMAF), who coordinates medical aid in Namibia. Other activities include working with private health service providers on VMMC and exploring avenues for private pharmacy dispensing of publicly procured ART and PrEP. In COP20 PEPFAR Namibia has held virtual engagements with the KP community, the health development community, and government coordination platforms such as the National AIDS Executive Committee (NAEC), and the Country Coordinating Mechanism (CCM) for Global Fund.

The Namibia Institute of Pathology (NIP) has gone through some major changes in the last year including finalizing selection, and in February 2021, initiating the tenure of a new permanent CEO. This stable command structure has already enabled PEPFAR Namibia to strengthen work towards operational sustainability of Namibia's public laboratory system, including moving to decentralize EID testing to VL labs. This, in turn, is enabling multiplexing of existing equipment to meet demand. A big focus in COP21 will continue to be a drive for diagnostic network optimization and the improvement of specimen tracking, transport and results return.

2.5 Alignment of PEPFAR investments geographically to disease burden

For COP21, improved program and national data have further refined the understanding of the epidemic and informed strategies to close the gaps. Figure.2.5.1 shows Namibia's population distribution geographically, which shows that most of the Namibian population lives in the far north, with other population centers in Windhoek and the central coast. Figure.2.5.2 shows HIV prevalence by district. Notably, high prevalence occurs in the same districts where there is higher density of population.

Figure 2.5.3 shows ART Coverage by District and Figure 2.5.4 shows ART Coverage Gap by District. Data from the highest burden regions along the northern border where PEPFAR has invested the most, indicate a high coverage of ART (Omusati, Oshana, Ohangwena, Oshikoto, Kavango West, Kavango East, Zambezi). However, in the most urbanized and affluent areas, there exists a larger treatment gap than anticipated, that is partly filled by the 22,000 ART clients in the private sector (Khomas, Erongo). Finally the regions that have a low prevalence and low population but also have the lowest treatment coverage rates, are where there is increased support with more focused technical assistance in COP19 through COP21 (Kunene, Omaheke, Hardap, !Karas). Figures 2.5.5 and Figures 2.5.6 show ART Coverage Gap by sex. These maps show gaps that mirror the overall population maps, with some remaining gaps showing up in the northern border for both males and females. Figure 2.5.7 shows ART Coverage Gap by age, which demonstrates the same potential gaps in the urban areas. Additionally, the younger aged and older aged gaps appear again in areas of the north.

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

Figure 2.5.9 shows viral load suppression for patients on ART by district, which demonstrates excellent on-treatment suppression rates with some room for improvement in districts with lower prevalence (Keetmanshoop, Rehoboth, Gobabis, Khorixas and Otjiwarongo).

Figure. 2.5.1. Namibia's Population Distribution

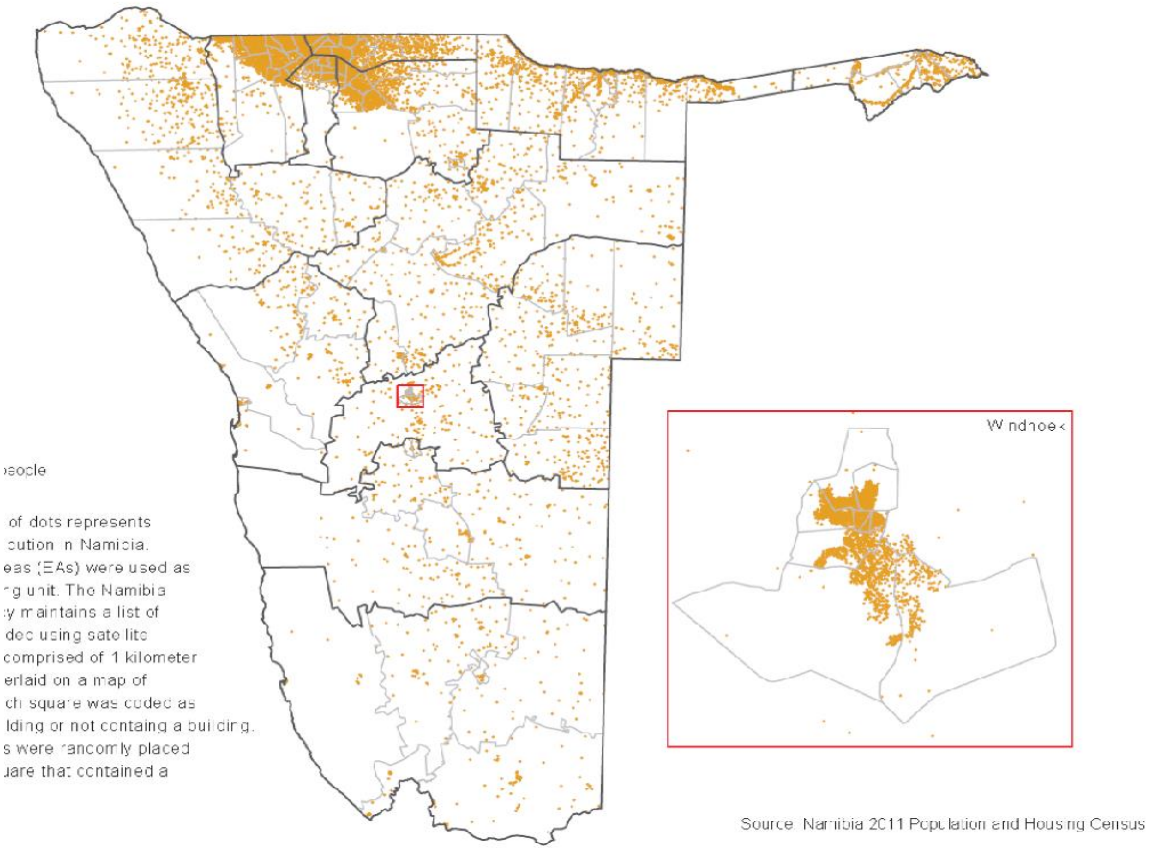
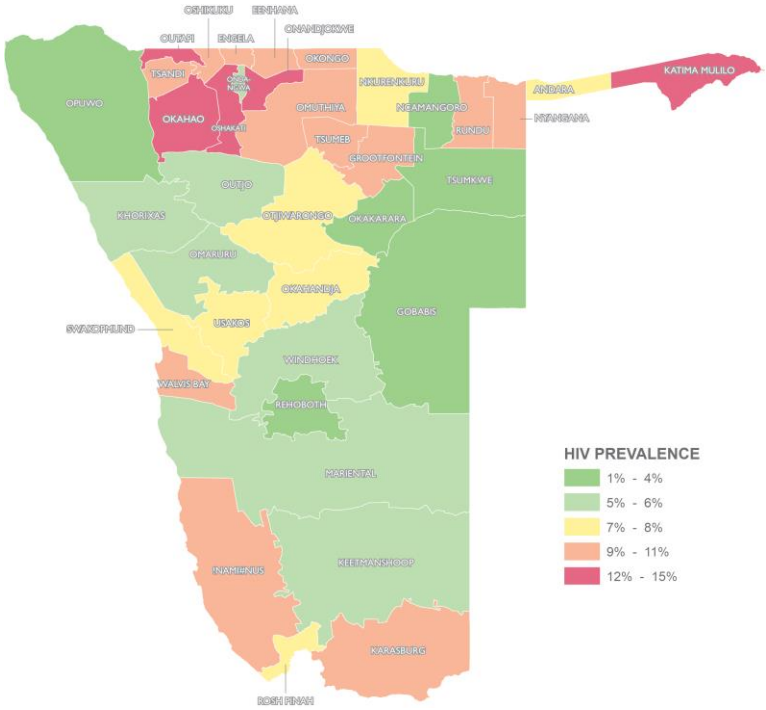
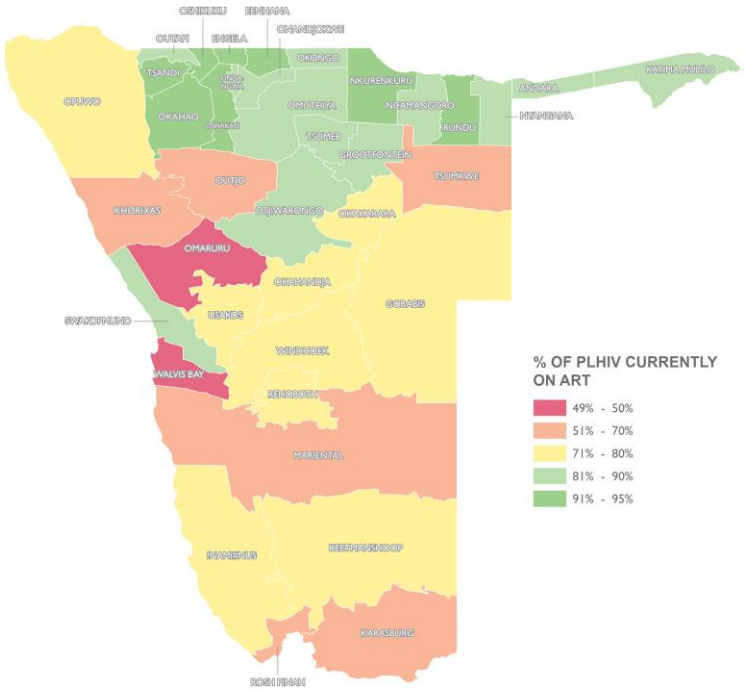


Figure. 2.5.2. HIV Prevalence by District



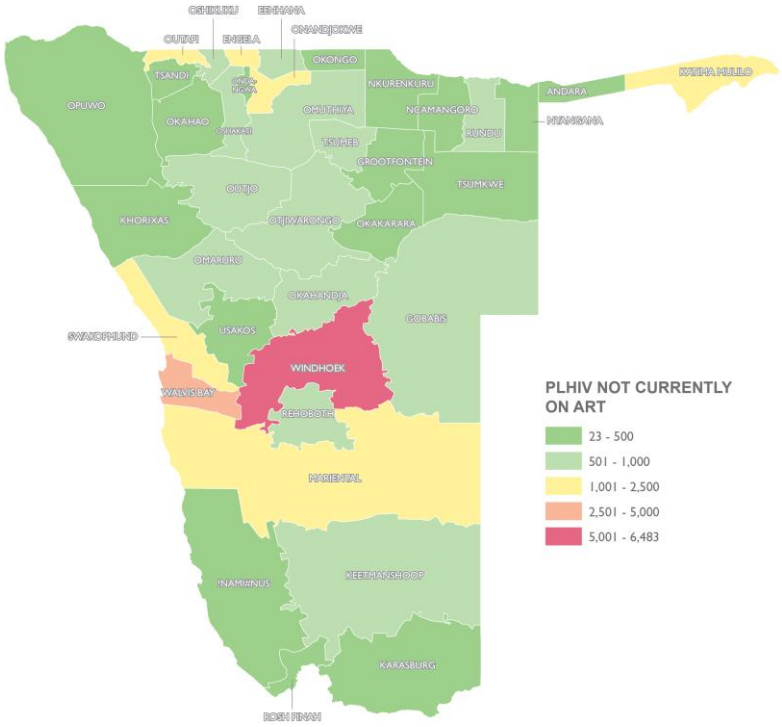
Source: Spectrum/Naomi est. for 9/21

Figure 2.5.3. ART Coverage by District



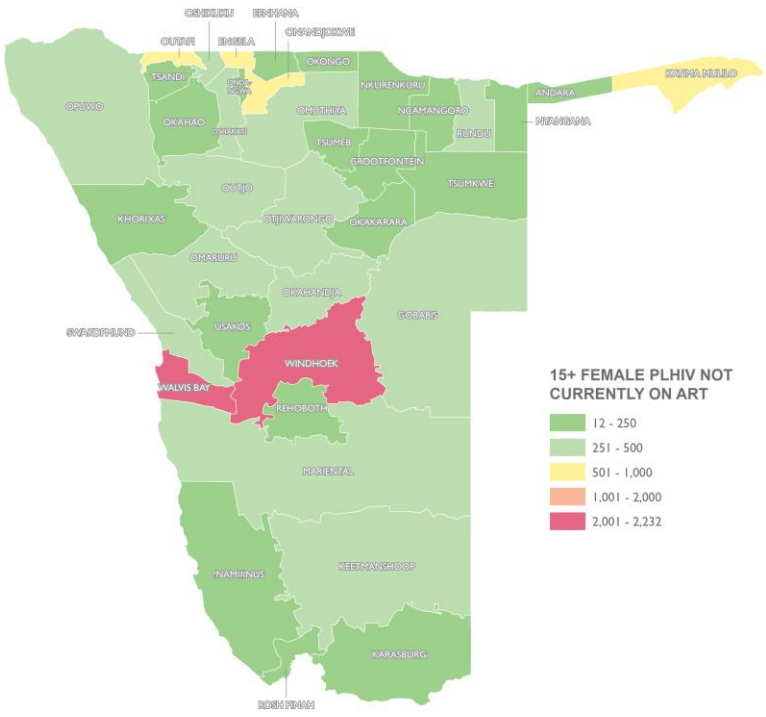
Source: Spectrum/Naomi est. for 9/21

Figure 2.5.4. ART Coverage Gap by District



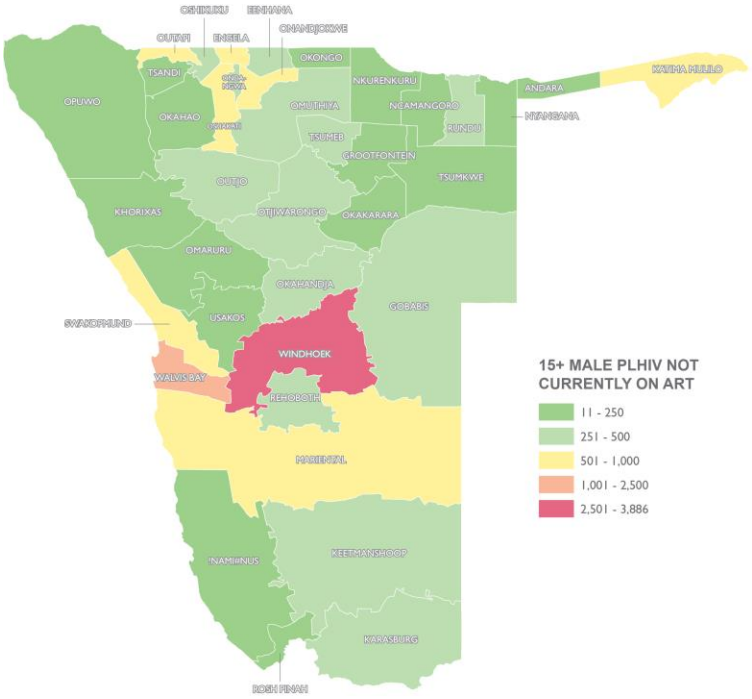
Source: Spectrum/Naomi est. for 9/21

Figure 2.5.5. ART Coverage Gap by Sex (females)



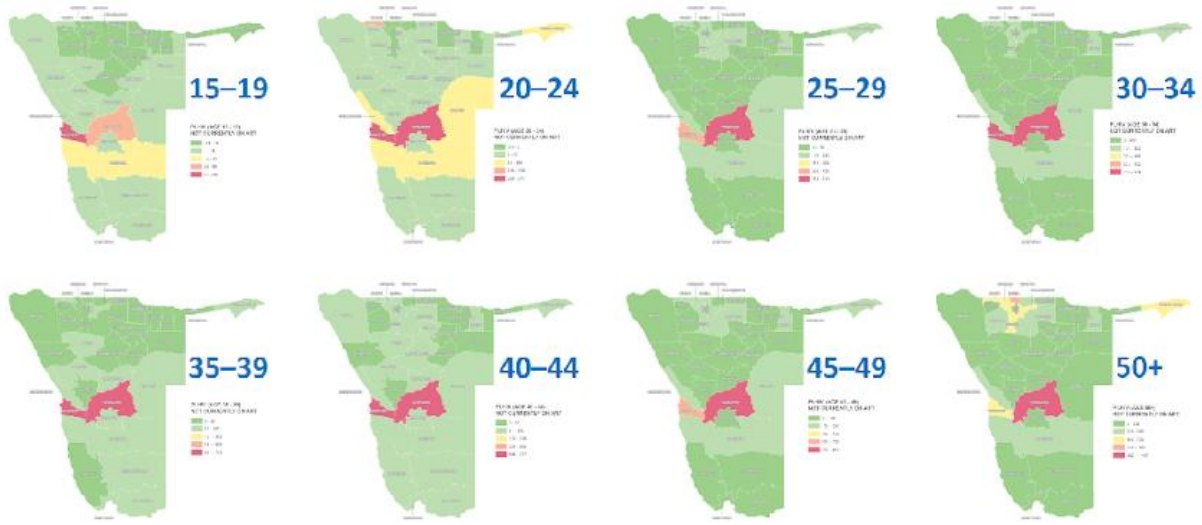
Source: Spectrum/Naomi est. for 9/21

Figure 2.5.6. ART Coverage Gap by Sex (males)



Source: Spectrum/Naomi est. for 9/21

Figure 2.5.7. ART Coverage Gap by Age



Source: Spectrum/Naomi est. for 9/21

Figure 2.5.8. Viral load coverage for patients on ART by District

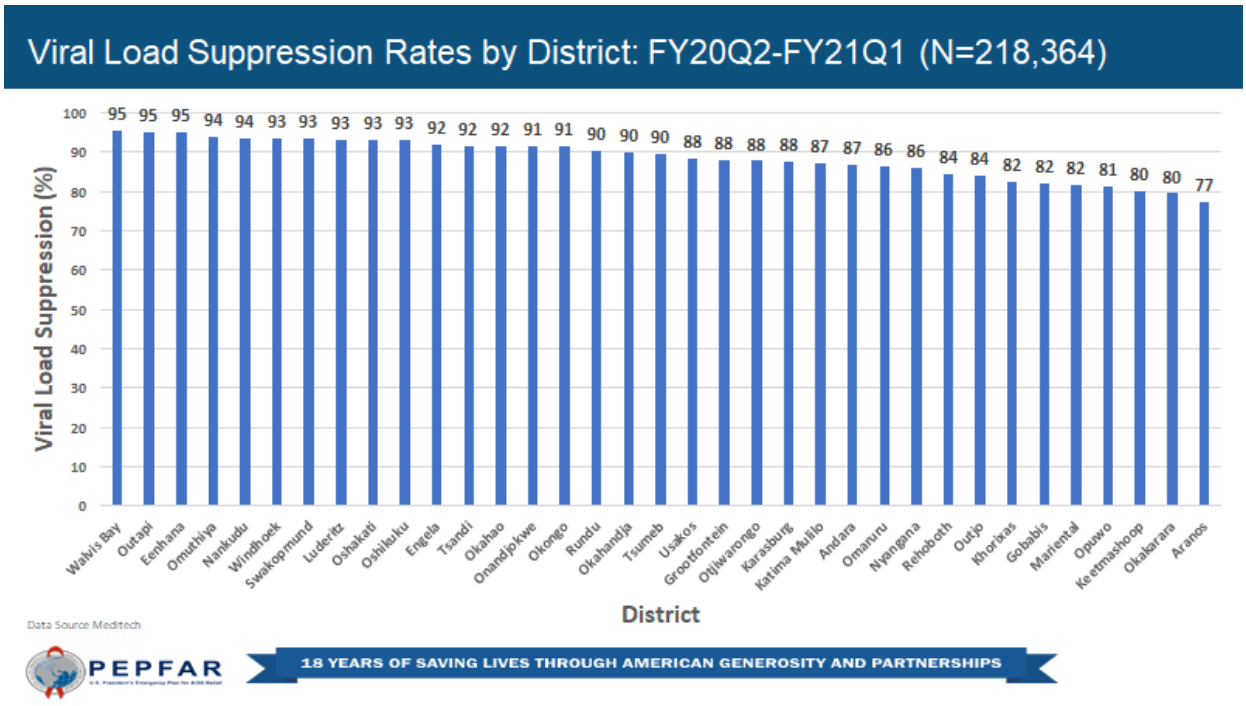
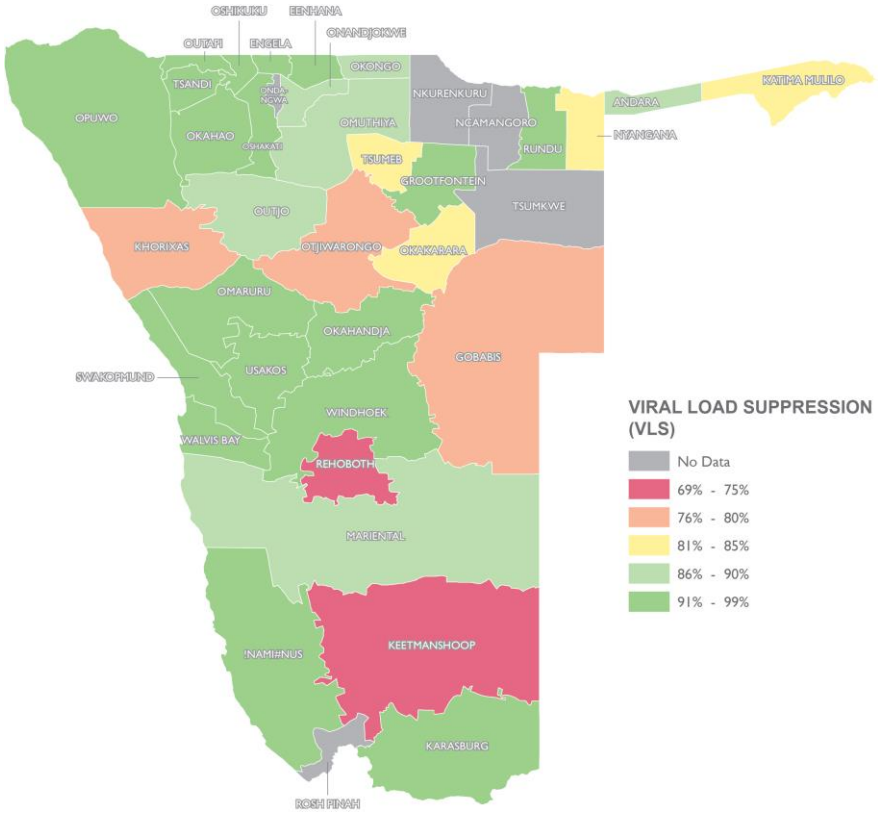


Figure 2.5.9. Viral load suppression for patients on ART by District



2.6 Stakeholder Engagement

Host Country Government

The strong working partnership between PEPFAR Namibia and GRN is demonstrated through various formal engagements, including regular meetings with the management team of the MOHSS, led by the Executive Director, and the leaders from the different directorates, particularly the Directorate of Special Programs (DSP).

PEPFAR Namibia participates in several TWG platforms where technical assistance is provided on a range of issues on an ongoing basis. The MOHSS takes center stage at key stakeholder forums such as periodic program reviews, and general stakeholder meetings including the development of the annual country operational plans. Leading up to the COP21 process, PEPFAR Namibia held regular consultative meetings albeit virtually with the Executive Director of the MOHSS and the DSP to update them on the latest program performance and the COP21 guidance ahead of drafting the country vision. The MOHSS was a leading partner in the subsequent virtual stakeholders retreat and planning meeting.

Global Fund and Other External Donors

PEPFAR Namibia prioritizes efforts directed at mobilizing the contribution of multilateral partners in the development and implementation of the national response. The GF was specifically involved in the initial consultations including the process of developing the COP21 process and participating in the virtual stakeholders retreat as well as the planning meeting. In all engagements, PEPFAR Namibia seeks to address funding gaps and duplication among multilateral donors with guidance from the MOHSS. The

UN agencies, such as UNAIDS, were engaged in the COP21 process during the virtual stakeholders retreat.

Civil Society/Faith-Based Organizations and Community

PEPFAR Namibia works closely with CSOs, including both implementing partners and organizations, that do not receive PEPFAR funding. These CSOs include key population led and focused organizations, entities that represent PLHIV, Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and other (LGBTIQ+) organizations, sex worker-led organizations, and organizations working with and for Orphans and Vulnerable Children (OVC) and adolescent girls and young women (AGYW).

CSOs, community as well as faith-based organizations were invited to participate in the virtual COP21 stakeholder retreat where they provided their input to the vision of Namibia's HIV response. CSOs worked in small, targeted groups to identify gaps, needs and potential challenges that COP21 should address. Following similar practices during previous COP processes, a peer nomination process was undertaken out of which four representatives were selected to attend the virtual planning meeting.

Private Sector

Private sector participants were invited and attended the COP21 virtual stakeholders meeting held on January 27, 2021. It has now become customary to engage the private sector on an ongoing basis on matters of sustainable health financing throughout the year.

3.0 Geographic and Population Prioritization

PLHIV burden and the unmet need for ART varies across Namibia, as shown in section 2.4. ART coverage by age and sex is lowest among individuals older than 25 who are unaware of their HIV positive status and not on treatment, especially men (Figure 3.1). These populations will be a priority for PEPFAR Namibia in COP21 for case finding and ART initiation. PEPFAR Namibia plans to implement targeted interventions to increase case identification and linkage to ART to fill these gaps. Looking by region at the total population with HIV and the number on ART supported by PEPFAR (section 2.4), the highest burden regions are those along the northern border where PEPFAR has invested the most, with high coverage across the cascade. In the most urbanized and affluent areas, there is a larger treatment gap than anticipated, which may be filled by the 22,000 ART clients in the private sector, which is concentrated in those regions. There are regions with low prevalence and low population but also with the lowest coverage rates. In COP19, PEPFAR Namibia increased support with more focused technical assistance in those regions. This support will be continued and refined in COP21.

Compared to the high VLS among adult populations in APR20, pediatrics, adolescents and young adults aged 0 to 24 years had comparatively lower VLS rates (Figure 3.2). Limited support for pediatrics disclosure and teen psychosocial support, and suboptimal ARV prescribing have been identified as contributing factors. Additional support for pediatric and adolescent viral load suppression will be provided nationally in COP21.

The integrated community HIV service model (community index tracing, linkage to care, patient tracing, community adherence groups, mother-baby pair follow-up) will be expanded to include all regions in COP21 through a mixed direct service delivery and technical assistance model. In COP21, PEPFAR Namibia will expand this integrated community HIV service model to include direct service delivery to important hotspot towns, to ensure that this integrated community model achieves maximum reach. Community teams or "Fivers" will be able to respond nimbly to the epidemiology and needs of each area, shifting from case finding to tracing and community adherence group support in saturated areas and back to index testing where gaps are found.

The current cohort of Clinical and Nurse Mentors covering all the 14 Regions of Namibia will be continued. The 28 District Nurse Mentors are assigned based on the number of sites in each district and the 17 Regional Mentors are assigned one (1) per region (this includes the management structure consisting of a Chief Clinical Mentor and a Deputy Chief Mentor).

The geographic focus in the areas with highest burden and unmet need will align all PEPFAR activities for OVC, AGYW, PLHIV, key populations, and other priority populations to create a synergistic impact. OVC activities will be implemented in 18 districts with an overlap of OVC implementation in nine Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) districts. OVC activities are aligned to geographic areas of the highest HIV burden and greatest unmet ART needs for children and adult populations. DREAMS interventions will be implemented in nine districts with high HIV prevalence rates, high prevalence of GBV rates and high teen pregnancy rates: Katima Mulilo, Omuthiya, Onandjokwe, Tsumeb, Windhoek, Oshakati, Rundu, Nyangana and Andara. DREAMS activities will target AGYW ages 10-24 to decrease the HIV incidence and ultimately keep them HIV-negative. In these districts, PEPFAR Namibia will ensure layered age-appropriate programming for girls and women up to age 24 (Figure 3.6) with a strong emphasis on economic strengthening and PrEP provision for older AGYW.

Interventions for HIV prevention, care and treatment targeting KPs will be implemented in ten districts across nine regions. In four of these districts (Katima Mulilo, Windhoek, Walvis Bay and Swakopmund), results from the NAM-IBBS 2019 show high HIV prevalence among FSW and MSM. ART coverage for KPs living with HIV who know their status was comparable to estimates for the adult general population, however the viral load suppression rate was low. KPs in these districts also had limited engagement with peer educators and despite its national rollout since 2016, uptake of PrEP among eligible KPs is low. Programmatic interventions in the priority districts will address key barriers to access and use of KP competent prevention, care and treatment services including violence response. In COP21, these activities will continue to be scaled up to ensure KPs have access to comprehensive HIV prevention and violence mitigation as well as linkage to high quality clinical services such as STI screening and treatment, HIV testing services, ART and viral load monitoring.

As a result of PEPFAR support to the MOHSS, national VMMC coverage among young men aged 15-29 years old is expected to reach 63% by the end of 2021, an increase from 35% in 2017. Regions with direct PEPFAR support recorded some of the highest coverage: Windhoek (Khomas region 62.2%), Katima Mulilo (Zambezi Region 84%), Oshakati (Oshana region 71%), Kavango East (105%), Oshikoto (71%), Omusati(86%) (DMPPT, Data validation, 2020/21). Newly supported regions had low VMMC coverage; Rosh Pinah and Luderitz (!Karas region 41%) and Kavango West region(55%). In FY22, PEPFAR Namibia will continue supporting the existing areas and VMMC programs in areas where GF services have decreased. FY22 activities will focus on the provision of direct service delivery support, demand creation and quality management and quality improvement for a rapid VMMC scale up in priority regions with low VMMC coverage (less than 80%). It is expected that the COP21 OU target will rapidly saturate an additional five priority regions (Khomas, Erongo, Ohagwena, Oshana, and Karas) to 80% VMMC coverage by the end of FY22. (Figure 3.7).

