Republic of Namibia

National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22

Ministry of Health and Social Services
Directorate of Special Programmes

2017

Republic of Namibia

National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22

Ministry of Health and Social Services
Directorate of Special Programmes

2017

Foreword

The National Multisectoral HIV and AIDS response has been a necessary and critical feature of Namibia's Health Sector since the first case of HIV infection was reported in 1986. As a nation, we have become an example to the world in terms of identifying and treating those living with the virus. This has led us to the point where we can declare our intent to End AIDS by 2030. To achieve this momentous feat however, in an environment with increasing economic constraints, we must increase our efforts to utilise resources in a more focused and targeted manner that will produce the effective strategies for efficient interventions that produce impactful results.

The NSF has been developed with this very much in mind. Utilising comprehensive data and research under the Investment Approach - initiated in the previous NSF (2012-17) - to identify the most at risk populations amongst whom interventions must be focused to prevent the spread of new infection and ensure quality of life for the infected. This intelligence of approach can be seen in the focus on Adolescent Girls and Young Women (AGYW) who are shown to be more vulnerable to infection. When coupled with interventions focusing on the partners of these women and girls a reinforced and complimentary effort results.

The key dynamic to Ending AIDS by 2030 is a reduction in new infections coupled with a fall in AIDS related deaths. We have seen consistent improvement in both these measures over the life of the precious NSF, but we know we must achieve more.

The 90-90-90 targets for 90% of all People Living with HIV to know their status, 90% of those to be placed on treatment and 90% of those on treatment to have the HIV virus suppressed within their systems forms the foundation for the approaches required to move from impact and control to bringing an end to AIDS as a Public Health threat. With this NSF, we have mapped out the 90-90-90 can be achieved in Namibia and act as a prelude to the ultimate goal of ending AIDS.. To ensure that our goals and priorities are translated into reality, we need all stakeholders, whether government, civil-society or private sector, Namibians and International partners, all people infected or affected by the disease, to come together and march in step in a common direction.

Once we felt that HIV threatened our very existence, now we can see our dreams on the horizon. My Government wishes us all the best in the next 5-years of our journey.

Hon. Dr. B. Haufiku, MP
Minister of Health and Social Services

Preface

The National Strategic Framework for HIV and AIDS (NSF) 2017/18 - 2021/22 is the guiding force for the HIV and AIDS response over the next five years. A response that sits firmly aligned within the National Development Pyramid through the Ministry of Health and Social Services (MoHSS) Plan and the Fifth National Development Plan (NDPS), both framed in the same time period. At the apex of the pyramid, sit our long term visions of 2030 and 2063 for which strategies such as the NSF act as a conduit from vision and aspiration to action and boots on the ground.

A comprehensive End Term Review (ETR) of the previous NSF (2011-17) provided important insights into the previous programme and gave us valuable lessons to learn. As a result, and after a comprehensive writing process engaging stakeholders from all corners of Namibia and across all sections of society we have a document describing a national response to HIV that is more focused, more coherent and more self-reliant than ever before.

This NSF continues to provide overall strategic direction for the response, describing priority results, key programmes, strategies and target populations. In line with the spirit of consolidation and efficiency, this NSF also brings the National Coordination Framework into the same document, providing a comprehensive description of how the grassroots responses and multi-sectoral programmes connect to the national level monitoring, planning and oversight.

It is clear to all that we live in globally difficult economic times which put constraints on all areas of the economy. The health sector is not immune from this and the HIV response which has been depended on external resources to a large extent, finds itself facing a future of reduced donor support. The Ministry, in cooperation with CSO and Private Sector stakeholders has, in this NSF, taken the challenge head on. In using the Investment Approach and Fast Track strategies, we have produced a leaner response that prioritises effective, cost-efficient interventions which will return high-yields in terms of impact results.

Ms Bertha Katjivena
Acting Permanent Secretary
Ministry of Health and Social Services

Tables of Contents

List of Tables

List of Figures

Executive Summary

The National Strategic Framework (NSF) is a five-year HIV and AIDS policy and planning document (2017/18 to 2021/22) developed to guide planning, programming and implementation of the national multisectoral and decentralised HIV and AIDS response. The design of the NSF is premised on the Investment Framework and Results-Based Management (RBM) approaches. These approaches have also mainstreamed gender and human rights issues. The Framework is catalytic, supporting delivery of innovation and best practices, necessary to ensure provision and sustainability of a quality and comprehensive HIV response. The key NSF message is to do *"better and more of the right things at the right time and at the right scale"* during the implementation. NSF strategies aim at leveraging resources (financial and technological), best practices, intensifying implementation at all levels, increasing coverage and targeting key populations and vulnerable groups at higher risk of HIV infections, and geographical hotspots.

At national level NSF is aligned with the objectives of Vision 2030, the National Development Plan 5 and the National HIV/AIDS Policy. At the global level, it is aligned with the Sustainable Development Goals (SDG) and in particular Goal 3, The Global Health Strategy, The Global Strategy for Women's Children's and Adolescent's health (2016-2030) (WHO), the African Agenda 2063 among others, and in particular the 90-90-90 Fast Track Strategy.

National Priorities and results

NSF has prioritised interventions that will contribute to the achievement of the following impact results by 2022.

Priority 1: HIV new infections reduced by 75%

Priority 2: HIV related deaths reduced by 75%

Priority 3: Elimination of MTCT to less than 2%

Priority 4: 100% of newly identified PLHIV enrolled and retained on ART

Priority 5: TB/HIV mortality reduced to 21 per 100,000 population by 2021

Priority 6: Domestic contribution towards the national multisectoral HIV and AIDS response increased to 80%[1]

To achieve these results, Namibia has prioritised the following high impact programmes and interventions. These programmes are also complemented by a set of priority social and programmatic enablers

- Adolescent Girls and Young Women
- Voluntary Male Medical Circumcision (VMMC)
- Prevention programmes for key populations –MSM and FSW
- Condom Promotion and distribution
- Male Involvement
- Pre Exposure Prophylaxis (PrEP)
- Prevention of Mother to Child Transmission (PMTCT)
- Treatment care and support (provision of ART)
- HIV Testing Services (HTS)
- Treatment of opportunistic infections

[1] Assuming constant overall funding levels from 2017/18

- **Adolescents and Young Women (AGYW):** The strategic focus for the NSF is to ensure that AGYW who are not infected with HIV remains negative, and those diagnosed with HIV are linked to care and treatment. Efforts will be made to identify AGYW living with HIV, and do not know their HIV status through differentiated HIV testing services. Special attention focus will be on AGYW key populations. Programming for AGYW will take a life cycle, and human rights approaches, and will be age and gender specific. The implementation will also target geographical hotspots where the unmet needs are high.

  For AGYW NSF suggests targeting regions with the most need. These include the following - Kavango East, Kavango West, Zambezi, Ohangwena, Omusati, Khomas, Oshikoto, Otjozondjupa and Erongo Region

- **Male Involvement:** Epidemiological and social data indicates that men are increasingly at risk and vulnerable to HIV and AIDS. Available evidence also shows low rates of HIV testing, male circumcision, condom use, and comprehensive knowledge of HIV and enrolment on ART. Retention on ART is equally low. The low uptake of HIV services has significant impact on men's mortality and morbidity, especially those living with HIV and AIDS. Men are equally affected by negative socio-cultural norms. Men are equally the key drivers of multiple and concurrent partnerships (MCP), sex work, gender-based violence (GBV), and inter-generational sex among others[2]. NSF interventions aim at addressing these challenges using differentiated models of service delivery. Male-targeted HIV interventions such as HTS, VMMC, Condoms, PrEP, and treatment of STIs will be scaled up. For Men living with HIV will also be tested for TB and offered IPT and CTX as appropriate.

- **Prevention programmes for Key Populations**: The primary focus of NSF is MSM and FSW. Activities will encourage these at risk groups to know their status and provide onward linkages to the treatment cascade.

- **Condom Promotion and distribution**: Stakeholders will focus on two objectives. First, to ensure that male and female condoms are readily available at the right places. Strategies for condom programming, promotion and distribution will be strengthened. Second, stakeholders' will promote and advocate for correct and consistency use of condoms. Promotion and distribution of condoms will be integrated in other health programmes including SRH, VMMC, PMTCT, HTS, and MNCAH. Strategic partnerships will be established with CSO, the private sector and communities to expand the scope of condom promotion and distribution.

- **Voluntary Medical Male Circumcision (VMMC):** VMMC will be intensified with a primary focus on males 10-29 years. Communities will be mobilised to create awareness and demand for VMMC. Eligible persons will be adequately counselled, informed and given the choice to make informed voluntary decisions. Men diagnosed with HIV will be linked to treatment and care. HIV-negative men in VMMC settings who are assessed to be at substantial risk of HIV acquisition (e.g. HIV-negative men in sero-discordant relationships) will be informed and linked to other high impact HIV preventive interventions such as PrEP and condoms. Advocacy will be intensified to reduce stigma and discrimination and help to galvanise increased support for VMMC.

[2] Mills EJ, Beyrer C, Birungi j, Dybul Mr (2012): Engaging Men in Prevention and Care for HIV/AIDS in AFric. PLoS Med 9(2): e1001167.doi:10.137/journal.pmed. 1001167

- **Pre-Exposure Prophylaxis (PrEP):** PrEP has been integrated in the national ART Guidelines to include the delivery of oral PrEP to populations at substantial risk. The package of services for PrEP shall be offered as part of the "combination prevention" package that includes HIV testing services, provision of male and female condoms, lubricants, ART for HIV+ sero-discordant couples, VMMC, and STI prevention. Oral pre-exposure prophylaxis (PrEP) will be used as an additional HIV prevention option for pregnant and breastfeeding women. Monitoring should be intensified to monitor potential adverse effects

- **Prevention of Mother to Child Transmission (PMTCT):** The package of services for PMTCT will include - maternal HTC, early infant diagnosis (EID); ARVs to prevent MTCT and for the life-long health of the mothers, provision of counselling and support for safe infant feeding practices; family planning, prophylaxis for opportunistic infections, and referral to other services such as sexual and reproductive health (SRH). These services will be complemented by a set of social and programmatic enablers such as community mobilisation, a strengthened health and community systems, improved male participation, and reduction of stigma, discrimination and GBV.

- **HIV Testing, Treatment Care and Support (provision of ART**): The programme aims to achieve two objectives. First, reduced morbidity and mortality of PLHIV, and secondly facilitate the achievement of the 90-90-90 targets with the aim of having PLHIV on ART attaining viral suppression. This programme component is largely dependent on effective community mobilisation, HTC, and linking PLHIV to treatment.