Figure 3.1. Namibia Population Pyramid (PLHIV Only)

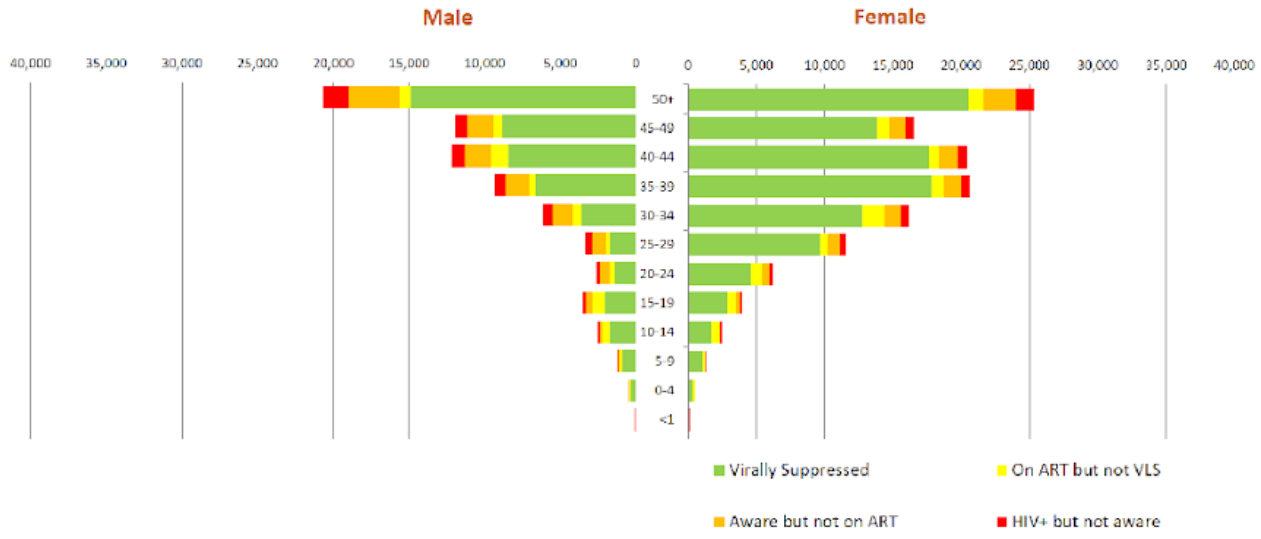


Figure 3.2. Viral Load Suppression Rates by Age/Sex, Namibia FY20Q2-FY21Q1: (N=219,425)

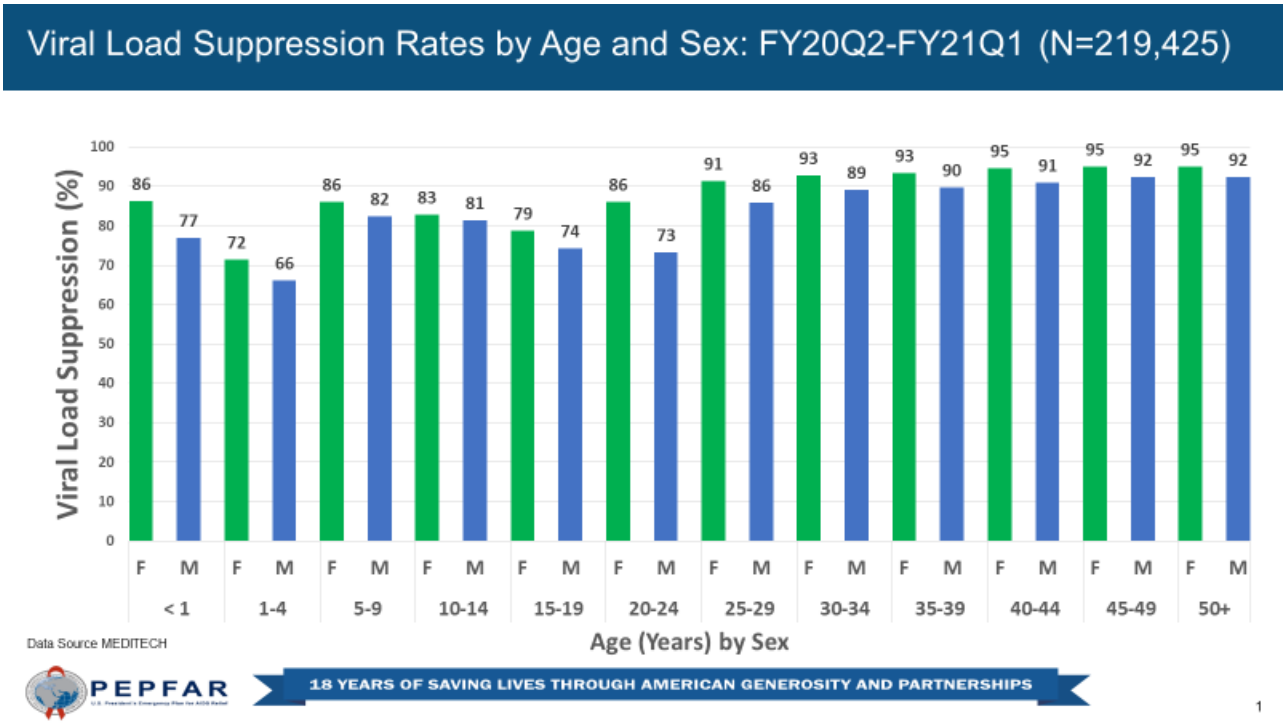


Figure 3.4. Clinical Mentorship Network Geographic Coverage COP21

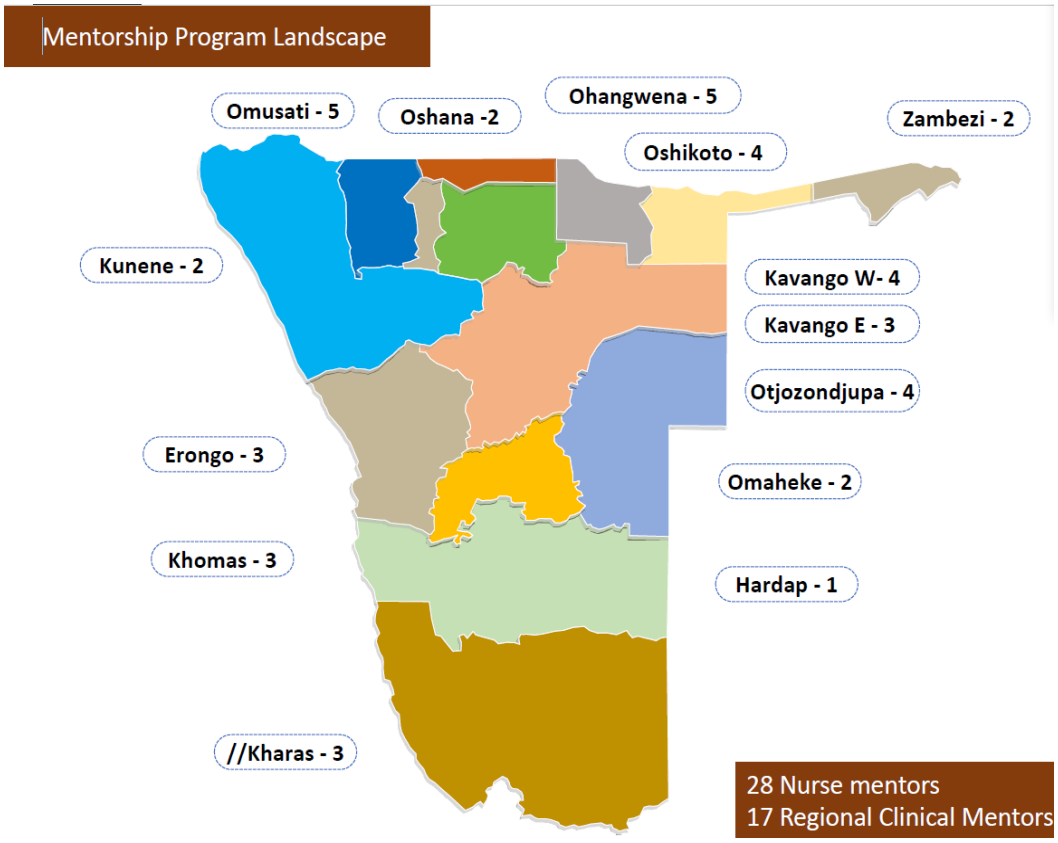


Figure 3.5. Clinical Mentorship Network Structure COP21

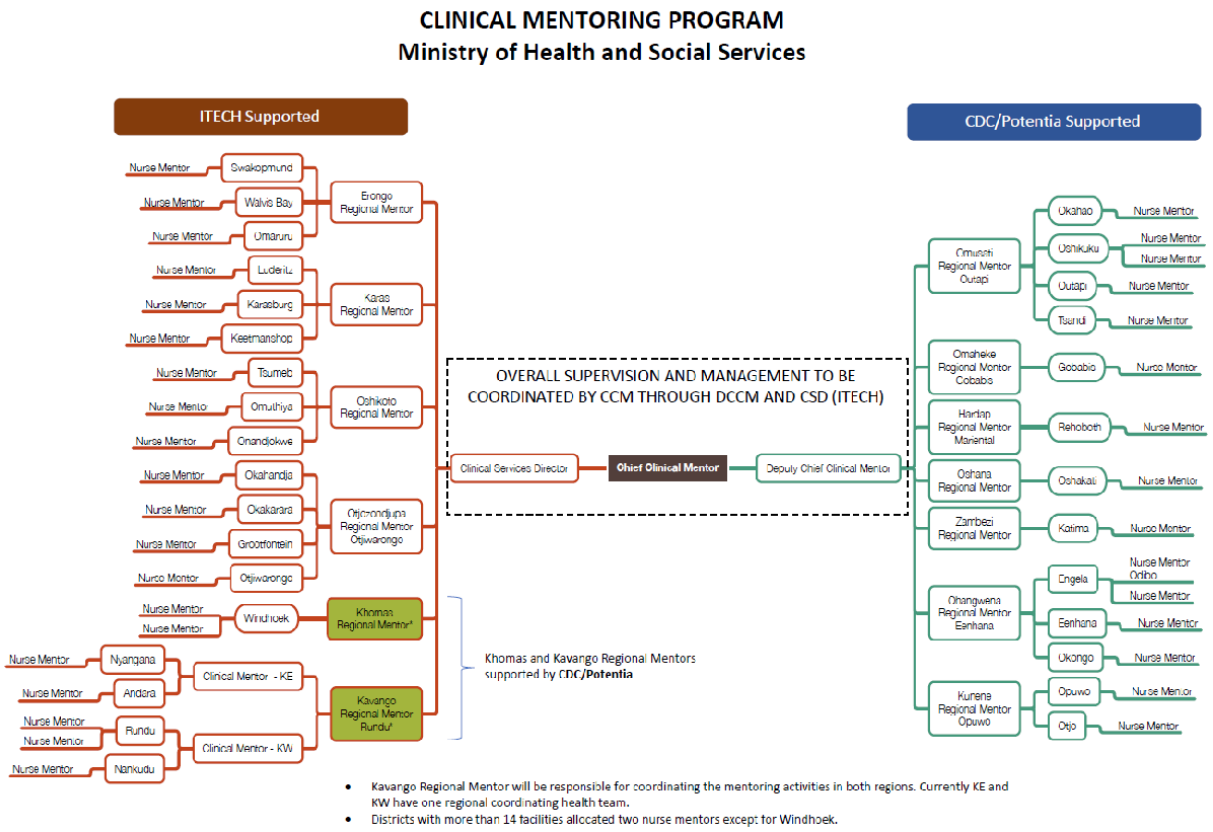


Figure 3.6. DREAMS and OVC Program Supported Health Districts and Regions

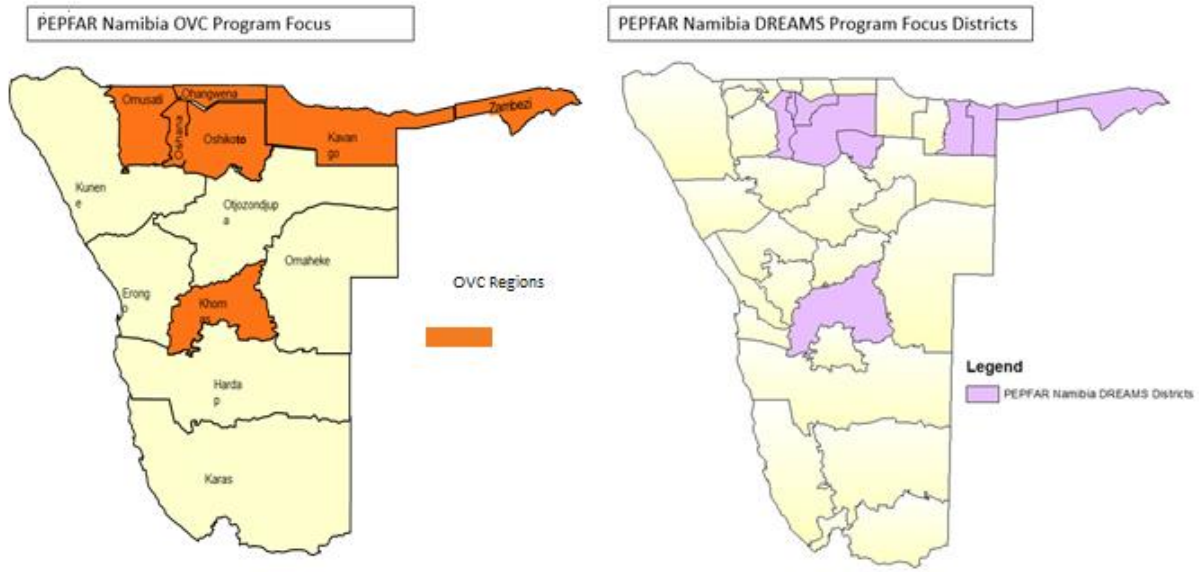
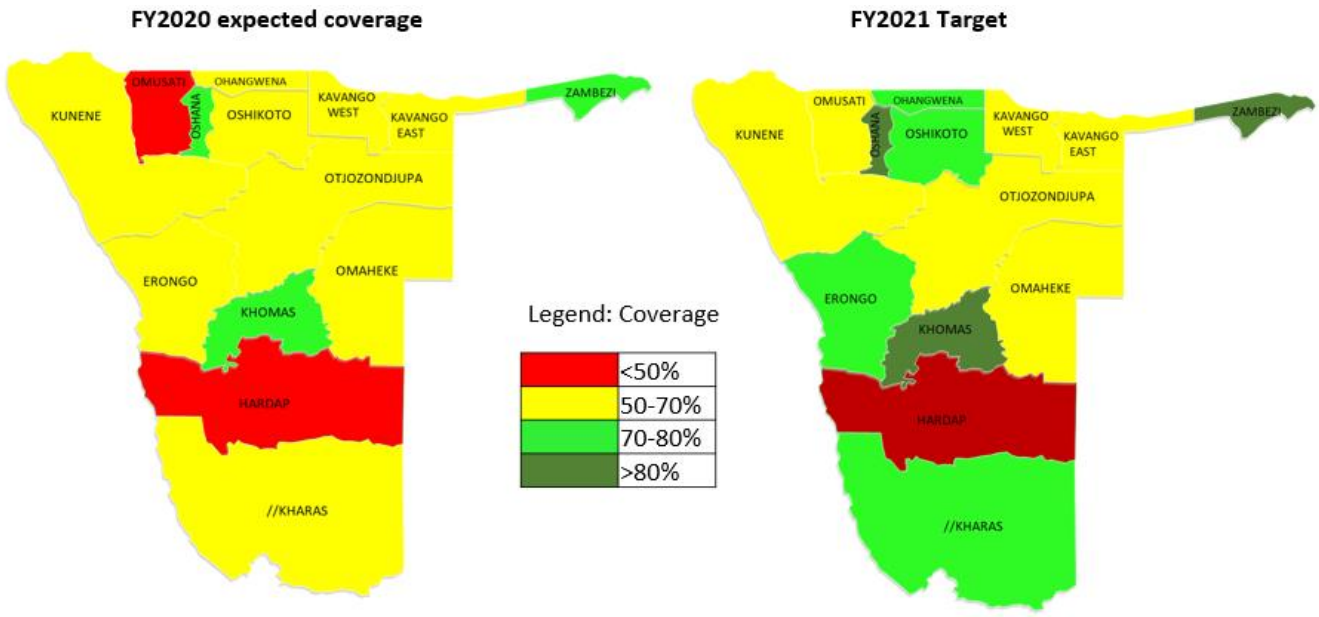


Figure 3.7. VMMC Coverage from FY20 expected Coverage and Targets for FY 2021



Peace Corps' plans for COP20 could not be fully actualized following the global evacuation of Volunteers during the second quarter of COP19 when COVID-19 was declared a global pandemic. In the absence of Volunteers, the agency engaged and supported former counterparts of the evacuated Volunteers to continue facilitating youth HIV prevention activities and outreach services to OVCs in selected sites. This approach will be strengthened in COP21 alongside the gradual return to full operations signified by the eventual arrival of Volunteers at sites. Other adaptations and changes in Peace Corps operations initiated in COP20 and anticipated to spread into COP21 include the "Virtual Service" where select former Volunteers are engaged in providing remote support to organizations in a variety skill areas. PEPFAR implementing partners have expressed interest in this support and Peace Corps has worked with those partners to identify assignment in such areas as communications, demand creation and monitoring & evaluation during COP20 and through COP21. Additionally, to maximize the contribution to PEPFAR aims during the initial return of Volunteers, and as the program builds back up to full strength, Peace Corps is working with partner organizations to develop special assignments in areas of critical skill need at the organizational levels. While these assignments will be available to evacuated volunteers seeking reinstatement in cases where those individuals have the desired skill sets. For more specialized skill needs, targeted recruitment will be done to identify Peace Corps Response Volunteers (PCRVs) to fill those assignments. The actual timing of the return of Volunteers to service is largely contingent on the CDC travel advisories being reduced to level 3 or below. Peace Corps continues to monitor the situation with the returning Volunteers to sites as soon as conditions permit.

Table 3.1 Current Status of ART Saturation and Progress Towards 95-95-95 Across all SNUs

Prioritization Area	# Current on ART (FY17)	# of SNU COP17 (FY18)	# of SNU COP18 (FY19)	COP19 (FY20)	COP21 (FY21)
Attained	10,444	2 Districts	12 Districts	All 14 Regions	35 Districts
Scale-up Saturation	114,737	11 Districts			
Scale-up Aggressive	10,153	3 Districts			
Sustained	22,177	8 Districts			
Central Support	9,124	9 Districts	9 Districts		

*UNAIDS 2020 Naomi District Estimates, 27 Jan2020

4.0 Client Centered Program Activities for Epidemic Control

4.1 Finding the missing and offering treatment initiation

In FY20, PEPFAR Namibia identified 13,141 HIV positive persons. Generally, a downward trend is observed which is not unexpected given Namibia's epidemic status of 90% of PLHIV knowing their status. COVID-19 has also impacted HTS positive results (Figure 4.1.1). This trend is expected to continue as the country continues to close the gap and reach sustainable epidemic control.

Spectrum estimates for 2020 indicate that 90% of PLHIV know their status. Data suggest that the remaining gap in testing may be highest among men 20 to 34 years of age and children <1-9 years of age. The geographical prominent gaps across most of the age cohorts are in Windhoek and Walvis Bay districts, with a very small absolute gap observed in all regions across all age cohorts.

Case finding results by sex, age, geography, and modality show that for FY20, index partner testing in both the community and facilities as well as provider-initiated testing and counseling (PITC) modalities were successful in finding HIV positive men in PEPFAR-supported regions (Graph 4.1.2). The number of HIV positives and yield by modality for FY20 show that the Index Testing modalities (Facility and Community Index Testing) achieved the highest percentage yields amongst all modalities with 22% for facility Index Testing and 23% for community Index Testing (Graph 4.1.3). Facility Index Testing yields increased significantly in FY20 in all regions of Namibia (Graph 4.1.4) which shows greater efficiency achieved with this modality during FY20. Community Index Testing also shows consistently high percentage yields across all regions for both FY19 and 20 (Graph 4.1.4). However, volumes remain low and have been decreasing because of the COVID 19 restrictions.

Other PITC modality shows some volume reductions with slight % yield increases (Graph 4.1.5). These changes are due to data cleaning processes and some implementation of the PITC screening tool. It is expected that this trajectory will continue given the constant refinement of both the Index Testing and PITC modalities in FY19. The HIV testing yield for FY20 is higher among men 30 years and older, than women and younger men. PEPFAR Namibia continues to find men with the current implementation modalities. The Ministry of Health and Social Services intends to intensify testing rates in the Index Testing program in COP21 and beyond.

In COP21, PEPFAR Namibia's overarching goal for case finding is to implement a national case-based surveillance system with integrated public health response at individual and community levels. This goal will be achieved through the provision of recency testing in all regions. The response will directly link into Namibia's comprehensive index partner testing program as well as provision of HIV self-testing, targeting hard to reach partners of HIV positive Index Cases and partners of high-risk HIV negative individuals.

Provision of Comprehensive Index Partner Testing

In COP18, the GRN committed to implement Index Partner Testing at scale in Circular 12 of 2019 in all districts and with all facility and community partners. Subsequently, the MOHSS trained all 14 regions on the Index Testing approach as well as PITC Optimization and HIV self-testing. Results from FY20 show a significant shift in programming especially for facility-based Index Testing. However, volumes for both facility and community index testing remain suboptimal. For COP21, PEPFAR Namibia will continue to support the MOHSS and other implementing partners to scale and refine their Index Testing and targeted testing approaches through intensified site level support as permitted by COVID 19 conditions. Additionally, PEPFAR Namibia will continue to provide direct service delivery support through a community partner to the low burden regions in identified hotspots to improve their community index testing programs with efficiency and fidelity. Ensuring the safety of patients through intimate partner violence (IPV) screening remains a critical component to index testing and will be tracked pre- and post- Index Testing services. In COP21, PEPFAR Namibia will continue to support case finding in high burden regions)/districts with the provision of community Index Testing Direct Service Delivery (DSD). Outside of the DSD districts, PEPFAR Namibia IPs will continue to provide TA support to the MOHSS. DSD support for community index testing will also be provided at hot spot towns within low burden regions/districts. HIV self-testing will be integrated into the Index Testing program to reach those "hard to reach sexual partners" as well as children who are contacts through secondary distribution.

PEPFAR Namibia will support the implementation of PEPFAR's minimum requirements for Index Testing. All sites have been assessed in FY20 and results show compliance to most of the minimum standards however a few standards were identified which needed remedial actions. Currently and in future, there is a plan to address these issues through continuous site support supervision utilizing the Ministry of Health and Social Services standardized tool. Continuous collaboration and oversight with in-country CSOs will be supported to ensure that Index Testing remains confidential, voluntary, and consented. Other modalities for HIV testing services will continue to be supported such as peer driven social network testing and outreach-based testing with integrated HIV self-testing programs among KPs.

Recency Testing

Recency testing was started in July 2018 and delivered in five high burden districts in 42 health facilities. As of April 2021, Recency cumulative results for calendar years 20 and 21 from 100 Health Facilities indicate that 3942 individuals were offered Recency testing, 76 (1.9%) tested recent, confirmed through RITA. These data indicate that there are significantly higher recent infections among women and younger age individuals. A higher number of recent cases were found in Nkurenkuru at 13% highlighted in red followed by Okahao at 5.4% and Outapi at 4.8% (figure 4.1.6). Recency testing expansion has been slowed significantly due to the COVID-19 restrictions in-country as seen in the (Figure 4.1.7). The status as of April 2021 showing Recency roll out is below 60% for most regions, with Khomas region at 83% coverage.

PEPFAR Namibia intends on increasing coverage in all regions by the end of COP20. At the end of COP21 we expect to have achieved a coverage of above 80% in all regions (80% was set as the threshold for saturation). The remaining few regions will be scaled in COP22. Due to COVID restrictions, scale up of

Recency has been slowed significantly. As a result, the program requested additional funding support through the ARPA mechanism to accelerate scale up efforts in line with the planned expansion. This rollout will ensure that all newly diagnosed and eligible persons who present for ART initiation will have a known recency status. Additionally, urine tenofovir point-of-care testing will be implemented to determine the percentage of known positives among the newly diagnosed. It is anticipated that for the remainder of COP20 that systems will be established at all levels in the health system to ensure an effective public health response. The program finalized the SOP for prioritized case investigation and data use which focuses on Prioritized Case investigation at the health facility and district levels. Linking to QI collaboratives will address service level gaps and data will lead to optimized index testing and prevention services, etc.

The recency response will pivot around ensuring those newly diagnosed receive a package of services including recency and Index Partner Testing (IPT) services as well as PrEP and ART provision. Enhanced IPT, PrEP and ART services will be offered to those who test recent and their partners. Additionally, this data will assist the program to identify potential hotspots of transmission.

Targeted Facility Based Testing

In COP19, the MOHSS trained all providers on the approved PITC screening tool and began rolling it out to all regions. In COP21, PEPFAR Namibia will intensify support to 71 high volume sites to expedite the reduction in volume through the systematic screening for HTS eligibility. PEPFAR Namibia recently received CDC Ethical approval for the validation of an HIV testing eligibility screening tool to identify adults living with HIV. PEPFAR Namibia is awaiting final approval from the MOHSS. Data collection will commence in COP21. The results regarding sensitivity and specificity of the tool will enable the program to further optimize their screening program. The mentoring program will continue to monitor and evaluate the program implementation and trouble shoot at site level throughout COP20 as COVID permits. Routine testing will continue for pregnant and breast-feeding women, STI and TB patients and children of women living with HIV. HIV Self-Testing will be integrated in services delivered to high risk negative pregnant and breast-feeding women, STI, family planning and TB clients through secondary distribution to their sexual partners. In COP21, it is anticipated that targeted testing will be routinely offered at all Public Health Facilities and this program will be fully transitioned to the Namibian government with no funding support from PEPFAR Namibia in COP22.

The case finding strategic vision for COP21 is essentially a continuation of COP20 with adjustments to address remaining gaps. Priority populations include males aged 15-34 years of age, children <15 years of age, pregnant and breastfeeding women. The goal remains to ensure the implementation of a national case-based surveillance and response through the expansion of Recency Testing at all Health facilities as well as key population drop-in centers in-country and ensure that these data is utilized to implement a robust public health response in “hotspot areas” especially within the Adolescent Girls and Young women programs. The main testing approach will continue to ensure the provision of safe, qualitative, and ethical Index Testing services for all priority populations. HIV self- testing will be utilized to test more biological children of Index clients and sexual partners of high-risk negatives and HIV positive clients. PITC will continue to be optimized through systematic routine screening for HTS eligibility. Effective linkage to Treatment and Prevention services remains a priority. Figure 4.1.8 shows the case finding vision for COP21.

Immediate ART initiation

Namibia successfully implemented test and treat at health facilities in all districts in 2016. Given the latest estimates (Spectrum 2021 combined with Program Data) of Namibia’s progress towards meeting the UN Fast track targets, of the 90% of PLHIV diagnosed with HIV, 98% were on treatment, which is an

indication that Namibia is successful in linking those who test HIV positive to treatment. In FY21 Q1, consistently high linkage rates are observed over time with some decreases observed in the last three quarters Q3 and Q4 and FY21 Q1 at 81%, 82% and 78% respectively (Figure 4.1.9). The proxy linkage rate among females is slightly lower compared to males (Figure 4.1.10). It is also worth noting that the number of females identified is twice as high as their male counterparts.

PEPFAR Namibia can achieve consistently high linkage rates through active linkage mechanisms, with healthcare providers physically escorting patients for ART initiation, and following up to ensure that patients who are positive are started on ART. The community index testing program equally achieves high linkage rates with a 99% linkage rate in FY21 Q1. (Graph 4.1.11). The same-day ART initiation data for FY21 Q1 show 84% were linked on the same day as HIV confirmed diagnosis and 90% were linked within seven days (Graph 4.1.12). Same-day linkage for the community index program stood at 97% for FY21 Q1 (Graph 4.1.13). Though linkage has been consistently high, Namibia aims to achieve greater than 95% linkage to care in all districts (Figure 4.1.14). This figure shows linkage proxy for FY21 by district.

FY21 Q1 shows high volume sites had a proxy linkage between 30% and 76%. Smaller sites, however, had much wider variability with some having above 100% linkage, this is a function of smaller sites also accounting for community testing data, which is not consistently recorded, especially during the COVID-19 pandemic. Further analysis reveals that challenges with linkages are experienced mostly at high-volume sites, District hospitals, clinics and health centers which serve as central hubs. This may indicate that some clients prefer not to take their medications at the same facility and choose to initiate treatment elsewhere. COVID 19 may have also impacted the program as movement restrictions resulted in fewer people physically visiting health facilities (4.1.15).

This is consistent with known data about the mobility of the population that while individuals may get tested positive in the urban high-volume sites, a significant number may prefer to go and start their ART at low volume ART sites, closer to their homes in smaller towns. The program identified 22 sites which constitute 80% of the volume of "Not linked clients" in FY21 Q1. Program officers and clinical mentoring teams will target these 22 health facilities with intensified support in coming quarters. Firstly, the teams will conduct rapid assessments to understand linkage challenges, develop site specific mitigation plans and support implementation of site-specific improvement plans while monitoring performance over time.

The current test-and-treat SOP recommends offering ART on the same day that an HIV diagnosis is made. Patients who opt out would be recorded into the national database and referred to the districts where they would prefer to continue their ART. However, Namibia does not routinely trace these patients and confirm that they made it to the next facility.

PEPFAR Namibia will expand tracing activities to all regions in COP21 to ensure that the lists of patients who are referred to other facilities for continuing ART elsewhere, are shared with implementing partners who will assist in tracing patients to confirm that they made it to the next facility. Additionally, patients newly initiating ART will be offered support at community level until they achieve stability and are enrolled in a DSD model.

Children and Adolescents

In August 2019, the new Namibia National ART guidelines were launched. These guidelines are progressive when considering pediatric populations and have already endorsed DTG as the preferred first line regimen across all age bands starting at 4 weeks old. This is in anticipation of DTG 10 becoming available in late 2021 and will be able to be rapidly implemented without having to undergo an additional

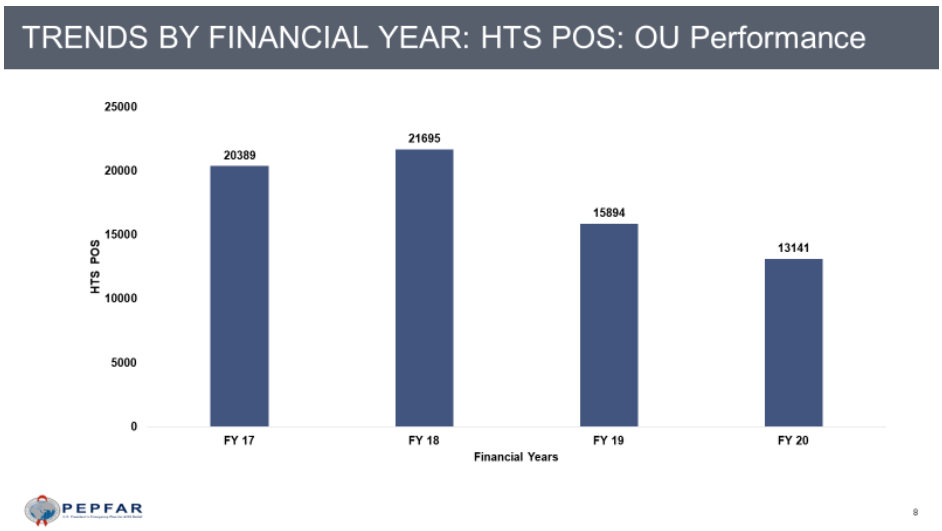
guideline revision. Of note is the optimization of the use of protease inhibitor (PI) formulations. The MOHSS is committed to no longer procuring LPV/r syrup and transitioning all eligible children to LPV/r granules due to the increased tolerability. Namibia is progressive in its policy to support the best ART regimens possible for children. By eliminating the use of NNRTIs in children, PEPFAR Namibia hopes to see improvement in overall viral suppression.

Namibia has been successful in implementing and rolling out differentiated service delivery models, including teen club support groups. In COP18 Q4, over 4,000 young people were receiving support through the teen club model. Teen clubs have rapidly expanded in Namibia over the past three years, with many regions now offering teen clubs at the clinical level. However, of the 9,364 adolescents living with HIV, only 3,803 are supported through a teen club model, translating to only 41% of eligible adolescents living with HIV. It is evident that children who are engaged in the teen club have good clinical attendance and undetectable viral loads. In a previous analysis of teen club attendees,20% of those individuals who did not have undetectable viral loads at entry had an improvement in suppression since joining a teen club.

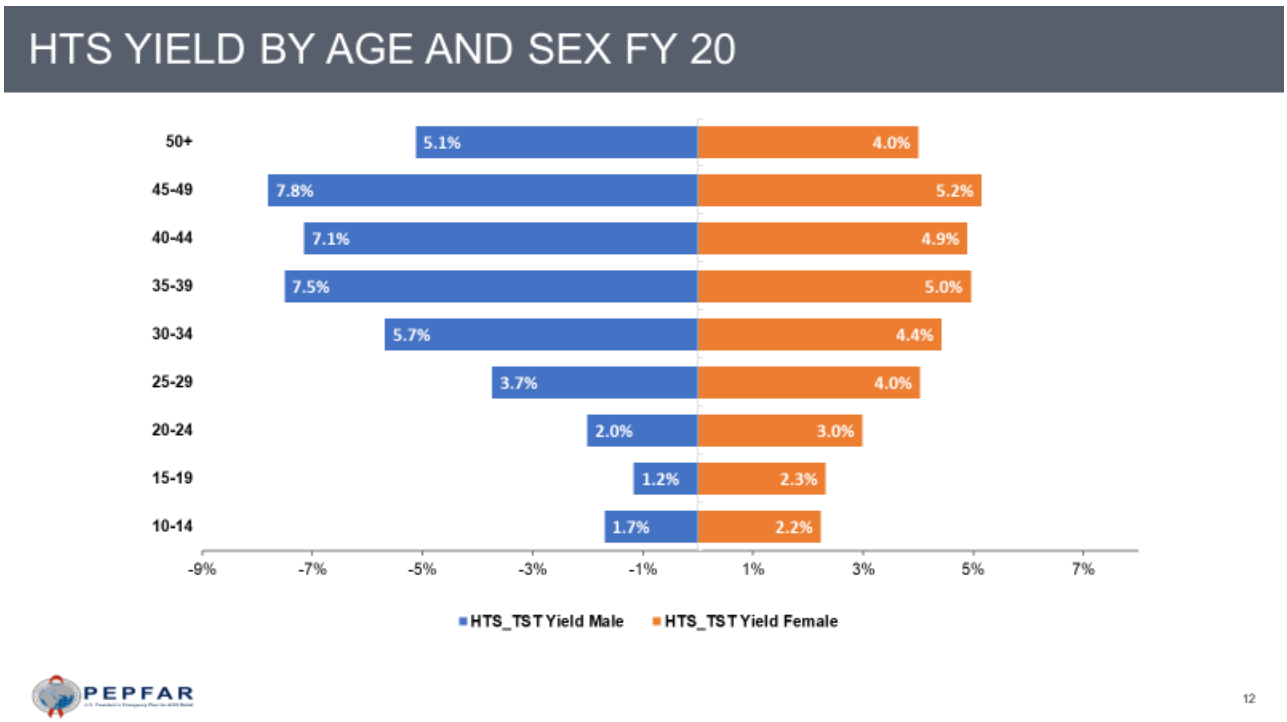
Nevertheless, the teen club model faces challenges. Currently, teen clubs are only offered at the facility level, which means they are dependent on available, private space that a facility can offer. It is also dependent on an HCW from that facility to organize and implement. Some facilities are not willing to add burdens for already overworked staff. Until April 2021, there was no standardized curriculum or guidance for HCWs on appropriate teaching topics, so teen clubs vary greatly from facility to facility. Some of these issues are being addressed in COP20. Planning for COP21 will continue to work on rolling out the standardized teen club curriculum, develop a youth club for those >19-year old's that aged out of teen clubs, increase support from peer mentors to decrease burden on HCWs, and increase reporting on the clinical outcomes of children enrolled in the teen club model.

The Zvandiri model of care through Community Adolescents Treatment Supporters (CATS) began implementation in COP19 through a Memorandum of Agreement with MOHSS and an implementing partner. It has started with two (2) regions. In COP21, this model will expand to eight regions, covering the highest burden regions in the country. The CATS program will continue to work across the clinical cascade to help mobilize at risk young people, children, and infants for testing. CATS also assists by linking newly identified children, families, and young people to care, assisting in counseling and adherence support, and working towards complete viral suppression for each of their clients. COP21 will look to formalize the referral between the teen clubs and CATS program to OVC and DREAMS services for a holistic approach to this population's needs.

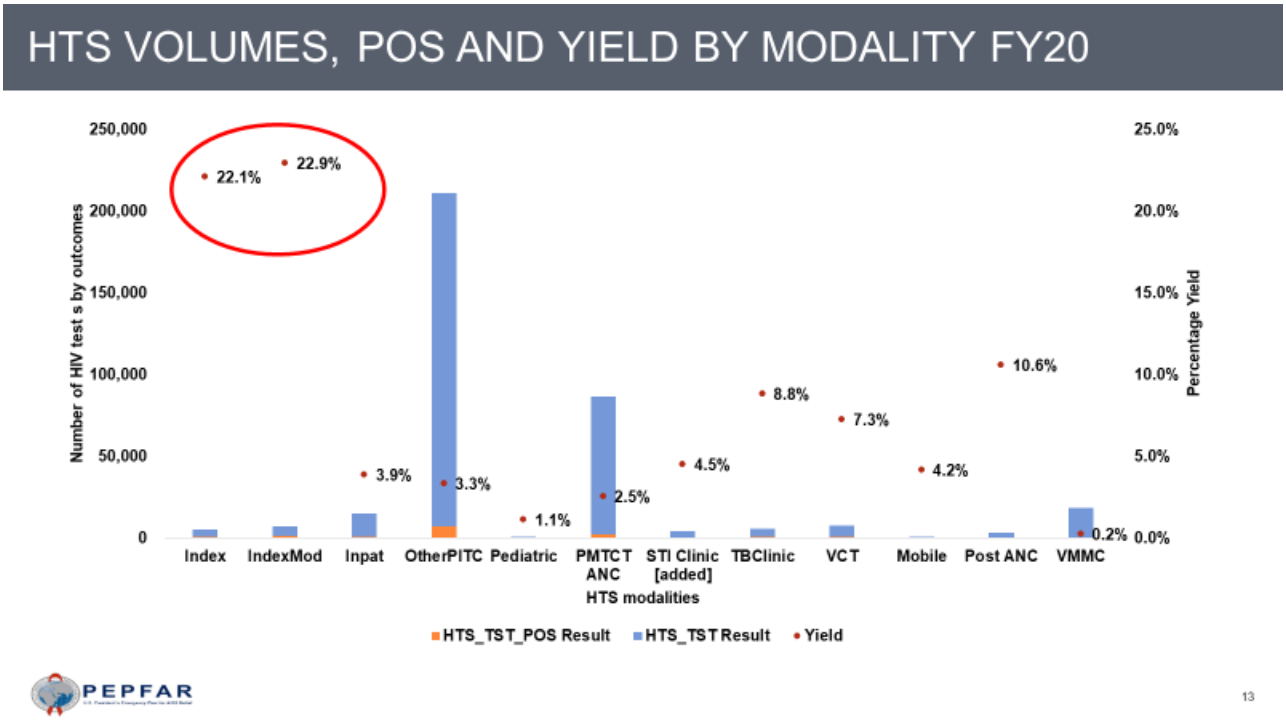
Graph 4.1.1 HTS Positive Results by Financial Year : OU Performance



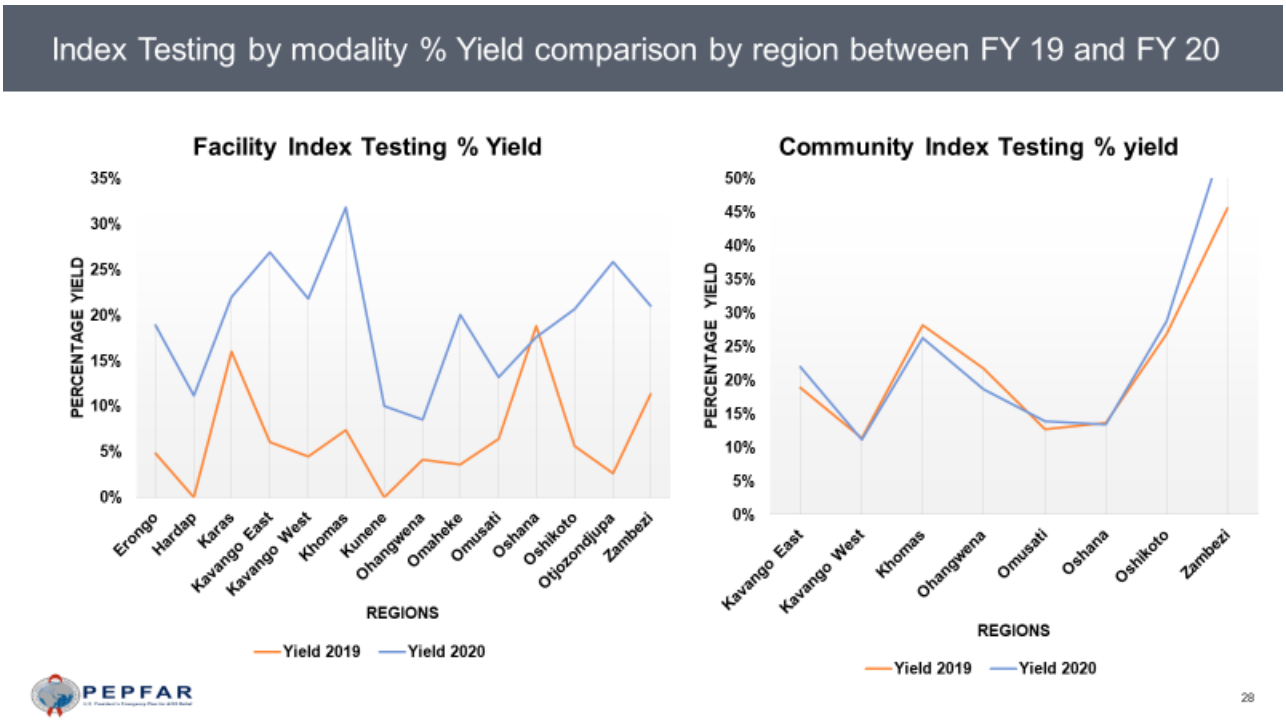
Graph 4.1.2. HTS Yield by age and sex FY 20



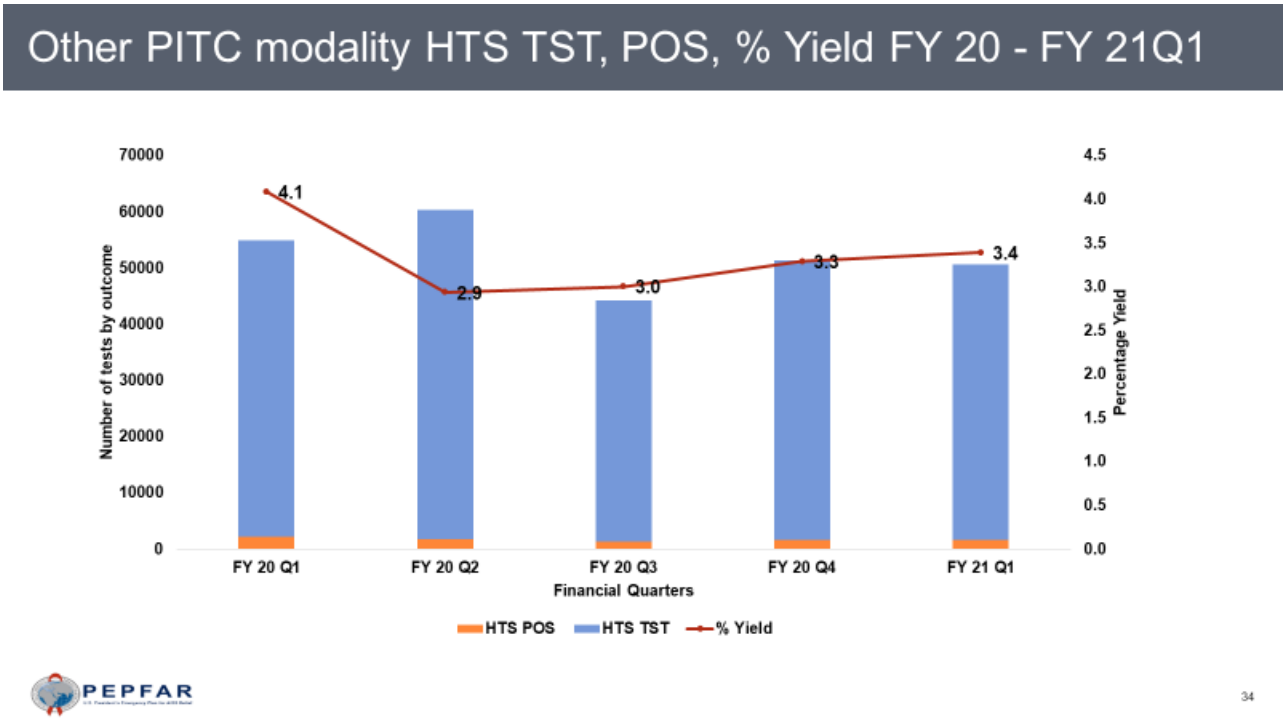
Graph 4.1.3. HTS volumes, pos and yield by modality FY 20



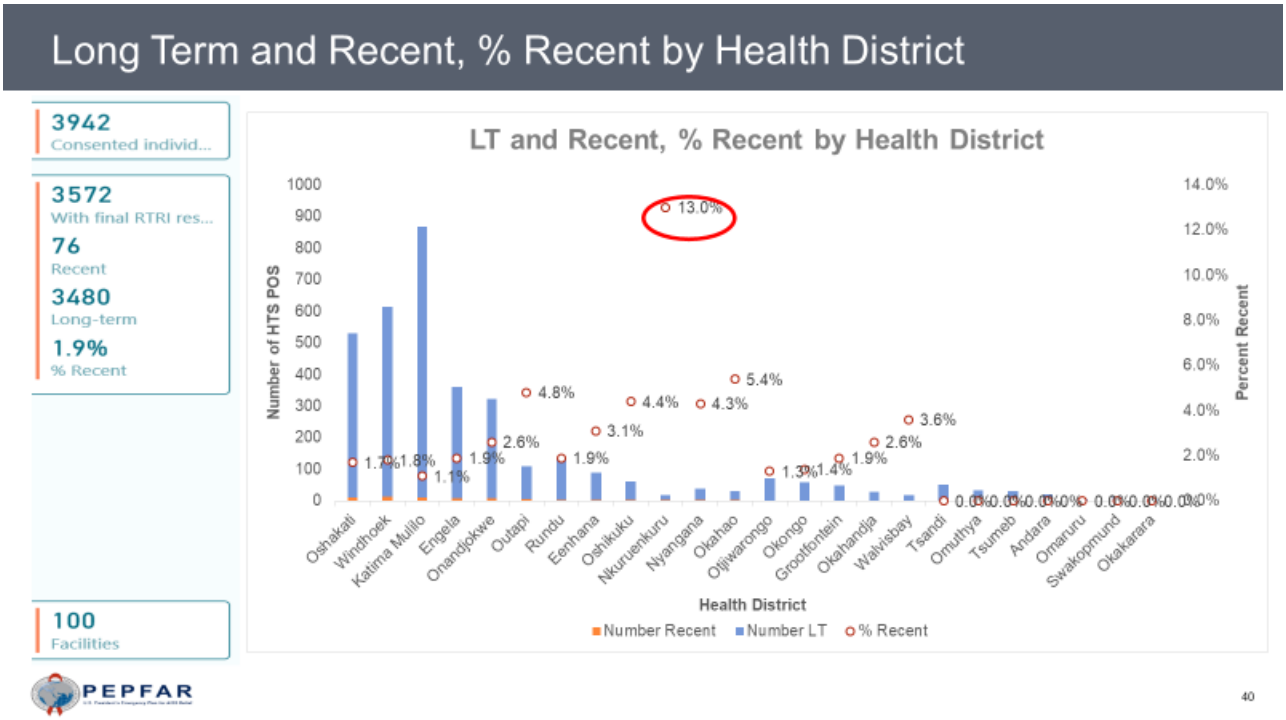
Graph 4.1.4. Index Testing by modality% Yield comparison by region between FY 19 and 20



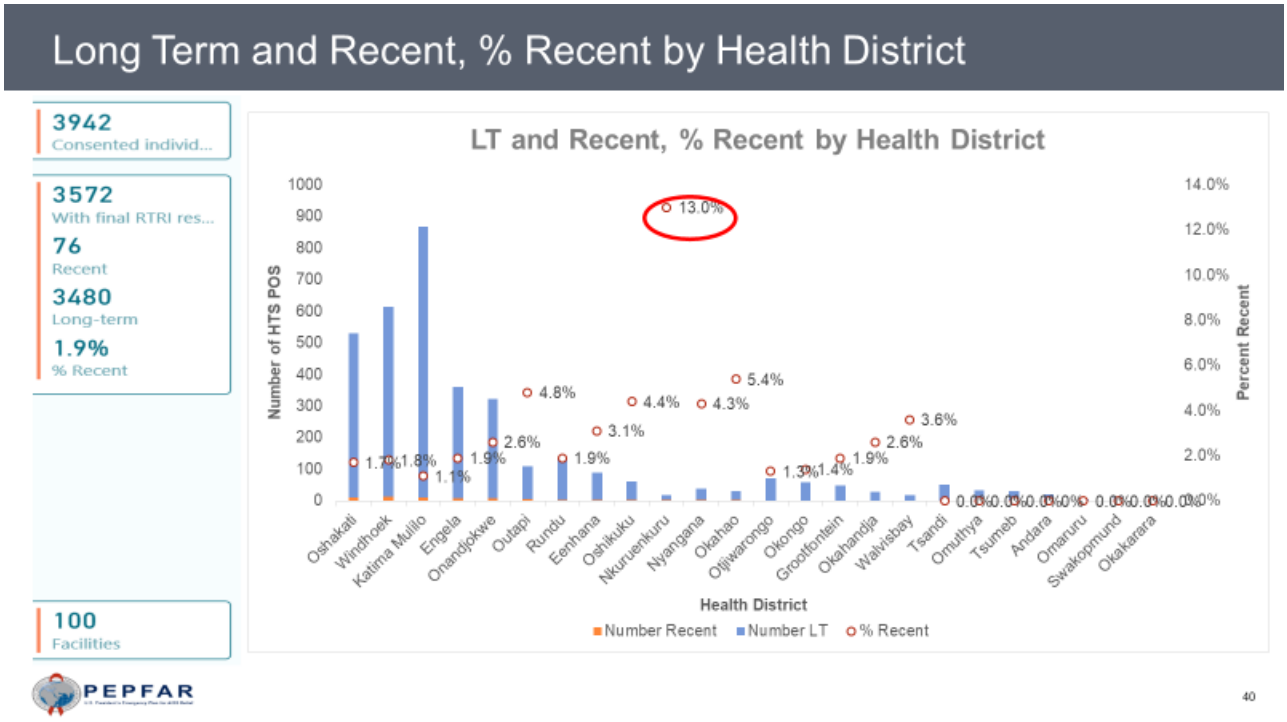
Graph 4.1.5. Other PITC modality HTS TST, POS, % Yield FY 20- FY 21 Q1



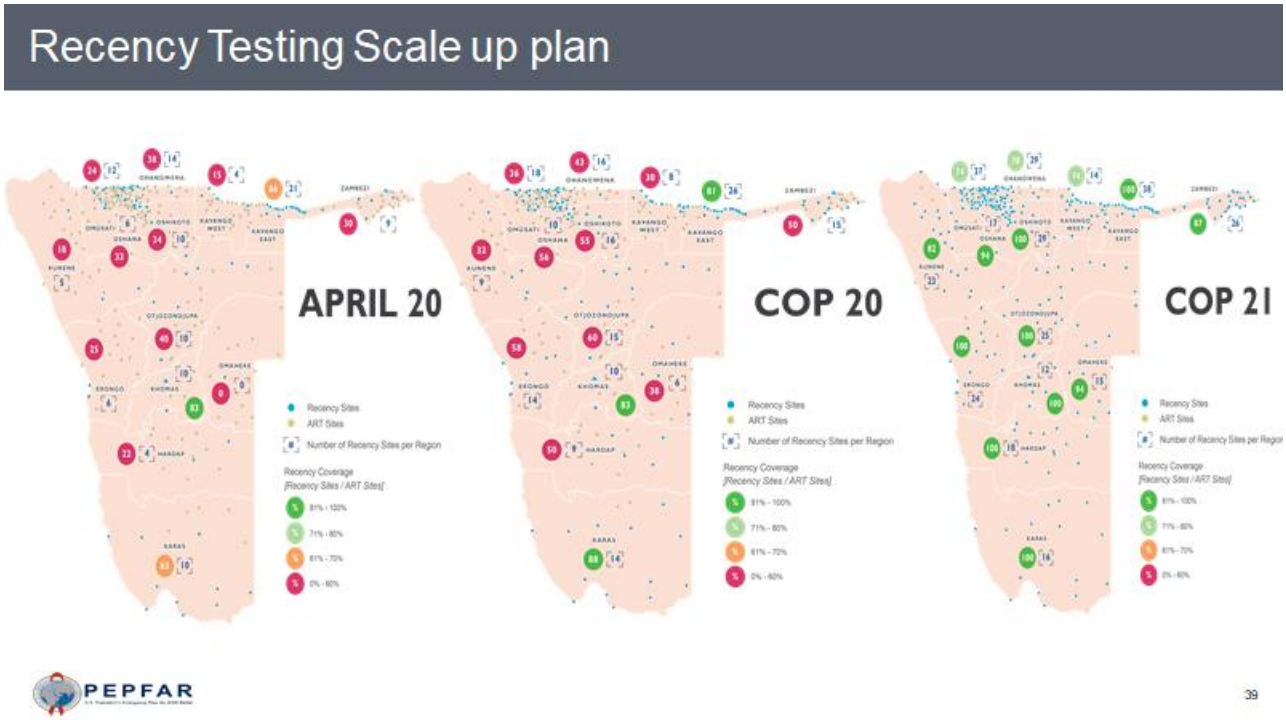
Graph 4.1.6. Long Term and Recent, % Recent by Health District



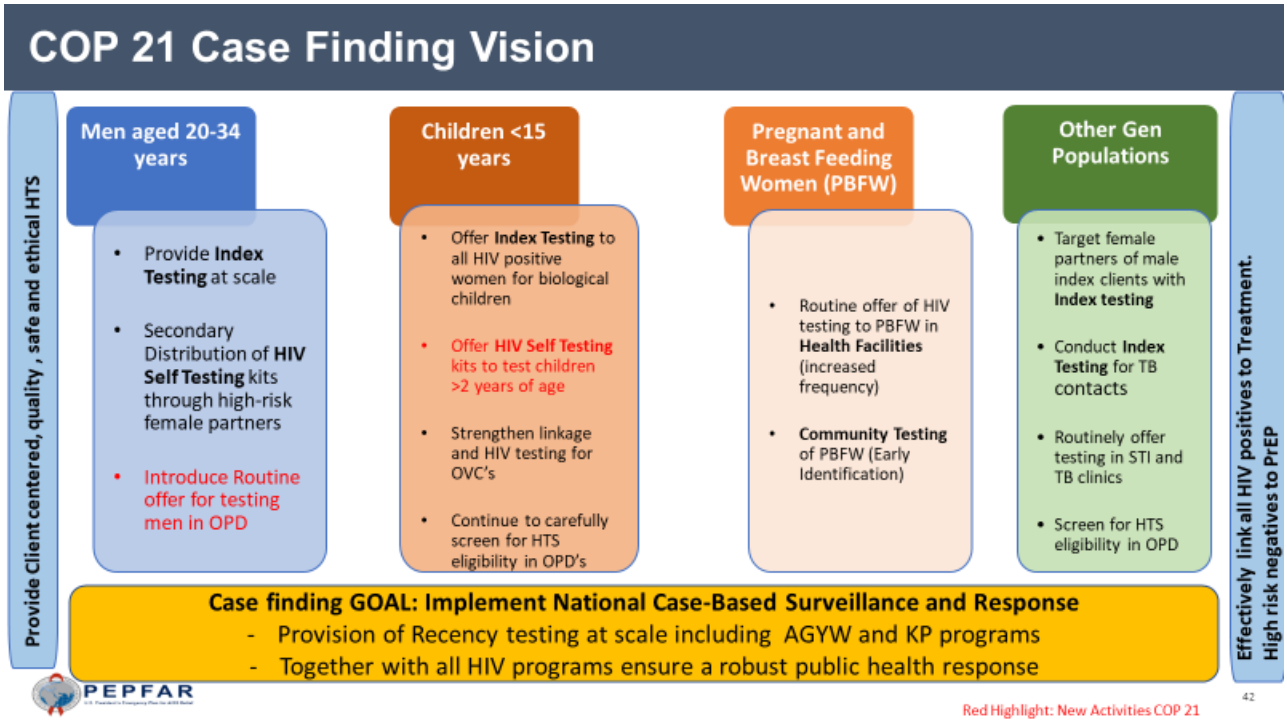
Graph 4.1.7. Long Term and Recent, % Recent by Health District