- **Treatment of opportunistic Infections**: This component will facilitate the identification of all PLHIV at a higher risk of acquiring opportunistic infection such as TB and STIs. Preventive and curative services will be offered with special attention to addressing the TB/HIV co-infection, Cryptococcal Meningitis and PCP. Services will also include routine screening, diagnosis and management of STIs among PLHIV, and addressing malnutrition and food insecurity among PLHIV. Referral to other essential services and sectors

- **Cross cutting programmes** identified in the NSF include STI prevention and Management, post exposure prophylaxis (PEP), Social Behaviour change communication (SBCC) and HIV testing Services. The social enablers that have been identified include: political commitment and advocacy, laws, legal policies, and practices, community engagement and mobilization, stigma reduction, use of mass media and local responses to change risk environment. The programme enabler's range from community centred design and delivery, programme communication (to galvanise support for behaviour change programmes), procurement and supply chain management, gender equality and gender-based violence interventions, research and innovation in addition to engaging local policy decision makers.

NSF Implementation and Operationalization Approaches

The implementation of the NSF prioritised programmes will be multisectoral and decentralised involving many and diverse stakeholders, at all national, regional, community and sector levels. The implementation will also be premised on the following approaches-

- **Combination Prevention Approach:** The Combination Prevention approach will be critical in ensuring synergies and complementarity between programmes and between specific interventions. The approach enhances efficiency and effectiveness in addressing behavioural, structural and biomedical interventions.

- **The Life-Cycle Approach:** The "Life Cycle" approach will ensure that targeted populations will receive appropriate care and services through the various stages of life. People are targeted as they transit from infancy through childhood, adolescence to adulthood taking into consideration their specific needs based on their age and gender, and the environment they are in.

- **HIV Mainstreaming:** HIV mainstreaming will aim at expanding the scope and coverage of the national HIV multisectoral response by galvanising and catalysing development sectors to undertake HIV mainstreaming in their internal and external programmes and projects. Mainstreaming at the workplace will provide a minimum package of services that will include - HTS, SBCC, PrEP, PEP, VMMC, Condoms, prevention of stigma and discrimination. People will also be linked to other services such as ART VMMC, PMTCT, treatment and management of STIs etc. Internal mainstreaming will also be integrated within the broader sector's wellness programmes. External mainstreaming will be adequately informed by the recommendations of the Environmental Impact Assessments (EIA) conducted for development and capital projects

- **HIV integration in the Health Care System:** Integration of HIV in other health services will be strengthened and will enable timely diagnosis and treatment HIV, TB and non-communicable diseases affecting PLHIV more efficiently.

- **Advocacy and Communication:** Advocacy will be intensified to ensure that stakeholders' focus on prioritised programmes, and the critical social and programmatic enablers. Advocacy work will also aim at strengthening an enabling social, policy and legal environment. This is particularly critical in ensuring efficient service delivery to key populations and other vulnerable groups. Communication will also be intensified to ensure that all stakeholders are kept abreast with the implementation of the response and on emerging technologies and best practices.

- **Community Mobilisation and Demand Creation:** Communities will be mobilised to create demand for HIV and AIDS services, promote and support adherence and retention. The process will also galvanise community support for key populations and other vulnerable groups. Community mobilisation will be linked to SBCC to improve comprehensive knowledge of HIV and AIDS.

- **Strengthening Strategic Partnerships and Alliances:** Existing strategic partnerships and alliances will be consolidated and new ones established where necessary. Strategic partnerships will be expected to advance innovative ideas, leverage technical assistance and resource flows, facilitate transfer of skills, knowledge, and best practices. Effective partnerships have the potential to rapidly scaling up service delivery, increase client and geographical coverage; and ensure equitable access and utilisation of services. The partnerships will be anchored on the principles of shared and common interests, shared resources (time, money, expertise, and people), risks and benefits.

- **Systems Strengthening:** Namibia will focus on developing resilient sustainable systems for health (RSSH) and community systems. Strong systems will ensure availability and accessibility of

comprehensive health and social services, adequate infrastructure, human and financial resources, health commodities, and increased use of evidence-based information to inform planning, allocation of resources and services delivery. Robust community systems will enhance and support community participation and engagement, and improve on community mobilisation and demand creation

- **Response Coordination and management:** Coordination structures already exist at national, regional, sector and community levels. The focus of the NSF is to improve on the coordination efficiencies and effectiveness. The coordination and management of the response is premised on the three-one principles.

- **Strategic information and knowledge management**: The M&E system will be strengthened to ensure the generation of empirical data and strategic information to inform the response strategic planning and programming, smart investments, and effective and efficient implementation, and coordination. The key priorities will be to harmonise data collection and reporting tools, standardise and define indicators, set national targets and strengthen the capacity of M&E officers. Efforts will be made to ensure that stakeholders report on implementation progress in a timely manner.

- **Resource Mobilisation and Sustainable Financing of the HIV response: A**dvocacy will be intensified to increase domestic funding both from government and private sector. The current donor base will be expanded and sustained. Implementing partners will forge to improve on service delivery efficiencies. Namibia will also develop a sustainable financing strategy for the HIV and AIDS response. SMART investments will be guided by, the Namibia Investment Case.

Section 1: Introduction

1.1 Background information

Namibia is situated on the South Western coast of Africa. It has a population of about 2.4 million, and is one of the most sparsely populated countries in the world (2.8 people/sq. km.)[3]. Namibia is an upper middle-income country with an estimated gross national income per capita of $5,630. The economy has grown on average by 5.6% between 2012 and 2015, and the Human Development Index (HDI) improved from 0.628 in 2014 to 0.640 in 2015[4]. Life expectancy is at 65.1 years from birth and the adult literacy rate is at 89%3. Gender Development Index has improved from 0.981in 2014 to 0.986 in 2015. Between 2010 and 2016, poverty in Namibia fell from 28.7% in 2009/10 to 18% in 2015/16.Thirty-two (32%) of women and 44% of female-headed households live below the poverty line. The unemployment rate in the country sits at 27.4%.

The economy is largely dependent on mining, fishing, large-scale farming and high-end tourism. This has given rise to a highly mobile population characterized by a system of circular labour migration to mines, ports, farms, urban areas and tourism nodes. Rural-urban migration is substantial and has resulted in growing informal settlements around cities, towns and smaller semi-urban localities. Socio- economic inequality is widespread and multi-dimensional. By 2015, 13.4% of the population were living in severe multi-dimensional poverty.[5] Socio-economic factors have tended to increase the likelihood of higher risk sex behaviour and vulnerability to HIV infection7. About 14% of total government expenditure is spent on health. Government is the biggest contributor to health spending in the country, representing 54% of total health spending.

1.2 Epidemiological Context

Namibia has a high HIV prevalence and incidence rates, generalized and matures HIV epidemic, with the majority of new HIV infections transmitted through unprotected heterosexual sex. Co-morbidities and opportunistic infections add to the HIV burden. HIV and AIDS continue to pose a significant challenge to Namibia's socio-economic development.

By 2014, HIV prevalence among adults aged 15-49 years was estimated at 14% while that of adults aged 50-64 years was 16.4%. [6] Prevalence is generally higher among women (16.9%) compared to men (10.9%) in the same age group. HIV prevalence peaks in the age 35-39 age group for both women (30.9%) and men (22.6%). It is lowest among people aged 15-24 (2.5 – 6.4% for women and 2.0 – 3.4% for men). Prevalence is higher in regions in the north i.e. - Zambezi (23.7%), Omusati (17.4%), Kavango (17%), Oshana (16.1%) and Ohangwena (15.6%]. While new HIV infections have seen a downward trend

[3] http://cms.my.na/assets/documents/p19dmlj9sm1rs138h7vb5c2aa91.pdf
[4] UNDP 2016, Human Development Report
[5] UNDP 2016 Human Development Report
[6] The Namibia Ministry of Health and Social Services (MoHSS) and ICF International. 2014. *The Namibia Demographic and Health Survey 2013.* Windhoek, Namibia, and Rockville, Maryland, USA: MoHSS and ICF
[6] UNICEF / UNAIDS, 2014: ALL IN – Ending AIDS epidemic Among Adolescents
[6] UNICEF / UNAIDS, 2014: ALL IN – Ending AIDS epidemic Among Adolescents
[6] Mills EJ, Beyrer C, Birungi j, Dybul Mr (2012): Engaging Men in Prevention and Care for HIV/AIDS in AFric. PLoS Med 9(2): e1001167.doi:10.137/journal.pmed. 1001167
[6] Draft IBBS, MSM Report, 2014
[6] Draft IBBS, MSM Report, 2014
[6] Synthesis of Namibia's AIDS Epidemic Based on Most Recent Epidemiological data 2015[6] Draft IBBS, FSW Report, 2015
[6] MOHSS 2006, Progress report on the Third Medium Term Plan on HIV/AIDS
[6] International HIV/AIDS Alliance and Commonwealth HIV/AIDS Action Group, Enabling Legal Environments for Effective HIV Responses: A Leadership Challenge for the Commonwealth 2010, p.22
[6] The Namibia Ministry of Health and Social Services (MoHSS) and ICF International. 2014. The Namibia Demograp

since the year 2000, East and Southern Africa has remained the most vulnerable region to HIV infection particularly among Adolescent Girls and Young Women (AGYW).

Figure 1: HIV prevalence by regions

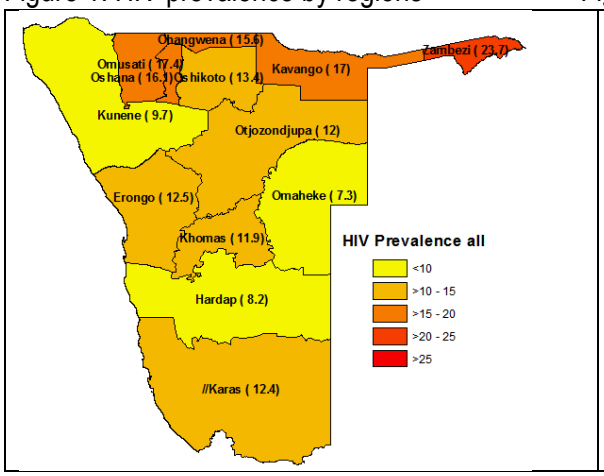
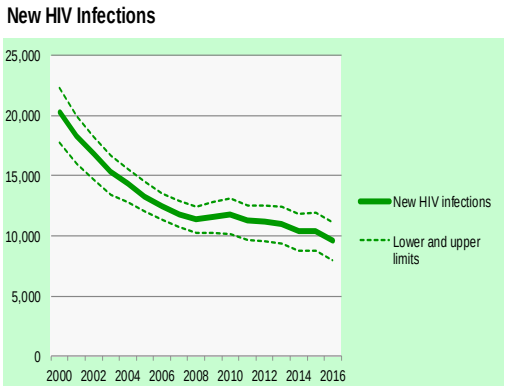


Figure 2: New HIV Infections

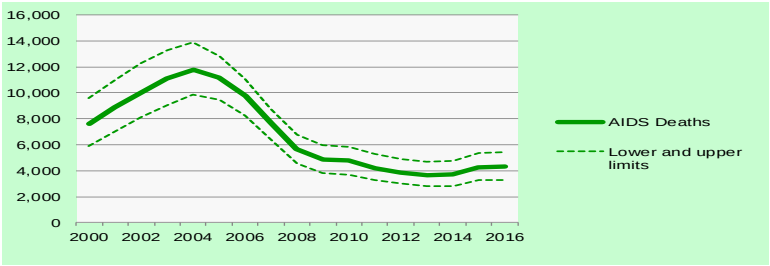


In 2014 and 2015, a total of 414,500 people tested for HIV. 77.1% of PLHIV were estimated to know their HIV status in 20167. HIV testing and counselling (HTC) data for 2014 indicates that voluntary counselling and testing (VCT) uptake is high in Ohangwena, Oshana, Khomas and Omusati. These are regions with a large number of people living with HIV (PLHIV). Discordance is also prevalent with 10% of couples tested in a public health facilities being discordant (DHS 2013). Of the 1,007 cohabiting couples who were tested for HIV in the Namibian Demographic and Health Survey (NDHS 2013) both partners were negative in 76.4% of the couples, while in 10.1% of the couples, both partners were HIV positive; and 13.5% of the couples were discordant.