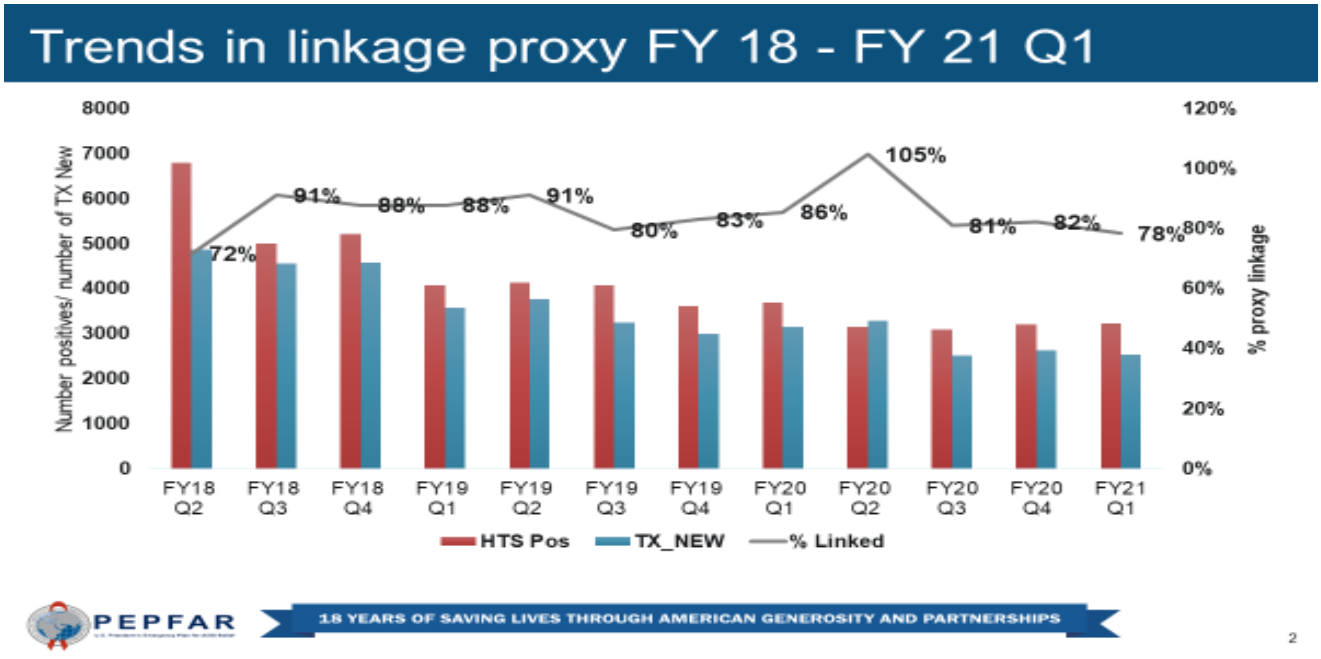
Graph 4.1.8. Recency Scale up plan



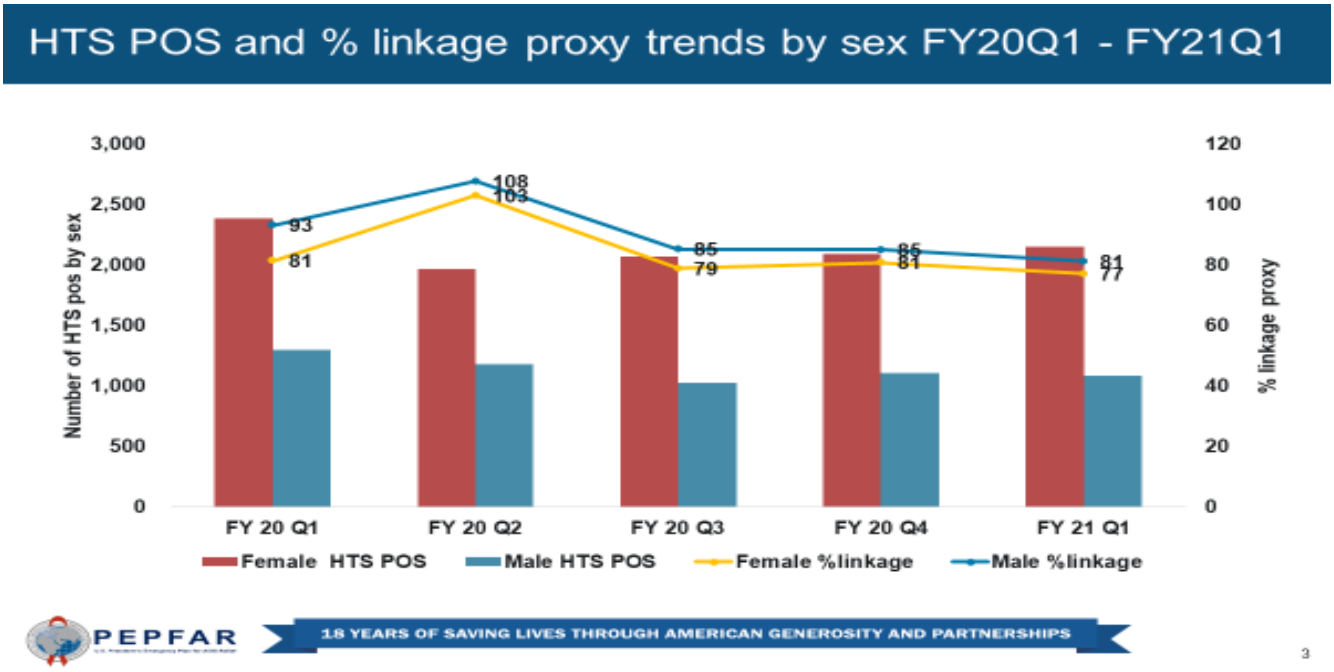
Graph 4.1.9. COP 21 Case Finding Vision



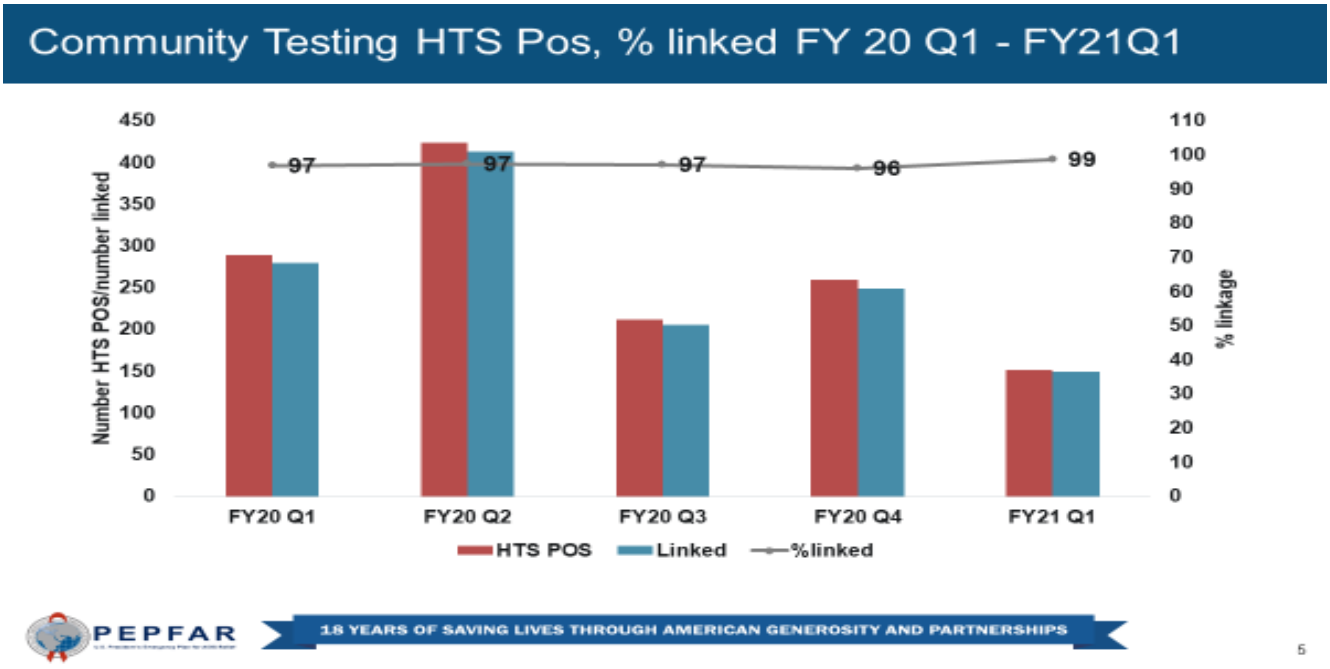
Graph 4.1.10. Trends in linkage proxy FY 18- FY 21 Q1



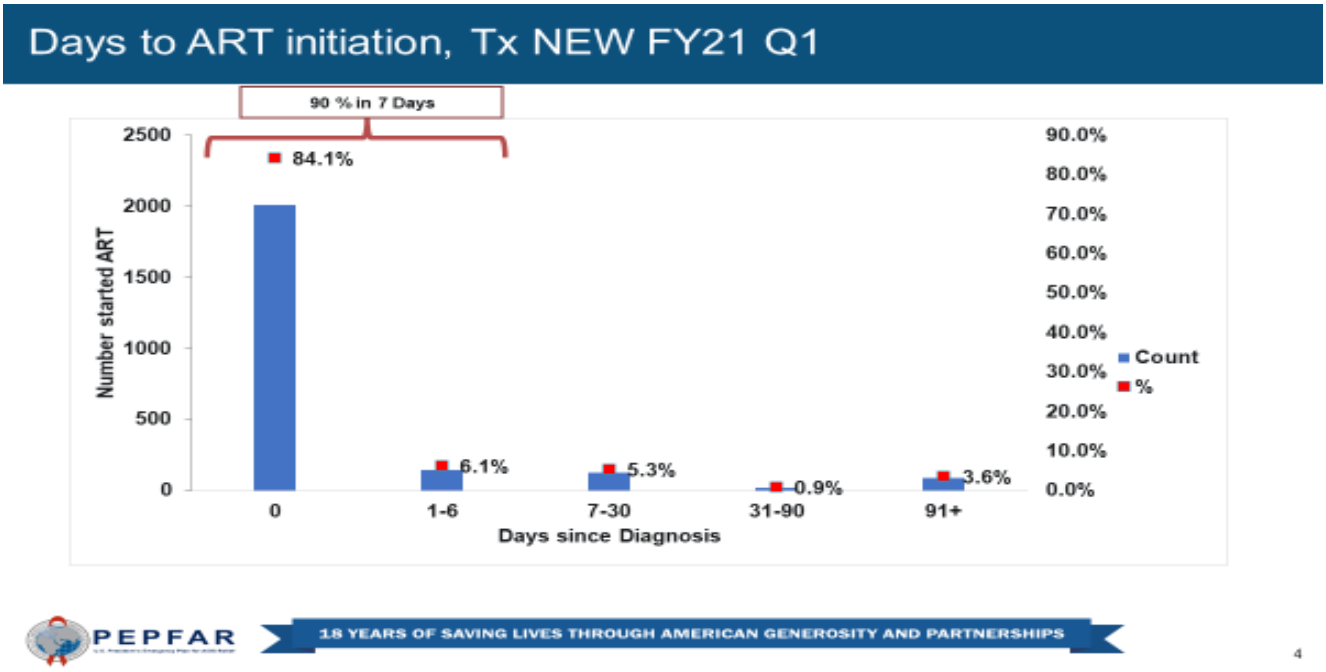
Graph 4.1.11. Trends in linkage proxy by sex FY 20 Q1-FY 21 Q1



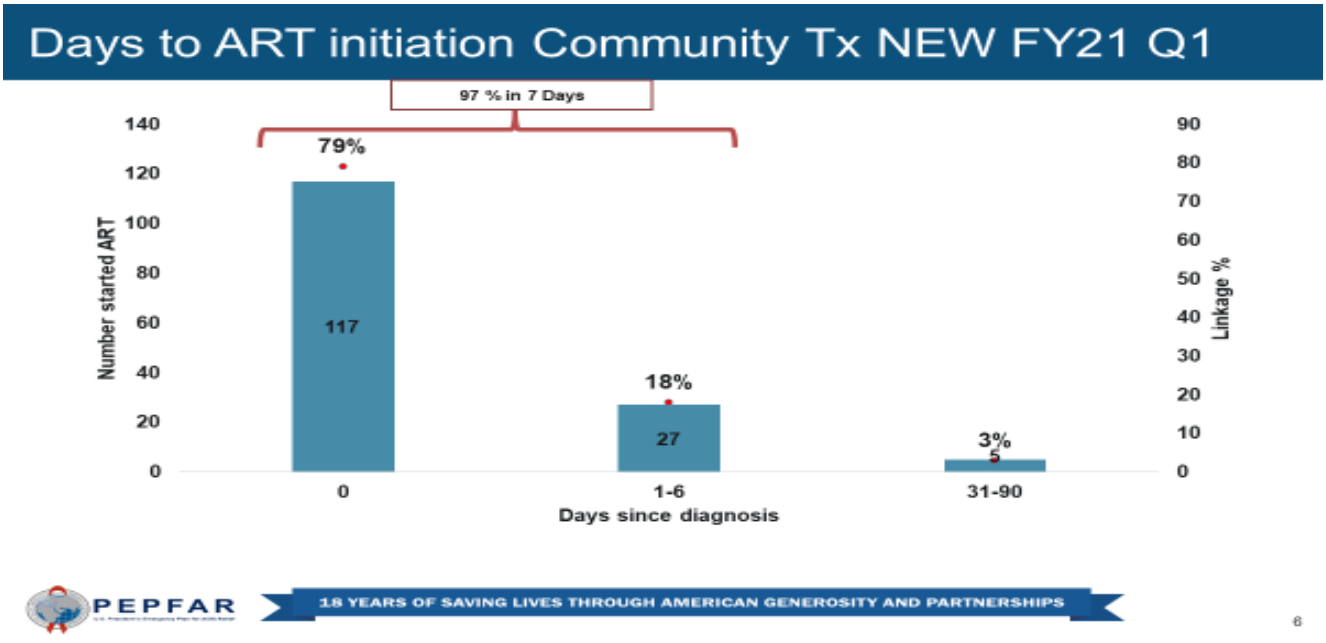
Graph 4.1.12. Trends in community linkage by sex FY 20 Q1-FY 21 Q1



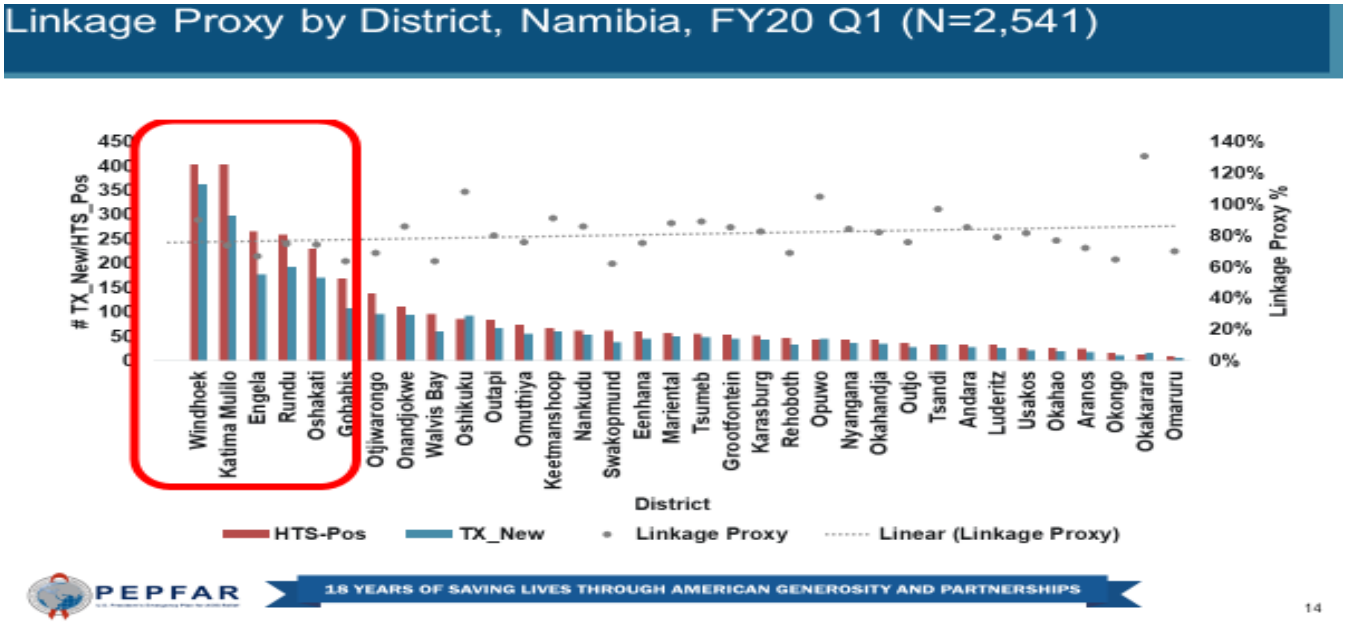
Graph 4.1.13. Days to ART , TX new FY 21 Q1



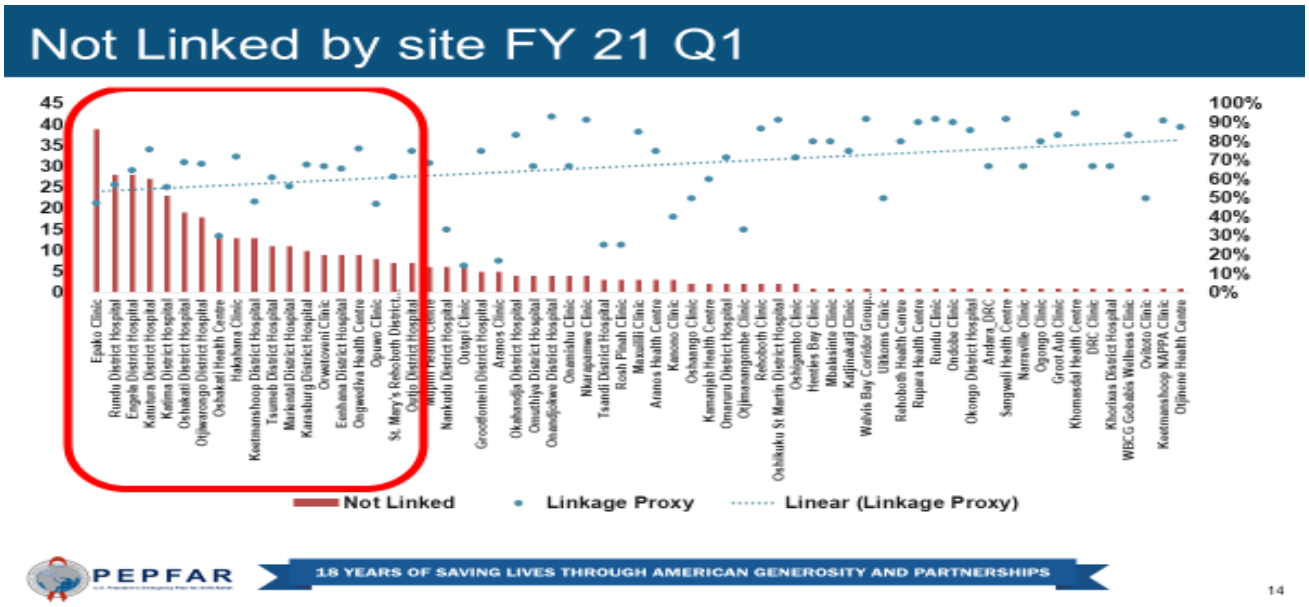
Graph 4.1.14. Days to ART initiation, Community TX new FY 21 Q1



Graph 4.1.15. Linkage proxy by district, Namibia, FY 20 Q1 (N=2,541)



Graph 4.1.16. Linkage proxy by site, Namibia, FY 21 Q1



4.2 Continuity of treatment and ensuring viral suppression

PEPFAR Namibia's COP21 strategy is to continue the COP20 trajectory with some additions to fill in gaps, the few new interventions highlighted in this section. The goal of this strategy is improving continuity of care and viral load suppression to achieve >95% for all sub-populations. These are designed to be both preventive of loss, and responsive to times when patients miss their appointments or leave the treatment cascade (Figure 4.2.2). The key concept is providing client-centered services throughout the cascade to be maximally responsive to patients needs and ensure uninterrupted services and durable viral load suppression. This will be achieved through optimizing use of TLD through urine TDF POC testing and

CADRE TLD monitoring. MMD for TLD will be further scaled up along with enhanced DSD models. The implementation of the High Viral Load Management SOP which is being introduced during COP20 will further strengthen viral load suppression interventions at site level. Innovative technologies such as SMS reminders and the PeleBox lockers will be scaled up at priority high volume sites to ensure uninterrupted and on-time pill pickups. New to COP21 will be an addition of post-tracing services to an already robust patient tracing program to ensure patients who are successfully traced are received back into care and immediately linked to services to prevent future IIT. The post-tracing algorithm will link patients to programs such as Common Elements Treatment Approach (CETA) for Mental Health and MenStar programs.

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

Once patients are enrolled into ART, there are several interventions which are designed to ensure that patients stay in ART. These include ART Optimization, which includes full scale implementation of TLD use among Adults and DTG- based regimens among pediatrics, multi-month dispensing (MMD) of ARVs, differentiated service delivery (DSD) models (Community Adherence Groups (CAGs) and Comprehensive Community-Based Health Services (CCBHS) previously referred to as CBART), and TRIOs (treatment supporters for patients initiating ART). In COP21, PEPFAR Namibia will further scale up interventions which began in COP20 such as CETA to address mental health issues in patients on ART, SMS Reminders, PeleBox Smartlocker System, Urine TDF testing for TLD adherence and CADRE TLD HIV drug resistance (HIVDR) monitoring. The implementation of the High Viral Load Management SOP, which is being introduced during COP20, will further strengthen viral load suppression interventions at site level.

PEPFAR Namibia began the SMS reminder system in COP20 to cover 73 sites which have EDT systems installed. SMS reminders help patients to remember their pill pick-up appointments and to adhere to their medication. With Ambition Funds, PEPFAR Namibia deployed the PeleBox Smartlocker system in 10 high volume urban sites in COP20. In COP21, PEPFAR Namibia will deploy this system to an additional 20 high volume sites. These dispensing points enable working men and women to collect their repeat chronic medication including other non-HIV medications such as Diabetes and Hypertensive medicines in under two minutes, 24 hours a day, seven days a week. In districts where PEPFAR Namibia supports KP interventions, individuals who are clinically stable on treatment will be linked to pick their medication from the PeleBox Smartlocker. This programmatic strategy will further strengthen adherence, minimize stigma, and support retention for KPs.

PEPFAR Namibia will continue implementing the urine TDF point-of-care testing, which began in COP20, to monitor TLD adherence among patients who are not suppressed. This is an inexpensive test that will be used to objectively measure recent adherence in patients failing TLD after a period of adherence counseling. This will avoid unnecessary costly repeat viral load testing or unnecessary switching to more expensive PI regimens. The study is called PANTHER-95 and will be rolling out to 50 ART sites, In the PLL, noting that due to the PEPFAR Namibia team's use of data and dedication, by supporting targeted genotyping/phenotyping research will be allowed in COP21, the team plans to add HIVDR testing to the PANTHER-95 protocol to assess the durability of TLD on those failing virologically. These data will help to determine the optimal time of switching off TLD after failure.

Namibia has an SOP for finding patients lost to follow up, this begins when patients missed clinical appointments by more than seven days. Patients are identified by using an EMR-generated list, to ensure clients are retained and remain in care prior to becoming lost to follow-up. In FY21 Q1, the tracing program was able to bring 99% of the patients confirmed to be missing back into care (Figure 4.2.3). This model will be scaled up to cover all ART clinics in Namibia starting in COP21. In COP20, the tracing SOP was revised to include a post-tracing services algorithm; once a patient has been traced and returned to care, they will receive adherence counseling which will include an assessment of the factors that contributed to interruption in treatment. The patient will be restarted on ART as soon as possible and assigned a differentiated service intervention or package that best addresses the barriers to continuity of care to prevent further recurrences of treatment interruption. Using these national standards, PEPFAR Namibia community-based partners can provide direct service delivery in high burden regions, technical assistance to the MOHSS in low burden regions, and will provide direct service delivery in hot spot towns (Figure 4.2.3).

With COP21, the integrated "fiver" system will continue scaling to bring tracing efforts nationwide. Fiver teams will be able to respond nimbly to the HIV disease epidemiology and needs of each area, shifting from case finding to tracing in saturated areas and back to index testing where gaps are found (Figure 4.2.4). Retention and tracing of individuals who are lost to follow up among key and priority populations, will be supported through a network of peer navigations. Peer navigators from KP led CSOs will be trained and equipped to implement MOHSS standards and SOPs for adherence counseling as well as tracing and returning individuals lost to follow up from within their social networks into care and treatment. All peer navigators will be attached to KP-competent health facility to support routine linkage to clinical services including ART.

Integrating mental health screening into HIV care and treatment services has several benefits, including improved adherence and continuity in care, reduced high risk behavior all of which ultimately led to improved viral load suppression and reduction in HIV suppression. PEPFAR Namibia has begun implementing CETA in COP20 and will be testing screening tools aimed at adolescents and adults with high VL and missed appointments/drug pickup as well as training healthcare workers on how to use the CETA screening tools and provide mental health interventions. In COP21, the CETA package will be rolled out to high volume facilities.

In COP21, PEPFAR Namibia will support MOHSS to develop new and refine existing and develop new treatment literacy materials on adherence, viral load monitoring and suppression, plus continuity of care. Treatment literacy messaging will be disseminated through various DSD channels and messaging will also be tailored to specific populations (e.g., men through MenStar, PBFW, youth).

All retention interventions across the cascade, will continue to implement interventions such as Improved Data Use, Clinical Mentoring and Continuous Quality Improvement, Positive Messaging (U=U) and Client-Centered Care. The current cohort of Physician and Nurse Mentors covers all the 14 Regions of Namibia. The new Clinical Mentorship oversight structure brings PEPFAR Namibia partners under the leadership of the MOHSS for a unified clinical mentoring program with full national reach. During FY19, mentors supported more than 300 sites in Namibia, largely targeting Nurses who form the bedrock of the Namibia HIV program through Nurse Initiated and Managed ART (NIMART). More than 2,400 nurses were mentored at site level during this period. This type of site level mentoring ensures rapid translation of national policies such as TLD transition, MMD, and Differentiated Service Delivery into practice at the clinic level. For QI sustainability, PEPFAR Namibia has supported MOHSS in the establishing and strengthening the Governance & Organizational Structure for Quality management that oversees the implementation of quality improvement and assurance in the country.

This structure manages and supports CQI and Quality assurance activities at all levels of healthcare service delivery within the ministry with two CDC supported staff, one for QM program, and the other for HIV QI. Following the successful implementation of NAMLIVE QI Collaborative (2018-2020), PEPFAR Namibia will continue utilizing the QI Collaborative approaches in COP20 and COP21, with two new QI collaboratives (NAMCOVIT & NAMREV) to accelerate improvements in new and ongoing quality gaps impacting retention such as Early Infant Diagnosis (EID), Maternal Neonatal and Child Health (MNCH), ART optimization among children, Viral Load Suppression among youth, and further TPT scale up. NamCOVIT (will cover 152,103 (83%) active patients on ART in 83 sites in all 14 regions), PMTCT: NamREV: (will cover 333, 666 (34%) of pregnant women attending ANC and 4,244 (36%) HIV exposed infants. In addition, CQI will also address the gaps identified in SIMS and Recency testing and conduct a psychosocial behaviors analysis to understand the root causes of high VL and poor retention on treatment and address these gaps in the population of 0-24 age and men.

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

Figure 4.2.1. Governance & Organizational Structure Framework of Quality Management in the MOHSS

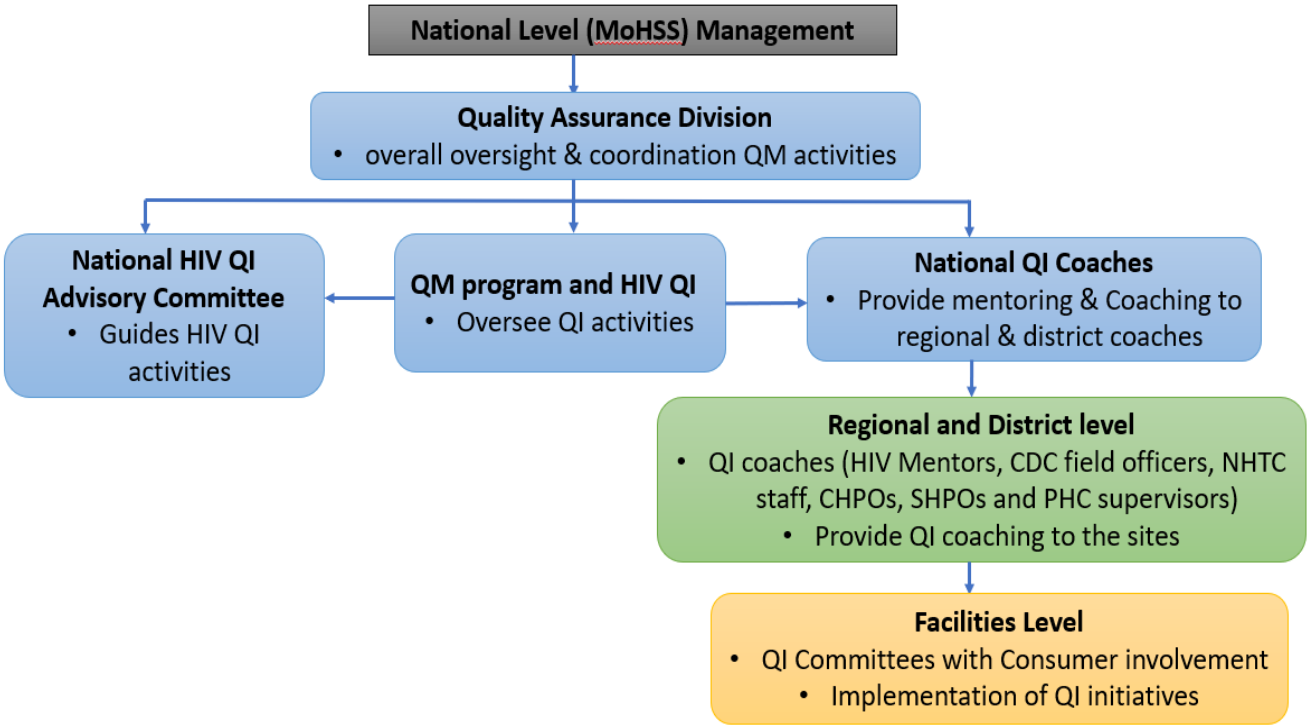


Figure 4.2.2. Continuity of Care Interventions

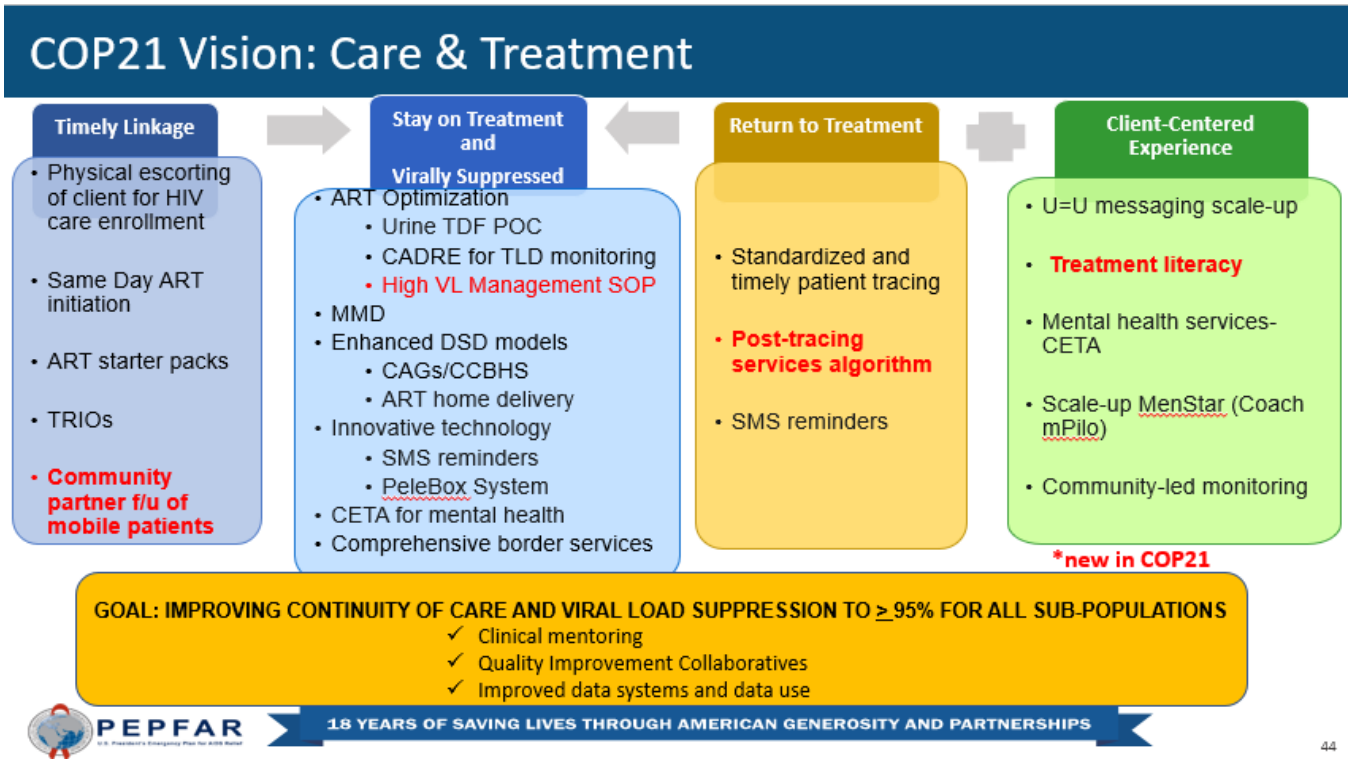


Figure 4.2.3. Patient Tracking Outcomes from Missed Appointments, FY21 Q1

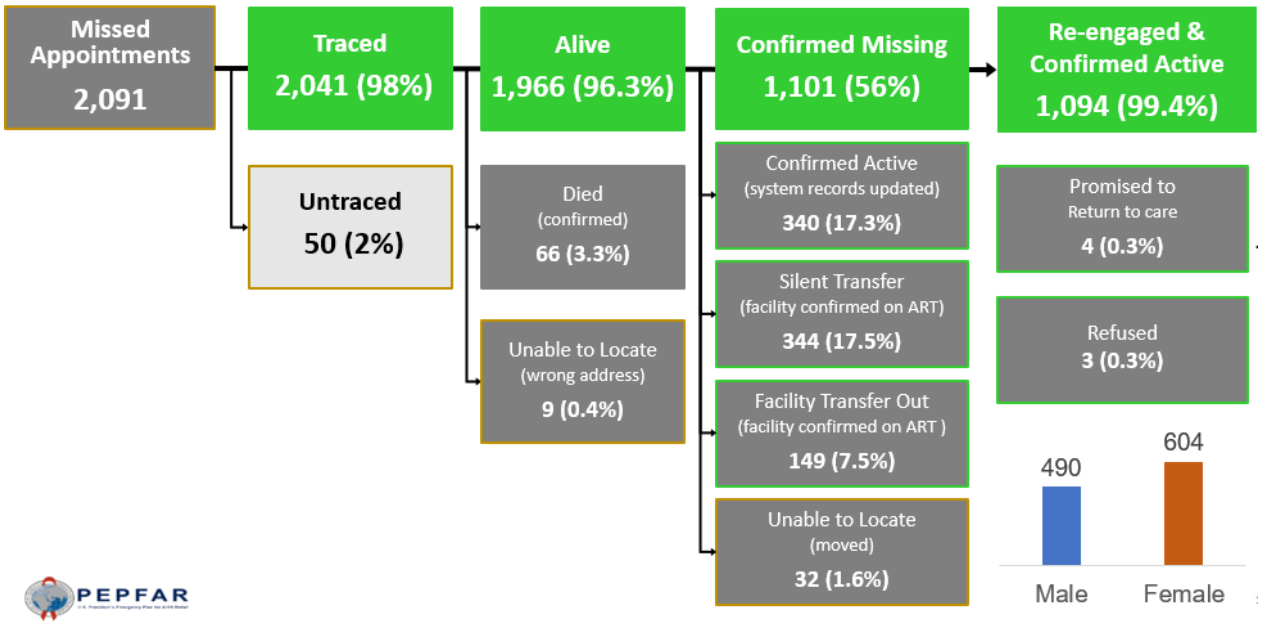


Figure 4.2.4. Geographic Coverage of Integrated Community Model (TRACING) COP21

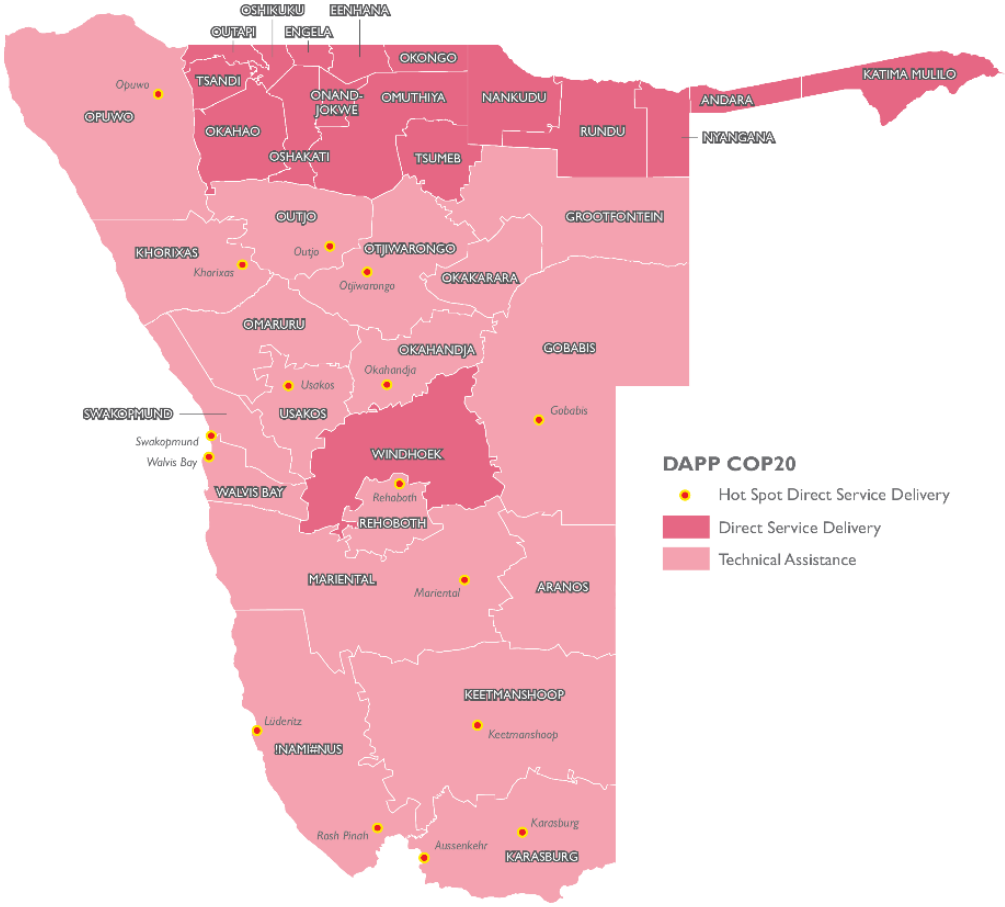
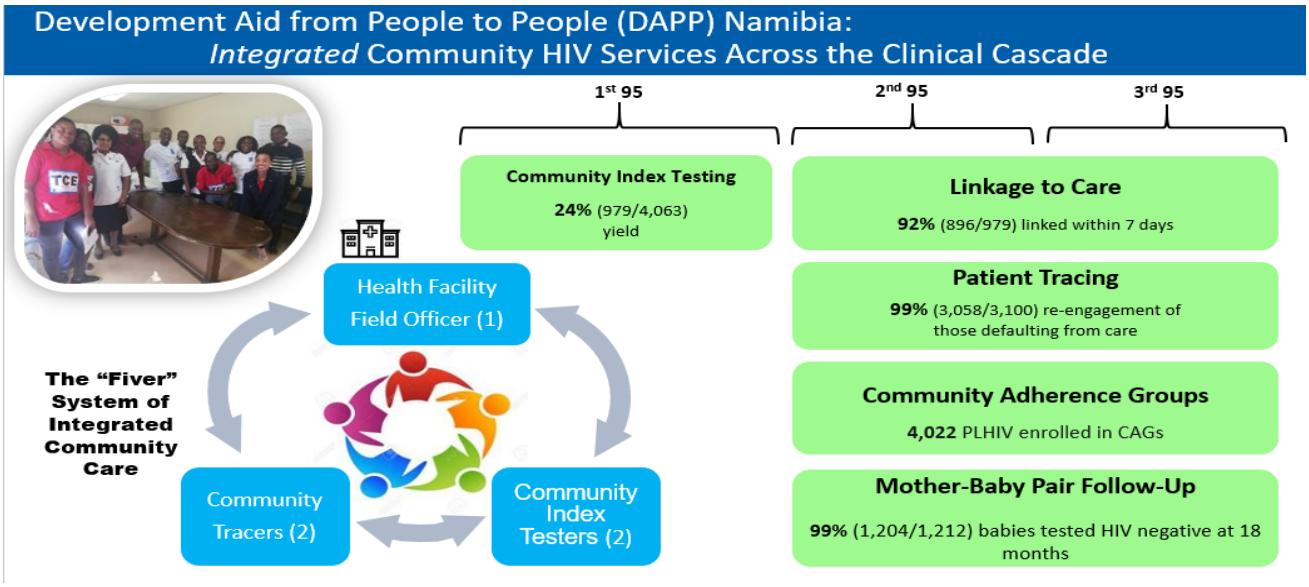


Figure 4.2.5. COP 19 Integrated Community HIV Services Across the Clinical Cascade



Interventions to Ensure Viral Load Suppression

PEPFAR Namibia continues to be successful in achieving excellent VLS results across most districts and record high VLS in individuals older than 25 years, but still have significant gaps in younger ages (Figure 3.2. above). However, some districts with lower suppression rates have room for improvement (Khorixas, Gobabis, Mariental Opuwo, Keetmanshoop, Okakarara, and Aranos). To close the remaining gap to reaching full epidemic control, an intensified focus will need to be implemented to achieve targets in COP21. PEPFAR Namibia will be targeting high volume sites with lower VLS performance for additional support (Figure 4.2.6). The PEPFAR Namibia COP21 vision for maintaining and improving viral load suppression includes: 1) ART Optimization through TLD adherence with assessment of urine TDF point of care testing and TLD drug resistance monitoring with CADRE; 2) Improving Adherence and Retention through Patient-Centered Models (MMD, CAG, CCBHS, PeleBox, SMS reminders); 3) Expanded Patient Tracing; 4) improving viral load monitoring (Clinical Mentorship Model, QI Collaboratives); 5) Client-Centered Experience (CETA mental health, positive messaging, healthcare worker trainings in customer service through MenStar methodology); and 6) investigating use of true point of care (POC) at priority locations (border sites, hard to reach populations, etc.).

Optimizing ARV regimens will be a critical component to achieving durable viral load suppression. Namibia will be fully transitioned to TLD in COP20 (see section 4.3), as per the updated national ART guidelines which include TLD as the first-line regimen for all eligible populations, and NVP-based regimens will be phased out. Viral load monitoring will be improved by providing near POC and some POC VL testing for pregnant and breastfeeding women and patients failing treatment with GeneXpert and mPIMA platforms. With the proposed targeted interventions to improve those few regions that are lagging, the aim is to achieve at least 85% VLS across all districts in Namibia by the end of COP21.

Figure 4.2.6 Viral Load Suppression by District

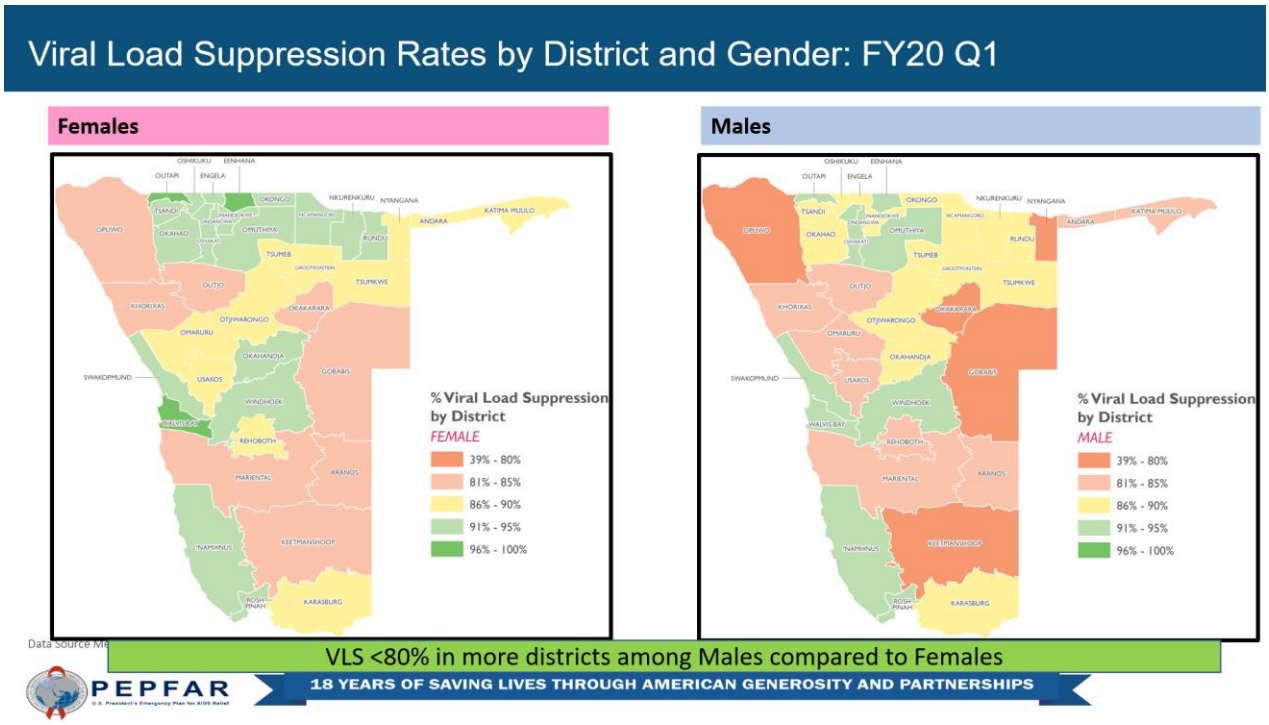
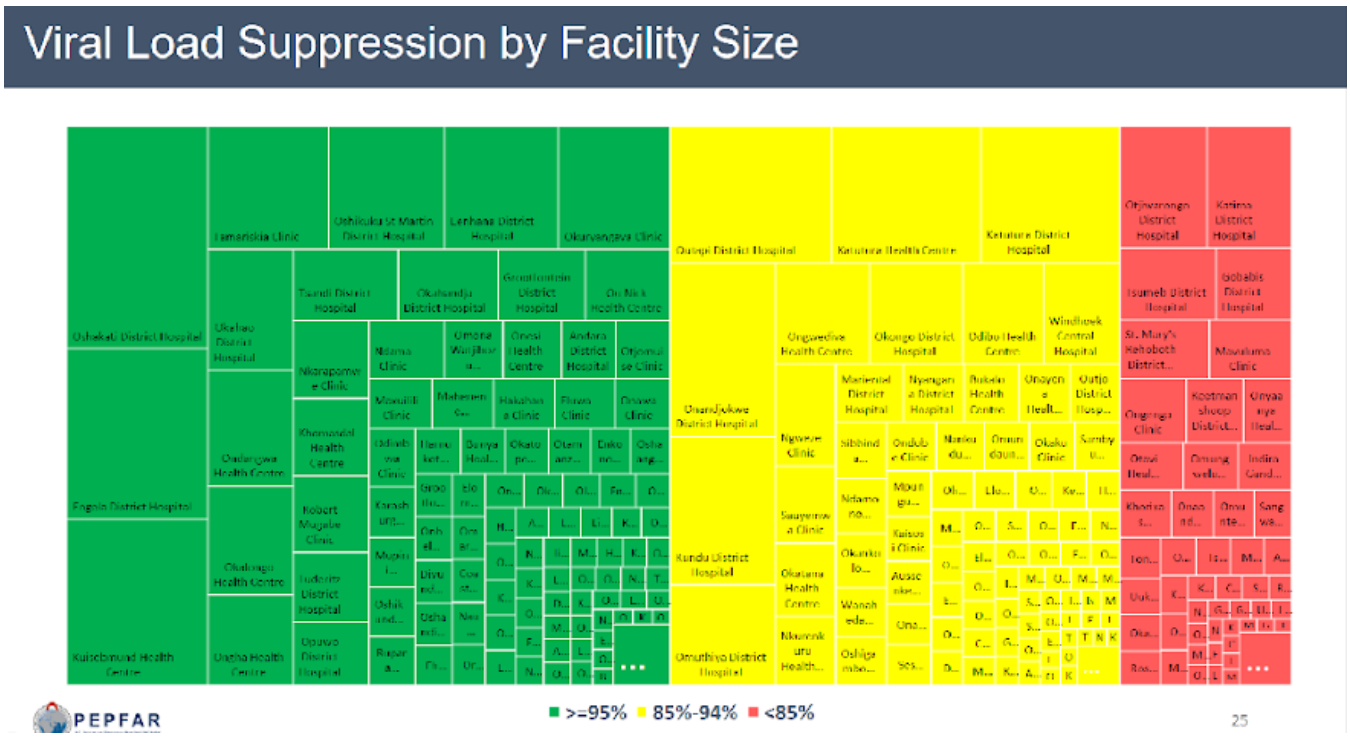


Figure 4.2.7. Viral Load Suppression by Facility Size



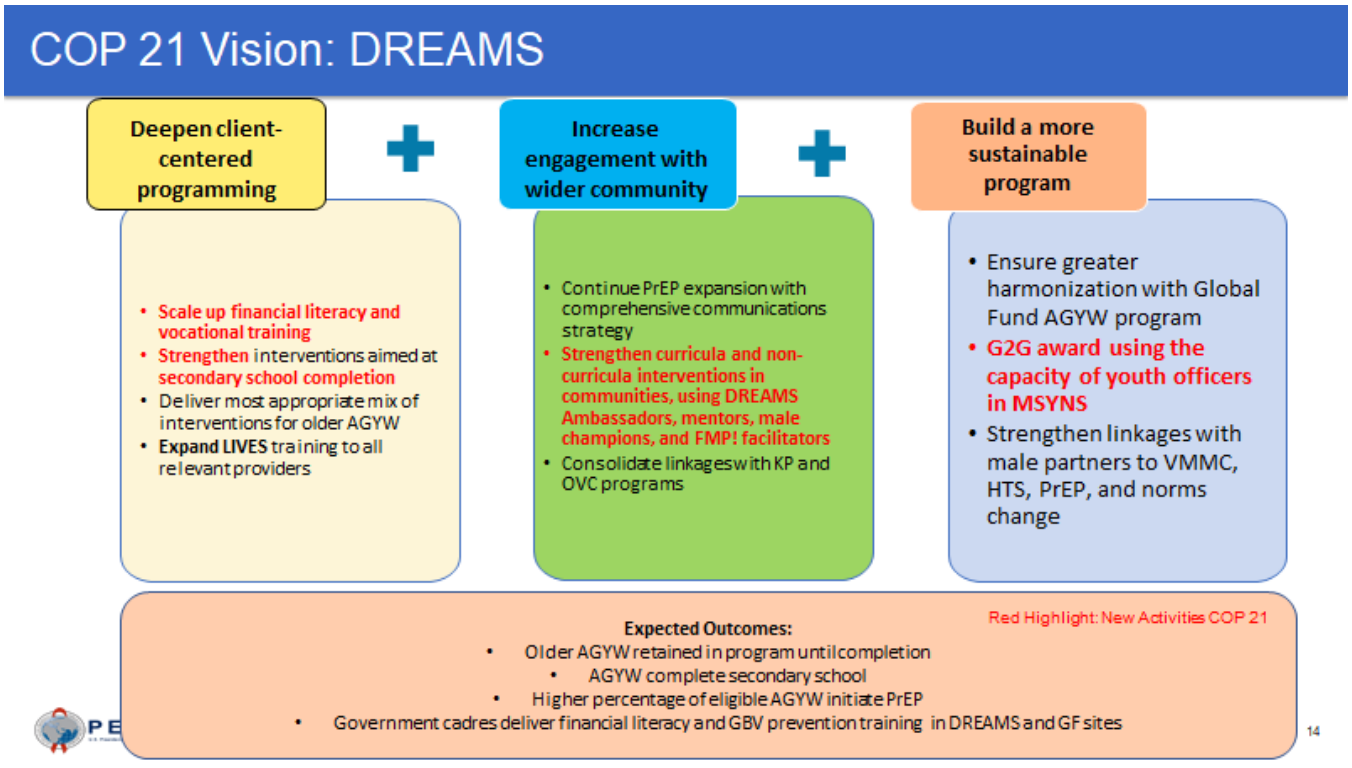
4.3 Prevention, specifically detailing programs for priority programming

HIV Prevention and Risk Avoidance for AGYW and OVC

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

In COP21, PEPFAR Namibia will continue to implement the approved DREAMS package to reach 75% saturation in all PEPFAR-supported districts and age bands. Important to note, is that districts like Omuthiya and Tsumeb were already closer to reaching 75% saturation in the younger age band of 10-14 in COP19. Implementation in COP21 will focus on closing the gap. PEPFAR Namibia is scaling up AGYW interventions covering two (2) regions added in COP20 (inclusive of four additional districts of Rundu, Nyangana, Andara and Oshakati) through a new mechanism. These regions were selected based on HIV incidence among AGYW, HIV burden among the general population and 10-24-year olds, new HIV cases among AGYW and AGYW population size. Other factors considered included presence of trucking corridors, teenage pregnancy rates and presence of universities.

Figure 4.3.1. COP21 Vision: DREAMS



PEPFAR Namibia supports rapid implementation of a layered DREAMS package of services. Interventions include adolescent-friendly sexual and reproductive health (SRH) services and partner notification referral to HTS or ART. In terms of non-clinical interventions, AGYW and OVC are linked to

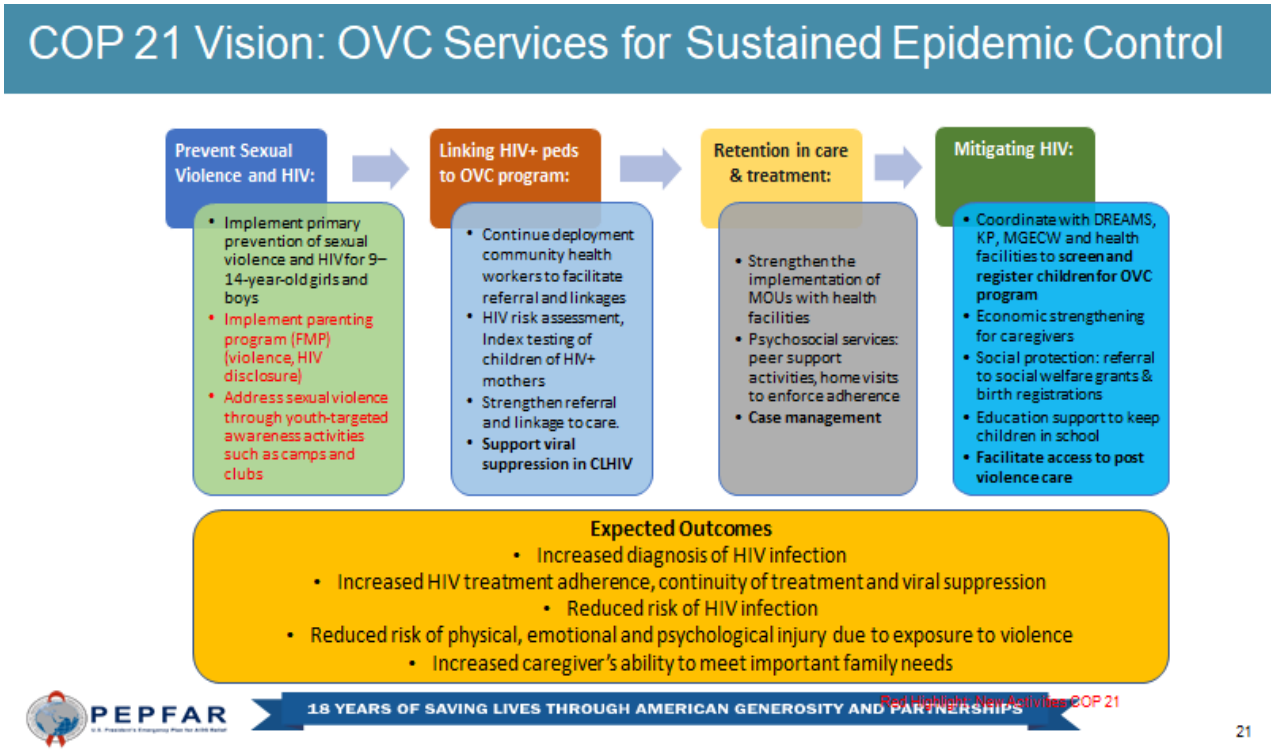
economic strengthening, social grants, and education support. Economic strengthening interventions for older AGYW in all DREAMS SNUs will utilize two pathways: employability and entrepreneurship. All partners use a unified DREAMS layering, tracking, and reporting system developed in COP17. Consolidated data will be reported by one partner in DATIM. Additionally, PEPFAR Namibia will draw on existing HQ mechanisms to assist local partners in accelerating DREAMS implementation in new districts. These mechanisms have expertise in pediatric, youth and community-based programming as well as AGYW and OVC.

In COP21, PEPFAR Namibia will continue to work with GRN and partners to saturate DREAMS districts by engaging with new schools to reach at-risk girls; increase the number of safe spaces, and support Peace Corps Volunteer placement in DREAMS districts. Through a new G2G agreement, PEPFAR Namibia will help the GRN to address implementation challenges for DREAMS and OVC, develop a sustainability strategy for DREAMS interventions, and strengthen the GRN coordination structure for AGYW. The G2G agreement will help build capacity of the Ministry, create stronger inter-government coordination with other ministries, and drive the institutionalization of DREAMS interventions within government systems.

At the end of COP19, the DREAMS project enrolled 17,213 individuals and 12,273 completed at least the primary package of services. 4,896 AGYW were enrolled on PrEP and 1,878 AGYW received post-GBV care. PEPFAR Namibia is making sure PrEP is accessible to high-risk AGYW by bringing PrEP to safe spaces and by ensuring clinics are staffed with AGYW friendly nurses. In COP20, the program started to make use of printed and electronic media to improve PrEP uptake. In COP21, PEPFAR Namibia will continue to employ demand creation strategies such as engaging teachers, community members, disseminating IEC materials, conducting routine healthcare worker sensitization, engaging AGYW champions as HIV prevention and PrEP ambassadors and considering medication repackaging to improve PrEP uptake. At the district level, DREAMS Ambassadors will jointly coordinate activities with existing program staff. At the OU level, the USG will recruit a DREAMS Coordinator responsible for program implementation. The PEPFAR Namibia program will create employment and leadership opportunities for AGYW as positions become available, such as serving as district assistant coordinators/ advisors, mentors, and community health workers.