Men aged 15-49 with a sexually transmitted infection (STI) or STI symptoms were more likely to test HIV positive 24.8%) than those who did not (11.7%).

In 2016, general ART coverage was estimated at 76%, while paediatric coverage was estimated at 95%. Of the 214,956 PLHIV (NDHS 2013) in Namibia, 61 % (131 721) were on ART, 84% of those were retained on the antiretroviral therapy (ART) at 12 months, and 86% of those retained were virally load suppressed8. Paediatric assessed on adherence to ART by pill count scored less than 50% nationally. However annual number of deaths amongst PLHIV aged 15 year and above had declined from 4,200 in 2010/11 to 2,900 in 2013/14.

Figure 3: AIDS related deaths



[7] UNAIDS estimates 2017
[8] ART PMIS Quarterly Feedback Report for the Period April to June 2016

The percentage of tuberculosis (TB) patients with known HIV status increased from 89% in 2012 to 92% in 2014. In 2013, 81% of PLHIV with new smear-positive TB were successfully treated. 87% of HIV positive persons were screened for TB. The coverage of cotrimoxazole preventive therapy (CPT) increased to 99% in 2014, from 92% in 2010. Coverage of ART among TB/HIV patients also increased from 43% (2010) to 84% in 2014. This is partly attributed to the increased use of Gene Xpert diagnostic technology. HIV testing for TB patients improved to 92% in 2014, from 76% in 2010. The number of TB cases diagnosed with rifampicin resistance using gene Xpert, have increased from 89 cases in 2013 to 199 cases in 2014.

The overall mother to child transmission (MTCT) rate declined from 23.7% in 2005 to 4.1% in 2015, with HTC and ART coverage for PMTCT at 95% by 2016. MTCT rate at six weeks dropped from 13.3% (2005) to less than 2%[9] in 2015. HTC coverage of pregnant women has increased to 95% and treatment of HIV positive women is estimated to be more than 95%. The percentage of women attending ANC, who tested for HIV, received results and disclosed their status to their partners stood at 87% (NDHS2013). 62.5% of all HIV- positive women were already on ART by their first antenatal care (ANC) (National HIV sentinel survey 2016). Approximately 97% (NDHS 2013) of pregnant women attending ANC reported receiving care from a skilled provider in 2013. Programme data showed that 15.3% pregnant women attending ANC in 2015, were 15-19 years and 0.5% were below 15 years. It is further estimated that AIDS related deaths among children (0-4 years) declined by 73.9% from 581 in 2010 to 152 in 2015.

The total fertility rate is 3.6 children per woman and the median age at first birth among women aged 15-49 is 21.6 years. Nineteen percent (19%) of young women (15-19 years old) have begun child bearing. 50% of all women in Namibia are using a modern contraceptive method. Despite this, 12% of women have unmet need for contraception and 10% of births are said to be unwanted. Unmet need for family planning in the general population has declined from 21.8% (1992) to 12% in 2013.

[9] Spectrum Policy Modeling System, Version 5.43 (2016); Namibia model May 2016 - Estimated

Section 2: Strategic Orientation of the National Response

2.1.1 Goal of the NSF

The goal of the national response is:

To reduce new HIV infections and AIDS related mortality by 75% by 2022 from 2015 levels, and move towards ending AIDS as a public health threat by 2030.

2.1.2 Strategic orientation

The National Strategic Framework (NSF) is a five-year (2017/18 to 2021/22) policy document intended to guide and inform the planning and implementation of the national multisectoral and decentralized HIV/AIDS response. At national level, the NSF is inspired by the objectives of Vision 2030, National Development Plan 5, the National HIV/AIDS Policy, the End Term Review (ETR) and the Investment Case. From a global perspective, NSF is aligned to the health goals of the Sustainable Development Goals (SDG) and in particular Goal 3, The Global Strategy for Women's, Children's and Adolescent's health (2016-2030) (WHO), the African Agenda 2063, and Fast Track Strategy that lays the foundations for ending AIDS by 2030.

Given the complexity and multisectoral nature of the epidemic, NSF advocates for strengthening synergies with strategic development sectors such as health, education, gender, agriculture, justice and youth. While all sectors are important, some sectors will have a direct impact on NSF and specific contributions necessary to achieve the desired results.

The NSF is designed to support high impact interventions that will contribute to the reduction of new HIV infections, eliminate mother to child transmission of HIV, and significantly reduce AIDS related illnesses and deaths. It is anticipated that this will be achieved through the implementation of prioritised high impact programmes, selected on the basis of their effectiveness and complimented by strategic critical social and programmatic enablers. The Namibian Investment Case will inform the strategic investments of the national response, improve efficiency and effectiveness in the use of financial resources.

The national response will target geographical areas with a high disease burden and specific epidemic hotspots. In these areas, implementation of interventions will be accelerated and intensified. The NSF will also target population groups most at risk.

Efforts will be intensified to ensure HIV and AIDS integration in the broader health care services. Synergies with development sectors (i.e. education, agriculture, social protection etc.) will not only be encouraged but will also be established, to maximise the effectiveness of the basic programmes.

The NSF will be catalytic, supporting delivery of innovation, and best practices, necessary to ensure provision and sustainability of quality and effective HIV services. Stakeholders will be encouraged to do *"better and more of the right things at the right time and at the right scale"*. In doing so, NSF strategies will support leveraging best practices, intensifying implementation, increasing coverage and targeting key populations at higher risk of HIV infections.

2.1.3 NSF Strategic results

Namibia aims to achieve the following six priority impact results by 2020, while laying strong foundations to eliminate AIDS by 2030.

Priority 1: HIV new infections reduced by 75%

Priority 2: HIV related deaths reduced by 75%

Priority 3: Elimination of MTCT to less than 2%

Priority 4: 100% of newly identified PLHIV enrolled and retained on ART

Priority 5: TB/HIV mortality reduced to 21 per 100,000 population by 2021

Priority 6: Domestic contribution towards the national multisectoral HIV and AIDS response increased to 80%[10]

NSF will be premised on the following principles:

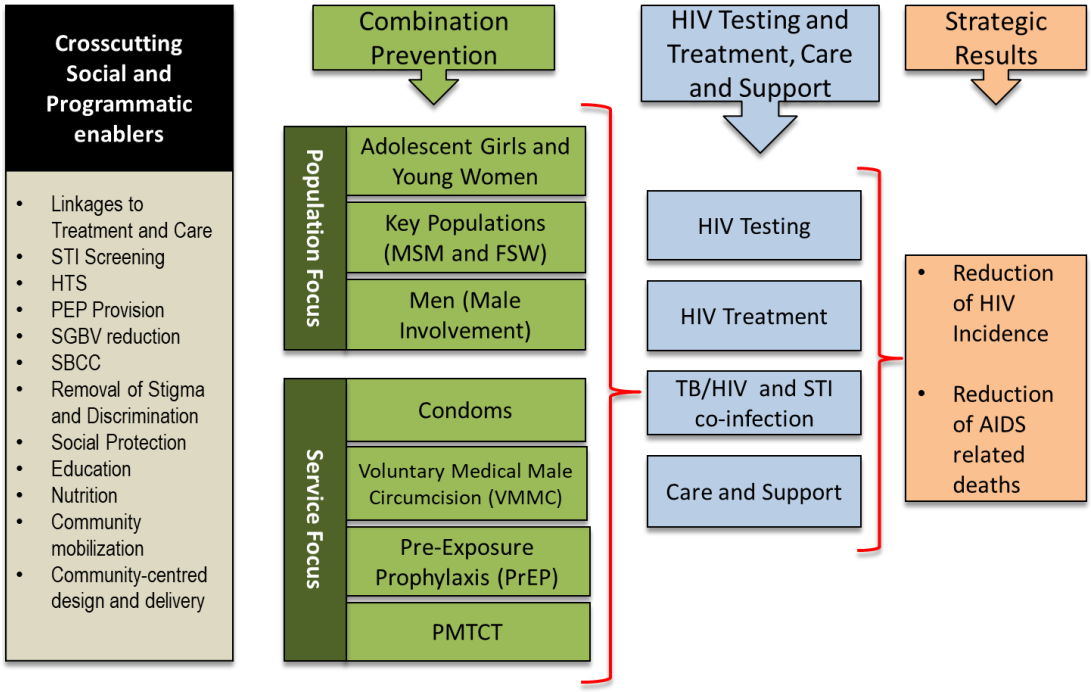
- *Firstly*, To accelerate and intensify targeted high impact interventions that will yield the desired results i.e. reduce new HIV infections and AIDS related deaths
- *Secondly,* To promote efficiency and effectiveness, strategic partnerships and meaningful participation by all stakeholders to ensure nobody is left behind by the response.
- *Thirdly,* To leverage resources (financial, technological, information, and human) to sustainably support the HIV multisectoral response.
- *Fourth:* To strengthen an enabling social, policy and legal environment necessary to support, the design and delivery of comprehensive services, with equitable access, uptake and utilisation.

These priorities and principles inform the **Conceptual Framework** of the NSF:

These priorities and principles inform the Conceptual Framework of the NSF. The Conceptual Framework for HIV illustrated below indicates that there are two main strategies to reducing AIDS related deaths and HIV incidence and these are Firstly, Scaling up Combination Prevention by focusing on the five pillars of prevention as well as PMTCT and Secondly, by scaling up Test and Treat. Social enablers including political commitment and advocacy, laws, legal policies, and practices, community engagement and mobilization, stigma reduction, use of mass media and local responses to change risk environment have all been identified. Additionally, programme enabler's range from community centred design and delivery, programme communication (to galvanise support for behaviour change programmes), procurement and supply chain management, gender equality and gender-based violence interventions, research and innovation in addition to engaging local policy decision makers.