In Q2 of COP20, the OVC program reached 32,714 beneficiaries, compared to its target of 54,868. The OVC program implements an HIV risk assessment for OVC and as a result, at the end of FY19, 100% of OVC under 18 reached had a known HIV status. All children reported as HIV positive were on treatment. PEPFAR Namibia supports case management, deployment of healthcare workers (HCW) and uses tools and training to strengthen layering and to address comprehensive needs of children, caregivers, and families. In COP21, PEPFAR Namibia plans to reach saturation of existing OVC districts where current **interventions are not at scale. (see Figure 4.3.2. COP21 OVC vision below).**

Figure 4.3.2. COP21 Vision: OVC Services for sustained epidemic control



One of the important pivots the OVC program made in COP17 was the deployment of HCW in health facilities to facilitate identification of HIV positive children, children of HIV positive caregivers, teenage mothers or pregnant teenagers, and children of other priority populations. HCWs were also tasked with linking these children to both OVC and health services. This pivot continued through COP18 and is currently implemented in COP19. The OVC program continues to second community health workers (CHWs) at high volume clinics to ensure all CLHIVs are invited to enroll in the OVC program. In FY20, OVC program supported districts had 26% of pediatric ART patients enrolled in the OVC program. In COP21, PEPFAR Namibia will invite 90% of children living with HIV in PEPFAR-supported districts to enroll into the OVC program.

The program additionally strengthens support for retention and adherence by monitoring viral suppression for CLHIV. PEPFAR Namibia will continue to implement and strengthen the index (HIV-infected) client-based household recruitment process. The OVC program works collaboratively with clinics to first identify HIV-infected children using the electronic dispensing tool (EDT) list and then offers family enrollment into the OVC program. This process provides needed psychosocial and family support to children, coupled with clinical care provided by health facilities.

To improve linkage to testing and treatment, the program will work with local Namibian HIV support groups and networks at sites to identify children of support group members and at-risk children. The OVC program leverages collaboration with pediatric, PMTCT, and treatment programs to ensure caregivers are trained on ART regimens and adherence support for CLHIV. For example, CHWs identify children with adherence or viral load suppression issues and refer them to the nurses or mentors for house visits and follow-up for further interventions, including education on regimens and disclosure support.

In COP21, both DREAMS and OVC programs will ensure that the PEPFAR primary prevention of sexual violence and HIV modules for 9-14-year olds is implemented with fidelity to ensure that that children are not infected in the first place. The focus for this group is evidence-based programming that prevents sexual violence, delays sexual debut, and prevents HIV. PEPFAR Namibia implements violence risk

assessments and reports experiences of violence at home and school for OVC. Additional support will strengthen disclosure for children and adults living with HIV. Parenting programs, such as the Families Matter! Program or other recommended programs, which focus on decreasing violence against children and promoting positive parenting to reduce adolescent HIV risk behaviors, will continue to be implemented. Through the OVC program, there will be an emphasis on reaching boys using specific curriculum such as Peace Corps Boys Respecting Others (BRO), Youth Exploring and Achieving in Health (YEAH) and Girls and Guys Leading Our World (GLOW). Household economic strengthening interventions to mitigate the impact of HIV will be conducted. Additionally, PEPFAR Namibia will provide technical assistance to GRN on social welfare grants, the development of a standardized case management system, social welfare training, service networks, and monitoring and evaluation (M&E) systems.

PEPFAR Namibia contributes to capacity building for local CSOs. As DREAMS and OVC programming is expanding to new districts, PEPFAR Namibia will engage in organizational capacity development services, primarily by using a central mechanism designed to rapidly prepare local organizations and governments to serve as prime partners for PEPFAR programming in African countries. The central mechanism serves as a support option for OU local partner strategies and assists with conducting Organizational Capacity Assessments (OCAs), Non-U.S. Organization Pre-Award Survey (NUPAS) assessments, capacity development technical assistance for financial, HR systems, PEPFAR reporting, and ensuring compliance with award requirements and performance. A flow chart has been developed detailing the linkages between the OVC, DREAMS and KP programs. This has been formalized in COP20 with a MoU between the partners and will be implemented with fidelity and revised as necessary in COP21 with the aim of ensuring eligible OVC and AGYW benefit from the full package of services available.

Key Populations

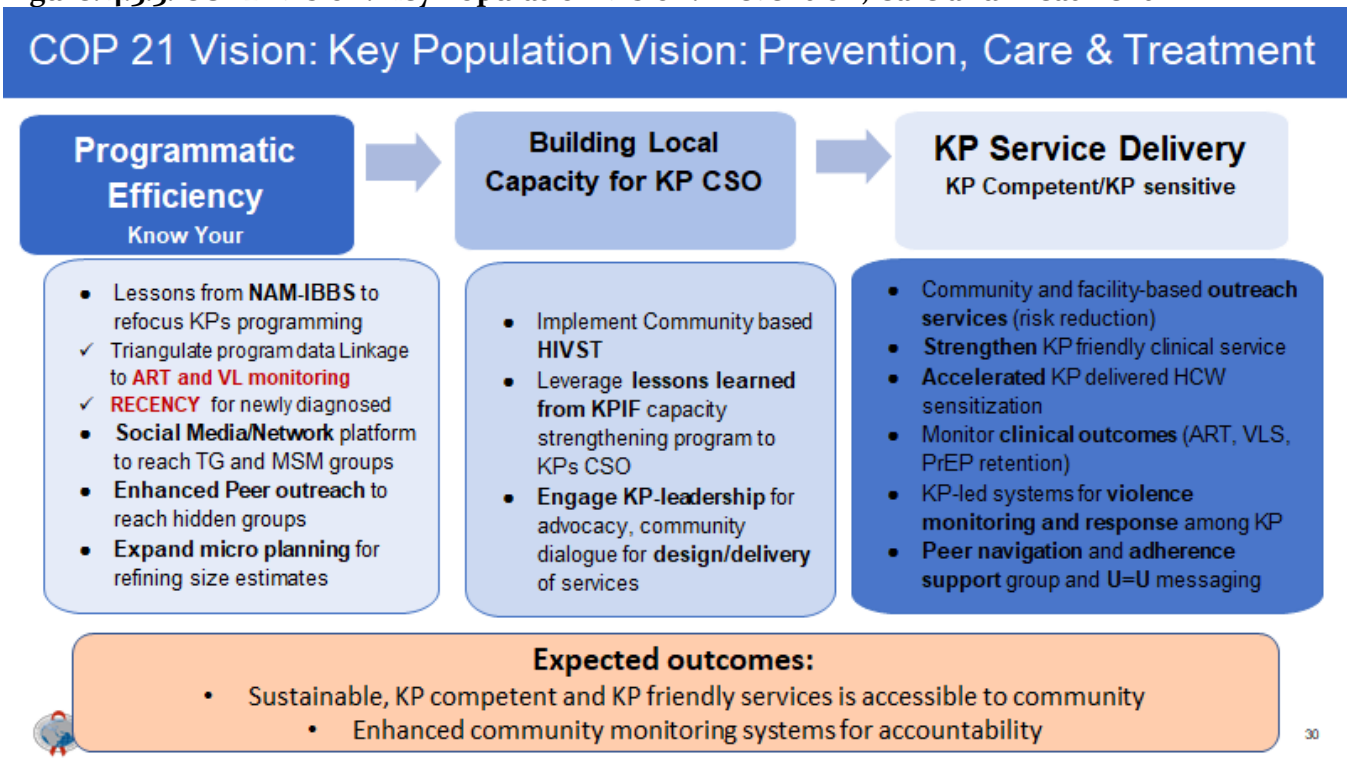
In FY19, programmatic data demonstrate strong linkage to treatment for all KPs diagnosed with HIV. Overall, linkage to treatment was 102% among FSW and MSM. However, only 57% of newly diagnosed TGWs were linked to treatment.

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

The NAM-IBBS highlighted gaps in reaching KPs through engagement by peer educators. Only a small fraction of KPs have interacted with peer educators within the past six months; (15% FSW vs 9% MSM in Windhoek, 12% FSW vs 10% MSM in Walvis Bay/Swakopmund and, 3% FSW in Katima Mulilo). In COP21, PEPFAR Namibia will use the findings from the NAM-IBBS to further improve reach and linkage strategies for KP in Namibia. High quality comprehensive HIV prevention services for KPs will be expanded to cover three more districts (Swakopmund, Otjiwarongo and Gobabis) in addition to the current seven districts (Walvis Bay, Katima Mulilo, Oshikango, Oshakati, Rundu, Keetmanshoop, and Windhoek). This expansion will ensure the program addresses gaps identified in the NAM-IBBS to reach previously unreached groups. In the ten priority districts, programmatic interventions will include engaging local FSW, MSM and TGW-specific CSOs. PEPFAR Namibia will also focus programmatic efforts towards training of peer educators and case workers within their networks to reach individuals. TGW and MSM peer educators will be trained and deployed to become agents to reach their peers and

link them to clinical services at KP-friendly facilities through enhanced peer outreach approach (EPOA). In COP21 we will ensure the delivery of KP competent services through greater use of information, communication technology, social media for both prevention and retention services (see Figure 4.3.3 below).

Figure. 4.3.3. COP21 Vision: Key Population Vision: Prevention, Care and Treatment



Programmatic approaches to improve HTS yield and increase case finding in COP21 will build on current activities supported in COP20. These include risk screening and optimized HTS among social networks, and assisted HIVST programming to complement outreach moonlight services. Unassisted HIVST programing will be linked through social media platforms and private sector clinics targeting MSM and TGW. PEPFAR Namibia will support the full implementation of PEPFAR Minimum Program Requirements for index testing and site certification procedures. Continuous dialogue with community members and oversight will ensure sites remain in compliance with all minimum requirements throughout implementation. The program will continue to expand coverage of PrEP among KPs by addressing context specific barriers to PrEP through HCW competency, peer education and engaging private medical facilities to enable uptake among all groups, particularly MSM and TGW.

Building institutional and technical capacity of CSOs from the LGBTI community will form the foundation of PEPFAR Namibia's programming in COP21. Programmatic work with KP-led CSOs will continue with integrated activities formerly supported by KPIF, through KP-STAR. KP-led CSOs will offer community monitoring and support violence response and reporting among key populations.

VMMC

The modeled national coverage for VMMC among priority age groups of 15-29 years old is 47.7% (Decision Makers Program Planning Tool, DMPPT-2 2019). PEPFAR Namibia's primary objective is to support MOHSS to increase coverage of VMMC services among priority age bands (15-29 years) in high volume priority regions/districts. As a result of PEPFAR Namibia support to the MOHSS in FY19, national VMMC coverage among young men aged 15-29 years old increased to 47.7% by the end of

calendar year 2019. Regions with direct PEPFAR support recorded some of the highest coverage: Windhoek (Khomas region 62.2%), Katima Mulilo (Zambezi Region 70%), Oshakati (Oshana region 61%), Swakopmund and Walvis Bay (Erongo region 55%) (DMPPT, Version 2.0, 2019).

In FY20, PEPFAR Namibia completed an agency portfolio shift, building on existing strategies to focus on uncircumcised men 15+ years old to increase national VMMC coverage. Challenges and restrictions related to COVID-19 led to only 19,439 of the overall OU target for FY20 of 50,203 being achieved. Priority regions include 12 of the 14 regions in Namibia, including Khomas, Hardap, Erongo, !Karas, Oshikoto, Oshana, Ohangwena, Omusati, Zambezi, Kavango West, Kavango East, and Otjozondjupa.

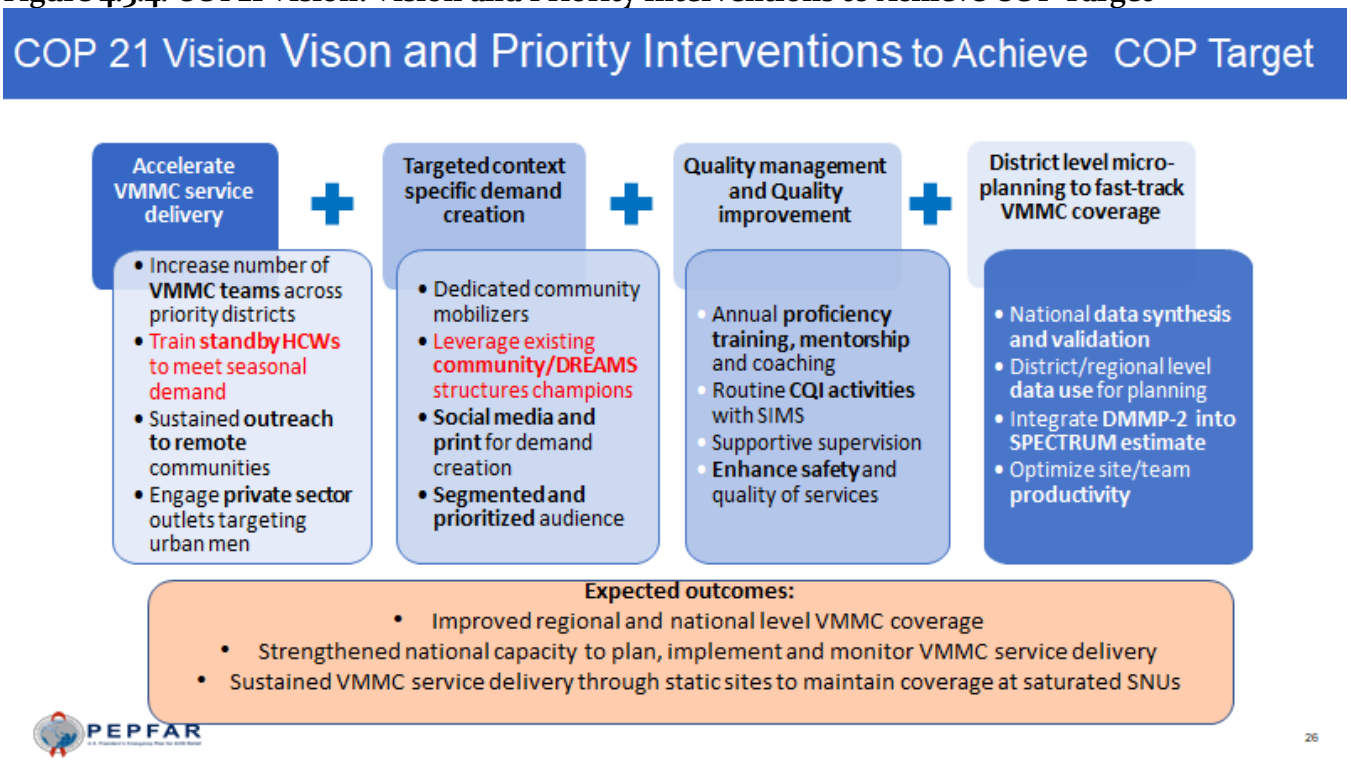
In FY21, PEPFAR Namibia will fully implement an age pivot and will achieve the overall OU target of 22,695. PEPFAR Namibia's COP21 target will continue to recover from COVID-19 control measures and safely scale to saturate in seven priority regions (Khomas, Zambezi, Ohangwena, Omusati, Oshana, Erongo, and Karas) to 78% coverage of VMMC. The delivery of VMMC services in Khomas, Zambezi, Oshikoto, Oshana and Kavango East regions will complement PEPFAR Namibia's DREAMS program in these regions. As part of the comprehensive package of services for DREAMS, young men will be referred for VMMC.

PEPFAR Namibia will continue to support age-specific, scientifically proven, and human-centered demand creation targeting for young men aged 15+, increase efficiencies of the clinical team at fixed and outreach sites, enhance site optimization, and provide direct service delivery to high volume sites. In FY21, the demand creation strategy will be refocused to reach priority age groups, 15-29 and geographic areas with unmet needs utilizing existing institutions, traditional leaders, mobilizers within the community and churches. These include public messaging, peer promotion by recently circumcised men, improving facility setup to increase privacy, enhanced community mobilization, and engagement of female partners.

PEPFAR Namibia will also support MOHSS to develop a sustainability plan for the regions approaching saturation (Zambezi, Oshana and Khomas), proficiency assessment for clinicians, development of quality management (QM) and quality assurance (QA) to ensure client safety in COP21. In COP21, PEPFAR Namibia will continue to support MOHSS to implement WHO/PEPFAR adverse event management protocols and establish a system to improve adverse events prevention, management, reporting, and referrals. Health care providers will be trained based on WHO/PEPFAR standards using an online training hub (OTH), developing quality monitoring and patient safety standards and onsite supervision.

By the end of FY21, all PEPFAR-supported VMMC sites will fully transition to the reusable dorsal slit technique in line with SGAC guidance and continue in COP21 (FY22). All new VMMC services providers will be trained on the dorsal slit method and refresher training for existing cadres will continue in FY22.

Figure 4.3.4. COP21 Vision: Vision and Priority Interventions to Achieve COP Target



PrEP

PEPFAR's support for PrEP programs in Namibia has continued to show high performance. In FY18 and FY19, PEPFAR Namibia achieved over 300% and 232% of the overall OU target for PrEP NEW. In FY20 the program enrolled more than 11,608 high risk individuals 15+years old on PrEP. Namibia is succeeding in reaching KPs, serodiscordant couples and AGYW through the different programs. With assistance from PEPFAR, the MOHSS has finalized and adopted PrEP standard operating procedures, training materials and demand creation, and M&E tools.

In COP21, PEPFAR Namibia will continue to expand PrEP services and will focus on the scale up of PrEP in four key priority service areas. PrEP will be used to address key gaps for prevention among KPs and increasing numbers of new infections among pregnant and breastfeeding women. Programmatic targeting for PrEP will also be tailored to emerging evidence of new HIV infections from recency testing. As a result, PrEP will be scaled up through: 1) Engaging ANC clinics to expand PrEP services to high risk HIV-negative pregnant and breastfeeding women, further reducing new infections among this vulnerable population and reducing MTCT; 2) PrEP will be integrated as a key component of routine family planning and STI services targeting high risk men and AGYW; 3) PrEP services will also be expanded as an integral part of Index Partner Testing ensuring that HIV- negative individuals who are at high risk of acquiring HIV infection are offered PrEP; and 4) PEPFAR will continue to prioritize KPs and AGYW for PrEP expansion through both community and facility-based service delivery approaches.

Routine Intimate Partner Violence (IPV) screening will continue to be a priority and new technologies will be explored in COP21, which will improve retention including new regimens like Dapivirine vaginal rings, as well as utilizing PELE BOXES to make PrEP more accessible.

PEPFAR Namibia will continue to support the implementation of operations research to gather insights from Namibia's national PrEP expansion, with a focus on adherence among AGYW and KP. Results from

this research will generate practical knowledge and insights into demand creation and adherence counseling, especially for AGYW, FSW, MSM, and TGW.

In COP21, PEPFAR Namibia will continue to expand the community based active screening for PrEP eligibility and linkage to PrEP among AGYW and KPs. These interventions will be delivered through a coordinated approach within the community during outreach, safe spaces for AGYW, DREAMS Ambassadors, trained peer educators and in collaboration with HCW at health facilities. Virtual platforms for targeted health promotion and demand creation have shown implementation success in FY21 and these will be scaled up to reach beneficiary populations in COP21 and to address the restrictions on large meetings due to the covid-19 pandemic. Findings from the study investigating effective use of PrEP among AGYW and KPs is expected by the end of FY21. These findings will be used to strengthen communication for PrEP uptake and retention.

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

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

The MOHSS has been leading the TLD transition which began in October 2019 with an initial target of transitioning 80% (149 021) of PLHIV on ART estimated to be eligible for TLD transition by June 2020. This target date was changed to December 2020 due to COVID-19 related supply chain interruptions which led to a significant transition slowdown in March to May 2020. The transition target was successfully reached by December 2020 and the MOHSS is now continuing to ensure that all new patients are initiated on TLD from the start. A few regions failed to meet their regional level transition targets by December 2020. There is an ongoing review of regional level TLD performance against regional targets. The Clinical Mentorship program works with the regions to ensure that clients who are eligible for TLD are promptly identified and transitioned to TLD.

To support the transition, PEPFAR Namibia allotted $300,000 in COP19 and a further $475,000 for TLD 180-day pack procurement to complement the GRN's ongoing procurement of TLD as first-line drug in COP20. The COP21 procurement of about 11,000 packs of 180-day bottles of TLD, is designed to accelerate 6-month multi-month dispensing.

PEPFAR Namibia will continue to support MOHSS in rapidly phasing out the use of NVP-based first line ART regimens among both adults and children. PEPFAR Namibia and MOHSS have undertaken to no longer procure nevirapine-based and efavirenz-based ARVs for treatment since COP19.

The protocol for the Cyclical Acquired HIV Drug Resistance (CADRE) monitoring was submitted and reviewed in COP19, but initiation of the first round of CADRE was put on hold due to COVID-19. Initiation is planned in COP20, continuing into COP21. These data will provide information about drug resistance emerging in patients largely failing pre-TLD phase 1st and 2nd line ART regimens in Namibia. However, a second round of CADRE in COP21 will allow Namibia to detect early emergence of HIV drug resistance mutations during and after TLD transition. Additionally, establishing lab-based drug resistance monitoring will assist Namibia to sustainably be able to monitor TLD resistance in the future.

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

Differentiated Service Delivery (DSD) continues being scaled up in many regions and by the end of FY20 Q1, Namibia had 206 Comprehensive Community-Based Health Services (CCBHS); 859 Community Adherence Groups (CAGs) and 98 teen clubs across the country. The number of patients enrolled in community-based models continued to increase steadily through FY20 Q1 ending the quarter with 13,280

patients enrolled in the community-based models and 3701 teens enrolled in teen clubs. Further expansion of the differentiated service delivery model will be accelerated in COP20 and COP21, including population-specific CAGs to address adolescents and men.

The MOHSS is committed to MMD scale up from 3 months MMD up to 6 MMD and PEPFAR Namibia continues to support the GRN in this endeavor. The proportion of patients receiving less than 3 months of ARVs has continued to decline from 47% in December 2019 to 27% by Feb 2021. The proportion receiving 3-5 months of ARVs remained relatively steady over the time while the proportion receiving 6 months dispensing has increased 5-fold from only 4% in December 2019 to 20% by February 2021.

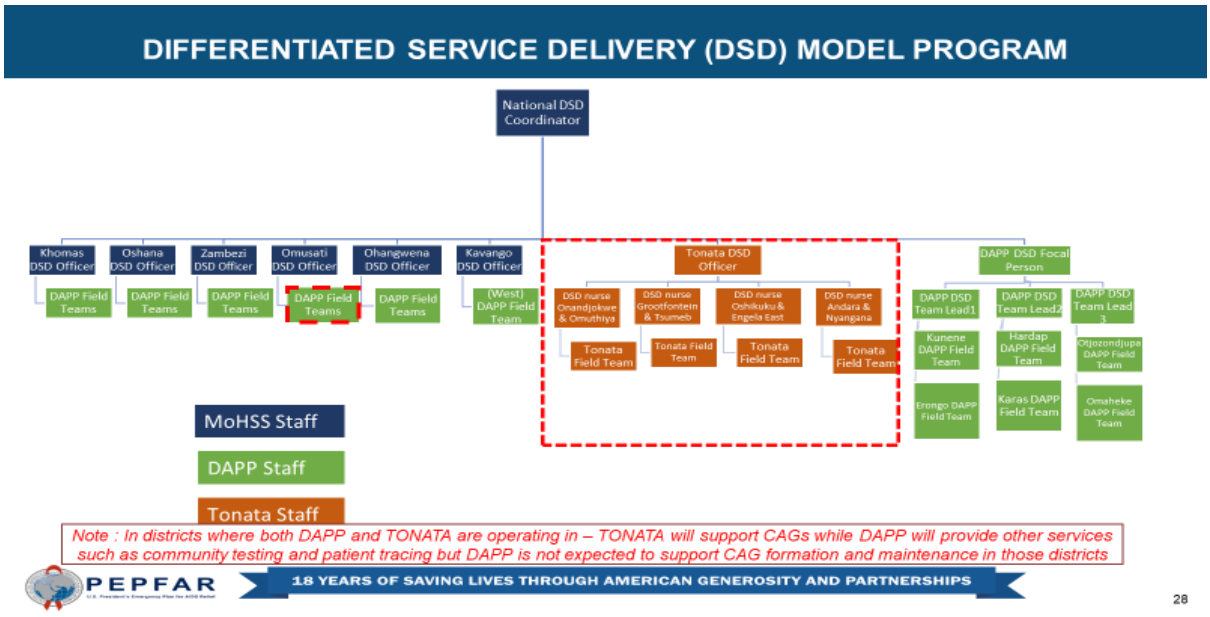
PEPFAR Namibia's latest data shows 73% of patients are picking up >3 months of MMD, up from 53%. These results are a direct result of the ART/TB Supply Chain TWG that convened at the beginning of the COVID-19 pandemic in 2020 and continued to meet regularly to ensure MMD was being rolled out during limited drug supplies.

Alleviating the challenges of costs and transport for clients is one area identified as common reasons for missed pill pickups. Namibia is well poised for further expansion of CAGs and CCHBS. In COP19, a National Differentiated Service Delivery Coordinator was hired and placed at the MOHSS National Office, to lead a coordinated scale up of DSD, ensuring that all stakeholders both within facilities and communities are working together in a well-coordinated scale up effort, while also closely monitoring the volume and quality of DSD services.

In COP19/20, PEPFAR worked with the MOHSS and community-based partners to develop a harmonized single framework for implementing PEPFAR supported DSD at health facilities and community levels in all the 14 regions of Namibia. The GRN, through the MOHSS PEPFAR supported Cooperative Agreement, has a sub-award with TONATA, a network of PLHIV to support DSD service delivery through CAGs in eight districts.

Figure 4.4.1. below illustrates the framework showing the geographic, staffing matrix and service package allocation between the MOHSS, DAPP and TONATA. This framework will ensure efficiency and standardized implementation of all MOHSS led PEPFAR supported DSD services across the country.

Figure 4.4.1. Differentiated Service Delivery (DSD) Model Program

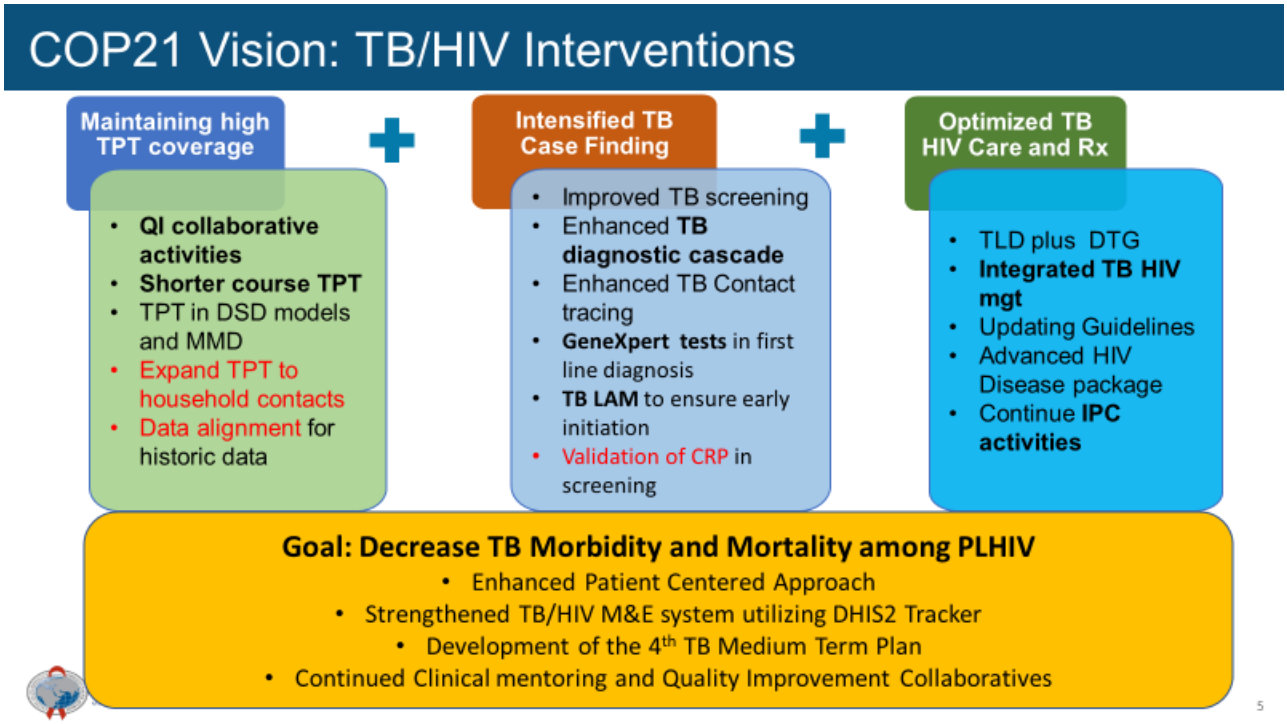


Addressing Low ART and VL Coverage in Four Low Burden Regions

Although most regions have been performing very well in terms of ART coverage and viral suppression, there are four regions that have been underperforming due to a lack of support as efforts in previous years focused on high-burden regions (!Karas Hardap, Kunene, and Omaheke). In COP19, PEPFAR Namibia began providing targeted support to these areas to improve the quality of clinical services to achieve improved viral load outcomes. In COP21, PEPFAR Namibia will continue strengthening support to these regions through targeted HR support, clinical mentoring, quality improvement infrastructural modifications to ensure quality client-centered care, as well as diagnostic network optimization and improving specimen transport activities to increase access. The implementation of the High Viral Load Management SOP which is being introduced during COP20 will further strengthen viral load suppression interventions at site level.