[10] Assuming constant overall funding levels from 2017/18

Figure 4: Conceptual Framework of the NSF



2.1.4 Programmes Implementation Approach

The implementation of the NSF is multisectoral and decentralised, and will be premised primarily on the 'Fast-Track' approach to ending AIDS by 2030 through the implementation of the Combination Prevention Approach, the life cycle approach, Integration of HIV services in the health care and a multisectoral approach.

a) Using a Combination Prevention Approach

The implementation of the HIV prevention, treatment, care and support programmes will be premised on the combination prevention approach. Combination prevention is a term used to describe a mix of behavioural, structural and biomedical interventions targeting specific populations based on their needs to optimally mitigate the acquisition or transmission of HIV. These evidence-informed and human rights based interventions work together to achieve prevention and care outcomes[11]. The approach aims at ensuring effective synergies and complementarity between programmes and between specific interventions through a Combination Prevention lens looking at the social, bio-medical and structural drivers fuelling the spread of HIV and the strategic barriers that prevent access, uptake and utilisation of services.

b) Fast-track/Maintenance Approach

The NSF will use Investment Approach thinking to identify the populations, regions and sites of that will produce the highest coverage and impact results from intensified programming. In order to ensure adequate levels of service delivery across the country, populations and regions not classified as priority will be designated as receiving the maintenance approach, which entails essential coverage. This approach will make it possible to achieve the 90-90-90 targets in a sustainable manner.

[11] de Zalduondo, 2010, AIDS 2010, 24 (suppl 4):S70–S80

Whilst Fast-track approaches will ensure high intensity programmes in areas and among populations of highest burden/impact, a maintenance approach ensures that access to needed services is provided to the entire population.

c) The life-cycle Approach

The "Life Cycle" approach will ensure that the targeted populations receive appropriate services as they transit from infancy through childhood, adolescence to adulthood, taking into consideration their specific needs. The life cycle approach can also be used as a lens to better understand the complex dynamics of the HIV epidemic and the response. Innovations in data collection reveal how the risks of infection, the challenges of accessing services and the solutions to these challenges change at different stages of life and hence the adoption of the life cycle approach. Based on the insights revealed by the life-cycle approach, prevention and treatment interventions will be contextualised to meet individual needs.

d) HIV Mainstreaming

To expand the scope of the response, HIV will be mainstreamed in the development sectors' workplace wellness programmes (internal mainstreaming) and in their development projects (external mainstreaming). Internal mainstreaming will ensure that sectors provide HIV prevention, and treatment services to their employees including HIV testing services (HTS) and linkages to treatment and care, ensuring that all PLHIV are enrolled on ART. Sectors will be able to refer employees to other HIV prevention services such as pre-exposure prophylaxis (PrEP) and voluntary medical male circumcisions (VMMC). External mainstreaming will prevent development projects from fuelling the spread of HIV.

e) HIV integration in the Health Care System

Service providers and in particular Ministry of Health and Social Services (MoHSS) will provide the leadership necessary for the integration of HIV services within the mainstream health care including non-communicable diseases. Integration will not only improve service delivery efficiency, but also increase uptake and utilisation.

f) Integrating and implementing critical social and programmatic enablers, and developing synergies

Specific social and programmatic enablers have been addressed or infused in the relevant sections of the prioritised basic programmes. Stakeholders will be oriented on mainstreaming and implementing these critical enablers.

Section 3: Basic Programmes, Critical Enablers and Development Synergies

3.1 Overview

The NSF prioritised high impact programmes based on their efficacy. The prioritisation is also premised on the investment thinking and approach to the national response. The process of prioritisation has also considered regions and districts where the disease burden is highest. The primary objective is to accelerate prioritised HIV prevention and treatment programmes and services, and related social and programmatic enablers, and strengthening of development synergies with the relevant development sectors.

The following section outlines the priority combination prevention and treatment programmes that will be fast tracked during the period of the current NSF.

3.1.1 Combination Prevention

Combination HIV prevention approach will support implementation of biomedical, socio-behavioural, and structural interventions that are premised on human-rights, gender-sensitivity and are evidence-informed. Interventions will be contextualised to respond to local needs and specific population groups. This NSF prioritises the following prevention population based and service based interventions which reduces HIV susceptibility and transmission

Table 1: Combination Prevention Strategies

Population Based Interventions	Service Based Interventions
Adolescent Girls and Young Women	PMTCT
Prevention programmes for key populations – MSM and FSW	Condom distribution and promotion
Male Involvement	PrEP
	VMMC
Cross cutting: • STI prevention and Management • Post exposure prophylaxis (PEP) • Social Behaviour change communication (SBCC) • HIV testing Services	

The following social enablers that have been identified: political commitment and advocacy, laws, legal policies, and practices, community engagement and mobilization, stigma reduction, use of mass media and local responses to change risk environment. The programme enabler's range from community centred design and delivery, programme communication (to galvanise support for behaviour change programmes), procurement and supply chain management, gender equality and gender-based violence interventions, research and innovation in addition to engaging local policy decision makers.

3.1.2 Population–Based Targeted Interventions

There are several sub-population groups in Namibia that are at higher risk or vulnerable to HIV infections. These groups include - men who have sex with other men (MSM), female sex workers (FSW), transgender (TG) people, people injecting drugs (IDU), migrant and mobile populations. Among the most vulnerable groups include – adolescents, young women, youth in general, people with disability, orphans

and vulnerable children (OVC). This categorisation may also include people living with TB and malaria and people working in settings that facilitate TB and malaria transmission. The degree of risk or vulnerability varies from one sub population group to another.

The NSF has prioritised ***MSM, FSW, adolescent girls and young women*** and greater male involvement. The NSF will promote and support programmes that will prevent new HIV infections and reduce AIDS related deaths among these prioritised groups. Those diagnosed with HIV and or TB/HIV co-infection will be linked to treatment (ART), clinical care and support. In addition to the groups mentioned above, the NSF will also target men in general for a number of reasons. First, uptake of HIV services (HTS, VMMC, access to general health care, participation in PMTCT) is low. In some cases the lifestyles of some men greatly affect the quality of health of women including adolescent girls.

However all the other key populations (migrant and mobile populations, IDUs, Inmates), and vulnerable groups such as people with disability [PWD], orphans and vulnerable children [OVC] will continue receiving HIV services as usual. Service delivery will be premised on the Combination Prevention Approach.

3.1.2.1 Adolescent Girls and Young Women

Programme Objective

To reach 90% of AGYW and their sexual partners in high burden geographic locations with high impact HIV combination prevention and sexual reproductive health (SRH) interventions to reduce new HIV infections by 2022.

Target Population: The primary target population is adolescent girls aged 10–-24yrs. Secondary target populations include: Sexual partners, Parents, School Counsellors, community gatekeepers, legal practitioners, law enforcement and health care workers.

For this target population, NSF has prioritised and will focus on the following nine high burden regions and hot spots: - Kavango East, Kavango West, Zambezi, Ohangwena, Omusati, Khomas, Oshikoto, Otjozondjupa and Erongo Region.

Situation Analysis

According to UNAIDS, 3 out of 4 newly infected Adolescent girls are in Eastern and Southern Africa (ESA). This is of great concern and demands concerted efforts to address their vulnerability ranging from behavioural, biological and structural factors.

In Namibia, modelled estimates of new infections among 15-24 year females in Namibia show a decline from 2,406 in 2005 to 1,670 in 2015. The NDHS (2013) data show that HIV prevalence among AGYW increases with age particularly in the age group 20-24 years at 6.4% with 3% for age cohort 15-19%. The HIV prevalence among young women is about twice as high as that among young men in Kavango and Oshikoto and is nearly six times as high in Oshana.

For an effective response it is imperative to understand the major causes of their vulnerability to new HIV infections. Besides their biological vulnerability, structural and behavioural factors continue to put AGYW at risk. Fewer young women (5%) had sex before age 15 compared to young men (13%). However in subsequent years 42% of women and 57% of men age 18-19 reported that they had sexual intercourse before age 18 years and 18.6% were either pregnant and had begun childbearing. The national rate of

adolescent pregnancy is 19% (DHS 2013). Regional data shows disparities with the highest teenage pregnancy rates observed in Kunene (38.9%) and Omaheke (36.3%) and lowest at 9% in Oshana and 12.3% in Khomas. These adolescents end up dropping out of school early and find it difficult to re-enter the formal school system due to challenges such as the poor implementation of the learner pregnancy policy and the burden of being a mother and a student at the same time. There is no available data on comprehensive knowledge on HIV among adolescents aged 10-14, however comprehensive knowledge about AIDS is relatively low among adolescent girls (55.9%) and boys (51.4%) aged 15-19 years (NDHS 2013). Sexually transmitted infections (STIs) are twice as high among girls aged 15-19 at 10% as opposed to their male counterparts. Alcohol abuse rates are also estimated at 20-27% amongst young women and remain a concern. Pervasive harmful social and cultural practices continue to put young women at risk such as early marriages in some cultures. Thirty four percent (34%) women reported having experienced physical or sexual violence. The socio -economic climate where there is wide spread poverty and high unemployment rates among youth (27.29%) continue to increase young women's vulnerability. Additionally, low VMMC coverage and low uptake of HTS and Treatment services by their sexual partners significantly elevates their risk. Available data show limited uptake of sexual reproductive health and rights and HIV programmes by AGYW. 29% of females aged 15-19 have never tested for HIV. Condom use also remains low (56%) among women of the same age group compared to their male counterparts at 68%. Family planning coverage also remains low at 24%.

ARV coverage among adolescents is 74% among girls and 86% among boys. ART coverage is highest among girls age 10-14 (92%) among girls and 94% for boys. There is a sharp decline in the age 15-19 especially among girls at 61% and 76% among boys. Coverage further declines in the age 20-24 with 39% among females and 14% among males. The declining ART coverage with age and corresponding low HIV testing rates indicates challenges in initiation and retention among newly infected adolescents and young adults patients on ART as they transition into adulthood.[12] Viral suppression has improved and is estimated at 74% for girls and 70% for boys.

Table 2: AGYW - Gaps, Challenges and Strategies

Gaps/Challenge (Behavioural, Structural and Bio medical)	Strategies
• Early sexual debut • Intergeneration and transactional sex • High Teenage pregnancy rates • School drop outs due to pregnancies • Low comprehensive knowledge rates	• Conduct community and social mobilization campaigns • Strengthen Life skills and Comprehensive Sexuality Education (CSE) • Strengthen School retention and re-entry programmes for learner mothers • Accelerate implementation and compliance of the Learners Pregnancy Policy
• Age of testing consent (16years) whilst sexual debut is earlier • Physical/Sexual violence (34%) • Gender inequality • Negative social and cultural norms: Early child marriages practiced in some cultures	• Expedite implementation of the lowered age of consent of 14years Child Care and Protection Act and • Intensify GBV interventions and strategies • Strengthen economic empowerment (provide job opportunities and income generating activities for out of school youth)

[12] UNICEF Preliminary Report of Rapid Adolescent Assessment (2015)

• Limited engagement of parents and care givers • High unemployment rates and widespread poverty. • Limited economic empowerment opportunities for young women. • Inadequate reach of vulnerable girls with social protection services.	• Strengthen engagement with parents and community gatekeepers through intergenerational dialogues to address harmful cultural practices and negative social norms • Strengthen social protection services
• Low condom use • Low testing uptake • Not all adolescents (26%) living with HIV are on treatment. • PrEP not yet available • Limited post exposure prophylaxis (PEP) uptake • Low HPV immunisation coverage • Low coverage of adolescent friendly service (AFS • Low/limited SRH/HIV Integration coverage	• Scale up facility and community based SRHR and HIV integrated services • Accelerate capacity building of health workers, teachers, social workers, police workers and parents • Scale up teen clubs for ALHIV to improve adherence and retention in care . • Update guidelines, protocols, and policies in line with new evidence • Accelerate the implementation of PrEP • Conduct HPV immunisation campaigns and screen ALHIV for cervical cancer
Sexual Partners: • Poor health seeking behaviour (low ART ,low VMMC Low HTS uptake) • Gender norms that define masculinity and virility affect health behaviours and attitudes negatively	• Provide mentorship and peer education • Intensify SBCC campaigns to address low health seeking behaviours and negative gender norms • Strengthen community system. • Create access for more targeted HIV services- HTS, Treatment and VMMC

3.1.2.2 Male Involvement in the HIV/AIDS response

Programme Objective

To improve male participation and increased uptake and utilisation of HIV and AIDS services. Appropriate mix of evidence-based HIV prevention strategies will be scale up to increase coverage and improve intensity to achieve optimal public health impact

Target population: General population, men aged 10-49, mobile populations, sea-farers, migrant workers, incarcerated populations, uniformed officers and workers from male dominated sectors such as long-distance drivers.

Situation Analysis

The epidemic in Namibia has a gender bias with more women (16.9%) living with HIV and AIDS than men (10.9%). HIV prevalence is also higher in rural (15.0%) than urban (13.3%) areas. More women live in rural areas. Women are at a higher risk of HIV infection than men because of their biological, social and economic vulnerabilities. However, epidemiological and social data indicates that men are increasingly at risk and vulnerable to HIV and AIDS. Available evidence shows low rates of HIV testing, male circumcision, condom use, and comprehensive knowledge of HIV and enrolment on ART participation in PMTCT to couple counselling among men. Retention on ART is equally low. The low uptake of HIV services has significant impact on men's mortality and morbidity, especially those living with HIV and AIDS. Men are equally affected by negative socio-cultural norms. Men are equally the key drivers of multiple and concurrent partnerships (MCP), sex work, gender-based violence (GBV), and inter-generational sex among others[13].

Health systems have not adequately addressed the needs of men, which have negative impact on the health of both men and women. With the exception of a few targeted interventions (i.e. VMMC) for men, most programmes are of generic nature. Men are being left behind by the HIV response and are more likely to be lost to follow-up. In the wake of the HPTN 052 trial results, demonstrating 96% efficacy of prevention in discordant couples with earlier ART treatment initiation, engaging greater numbers of men with HIV in treatment could have important prevention benefits for women and girls, and for primary prevention of vertical transmission.

Integration of HIV prevention programmes into the workplace, and programs that offer peer education have potential to yield better health outcomes by engaging men in HIV testing, care, and treatment. To achieve better results and impact, HIV prevention tools, must be brought to scale. This means ensuring an appropriate mix of evidence-based HIV prevention strategies necessary to achieve sufficient coverage, intensity, and duration to have optimal public health impact

Table 3: Male Involvement - Gaps, Challenges and Strategies

Gaps and Challenges (Behavioural, Structural and Biomedical Interventions	Strategies
• Poor health seeking behaviours among men • Prevalence of intergenerational and transactional sex • Gender norms that define masculinity and virility affect health behaviours and attitudes • Social and cultural norms that make some communities tolerate and accept multiple concurrent partners. • Structural barriers blocking access to services	**3.1** Conduct Targeted HIV awareness and education interventions to improve knowledge on HIV and uptake of VMMC, HTS and ART services **3.2** Scale up of SBCC programs in hot spot areas- Encourage uptake of services and supporting pregnant partners **3.3** Conduct community mobilization and address the underlying social issues and change public policy related to gender norms **3.4** Support and implement intergenerational dialogue to identify and challenge negative social norms to address intergenerational and

[13] Mills EJ, Beyrer C, Birungi j, Dybul Mr (2012): Engaging Men in Prevention and Care for HIV/AIDS in AFric. PLoS Med 9(2): e1001167.doi:10.137/journal.pmed. 1001167

	transactional sex and multiple concurrent partnerships **3.5** Strengthen community leaders engagement and involvement in interventions that address and change negative social norms **3.6** Conduct interventions to identify and tackle structural barriers to uptake of services for different male populations.
• Health structures and services, that are men unfriendly and seem to be more inclined to women, limit timely health seeking among men • Job opportunities that are geared towards men and result in men being away from their families for long periods (e.g. truck drivers, construction, mining, uniformed services, etc.) • Alcohol and drug abuse	**3.7** Strengthen community systems for increased coverage of services for men at workplaces etc. Undertake acceptability studies on new prevention technologies suitable to cater for the needs of men **3.8** Reinforce compliance with existing laws and policies: i.e. limit the number of alcohol outlet /shebeens in residential areas; develop programs targeting
• Low HTS, PreP, VMMC and ART coverage	**3.9** Strengthen Scale up male-targeted HIV interventions such as HTS, PreP, VMMC, Condoms promotion and use. Offer HTS and link males diagnosed with HIV to treatment and care, to TB / (IPT/ CTX) treatment.

3.1.2.3 Men who have Sex with Men (MSM)

Programme Objective

To target MSM with high impact HIV testing; prevention, treatment and care interventions necessary to achieve the fast track targets i.e. 90-90-90 among the MSM by reaching them with combination prevention services by 2022.

Target population: Primary Target population: Men having sex with Men (MSM), Secondary target population: Law enforcement, health care workers, law makers

Situation Analysis

In 2014, Namibia conducted the Integrated Biological and Behavioural Surveillance (IBBS) Study among Men who have sex with other men (MSM). It is estimated that there are approximately 6500 MSM [14] in Namibia. However due to stigma and discrimination this study may not show a representative figure. Unprotected anal sex puts MSM at a higher risk of HIV infection. Some MSM are also known to be married or in heterosexual relationships, or are in single-sex incarceration environments or engage in transactional sex. These sexual practices have been found to serve as an epidemiological bridge for HIV transmission between different population groups. HIV transmission is often aggravated if STIs are present.

HIV prevalence amongst MSM varies from 10.2% in Keetmanshoop, 7.1% in Oshakati, 10.1% in Swakopmund/Walvis Bay and 20.9% in Windhoek. Each of these estimates, are above the conventional 5% threshold used to define a "key population" at elevated risk for HIV.[19] Prevalence in Windhoek exceeds national prevalence (14.3%) in adults. There is association between age and susceptibility, prevalence rate among those beyond 30 years was estimated at 30% where as MSM less than 20 years is 3%. (IBBS2014)

The vast majority of MSM are not engaged in HIV care or have ever been on ART (89.8%) in Windhoek, 88.2% in Oshakati, 84.9% in Walvis Bay/Swakopmund, and 77.3% in Keetmanshoop) [15]. Lack of awareness of HIV serostatus appears as a major barrier to accessing services and the greatest contributor to the low proportion of HIV positive MSM receiving ART. By 2015/16 only 23% of infected MSM were aware of their HIV positive status and among those diagnosed, 85% have received care. However, a review of epidemiological data[16] indicates that retention amongst MSM on ART is estimated at 100%. MSM also knows where to get a HIV test and more than 50% of identified MSMs had received a HIV test in 2015. Providing services to MSM remains a challenge, as societal attitude, norms and values do not affirm people of non-heterosexual identities or behaviours. In addition, the 1920 common law criminalises anal sex between two males. The patriarchal structure of Namibian society has also contributed to the strict definition of male and female identities and roles and expected behaviours that drive men with alternative sexual behaviours and identities underground and hard to reach with health services.

Disclosure of sexual orientation was associated with experiencing human rights abuses and discrimination of minorities including MSM was leading to poor mental health outcomes, which lead to diminish HIV treatment outcomes. (Zahn et all, 2013). IBBS has found that once the MSM has been initiated on treatment 100% are likely to be retained. However, there was a high rate of unknown positives.

[14] Draft IBBS, MSM Report, 2014
[15] Draft IBBS, MSM Report, 2014
[16] Synthesis of Namibia's AIDS Epidemic Based on Most Recent Epidemiological data 2015

Table 4: MSM Response - Gaps, Challenges and Strategies

Regional Gap/Challenge analysis (Behavioural/Structural/Biomedical)	Key Strategy
• Low uptake of HIV prevention programmes (including testing)	• Use of navigators and community health workers to establish linkage to prevention services • Collaboration with KP-led organizations for engagement of MSM • Health promotion of biomedical HIV prevention options in MSM friendly hotspots and community networks e.g. HIVST and PrEP • Accelerate provision of HTS using the mixed outreach models (community testing, mobile testing, HIV self-testing, testing with PrEP) • Use of navigators and community health workers to establish linkage to HTS • Use of index-case testing • Collaboration with KP-led organizations for HTS mobilization • Youth-friendly services for MSM • Sensitize teachers especially life skills and school-based counsellors on how to present sexual orientation and gender identity in the curriculum
High risk sexual behaviour amongst MSM that include • Multiple sexual partners, • Low and inconsistent use of condoms, • Intergenerational sex, etc.)	• Delivery of targeted prevention messaging for MSM • Intensify advocacy on consistent and correct use of condoms and lubricants among MSM • Promotion of VMMC • Diagnosis and treatment of STIs • PrEP
Challenges to linkage and adherence to ART	• Use of navigators and community health workers to actively link HIV-positive MSMs to ART services • Provide ART services in MSM testing facilities • Strengthen treatment and adherence and tracing services for MSM through navigators and community health workers • Establish CBART groups for MSM • Establish adherence support groups for MSM
Lack of comprehensive health care package for MSM	• Integration of sexually-transmitted infections (STI) and sexual reproductive health (SRH) services with HIV services • Address the HIV-HPV co-infection • Address non-communicable diseases (NCD) in MSM • Provide psychosocial support and mental health services for MSM
Lack of standardized health education materials for MSM and providers	• Development of standardized education materials for MSM • Training and capacity building of community service providers and health care workers, and MSM on MSM issues
Inadequate comprehensive knowledge and data on MSM	• Conduct surveys to assess MSM population, HIV prevalence, and engagement into services • Conduct mapping and get an overview of MSM (surveys, studies of MSM hotspots)

	• Strengthen national M&E system on the collection of data for MSMs
Inadequate policy and legal environment to support programming and service delivery for MSMs	• Strengthen policy level interventions (a policy on key populations) and advocate for legal review and reform
Prevalence of stigma, discrimination and social exclusion	• Development information, educational communication materials for MSM • Undertake capacity building and sensitization of health care workers on MSM
Human rights violation and social justice issues	• Establish safe spaces (i.e. shelters) for victims of abuse • Capacity building of MSM community on human rights advocacy • Document human rights violations for evidence based mitigating interventions • Promote and advocate for review and reform of structural barriers to health seeking behaviour, legal and social justice, and social protection

3.1.2.4 Female Sex workers (FSW)

Programme Objective

To target FSW with high impact HIV testing and prevention; treatment and care interventions necessary to achieve 90-90-90 fast track targets by 2022.