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

Figure 4.4.2. COP21 Vision: TB/HIV interventions



There has been a steady rise in PLHIV screened for TB since FY17 Q2 (36%), peaking at 95% in FY20 Q2 but reduced to 71% in Q4FY20. Furthermore, Namibia has a high coverage of TB clients knowing their HIV status and HIV positive clients being started on ART. The number of people who know their HIV status rose from 88% in 2017 and has remained high at 99% since then. The percentage of HIV-positive TB-co-infected patients has declined over the years from about 60% in 2007 down to 32% in 2019. This has been coupled by an increase in clients being put on ART and cotrimoxazole preventive therapy, with rates reported at 99% in APR20.

Although there has been an increase in the TB screening rates, there is a need to improve the quality of screening to achieve a positivity rate of 5% in those already on ART and at least 10% in those newly initiating ART. As part of strategies to improve TB case finding, TB LAM has been rolled-out since

December 2019. Implementation is done using the revised WHO November 2019 criteria for both in- and out-patient settings. In COP21, PEPFAR Namibia will support the full implementation of TB-LAM in all Regions. NIP has also migrated to Xpert MTB RIF Ultra. To strengthen TB contact investigation for PLHIV with TB and scale up testing of their sexual partners and biological children for HIV, PEPFAR Namibia will capacitate TB field promoters to support HIV self-testing. The HIV CHWs will also be capacitated to support TB contact tracing.

Namibia is utilizing a revised TB sputum register, which includes a section on HIV testing to ensure that all presumptive TB cases are also tested for HIV. TB infection control guidelines were revised in COP20 with full implementation of activities in COP21.

TB Preventive Therapy data in DATIM shows a total of 52,550 having completed TPT by September 2020. However, to understand the actual number of patients who completed TPT, data reviews were done as part of the NAMLIVE initiative at most of the sites as well as utilizing temporary data clerks to update the electronic patient system. Utilizing ePMS as well as using the new definition of Tx_Curr of 28 days for LTFU, a total of 154,778 active patients had evidence of initiating TPT and 124,956 had documented TPT completion. This translates to a 68% TPT completion rate as of September 2020. There has been excellent improvement in completion rates in the last reported cohort with completion rates at 81%. COP21 funds will be used to continue supporting the Quality improvement collaboratives.

3HP was introduced in September 2020 to support TPT scale-up. COP21 resources will be used to roll-out 3HP with supplies for an additional 16,064 clients procured. This will be supported by conducting TPT scale up campaigns, continued quality improvement projects as well incorporating TPT in the DSD and community-based models.

Border Epidemic

Namibia has a growing population of non-Namibians accessing health services along its borders. Since COP19, PEPFAR Namibia has been supporting many service delivery points along the northern border. Health system and service delivery challenges limit seamless access, utilization of services and availability of strategic information for planning, decision-making, quality management, and tracking patient level data to determine health outcomes.

PEPFAR Namibia is supporting the optimization of services alongside the Namibian border with the goal to improve health outcomes for non-Namibians seeking and accessing services at service delivery points alongside the border and to decrease HIV incidence in Namibia. Data from the ePMS for ART patients was analyzed and stratified by nationality for the period January 2017 to September 2019, in four regions of Namibia that share a border with neighboring countries. Analyses show that for both the adults and children diagnosed with HIV in those four regions (2,732 immigrants, 20,805 Namibians), ART was rapidly initiated at the same rate regardless of citizenship. This indicates that Namibia is aggressively addressing the HIV epidemic at the border without regard to nationality.

PEPFAR Namibia will continue scaling up high quality, high yield case finding services in communities near the border in five key regions, namely Omusati, Oshana, Ohangwena, Kavango West, and Kavango East, inclusive of providing self-testing kits to newly diagnosed non-Namibians which they can give to sexual partners or family members. Care and treatment services will include uninterrupted 3-6 months ARV refill, retention interventions, viral load monitoring, and multi-month prescribing and dispensing to reduce cross-border burdens for the clients.

TB preventive therapy and cervical cancer screening will continue being provided at fixed sites and through community outreach services. Health system strengthening will include adequate HRH and commodity assistance while continuing to support cooperative meetings between the national

governments. PEPFAR Namibia will continue to ensure HIV and related services such as ANC, and TB client services including HIV testing and treatment and prevention, are provided free-of-charge in the public sector for Namibians and non-Namibians. Finally, strategic information will also be strengthened, to gather patient-level data management, monitoring and reporting, and documentation of non-Namibians accessing services in Namibia.

With COVID19 response to ensure uninterrupted HIV services at the borders due to lockdown, PEPFAR Namibia has supported MOHSS with setting-up of 26 community ART dispensing sites located in the three Regions of Omusati, Ohangwena and Kavango in the northern part of the country along the border where Angolans could go to pick up their medications without crossing into Namibia. From April till December 2020, close to 10,000 pill pick-ups occurred and the majority (68%) received three months or more MMDs. Under the system, Namibian healthcare workers staff at border sites, with the help of immigration officials, collect health passports from Angolan patients, distribute the necessary medications, and provide other essential health services.

In COP 21, PEPFAR Namibia will be working towards strengthening border services by making some sites permanent outreach points to increase PMTCT services, lab optimization, case finding and prevention services by offering PREP to pregnant and breastfeeding mothers and strengthening data capturing and reporting of all services delivered.

Improve Access to HIV Services in Prisons

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

In COP19, as part of the DSD models, PEPFAR Namibia and the MOHSS began supporting the Correctional Services in addressing the epidemic in prisons and police holding cells. Working with the MOHSS and the Ministry of Safety and Security, teams conducted a baseline assessment in all the 14 Correctional Services facilities. In COP20, services were extended to NAMPOL with 54 police holding cells assessed across Namibia to determine the burden of disease (% current on ART on the day of assessment) and the quality of services. Site visit assessments were conducted using a standardized tool for quality assessment. Available Medical Officers/ Nurses, Health Assistants/Counselors, together with case management and programs or rehabilitation coordinator officers were interviewed. Monthly and quarterly reports and relevant records were also reviewed, and offenders' living quarters were inspected.

During the assessment, PEPFAR Namibia found that between 5 and 17% of the clients in the correctional facilities and between 3% to 19% of inmates in police holding cells were on ART at the time of assessment. Several quality gaps were identified and needed to be addressed to ensure high quality of HIV services that comply with the national standards set by the MOHSS. Based on the findings from the assessment- technical assistance for the development of a Minimum Package of Services for the Prisons and Police Holding Cells will be provided. A QI training for selected HCWs from all 14 correctional facilities was conducted. Key QI indicators for monthly reporting were selected and they include TB screening, TPT initiation and completion, VL monitoring and VLS. Technical QI support visits were conducted to follow up on QI initiatives. In COP21, PEPFAR Namibia will support the Ministry of Safety and Security in the implementation of continuation of HIV services by rolling-out the implementation of the Minimum Package of TB and HIV Services throughout all the Correctional Facilities as well as the Police Holding Cells and development and implementation of linkage to HIV care after releases in correctional facilities and police holding cell SOP.

Common Elements Treatment Approach (CETA)

In COP19, PEPFAR Namibia began supporting the Ministry of Health to introduce mental health care into HIV services. The Common Elements Treatment Approach (CETA) continues to be used, which is an integrated program fully delivered by lay providers and designed for low-resource settings. In COP19 a brief baseline assessment was conducted to determine how the CETA approach can be adapted into the Namibia HIV Care and Treatment program setting. In COP20, PEPFAR Namibia is testing two CETA screening tools aimed at adolescents and adults with a high viral load and/or missed appointment or interruption in treatment. In COP21 PEPFAR Namibia will continue developing a package of interventions for multi-condition screening and treatment by lay workers using the CETA approach. A package of interventions will be rolled out to high volume ART sites which account for most cases needing mental health interventions.

4.5 Commodities

PEPFAR Namibia currently provides program-critical support to MOHSS, and particularly the Central Medical Stores (CMS), to prevent maldistribution, stockouts, and wastage of HIV-related commodities. This work will continue in COP21, supporting the MOHSS to avoid stockouts and service interruptions. The program will focus on improved supply chain strategy and planning, supporting efforts to transition to and scale up optimal product options and expand MMD, and strengthening in-country systems and capacity to undertake timely and best value commodity procurement. PEPFAR Namibia will also support the institutionalization of systematic analysis and use of distribution, dispensing, and patient data, and furthering the establishment of GS1 standards for greater transparency and traceability. Additionally, we will accelerate efforts toward a more country-led supply chain in Namibia, working closely with the MOHSS to ensure stable funding for commodities, stable staffing within CMS, and a clear path forward for the health supply chain.

In October 2019, Namibia began a transition from TLE to TLD as the first-line regimen for eligible adults. In COP20, PEPFAR spent more than $650,000 for procurement of TLD-180 to complement the GRN's procurement of first-line drugs, and to catalyze increased multi-month dispensing. By the end of December 2020, nearly 150,000 individuals had initiated TLD.

With relatively few pediatric ARV patients, the GRN has struggled to locate suppliers for small batches of drugs. In COP21, PEPFAR Namibia will procure 25,000 90-count bottles of dolutegravir 10mg tablets to support the MOHSS to scale up its use among CLHIV. PEPFAR will also procure 8,400 100 mL bottles of 10mg/mL suspension of nevirapine and 8,400 240mL bottles of 10mg/mL suspensions of zidovudine for infant prophylaxis.

For COP21, PEPFAR Namibia has allocated $300,000 to procure an estimated 16,000 3x12 packs of Rifapentine/Isoniazid 300/300mg tablets to continue supporting the introduction and expansion of shorter-course TB regimens. To support the VMMC program in COP21, the program has set aside $100,000. Of this, $75,000 will be used to procure autoclaves, diathermy electrodes, and reusable VMMC kits, with the remainder to be spent on single-use kits of essential consumables. In addition, the OU was allocated $400,000 from the Central Condom Fund which will be used for approximately 6.5 million condoms and 2.5 million sachets of lubricant, primarily to support PEPFAR Namibia's KP Program.

To support COP21 PrEP expansion, PEPFAR will procure nearly 145,000 bottles of 30 tablets of Emtricitabine/Tenofovir 200/300 mg and will work with the MOHSS to prepare for and introduce the dapivirine ring to expand the availability of PrEP options in the country. In addition, PEPFAR Namibia will procure 123,000 HIVSTs and 15,000 HIV recency tests. Laboratory support will include the procurement of $257,000 worth of urine LAM assays, Urine TDF tests, and EID and VL tests.

4.6 Collaboration, Integration and Monitoring

PEPFAR Namibia's interagency coordination continues to function well following the completion of the realignment of programs. This maintains fewer international partners over time, and more ability for the MOHSS to lead a unified, coordinated nationwide HIV program. No client services have been disrupted, which was a primary goal during realignment of programs. Further, program areas form an integrated cascade across the three 95s, with the community, facility, and health system partners successfully providing comprehensive services. This model represents Namibia's vision of streamlined, efficient partners**,** coordinated as one portfolio by the Ministry and includes PEPFAR, MOHSS and other stakeholder-funded services. This extends to a comprehensive and integrated prevention approach, with a focus on highest risk or unreached populations. This model in Namibia is designed to increase domestic ownership and quality of care with successful outcomes (Figure 4.6.1). The streamlined and integrated cascade diagram used to guide the development of plans and results for the different program areas.

Working with host government structures and international implementing partners to increase the capacity of indigenous partners is a continued key focus for COP21 collaboration, integration and monitoring. Approximately 70% of PEPFAR Namibia COP20 funds were allocated to indigenous organizations and about the same amount was allocated in COP21. There is potential for this to increase once the to-be-determined (TBD) mechanisms are awarded and transitioned to local partners from international mechanisms. PEPFAR Namibia is accomplishing a higher percentage of funds to indigenous partners by continuing the following:

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

In coordination with the GRN, civil society organizations, private sector, and other key donors/agencies (i.e., Global Fund and UNAIDS), PEPFAR Namibia is supporting the GRN to determine data needs for data integration from legacy systems to an integrated system and provide support for necessary assessments and analyses to create and implement a national HIV response sustainability plan. In FY 2018/2019, HRH planning and analysis, social contracting, efficiency technical assistance and studies, and a public health expenditure review were completed, and the results have informed COP20 implementation and COP21 planning for HRH support. Furthermore, PEPFAR Namibia will support an integrated laboratory sample referral and result reporting using the existing GRN systems.

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

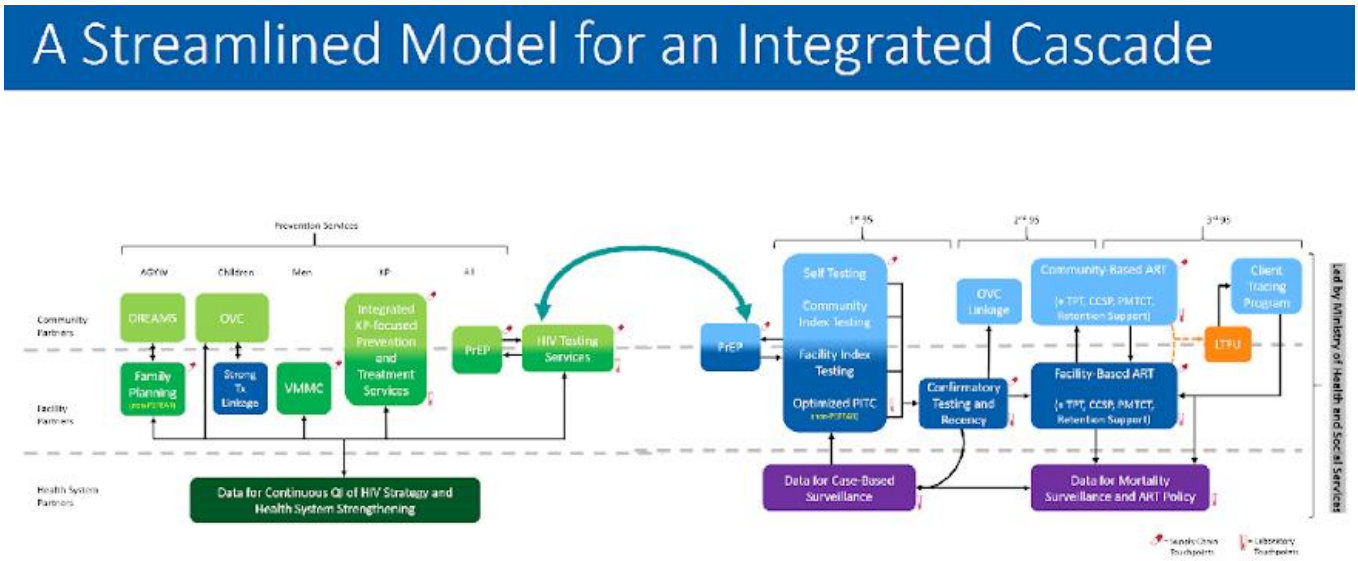
CDC and USAID conduct active management of implementing mechanisms via in-person and virtual meetings with partners, agency project officers, and respective technical advisors. Reviews of quarterly national and SNU performance against MER and custom indicators and an analysis of SNU and site-level data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

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

The interagency team will also improve service delivery quality and efficiency by continuing to scale-up implementation of viral load suppression in younger age groups; accelerating multi-month dispensing of ARVs in COP21 by procuring a limited supply of TLD 180 packs; and introducing innovative technologies to mitigate the impact of COVID-19 and SMS reminders for ARV refills, PeleBox for SmartLockers for ease of repeat medicine collection in urban settings, and urine TDF point-of-care testing to monitor TLD adherence among patients who are not suppressed. The use of Funding Allocation to Strategy Tool (FAST) ensures that targeted site level and above-site activities are mapped to optimize country systems to govern and manage the HIV response by focusing on key programmatic barriers.

The use of the Funding Allocation to Strategy Tool (FAST) ensures that targeted above-site activities are mapped to optimize country systems to govern and manage the HIV response by focusing on key programmatic barriers.

Figure 4.6.1. Streamlined Model for an Integrated Cascade



4.7 Targets for scale-up locations and populations

PEPFAR Namibia does not have any scale up locations.

Table 4.7.1. VMMC Coverage and Targets by Regional SNU for 15-29 yr olds (2021 SDS)

Target Populations [Specify age bands for focus]	FY21 Population Size Estimate (Gap per SNUs)	Current Coverage (Expected)	VMMC_CIRC Target	Expected Coverage
	(SNUs)	FY21	FY22	FY22
Erongo	34,036	56%	1,886	61%

Hardap	12,914	57%	2,155	73%
Karas!	11,800	48%	1,848	63%
Kavango East	26,485	80%	1,006	84%
Kavango West	5,430	97%	1,385	122%
Khomas	76,405	65%	1,604	67%
Ohangwena	33,744	63%	3,203	72%
Omusati	33,149	74%	2,631	81%
Oshana	28,764	69%	1,246	73%
Oshikoto	28,854	66%	3,348	78%
Otjozondjupa	22,416	54%	2,480	65%
Zambezia	15,138	86%	208	87%
Total COP21 Target	329,135	66%	23,000	73%

Target Populations for Prevention Interventions

PEPFAR Namibia has made concerted efforts to improve available information regarding key populations, as reaching KP is critical for sustainable HIV epidemic control. In 2019, PEPFAR Namibia completed an Integrated Biological and Behavioral Survey (NAM-IBBS), which provided updated information on population size estimates for FSW, MSM and TG people in three priority districts. A summary of population size estimates is provided in standard table 4.7.2.

The PEPFAR Namibia COP21 target for KP_PREV in scale-up districts has taken into consideration the population size estimates from the 2019 NAM-IBBS and program data from seven districts. Additionally, findings from the 2018 PLACE study have also been used to validate size estimates for MSM and FSW in Windhoek. Overall, the COP21 targets align with the goal of reaching 90% of estimated KP through peer-driven interventions and linkage to clinical services that include HTS, PrEP and ART. As the COVID 19 restrictions are relaxed and hotspots begin to open, other high-risk groups who form important bridge populations, will be reached alongside reaching key populations with HIV prevention interventions. These include children living with key populations in hot spots and other high-risk groups, such as seafarers at the coast.

Table 4.7.2. Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate	Coverage Goal	FY22 Target

	(scale-up SNUs)	(in FY22)	
FSW (KP_PREV)	*8,082, 2,196↑ 1,057↑↑, 674↑↑↑	90%	16,755
MSM (KP_PREV)	2,210↑, 670↑↑	90%	4,964
TG Women (KP_PREV)	N/A	90%	1,406
PP_PREV (General Pop)	205,684	35% (Eligible high risk)	52,353
PP_PREV (AGYW 10-24)	**94,870 (Vulnerable Pop)	90%	43,482
AGYW (AGYW_PREV)	**94,870 (Vulnerable Pop)	75% (Eligible high risk)	28,912 (N), 38,546 (D)
PrEP_NEW (General Pop)	N/A	N/A	15,052
PrEP_NEW (KP)	14,889	85% (100% of HIV neg)	3,043
PrEP_NEW (AGYW)	**190,559	50%	10,350

*IBBS 2013
**2018 Projected Population for girls 10-24 years old (Kavango East, Khomas, Oshana, Oshikoto and , Zambezi and Khomas)
Population size estimates, NAM-IBBS 2019: ↑Windhoek, ↑↑Walvis Bay/Swakopmund, ↑↑↑Katima Mulilo

OVC and Pediatric - Entry Stream Target Setting Process and Assumptions

The OVC target setting process started with an analysis of the current cohort of OVC beneficiaries supported in FY20. All beneficiaries living in households that were not affected or infected by HIV (24% of households) were marked for graduation in COP20. The number of HIV positive OVCs in FY 20 was also compared to the number of actively enrolled pediatric ART patients, with the OVC_SERV target increasing in each SNU so that all 100% of all CLHIVs on ART are enrolled in the OVC program. The COP20 OVC targets include Children Living with HIV ages 0-17 and HIV-affected children (e.g., children of HIV+ caregivers, HIV exposed infants, children of key populations, children at risk or who have experienced violence, at risk AGYW ages 10-17). The target for OVC_SERV is also based on the estimated number of orphans and vulnerable children from the 2020 Spectrum and 2020 population projections. Furthermore, for DREAMS OVC related targets, consideration was given to the current epidemiological context of the AGYW population in the DREAMS SNUs and vulnerability based on program screening, VACS data, and eligibility criteria. An anticipated 80% of all HIV infected and affected OVCs in all implementation sites will need specific HIV-related services within facilities and communities. These services include linkage to HTS, violence and HIV prevention, psychosocial counseling, referrals to care and treatment, support for ART adherence and retention, and HIV disclosure.

In COP21, PEPFAR Namibia will reach a total of 53,308 OVCs in all implementation SNUs. 29,997 (56%) of the total targets will be attributed to OVC comprehensive, 15,859 (30%) to DREAMS, and 7,444 (14%) are for OVC Preventive. 24,006 represent active OVC beneficiaries of the OVC comprehensive approach and over 5,991 beneficiaries are expected to graduate). The total OU OVC targets have decreased slightly by 2% from 54,858 to 53,308. Some of the reasons for the decrease in targets include the change in Peace Corps operations which also saw their targets decreased. OVC comprehensive targets for children under 18 have increased to reflect the CLHIV enrollment goals to be in line with the program direction HIV risk assessments will be conducted to ensure that 100% of all 26,180 OVC under age 18 in the OVC comprehensive approach have a known HIV status. 100% of HIV-positive OVC in PEPFAR Namibia supported sites will be linked to treatment and have their viral load monitored.

Table 4.7.3. Targets for OVC and Linkages to HIV Services

SNU	Target # of active OVC (FY21 Target) OVC_SERV*	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target) OVC*	OVC_SERV Preventive*
Andara	1,366	542	149
Eenhana	3,598	2,528	703
Engela	7,671	5,396	1,505
Katima Mulilo	7,789	4,099	1,059
Nankudu	928	653	183
Nkurenkuru	157	101	40
Nyangana	1,409	610	171
Okahao	577	353	99
Okakarara	6	0	6

Okongo	370	223	67
Omuthiya	2,655	958	237
Onandjokwe	4,296	1,408	364
Oshakati	6,177	2,708	805
Oshikuku	1,658	1,166	324
Otjiwarongo	8	0	8
Outapi	1,321	754	283
Rundu	5,275	2,116	611
Swakopmund	19	0	19
Tsandi	514	302	97
Tsumeb	2,507	1,419	413
Usakos	4	0	4
Walvis Bay	6	0	6
Windhoek	4,997	844	291
Total	53,308	26,180	7,444

*COP21 Datapack

4.8 Cervical Cancer (CXCA) Program Plans

Namibia formally started providing screen and treat services in February 2019, and over the course of COP18 was able to successfully establish 42 static sites providing VIA, cryotherapy or thermal coagulation, along with decentralizing LEEP services from one hospital in Windhoek, to 11 district hospitals nationally. Of these 11 active LEEP sites, seven are fully integrated cervical cancer screening and treatment service units. The fully integrated prefabricated units are in Khomas, Zambezi, Ohangwena, Omusati, Erongo, Kavango and Oshikoto regions. These units offer VIA, cryotherapy, thermal coagulation and outpatient LEEP procedure all in one location, allowing more women who screen positive immediate access to the appropriate treatment modality. As of December 2019, this service had

screened 8,011 WLHIV, of which 1,170 HIV positive women were VIA positive and 103 of those who screened positive received treatment, translating into 86% treatment rate for the country. This expansion continued in COP19 to an additional 18 ART sites. In COP20, the country expanded the see and treat approach to 3 additional regions and the services are now provided in all 14 regions in the country and a total of 65 sites are established nationwide. The program has screened 18,018 WLHIV from FY19-FY20. Namibia has been improving on the treatment rate from 57% in FY19 Q2 and was close to the 80% target at the end of FY20 . This was despite a decrease in the number of women coming into facilities, and staffing issues exacerbated by COVID-19 restrictions.

By the end of COP21, the country is planning to expand access of cervical cancer screening services and to increase targeted screening and treatment rates for WLHIV to least 90%. In addition, the program will optimize cervical cancer screening through establishing a fast-track escort system and patient navigation in health facilities and pivoting the program to demand creation activities in the community by conducting targeted training of community-based partners to establish a bidirectional referral system. The country will continue to implement the Mixed Model Approach to provide cervical cancer screening at fixed and mobile outreach services with emphasis on the outreach model to CCBHSs, CAGs, rural ART clinics by using mobile vans for outreach services. Organized campaigns will occur, targeting specifically WLHIV and optimizing ART/PMTCT visits to increase same day screening of WLHIV as standard of care. The program will track eligible clients for cervical cancer screening and treatment within the well-established community tracing program to scale up cervical cancer screening and close treatment gaps.

Other priority areas for the program will include strengthening the referral system for treatment of invasive cervical cancer, to ensure that women diagnosed through the screen and treat program will be able to be treated for invasive cervical cancer, preventing further disease progression. Thermal coagulation will continue to be scaled up to increase the rate of same day treatment of eligible pre-cancerous cells to 100%. An increased public-private partnerships and stakeholder involvement is needed to create a sustainable national program and will commence negotiation with local medical AID to incorporate See and Treat in benefits packages. There is a need to standardize data collection tools and implement M&E into national reporting framework to improve data quality and timeliness of reporting.

A target of 48,686 WLHIV will be screened in COP21. To address specific policy related activities that will increase access and scale up of cervical cancer screening, the country will develop a 5-year strategic plan for the MOHSS, to expand national programing of the CECAP program outside of PEPFAR. A circular to communicate the change in VIA re-screening intervals for WLHIV to every two years and the post treatment follow up interval to 4-6 months is being developed in COP20 and later incorporated in the CECAP guideline once formally reviewed. A CECAP Technical Working Group (TWG) was established to meet regularly to discuss issues pertaining to CECAP and to advise programing. To ensure quality assurance in the program mentoring, supervision and clinical oversight to CECAP providers is provided and regular program data analysis is conducted. The program will conduct regular review of cervigrams to prevent misdiagnosis and improve treatment quality.

4.9 Diagnostic Network Optimization

Namibia, on the national level, is well poised to meet the testing needs of patients for VL, EID and TB testing using molecular platforms. To work towards further optimizing the system, in COP21, the program will complete a full analysis of the current utilization and workflow at all molecular sites (high throughput and GeneXpert). Currently, there are eight regional high throughput VL laboratories with 15 total instruments. These instruments at 250 working days have a capacity of 533,000 tests per year. The approximate usage, based on COP18 (FY19) MEDITECH testing numbers, is 33% of capacity (Table 4.9.1).

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

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

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

EID testing is centralized to a single laboratory with two instruments and a capacity of 63,000 tests per year, of which approximately 31% is used (Table 4.9.2). There are 35 GeneXpert TB testing sites with 48 machines and a capacity of 380,000 tests. The approximate usage is 9% (Table 4.9.2). There are additional 15 GeneXperts owned and operated by the MOHSS that were operationalized for targeted VL testing in COP19 (Table 4.9.2), but were instead co-opted for COVID-19 testing, which the MOHSS plans to transition back to VL testing in COP20. The aim is to add additional testing capacity to those machines in COP21.

Table 4.9.2 Summary of laboratories at the national level.

Number of Laboratories	Test Type	Number of Instruments	*Theoretical Capacity per year	+Approximate Usage (%)	Testing Need	Coverage(%)
8	Viral Load (2 also used for EID as needed)	14	556,250	219,000 (39)	180,000	92%
1	Infant Virological Testing	2	73,500	20,000 (27)	15,000 (x2)	67%
35	GeneXpert TB (35 GX4, 12 GX16, 1 infinity)	48	380,000	34,500 (9)	45,000	77%
15	~GeneXpert (not currently in use)	15 (10 GX4, 5 GX16)	150,000	N/A	N/A	N/A

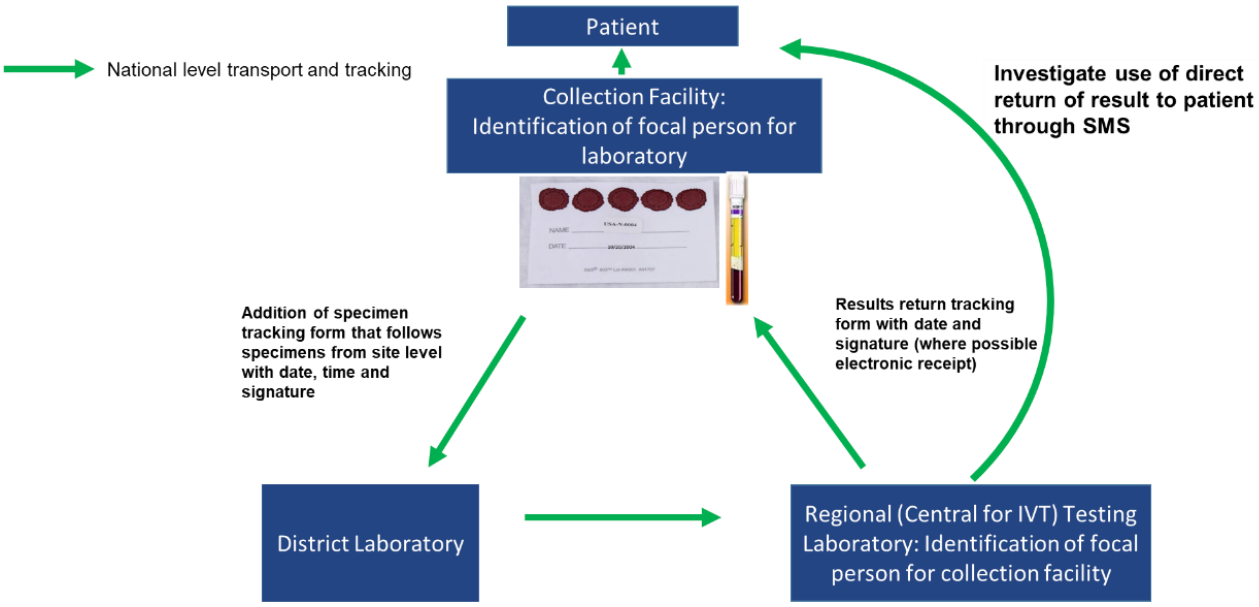
Data source: MEDITECH, Spectrum and Panorama based on COP18 (FY19) quarters one through four.
*Capacity based on 250 working days with one technician during an 8 hour day.
+ Approximate usage is per test and includes duplicates and controls and therefor is without true deduplication which is not possible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

In COP21, PEPFAR Namibia will expand EID testing to all capable VL laboratories to address low coverage issues and the long-time it takes to initiation positive babies on ART. Three laboratories in Outapi, Rundu and Katima, have Hologic Panther systems. These systems do not currently do DBS specimens, but laboratories do have GeneXpert platforms for TB that can be utilized for this expansion. Once that is complete, further expansion of access to EID will be done by adding multiplexing of existing

GeneXperts currently used for TB in sites with high need and low coverage for EID. Addition of true POC testing (mPIMAs) continues to be investigated for selected sites at the borders as well as hard to reach areas.