Target population: Primary Target populations: Female Sex Workers and Secondary Target population: law enforcement, law makers and health care workers

Situation Analysis

In 2012/13, Namibia conducted the Integrated Biological and Behavioural Surveillance (IBBS) Study among female sex workers.[17] Most female sex workers were found to be single women below 35 years and have never been married. In Katima Mulilo 46% of FSW were between 18-24 years. Most sex workers had completed secondary education, and more than two-thirds were unemployed (2014/15). It was also found that some FSW also had stable relationships with a male partner.

While there is no specific law that criminalizes sex work, the practice is considered immoral and hence illegal[18]. Criminal laws related to sex work are often covered under sexual offences, vagrancy, public order offences and human tracking offences. The criminal acts related to sex work include, living off the earnings of sex work, soliciting and the use of premises for sex work.[19] In recent years there has been an increase of young girls engaging in sex work. Most of the young girls engaging in sex work come from poor family backgrounds, dysfunctional homes while others have been victims of sexual abuse. Anecdotal information also suggests that some men are selling sex. Data from the IBBS (2015) show that clients of sex workers, and their sexual partners including spouses are at higher risk of HIV infection.

[17] Draft IBBS, FSW Report, 2015
[18] MOHSS 2006, Progress report on the Third Medium Term Plan on HIV/AIDS
[19] International HIV/AIDS Alliance and Commonwealth HIV/AIDS Action Group, Enabling Legal Environments for Effective HIV Responses: A Leadership Challenge for the Commonwealth 2010, p.22

Female sex workers (FSW) are 3.5 times more likely to be living with HIV than other women in the general population[20]. HIV prevalence amongst FSW was estimated to be 52.3% in Katima Mulilo, 31.0% in Oshikango, 37.3% in Swakopmund/Walvis Bay, and 39.3% in Windhoek[21]. These rates are above the national HIV prevalence rates, when compared to women of reproductive age. Key risk factors identified by the IBBSS were, amongst others, age, number of clients, abuse/assault, Socio-economic Status, and condom use at last sex. The cascade of HIV care is weak for SW because significant number of SW are unaware they are infected with HIV. However, retention in care was more than 70% in all the four study sites.

Sex workers are often physically or sexually abused. In most cases perpetrators of sexual abuse are men including spouses, intimate friends or associates or relatives. FSW are unable to negotiate for safe sex due to gender inequality, or because men prefer to pay more money for un-protected sex. Sexual abuse cases amongst FSW are underreported for fear of facing criminal charges themselves.

The NDHS indicates that 67% of men reported using a condom at their last paid sexual intercourse with a FSW. Consistent condom use varies from one region to another amongst FSW. 80% of FSW in 2012/13 indicated that they used a condom the last time they had sexual intercourse with a client sex partner. The percentage of FSW who reported diagnosis or symptoms of STI during 2012/13 ranged from 15.3% in Oshikango to 35.6% in Windhoek and those who sought treatment ranged from 72.8% in Windhoek to 92.2% in Oshikango.

Almost all FSW knew where to get an HIV test. However data from the IBBS (2014) study shows that only 53% of infected FSW were diagnosed. Among those diagnosed, 95% have ever received care. 72% of FSW diagnosed are enrolled on ART. The level of retention amongst FSW on ART is high (95%). It is also evident that a focus on sex workers alone is not sufficient to address the HIV and AIDS challenges associated with sex work. Available evidence establishes the need to target clients of sex workers with prevention services, including linking them to HTS, providing condoms and lubricants, and referring them to other services such as treatment of STIs, SRH and PMTCT.

There are various factors including poverty, that have led to women engaging in sex work.. Sex workers are financially depending on their clients and this may come with a price. For example, with the power dynamics the female sex workers are more than often not able to negotiate for condom use, hence risking unwanted pregnancy, and STI and HIV infections.

Table 5: FSW - Gaps, Challenges and Strategies

Gap/Challenge (Behavioural/Structural/Biomedical)	Key Strategy
Low uptake of HIV prevention programmes amongst FSW including Testing	• Use of navigators and community health workers to establish linkage to prevention services • Intensify collaboration with KP-led organizations for engagement of FSW

[20] The Namibia Ministry of Health and Social Services (MoHSS) and ICF International. 2014. The Namibia Demograp[20] ART PMIS Quarterly Feedback Report for the Period April to June 2016

[20] Spectrum Policy Modeling System, Version 5.43 (2016); Namibia model May 2016 - Estimated

hic and Health Survey 2013. Windhoek, Namibia, and Rockville, Maryland, USA: MoHSS and ICF International

[21] Namibia Men's Health Study: Integrated Biological and Behavioural Surveillance Studies among Men who have Sex with Men in Namibia, September, 2014

	• Accelerate provision of HTS using the mixed outreach models (community testing, mobile testing, HIV self-testing, testing with PrEP) • Use of index-case testing • Strengthen collaboration with KP-led organizations for HTS mobilization
High risk sexual behaviour amongst FSW (multiple sexual partners, low and inconsistent use of condoms, intergenerational sex, etc.)	• Delivery of targeted prevention messaging for FSW • Intensify advocacy on consistent and correct use of condoms and lubricants among FSW • Accelerate provision of PrEP
Challenges to linkage, adherence and retention on ART	• Strengthen treatment, adherence and tracing services for FSWs through navigators and community health workers • Establish adherence support groups for FSWs • Accelerate provision of ART services in FSW-friendly clinics
Lack of standardized health education materials for FSW and providers	• Develop standardized education materials for FSW • Conduct training and capacity building of community service providers and health care workers, and FSW on FSW issues
Lack off targeted services for adolescents and young FSW	• Provide youth-friendly services for FSW • Strengthen linkages to FSW organizations for support
Inadequate comprehensive knowledge and data on FSW	• Conduct surveys to assess FSW population, HIV prevalence, and engagement into services • Conduct mapping and get an overview of FSW (surveys, studies of FSW hotspots) • Strengthen national M&E system on the collection of data for FSWs
Inadequate policy and legal environment to support programming and service delivery for FSWs	• Strengthen policy level interventions (a policy on key populations)
Prevalence of stigma, discrimination and social exclusion	• Support development of information, educational communication materials for FSW • Intensify capacity building and sensitization of health care workers on FSW
Human rights violation and social justice issues	• Support Provision of safe space for victims of abuse • Intensify capacity building of FSW community on resources available for advocacy of human rights

3.2 Service Based Prevention Interventions

In this section high impact HIV primary prevention service based interventions are prioritised and they include the following programmes; Condom Promotion and Distribution, Voluntary Medical Male Circumcision, Pre- Exposure Prophylaxis and Prevention of Mother to Child Transmission.

3.2.1 Condom Promotion and Distribution

Programme Objective

The objective is to strengthen condom programming, promotion and distribution of both male and female condoms, and promote consistent and correct use. During the implementation of the NSF, it is anticipated that advocacy will be intensified to increase the use of condoms with the last sexual partner at high risk sex from 74.7% (2013) to 90% by 2022.

Target population: General population sexually active individuals aged 15-49 years.

Situation Analysis

Namibia's Condom Program distributes over 30 million free male and female condoms annually. Additional condoms are distributed through the commercial market and limited social marketing efforts. Trends observed across three Demographic and Health Surveys indicate a high level of acceptance and utilization of male condoms, and to a less degree of female condoms. However disparities exist between urban and rural settings and among use by priority populations. Limited country-specific information exists regarding practices, utilization rates and on-going misconceptions.

Table 6. Condom use among 15 – 24 Year – Male and Female

15 – 24 Years Age Band	Condom use at last higher risk sex (with a non-marital, non-cohabiting partner) [Women], %	Condom use at last higher risk sex (with a non-marital, non-cohabiting partner) [Men], %	Young women using a condom at last sexual intercourse, %	Young men using a condom at last sexual intercourse, %
2013 NDHS	67.5	82	67.8	79.4
2006-07 NDHS	64.2	81.1	73.7	81.8
2000N DHS	48	69.4	55.4	73.9

The Ministry of Health and Social Services provides condom procurement and distribution services to support broad availability at health facility and community level using a network of Condom Logistics Officers. The MOHSS partners with the private sector and non-governmental organizations to extend condom distribution to-hard-to reach populations. Namibia systematically conducts quality control procedures on batches of condom commodities. A national HIV commodity quantification was conducted for a period of 2012 – 2016. However, reliable data on male condom consumption was not available. Dual forecasting of STI prevention and Family Planning needs of Namibians was incorporated. As a result the total forecasted need for 15 – 59 year old males and females reporting the use of male condom as a primary method of contraception was 37 million units in 2016. Forecasting of female condoms and lubricants is not available.

Condom promotion and distribution at health facilities will continue to be integrated with other health services such as sexual and reproductive health (SRH), VMMC, PMTCT, HTS, and maternal, New-born and Child Health services (MNCH). Stock rationing is reported due to logistics management. Condoms are also available in the community in such places as bars, cars washes and at the work place. Condom dispensers have been located in different places that are easily accessible. Distribution of condoms in primary and secondary schools, and in correctional facilities is currently not allowed.

During the operationalization of the NSF condoms will be distributed through multiple channels including the public and private sector, and CSO organisations. Condom outlets will be increased and placed in user-friendly locations for key populations, adolescent and young people to improve access. The condom self-dispersers used to access free condoms and the condom vending machines used to dispense condoms for sale will be increased and placed in strategic and convenient locations. The MoHSS will lead efforts to reinvigorate the social marketing of condoms and will promote the expansion of new outlets in strategic locations such as bars, sports and social clubs.

Special condom branding will be undertaken to encourage uptake among adolescents and youth, and uniformed forces. Government will establish strategic partnerships with the private and CSO sectors as

part of the public-private partnerships (PPP) to accelerate condom promotion and distribution. Similarly targeted interventions will be implemented to increase condom awareness and knowledge.

To a large extent the success of the condom programme will depend on availability, accessibility and acceptability of condoms by both men and women. However this will also depend on the extent the communities are mobilised and engaged, the degree of social change, availability, implementation and compliance with enabling policies and legislations, and an effective supply chain management to ensure sustained supply of condoms. Condom promotion and distribution will also be integrated with other health services such as sexual and reproductive health (SRH), VMMC, PMTCT, HTS, and maternal, new-born and Child Health services (MNCH).

Table 7: Condom Response - Gaps, Challenges and Strategies

Gap/Challenge: (Behavioural/ Structural/ Biomedical)	Key Strategy
Inadequate monitoring of correct and consistent use of condoms Limited acceptability or utilization of female condom by both women and men. Limited targeted programming for high risk populations	Strengthen condom monitoring systems Support operational research anchored in an effective HIV research agenda Finalise condom provision strategy especially for high risk populations
Limited social marketing of both male and female condoms	Establish and maintain a functional PPPs for condom promotion Support targeted social marketing
Gaps in supply chain Limited social marketing	Strengthen supply chain including utilisation of private sector supply chains
Inadequate levels of behaviour change, that compromises correct consistent use of condoms.	Strengthen condom integration with other health care and social services

3.2.2 Voluntary Medical Male Circumcision (VMMC)

Programme Objective / strategic orientation

To conduct 300,000 Male Circumcisions among HIV negative males to reach saturation of 80%.

Target populations: HIV negative males aged 10-49 years. Additional priority for 10-29 years.

Situation Analysis

VMMC is a highly effective HIV prevention intervention that has the potential to reduce the risk of female to male transmission by at least 60%. Male circumcision also reduces the probability of sexually transmitted infections (STIs), particularly ulcerative STIs, including herpes and syphilis; and of penile cancer.[22] According to NDHS 2013, no region has reached the target of 80% MC prevalence aimed for in the Namibian VMMC strategy and implementation plan. Based on the epidemiologic data analysis of low male circumcision prevalence and high HIV prevalence by region, Namibia's has identified the following priority regions for accelerated VMMC programming. These regions are -Zambezi, Kavango East, Kavango West, Khomas, Ohangwena, Omusati, Oshana, Oshikoto, identified hot-spots

VMMC impact modelling using the Decision Makers Program Planning Tool 2.0 conducted by the MoHSS in 2016 estimated that 54 circumcisions could avert one new HIV infection among males 15 – 25 year olds. Analysis indicates that a greater focus on ages 15–29 years can achieve the most immediate impact on HIV incidence and that introduction of early infant circumcision, estimated at fifty percent (50%), the cost of adult circumcision, increases sustainability and reduces total costs of meeting targets.

[22]Tobian AAR et al. 2009. Male circumcision for the prevention of HSV-2 and HPV infections and syphilis. *New England Journal of Medicine* 360(13): 1298–1309. http://www.nejm.org/doi/full/10.1056/NEJMoa0802556.

By 2013, 25.5% of men aged 15-49 self-reported being circumcised (NDHS 2013) and circumcision rates stood at 30.0% among men living in urban areas compared to 19.7% in rural areas. Omaheke had the highest rate (48.2%) of male circumcision, with Ohangwena reporting the lowest rates (12.2%). In terms of age group circumcision, prevalence was highest among men aged 40-49 years (30.3%), followed by those aged 25-29 years (27.8%) and 30-39 years (27.4%). A circumcision rate among male adolescents 15-19 years was reported at 21.0% and at 22.8% for young adults 20-24 years.

According to NDHS (2013) approximately 80.4% of men aged 15-49 years believe that there are benefits to male circumcision compared to adolescents 15-19 years (79.1%), and young adults 20-24 years (84.3%). Among men aged 15-64, 56% believe that male circumcision can protect against HIV infection, while 54% believe that it protects against sexually transmitted infections. Eighty percent (80%) of men aged 15-49 agree that they would have their babies circumcised.

VMMC has been rolled out to health facilities across the country. The NDHS 2013 show that 46% of circumcisions were done by a professional health worker, while 47% were conducted by traditional practitioner or a family friend. Forty three percent (43%) of circumcisions occurred in health facilities while 23% took place at the client's home and 10% took place at the residence of a health worker or a ritual site. Only 8% took place in other undesignated places

The VMMC program coverage increased in the last two years (2015-2017). Program data reveal that between 2010 and March 2017 program a cumulative total of 64 551 men were circumcised through the national VMMC program. Between 1% and 3% of men whom got circumcised in the program between 2014 and 2016 were reported as HIV-positive.

Despite achievements to date there is a significant unmet need for VMMC in all regions of Namibia. While demand for VMMC has grown, utilization rates remains a concern. Early Infant Medical Circumcision (EIMC)has not yet been scaled up as a public health programme and strategic planning for introduction of EIMC in public health facilities will be conducted during this NSF period. During community mobilisation and demand creation efforts, all people eligible for VMMC will be adequately counselled, informed and given the choice to make informed voluntary decisions. Men who will be diagnosed with HIV will be linked to treatment and care. Linkage to treatment and care is strategically important as it will ensure (i) the health of individual HIV-positive men (ii) reducing the risk of HIV-transmission to their female sexual partners as a result of effective ART. In addition HIV-negative men in VMMC settings who are assessed to be at substantial risk of HIV acquisition (e.g. HIV-negative men in sero-discordant relationships) will be informed and linked to other high impact HIV preventive interventions such as PrEP. Advocacy will be intensified to reduce stigma and discrimination and help to galvanise increased support for VMMC.

Table 8: VMMC - Gaps, Challenges and Strategies

Gap/Challenge:(Behavioural/ Structural/ Biomedical)	**Key Strategy**
Inadequate demand creation Social cultural beliefs that act as barriers to VMMC	Conduct focused advocacy and communication campaigns improve VMMC uptake Conduct community dialogues to address social norms and cultural barriers that act as barriers to VMMC.
Limited dedicated staff Supply chain challenges experienced	Accelerate task shifting for VMMC to increase the supply capacity for service provision

	Strengthen Supply Chain
Low uptake of VMMC Inadequate VMMC coverage in all regions. Inadequate targeting of male population groups at high risk of HIV infection. Inadequate linkage to HIV care and treatment services for men identified as HIV-positive in VMMC settings	Scale up VMMC services at health facilities and communities Improve Private Sector Partnership Enhance linkage to immediate treatment and care services for those men that are tested HIV positive Introduce new MC technologies as they become available Ensure Integration of services with other prevention programmes Continue to evaluate progress and develop updated strategies to increase uptake of VMMC

3.2.3 Pre-Exposure Prophylaxis (PrEP)

Programme Strategic Objective

To accelerate the provision of PrEP to reach 2,500 people at substantial risk of acquiring HIV by 2022.

Target population: HIV negative people at substantial risk of acquiring HIV including sero- discordant couples, MSM, FSW and Adolescent Girls and Young women (AGYW).

Situation Analysis

Oral pre-exposure prophylaxis of HIV (PrEP) is the daily use of ARV drugs by HIV-uninfected people to block the acquisition of HIV. Pre-exposure prophylaxis (PrEP) is now widely accepted as an effective HIV prevention strategy. Clinical trials and demonstrations have been carried out in several parts of Africa to develop feasible models for delivery of oral PrEP especially to populations at substantial risk of HIV acquisition. Apart from the provision of ARV, other products such as including ARV-based long-acting injectables, impregnated vaginal rings, patches and oral/anal gels are currently under clinical trial. During the implementation of NSF additional PrEP technologies are expected to emerge and will be put in use during the period of the NSF.

In Namibia, the Ministry of Health and Social Services (MoHSS) began laying the foundation for the introduction of new and innovative ARV-based prevention methods as they become available during the NSF in 2016 by reviewing the national ART Guidelines to include the delivery of oral PrEP to populations at substantial risk. Civil society held a stakeholders meeting in 2016 to sensitize themselves to PrEP evidence and service delivery models. MoHSS conducted an external study tour to gain further understanding of PrEP service delivery to populations at substantial risk. Policies, procedures and quality standards and M&E systems need to be developed and routinely revised by the government to ensure develop appropriate procedures and regulations in the use of PrEP.

The package of services for PrEP shall be offered as part of the “combination prevention” package that includes HIV testing services, provision of male and female condoms, lubricants, ART for HIV+ sero discordant couples, VMMC, and STI prevention.

Pre-exposure prophylaxis for pregnant and breastfeeding women: Oral pre-exposure prophylaxis (PrEP) will be used as an additional HIV prevention option for pregnant and breastfeeding women. Monitoring should be intensified to monitor potential adverse effects. Pregnant and breastfeeding women within serodiscordant couples, where the male partner is living with HIV should consider PrEP in addition to ART for the male partner until viral suppression is achieved. Available evidence (WHO 2012) shows that preventing HIV infection during pregnancy and breastfeeding has important implications for transmission to the child because women who seroconvert during pregnancy or breastfeeding are 18% and 27% likely to transmit the virus to their unborn child, respectively.

Table 9: PrEP - Gaps, Challenges and Strategies

Gap/Challenges (Behavioural ,structural and biomedical)	Key strategy
PrEP as a new technology not known by target populations	Intensify awareness and education on PrEP, especially with regard to eligibility criteria and client literacy targeted campaigns
PrEP provision as part of a comprehensive package for those who are at substantial risk not available	Scale up PrEP services to populations at substantial risk through state health facilities and collaboration with non-governmental organisations working with hard to reach key populations
Service providers are not fully oriented on the PreP provisions in the 2015 5th edition of the National ART guidelines for PrEP,	• Orient service providers on the 2016 ART guidelines (facility based and community based facilities). • Encourage and strengthen technical partnerships with other domestic or international organisations/ institutions that have experience with PrEP services as part of an on-going learning process
Limited human and financial resources to scale up PrEP	Continue resource mobilisation efforts
Limited country specific evidence on feasibility.	Conduct feasibility studies among target populations.
Lack of Standard Operating Procedures (SOPs and M&E or adherence retention and Quality Improvement mechanisms) in place	Develop SOP, M&E and Quality Improvement systems for tracking PrEP uptake

3.2.4 Prevention of Mother to Child Transmission (PMTCT)

Programme Objective

To eliminate mother to child transmission of HIV by 2022, and improve child survival and keep mothers alive.

Situation Analysis

The PMTCT implementation strategies are premised on the four (4) prongs shown in the table below.

Table 10: Components of a comprehensive approach to PMTCT

Component	Target Population	Why the Focus on the prong
Prong 1: Primary prevention of HIV infection	Sexually active women and their partners	To prevent new HIV and STI infections
Prong 2: Address the family planning unmet needs of women	HIV infected women	To address the long-term family planning needs of women living with HIV and prevent un-intended pregnancies
Prong 3: Prevention of HIV transmission from women infected with HIV	HIV infected women and their exposed infants	To eliminate MTCT of HIV and keep mothers alive. Diagnosed HIV+ women will be linked to treatment (enrolled on ART) care and support, infants receive ART prophylaxis
Prong 4: Treatment, care and support for women infected with HIV, their infants and partners	HIV infected women, their children and families	Improve retention and adherence to care and treatment along the continuum of care through health facility and community –based care and support,

Namibia PMTCT programme has aligned its guidelines to the 2013 and 2015 WHO recommendations[23]. The National Strategy for the Elimination of MTCT offers a package of services that include: maternal HIV counselling and testing, early infant diagnosis (EID); ARVs to prevent MTCT and for the life-long health of the mothers, provision of counselling and support for safe infant feeding practices; family planning, prophylaxis for opportunistic infections, and referral to other services such as sexual and reproductive health (SRH).