Further optimization activities involve assisting the country develop a national specimen transport, tracking, and results return system. Currently, there is no tracking of specimens or results and movement of specimens and results from the facilities and back to the facilities is largely done in an ad hoc manner. NIP currently manages specimen transport between laboratories and in a few designated clinical settings. In COP21, PEPFAR support will move Namibia closer to a national system by continuing to support personnel and developing a team that involves both MOHSS and NIP to investigate best practices and develop a framework for a national system (Figure 4.9.1).

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



Continuous quality improvement (CQI) will continue in COP21, by supporting virtual SLMTA training for laboratory technicians and supporting the gradual transition of accreditation activities for the regional laboratories to NIP. As of COP20, six VL molecular laboratories have been accredited leaving only two in the country lacking accreditation. PEPFAR will further support CQI activities by continuing with the HIV rapid testing proficiency testing (PT) production, recency, and addition of PT production for TB-LAM and in-country production of GeneXpert TB.

COP21 will also see support for laboratories to continue recency testing, including quality control site assessments and VL testing. PEPFAR, through NIP will support the MOHSS to conduct a clinical evaluation of urine TDF for TLD adherence monitoring, as well as support for CADRE HIV drug resistance genotyping to detect early emergence of TLD resistance. PEPFAR Namibia will further fund NIP to support the MOHSS rollout and scale-up of TB-LAM through completing the validation of the assay to fulfil requirements for MOHSS procurement.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

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

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

PEPFAR Namibia's COP21 vision for achieving epidemic control employs an agile and adaptive approach to management, operations and staffing that is aligned with PEPFAR Namibia's focus on preventing new infections and maintaining the treatment cohort while laying the foundation for a sustainable transition post epidemic control by strengthening critical health system capacities.

Each year, PEPFAR Namibia's USG agencies conduct a review during COP planning to examine staffing footprints and associated technical and operational functions. Analysis indicated a need to repurpose existing staff through revised position descriptions, fill all vacant positions and transition to locally employed staff (LES) positions where feasible.

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

- CDC converted the Locally Employed Staff (LES) Workforce Management Officer into a Senior Prevention Advisor to focus on enhanced case finding strategies.
- The USAID Donor Coordination and Community Care Advisor LES position is currently vacant and will be repurposed to a USAID Senior Resilience Advisor. This new repurposed position will serve as the point person for coordinating and tracking emerging risks to the health system (drought, COVID-19, etc.). and support technical work in preparing for, adapting to and responding to stressors, as per PEPFAR guidance.
- The existing USAID Senior Quality Assurance Advisor, LES position is currently vacant and will be repurposed to a USAID Senior OVC Advisor. The new repurposed position will provide leadership and expertise level support to enroll 90% of Children living with HIV (CLHIV) to OVC program, coordinate HIV and sexual violence prevention activities among OVC 9-14 years, and coordinate linkage between OVC, DREAMS and Key Population programs. These new repurposed positions are expected to be filled by the end of FY22 Q1.
- USAID Namibia, either through USAID Washington mechanisms (STAR, GH-TAM) or CODB funding allocation, will designate a short-term Private Sector Engagement (PSE) Fellow. The fellow will work with USAID's Health Systems Strengthening Advisor to support broader engagement with the private sector to address gaps in public funding and programming and achieve greater health impact and sustainable HIV epidemic control.
- USAID's US Direct Hire Health & Population Development Officer (Deputy Health Director) is being repurposed as a USPSC – DREAMS Coordinator. The position will be filled before the end of this fiscal year.

While no new positions are requested in COP21, there are seven vacant positions, which the team is actively working to fill, including:

- CDC's LES HIV Prevention Advisor and LES Science Advisor are currently all in the recruitment process. Interviews will be conducted in May 2021.
- The CDC Associate Director for Science (ADS) will be arriving in country mid-2021.
- There are currently three vacant USAID positions; two existing LES positions are being repurposed: The Donor Coordination and Community Care Advisor to a Senior Resilience Advisor, the Senior Quality Assurance Advisor to be repurposed to a Senior OVC Advisor, and the Supervisory Health Development Officer (USDH) is in the bidding process.

In terms of the cost of doing business (CODB), after three years of steady decreases, COP21 will see a 2% increase in CODB from $15 million in COP20 to $15.4 million in COP21. CODB remained streamlined and flat for USAID and CDC, however, increases for Peace Corps and State due to increased ICASS costs and pipeline adjustments account for the full OU CODB increase. Namibia was able to contain increase in CODB due to reduced travel and training engagements forced by COVID, and by adapting to virtual training and supervisory engagements.

7.0 American Rescue Plan Act (ARPA) Activities

The American Rescue Plan Act (ARPA) COVID-19 Appropriation for PEPFAR designates ($250,000,000) to the Department of State "to support programs for the prevention, treatment, and control of HIV/AIDS to prevent, prepare for, and respond to coronavirus, including to mitigate the impact on such programs from coronavirus and support recovery from the impacts of the coronavirus. PEPFAR Namibia will receive $4,500,000 of these funds to solely focus on mitigating COVID-19 impact on PEPFAR programs and beneficiaries and support program recovery from the impacts of coronavirus. These interventions are aligned with the broader USG global COVID-19 response and recovery strategy and objectives; approximately 1 million of these funds will be received in COP20 and 3.5 million in COP21.

The Namibia ARPA strategy is focused on 1) repairing injury to our HIV/AIDS program, by enhancing the capacity of key above site interventions (supply chain management, laboratory and Strategic Information) which have been pushed to the limit by additional demands to support the COVID-19 outbreak; and 2) to accelerate interventions and programming that had been disrupted by COVID-19 containment measures such as a lengthy nation-wide lockdown, and restrictions on public gatherings, which all affected the implementation of both the prevention and treatment portfolio programs. The specific proposed activities and interventions are summarized in the table below.

Funding Agency	Brief description of activity	Estimate number of patients, HCW and/or sites that would be supported with these activities. (e.g. implement IPC for 100 sites and 400 HCW)
USAID	Support to PEPFAR and Ministry of Health and Social Services (MOHSS) Central Medical Stores (CMS)' procurement to improve HIV and related commodities' security ($100k budget to pay for two temporary procurement assistants - one at PSM & one at CMS)	2 sites to receive HR support (procurement assistants)
USAID	Support community structures and households to prevent and respond to Gender Based Violence (GBV) and Violence Against Children (VAC) through sensitization, identification, providing services and reporting of GBV and VAC cases	7,000 children and adults sensitized, 500 community care workers and frontline health workers trained
USAID	Humanitarian Non-health (income generation and economic strengthening activities such as strengthening small and medium enterprises, strengthening village saving and loans (VSL) mechanisms that will provide support to households with moderate and severe hunger) food security support to improve adherence.	Support 7000 households in income generating activities, strengthen 16 small and medium enterprises and 20 VSL
USAID	Increase community index testing for Key Populations through enhanced peer outreach worker training, re-establishing community support groups in 10 priority districts, and communication and demand creation for self-testing	75 peer educators trained; 4,000 self-testing posters printed and distributed; and 400 participants mobilized for KP related index testing, self-testing and PrEP
USAID	Maintain and expand income generating activities that support food vouchers to vulnerable households with OVC, KP and AGYW to ensure food security for the most vulnerable households in DREAMS districts	Vouchers to support approximately 15,000 OVC and AGYW and 250 KPs
USAID	Community advocacy and demand creation for VMMC services: Procure VMMC branded face masks and promotional T-Shirts and distribute to all 15-19 year olds in school and targeted communities	Mobilize 10,000 schoolboys and communities (100% 15+ years) with appropriate VMMC messaging
USAID	Revamp VMMC services in private sector urban sites: Re-engage private sector facilities in urban areas to provide VMMC	Circumcise an additional 4,000 men 15+ years
USAID	Support clinics to provide GBV prevention and care services to OVC and AGYW clients: targeted staff, training of staff in LIVES and GBV screening and care, provision of IEC materials	Support five clinics in DREAMS Regions contributing to the Gend-GBV target of 8,306

CDC	Investing in replacing and updating of laboratory equipment/supplies to keep up with VL, EID, TB COVID-19, and other testing needs.	The support for molecular testing capacity will support up to 20 sites.
CDC	Sequencing system support	Sequencing system support will cover an estimated 5 sites.
CDC	Staffing for laboratory capacity - shortage of molecular expertise	Approximately 20 staff will benefit from additional molecular expertise.
CDC	Community Adherence Group (CAG) income-generating projects	The support will cover 300 CAGs, with an estimated 2800 members.
CDC	Community Adherence Group (CAG) income-generating projects	The support will cover 300 CAGs, with an estimated 2800 members.
CDC	Mother-Baby Follow-up (MBFU) expansion	Intervention will enroll 500 MBFU pairs.
CDC	HIV index testing surge to clear backlog	A backlog of contacts (1000) will be traced and tested.
CDC	Recency scale up staffing to help with trainings and CQI work and equipment to make real-time data available	60% of ART sites will be covered by the end of COP20, or an additional 70 health care facilities.
CDC	Internet connectivity support to support virtual meetings/trainings	The support will go towards ensuring consistent connectivity at the Emergency Operations Centre, and data distribution covering all regions.
CDC	Tracing Activity - data system & facility tracing- for expanded tracing	Support will go towards tracing and returning patients (6000) to treatment in 16 districts
CDC	Tracing Activity - data system & facility tracing- for expanded tracing - hire data clerks to extract and enter results.	Support will go towards tracing and returning patients (6000) to treatment in 16 districts
CDC	Cervical Cancer (CECAP) staffing (enrolled and registered nurses) & demand creation activities	Support would go towards recruiting and supporting an additional 6 enrolled and registered, and to support demand creation at 100% of the sites with cervical cancer screening and treatment.
HRSA	Cervical Cancer (CECAP) staffing (enrolled and registered nurses) & demand creation activities	Support would go towards recruiting and supporting an additional 6 enrolled and registered, and to support demand creation at 100% of the sites with cervical cancer screening and treatment.
CDC	Cervical Cancer (CECAP) staffing (enrolled and registered nurses) & demand creation activities	Support would go towards recruiting and supporting an additional 6 enrolled and registered, and to support demand creation at 100% of the sites with cervical cancer screening and treatment.
CDC	Border site M&E activities & clinical M&E	The support will go towards 26 border health sites, in 9 districts.
CDC	Border site M&E activities & clinical M&E	The support will go towards 26 border health sites, in 9 districts.

APPENDIX A -- PRIORITIZATION

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

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Table A.1 Continuous Nature of SNU Prioritization to Reach Epidemic Control														
COP15 SNU	SNU Priority COP15	Achievement APR COP15	COP16 SNU	SNU Priority COP16	Expected Achievement COP16	COP17 SNU	SNU Priority COP17	COP17 Target: (APR18)	COP18 SNU	SNU Priority COP18	COP18 Target: (APR19)	COP19 SNU	SNU Priority COP19	COP20 SNU	SNU Priority COP20 and COP21
!Karas	2 Hot spots	55%	Andara	ScaleUp Agg	63%	Nyangana	Attained	100%	Namibia Cluster 1	ScaleUp Sat	90%	!Karas	Attained	Andara	Attained
Erongo	2 Hot spots	59%	Eenhana	ScaleUp Agg	72%	Outapi	Attained	100%	Kavango East-West Cluster	ScaleUp Agg	90%	Erongo	Attained	Eenhana	Attained
Hardap	Non-PEPFAR	47%	Engela	ScaleUp Agg	72%	Okahao-Tsandi Cluster	ScaleUp Sat	81%	Tsumeb	ScaleUp Sat	90%	Hardap	Attained	Engela	Attained
Kavango	Priority	84%	Katima Mulilo	ScaleUp Agg	62%	Oshakati Ondangwa Cluster	ScaleUp Sat	81%	Windhoek	ScaleUp Sat	90%	Kavango	Attained	Katima Mulilo	Attained
Khomas	Priority	61%	Ncamangoro	ScaleUp Agg	92%	Oshikuku	ScaleUp Sat	100%	Katima Mulilo	ScaleUp Agg	90%	Khomas	Attained	Ncamangoro	Attained
Kunene	Non-PEPFAR	48%	Nkurenkuru	ScaleUp Agg	92%	Tsumeb	ScaleUp Sat	90%	Walvisbay	Sustained	90%	Kunene	Attained	Nkurenkuru	Attained
Ohangwena	Priority	64%	Nyangana	ScaleUp Agg	161%	Windhoek	ScaleUp Sat	80%	!Nami#nus-Rosh Pinah Cluster	Sustained	90%	Ohangwena	Attained	Nyangana	Attained
Omaheke	Hot spot	56%	Omuthiya	ScaleUp Agg	105%	Andara	ScaleUp Agg	90%	Gobabis	Sustained	90%	Omaheke	Attained	Omuthiya	Attained
Omusati	Priority	91%	Ondangwa	ScaleUp Agg	76%	Engela-Eenhana-Okongo Cluster	ScaleUp Agg	82%	Grootfontein	Sustained	99%	Omusati	Attained	Ondangwa	Attained
Oshana	Priority	80%	Tsandi	ScaleUp Agg	62%	Katima Mulilo	ScaleUp Agg	73%	Keetmanshoop	Sustained	92%	Oshana	Attained	Tsandi	Attained
Oshikoto	Priority	110%	Okahao	ScaleUp Sat	62%	Ncamangoro-Nkurenkuru-Rundu Cluster	ScaleUp Agg	97%	Okahandja	Sustained	100%	Oshikoto	Attained	Okahao	Attained
Otjozondjupa	3 Hot spots	56%	Onandjokwe	ScaleUp Sat	105%	Omuthiya-Onandjokwe Cluster	ScaleUp Agg	109%	Opuwo	Sustained	90%	Otjozondjupa	Attained	Onandjokwe	Attained
Zambezi	Priority	53%	Oshakati	ScaleUp Sat	76%	!Nami#nus-Rosh Pinah Cluster	Sustained	45%	Otjiwarongo	Sustained	90%	Zambezi	Attained	Oshakati	Attained
			Oshikuku	ScaleUp Sat	90%	Gobabis	Sustained	50%	Swakopmund	Sustained	90%			Oshikuku	Attained
			Outapi	ScaleUp Sat	181%	Grootfontein	Sustained	65%	Karasburg	Ctrl Supported	0%			Outapi	Attained
			Rundu	ScaleUp Sat	92%	Keetmanshoop	Sustained	83%	Khorixas	Ctrl Supported	0%			Rundu	Attained
			Tsumeb	ScaleUp Sat	166%	Okahandja	Sustained	90%	Marienta l	Ctrl Supported	0%			Tsumeb	Attained
			Windhoek	ScaleUp Sat	76%	Opuwo	Sustained	48%	Okakarara	Ctrl Supported	0%			Windhoek	Attained
			!Nami#nus	Sustained	41%	Otjiwarongo	Sustained	50%	Omaruru	Ctrl Supported	0%			!Nami#nus	Attained
			Gobabis	Sustained	60%	Rehoboth	Sustained	50%	Outjo	Ctrl Supported	0%			Gobabis	Attained
			Grootfontein	Sustained	59%	Walvis Bay-Swakopmund Cluster	Sustained	77%	Rehoboth	Ctrl Supported	0%			Grootfontein	Attained
			Keetmanshoop	Sustained	81%	Karasburg	Ctrl Supported	0%	Tsumkwe	Ctrl Supported	0%			Keetmanshoop	Attained
			Okahandja	Sustained	89%	Khorixas	Ctrl Supported	0%	Usakos	Ctrl Supported	0%			Okahandja	Attained
			Okongo	Sustained	72%	Marienta l	Ctrl Supported	0%						Okongo	Attained
			Otjiwarongo	Sustained	53%	Okakarara	Ctrl Supported	0%						Otjiwarongo	Attained
			Rehoboth	Sustained	58%	Omaruru	Ctrl Supported	0%						Rehoboth	Attained
			Swakopmund	Sustained	79%	Outjo	Ctrl Supported	0%						Swakopmund	Attained
			Walvis Bay	Sustained	79%	Usakos	Ctrl Supported	0%						Walvis Bay	Attained
			Karasburg	Ctrl Supported	0%									Karasburg	Attained
			Khorixas	Ctrl Supported	0%									Khorixas	Attained
			Marienta l	Ctrl Supported	0%									Marienta l	Attained
			Okakarara	Ctrl Supported	0%									Okakarara	Attained
			Omaruru	Ctrl Supported	0%									Omaruru	Attained
			Opuwo	Ctrl Supported	44%									Opuwo	Attained
			Outjo	Ctrl Supported	0%									Outjo	Attained
			Rosh Pinah	Ctrl Supported	41%									Rosh Pinah	Attained
			Tsumkwe	Ctrl Supported	0%									Tsumkwe	Attained
			Usakos	Ctrl Supported	0%									Usakos	Attained

APPENDIX B – Budget Profile and Resource Projections

B1. COP21 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP21 Budget by Program Area and Sub-Program Areas

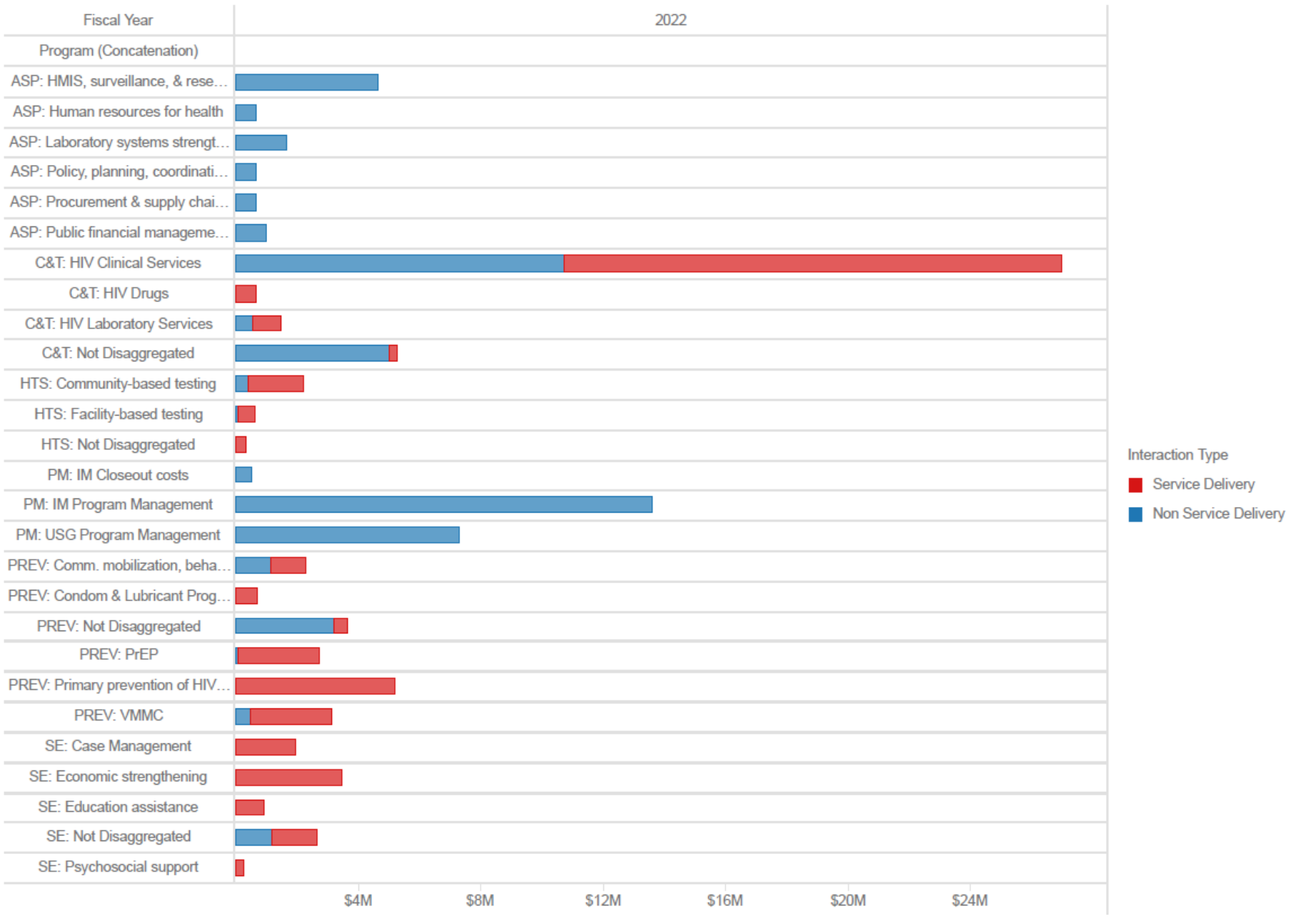

Table B.1.2. COP21 Budget by Program Area

Program Area	Subprogram	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		**$53,494,786**	**$41,405,214**	**$94,900,000**	**56.37%**	**43.63%**	**100.00%**
C&T	**Total**	**$16,296,157**	**$18,031,918**	**$34,328,075**	**47.47%**	**52.53%**	**100.00%**
	HIV Clinical Services	$10,710,584	$16,245,082	**$26,955,666**	39.73%	60.27%	**100.00%**
	HIV Drugs		$650,000	**$650,000**		100.00%	**100.00%**
	HIV Laboratory Services	$553,000	$900,500	**$1,453,500**	38.05%	61.95%	**100.00%**
	Not Disaggregated	$5,032,573	$236,336	**$5,268,909**	95.51%	4.49%	**100.00%**
HTS	**Total**	**$500,000**	**$2,646,439**	**$3,146,439**	**15.89%**	**84.11%**	**100.00%**
	Community-based testing	$400,000	$1,793,188	**$2,193,188**	18.24%	81.76%	**100.00%**
	Facility-based testing	$100,000	$503,251	**$603,251**	16.58%	83.42%	**100.00%**
	Not Disaggregated		$350,000	**$350,000**		100.00%	**100.00%**
PREV	**Total**	**$4,924,191**	**$12,645,055**	**$17,569,246**	**28.03%**	**71.97%**	**100.00%**
	Comm. mobilization, behavior & norms change	$1,132,006	$1,137,596	**$2,269,602**	49.88%	50.12%	**100.00%**
	Condom & Lubricant Programming		$695,419	**$695,419**		100.00%	**100.00%**
	Not Disaggregated	$3,218,185	$397,000	**$3,615,185**	89.02%	10.98%	**100.00%**
	PrEP	$100,000	$2,606,972	**$2,706,972**	3.69%	96.31%	**100.00%**
	Primary prevention of HIV and sexual violence		$5,192,468	**$5,192,468**		100.00%	**100.00%**
	VMMC	$474,000	$2,615,600	**$3,089,600**	15.34%	84.66%	**100.00%**
SE	**Total**	**$1,146,571**	**$8,081,802**	**$9,228,373**	**12.42%**	**87.58%**	**100.00%**
	Case Management		$1,962,265	**$1,962,265**		100.00%	**100.00%**
	Economic strengthening		$3,452,944	**$3,452,944**		100.00%	**100.00%**
	Education assistance		$927,944	**$927,944**		100.00%	**100.00%**
	Not Disaggregated	$1,146,571	$1,493,110	**$2,639,681**	43.44%	56.56%	**100.00%**
	Psychosocial support		$245,539	**$245,539**		100.00%	**100.00%**
ASP	**Total**	**$9,196,831**		**$9,196,831**	**100.00%**		**100.00%**
	HMIS, surveillance, & research	$4,630,000		**$4,630,000**	100.00%		**100.00%**
	Human resources for health	$645,000		**$645,000**	100.00%		**100.00%**
	Laboratory systems strengthening	$1,650,327		**$1,650,327**	100.00%		**100.00%**
	Policy, planning, coordination & management of disease control programs	$641,500		**$641,500**	100.00%		**100.00%**
	Procurement & supply chain management	$643,000		**$643,000**	100.00%		**100.00%**
	Public financial management strengthening	$987,004		**$987,004**	100.00%		**100.00%**
PM	**Total**	**$21,431,036**		**$21,431,036**	**100.00%**		**100.00%**
	IM Closeout costs	$535,000		**$535,000**	100.00%		**100.00%**
	IM Program Management	$13,578,645		**$13,578,645**	100.00%		**100.00%**
	USG Program Management	$7,317,391		**$7,317,391**	100.00%		**100.00%**

Table B.1.3. COP21 Total Planning Level

Table B.1.3 COP21 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$US 11,443,324	**$US 83,456,676**	**$US 94,900,000**

Table B.1.4 COP21 Resource Allocation by Program and Beneficiary

Program	C&T		HTS		PREV		SE		ASP		PM		Total	
Beneficiary	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total
Total	**$34,328,075**	**100%**	**$3,146,439**	**100%**	**$17,569,246**	**100%**	**$9,228,373**	**100%**	**$9,196,831**	**100%**	**$21,431,036**	**100%**	**$94,900,000**	**100%**
Females	$2,570,810	7%			$10,443,355	59%	$6,090,024	66%	$367,000	4%			**$19,471,189**	**21%**
Key Pops	$848,194	2%	$663,587	21%	$1,114,651	6%			$30,500	0%			**$2,656,932**	**3%**
Males					$3,239,600	18%			$50,000	1%			**$3,289,600**	**3%**
Non-Targeted Pop	$29,939,071	87%	$2,256,852	72%	$1,653,176	9%			$8,399,831	91%	$21,431,036	100%	**$63,679,966**	**67%**
OVC					$918,464	5%	$3,138,349	34%	$50,000	1%			**$4,106,813**	**4%**
Pregnant & Breastfeeding Women	$970,000	3%	$226,000	7%	$200,000	1%			$299,500	3%			**$1,695,500**	**2%**

B.2 Resource Projections

Epidemiological and Program Data Analysis

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

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

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

Finally, the PEPFAR Namibia team considered the impacts of COVID-19 on program implementation and took this into consideration when determining the budget for service provision in COP21. COVID-19 introduced some best-practices when delivering services that need to be realigned in how we continue doing business in the foreseeable future.

Gap Analysis

PEPFAR Namibia continues to work closely with stakeholders, particularly GRN representatives, Bilateral and CSOs to identify gaps and bottlenecks and mutually recommended solutions to address these gaps. During COP21 planning consultation meetings with stakeholders, the participants were presented with the achievements and challenges with COP19 implementation as well as soliciting their inputs into COP21 priority areas based on the gaps identified. PEPFAR Namibia and GRN recognized that specific gaps to address the continuum of HIV services, (especially adherence and retention) vary by district and program, and the strategies have been adjusted to meet the specific needs accordingly, with the primary goal of ensuring maintenance of the treatment current cohort (Retention) as well as providing client-centered care.

Funding Allocation to Strategy Tool (FAST)

The interventions as identified through COP20 expenditure reporting were used as the basis for funding activities in COP21 to fill the identified gaps. The total notional budget of **$94,500,000** is inclusive of at least $1,000,000 dedicated to cervical cancer, DREAMS funding of $20,000,000 and $2,880,000 for VMMC. Activities with appropriate budget codes were allocated to IMs with the highest probability of achieving PEPFAR targets taken into consideration.

APPENDIX C – Tables and Systems Investments for Section 6.0

Table 6 and SRE Tool are not required for COP21.

APPENDIX D– Minimum Program Requirements

Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	✓
Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are >4 weeks of age and weigh >3 kg, and removal of all NVP- and EFV-based ART regimens.	✓
Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	✓
All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	✓
Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	✠
Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	✓
Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)	✓
Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	✓
Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention	✓
OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.	✓
Alignment of OVC service packages and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	✓
Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	✓
Clear evidence of agency progress toward local, indigenous partner direct funding.	✓
Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	✓
Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	✓
Scale-up of case surveillance and unique identifiers for patients across all sites.	✠