HIV prevalence among pregnant women increased from 4.2% in 1992 to reach a peak of 22.5% in 2002 before declining to 19.7% in 2002, 18.8% in 2008, 16.9% in 2014 and 17.2% in 2016. In 2016, HIV prevalence was more than national average in 17 districts - the highest was in Katima Mulilo (33%) and below national average in 21 districts with Opuwo (5.2%) was lowest. HIV prevalence was highest among women age 35-39 years (32.3%) and lowest among women age 15-19 years (5.7%) followed by women age 20-24 years (10.2%)[24]. NDHS 2013 showed that 45% of partners of ANC clients were tested for HIV during ANC visits, ranging from 31.2% in Kavango to 57.3% in Oshikoto.

The overall MTCT rate was estimated at 4.1% and 1.9% at six weeks in 2016. Pre-elimination service coverage targets[25] have been achieved at national and regional levels with the exception of HTC in Omaheke (HTC 84.5%), Otjozondjupa (HTC 87.3%) and ART for PMTCT in Oshikoto (ART 89.1%),

[23] WHO, 2013: Cconsolidated Guidelines on the "Use of ARV Drugs for Treating and Preventing HIV Infections
[24] Surveillance Report of the National HIV Sentinel Survey, 2016
[25] Pre-elimination service coverage – 1st ANC 90%, HTC at 1st ANC 90%, PMTCT -ART 90%

Erongo (85.1%) and Kunene (58.6%) regions[26]. However, achieving required case rates[27] for EMTCT remains a challenge due to high HIV prevalence rates.

In 2016, 75% of all HIV positive pregnant women knew their HIV positive status before 1st ANC visit, ranging from 75% of adolescent and young pregnant women 15-24 years to 90% of those aged 25-49[28]. According to national HIV sentinel survey report (2016), 62.5% of all HIV- positive women were already on ART by their first ANC with age variations from only 25% of HIV positive pregnant women aged 15-19 to 89% of 40-49 years old.

Coverage of early infant diagnosis (EID) of HIV-exposed infants using DNA PCR was estimated at 88% in 2014. However, testing coverage at recommended 6-8 weeks was lower than 80%. New paediatric infections declined by 75.5% from 1,521 in 2010 to 372 in 2015. It is further estimated that AIDS related deaths among children (0-4 years) also declined by 73.9% to 152 in 2015.

Breastfeeding is almost universal, with 96% ever breastfed (NDHS 2013) and exclusive breastfeeding in the first 6 months in the general population increased from 23.9% in 2006-7 to 49% in 2013.

The total fertility rate is 3.6 children per women, median age at first birth among women aged 15-49 is 21.6 years and 19% of young women start child bearing at the age of 15-19. Fifty percent (50%) of all women in Namibia are using a modern contraceptive method. However, 12% of women have unmet need for contraception (8% for spacing and 4% for limiting births) and 10% of births are unwanted.

Prevention of mother to child Transmission of HIV (PMTCT) is a vital component of the prevention continuum. Mother to child transmission (MTCT) rate declined from 23.71% in 2005 to 4.1% in 2015, with HTC and ART coverage for PMTCT at 95% by 2016. MTCT rate at six weeks dropped from 13.28% (2005) to less than 2% in 2015. HTC coverage of pregnant women has increased to more than 95% and that treatment of HIV positive women is estimated to be more than 95%. The percentage of women attending ANC, tested for HIV test, received results and disclosed their status to their partners stood at 87% (DHS2013). 62.5% of all HIV- positive women were already on ART by their first ANC (National HIV sentinel survey 2016). Approximately 97% (NDHS 2013) of pregnant women attending antenatal care (ANC) reported receiving care from a skilled provider in 2013. Programme data showed that 15.3% pregnant women attending ANC in 2015, were 15-19 years and 0.5% were below 15 years. It is further estimated that AIDS related deaths among children (0-4 years) declined by 73.9% from 581 in 2010 to 152 in 2015.

Effective implementation of PMTCT is complemented by a set of cross cutting enablers such as community mobilisation, adequate numbers of skilled and experienced human resources, appropriate health (facility & community) systems, sustainable financing, and effective monitoring and evaluation systems.

Table 11: PMTCT - Gaps, Challenges and Strategies

Target Groups	Gap/Challenges	Key strategy
Sexually active women and their partners	Missed opportunities for access to HTC especially for adolescent girls and young women due to	• Intensify IEC and community mobilisation to increase demand and support for HIV in context of SRH and PMTCT services • Promote couple counselling and empower

[26] PMTCT evaluation Report 2016
[27] Case rate for EMTCT: ANC HIV prevalence X MTCT rate X 10
[28] 2016 programme data

	limited integration of PMTCT in family planning (FP) and HIV/STI services	couples to disclose their HIV status, mobilise and engagement men in PMTCT and MNCH. • Integration of HIV and SRHR services (FP and HIV/STIs).
All pregnant & breastfeeding women	Re-testing of previously HIV negative women (pregnant, breastfeeding) not always taking place at recommended intervals.	Conduct routine and targeted PITC services for pregnant and breastfeeding women including retesting of previously negative women at recommend intervals.
HIV infected pregnant and breastfeeding women	Unmet need for family planning	Integration of HIV and SRHR services (FP and STIs).
	Access to ART for PMTCT at PHC clinics	Initiate and manage lifelong ART for HIV positive pregnant and breastfeeding women
	Viral load assessment among pregnant and breastfeeding women on ART	Decentralization and maintenance of quality ART laboratory services (Refer to RSSH)
	Follow up, retention; adherence and viral load suppression	Strengthen monitoring and patient tracking system, including use of unique ID for the mother and the baby for cohort analysis to measure retention, uptake of interventions and final HIV outcomes in the PMTCT programme.
HIV exposed infants	Access to ARV and other prophylaxes	Ensure availability of ARVs and other infant prophylaxes
	Access to counselling and support for appropriate infant feeding	Ensure access to counselling and support for appropriate infant feeding options in context of maternal HIV infection
	Access to EID services	Intensify facility based early infant diagnosis and explores modalities to expand access beyond facilities
	Inadequate follow up, retention and retesting of HIV exposed infants to determine final outcomes	Implement systematic follow-up and care strategies of mother-infant pairs using facility and community-based systems
Male partners of pregnant and breastfeeding women	Limited male participation in PMTCT, especially with attendance to ANC or couple testing.	Implement strategies that promote couple counselling in the context of PMTCT/MNCH and empower couples to disclose their HIV status
All PMTCT Clients	Weak M&E Systems	• Strengthen monitoring and patient tracking system, including use of unique ID for the mother and the baby for cohort analysis to measure retention, uptake of interventions and final HIV outcomes in the PMTCT programme. • Regular PMTCT data reviews at all levels

	Human resources shortage	• Address human capacity building needs for health care providers (Training, Mentorship & supervision) • Integration of PMTCT in pre-service and in-service trainings for health professionals
	Limited IEC on PMTCT	Intensify IEC and community mobilisation to increase demand, adherence, retention and support for PMTCT
	Coordination & Partnerships	Strengthen strategic partnerships at all levels of health system between the public, private and CSO sectors.

3.3 Treatment and Clinical Care and Support

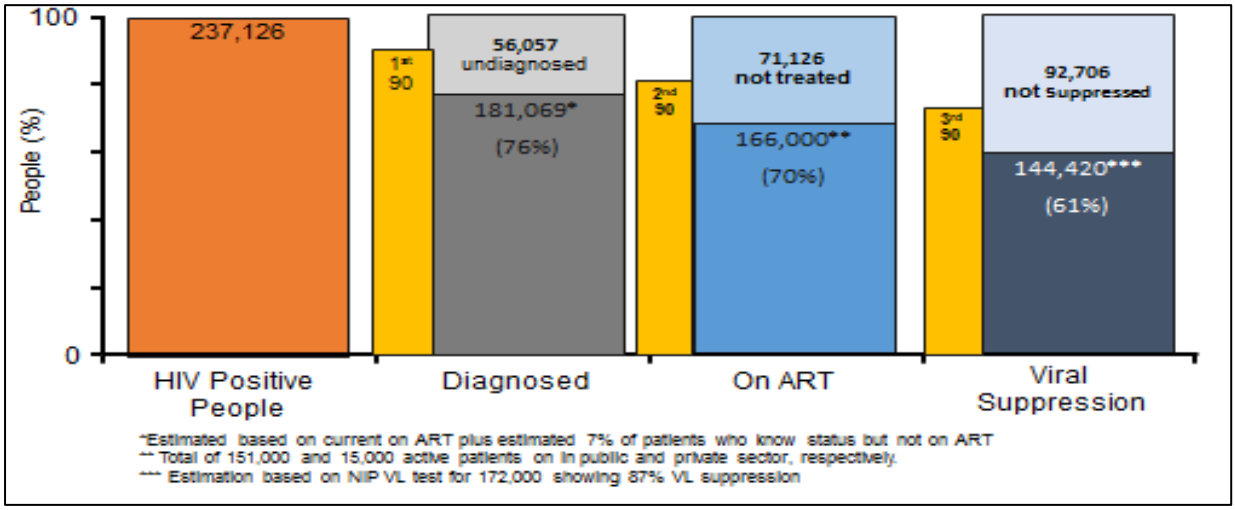
Overall Programme Objective

To ensure that at least 73% of all PLHIV achieve viral suppression by 2022

Basic Programme Overview

This programme component aims to improve the health of PLHIV by reducing morbidity and mortality. The programme is aligned to the 90-90-90 Fast Track Strategy with the aim of achieving the 2020 targets and strengthening national efforts to end AIDS by 2030. To achieve the 90-90-90 targets at least 90% of all PLHIV should be diagnosed, at least 90% of those diagnosed should be put on ART and at least 90% of those on ART should have maximal viral load suppression by 2022. The figure below illustrates the progress (by September 2016) made in the implementation of the Fast track strategy

Figure 5: Progress in Fast Track Strategy Implementation



The figure above shows that by September 2016 an estimated 76% of PLHIV were diagnosed, 70% of those diagnosed were on treatment and an estimated 61% of ALL PLHIV in had viral load suppression. The gaps that exist in the cascade are largely due to the PLHIV who do not yet know their HIV status. Once PLHIV know their HIV status they are being put on ART and for those PLHIV that are on ART; the majority (87%) are achieving viral load suppression.

3.3.1 HIV Testing Services (HTS)

Programme Objective

To ensure that 90% of PLHIV are diagnosed by 2022

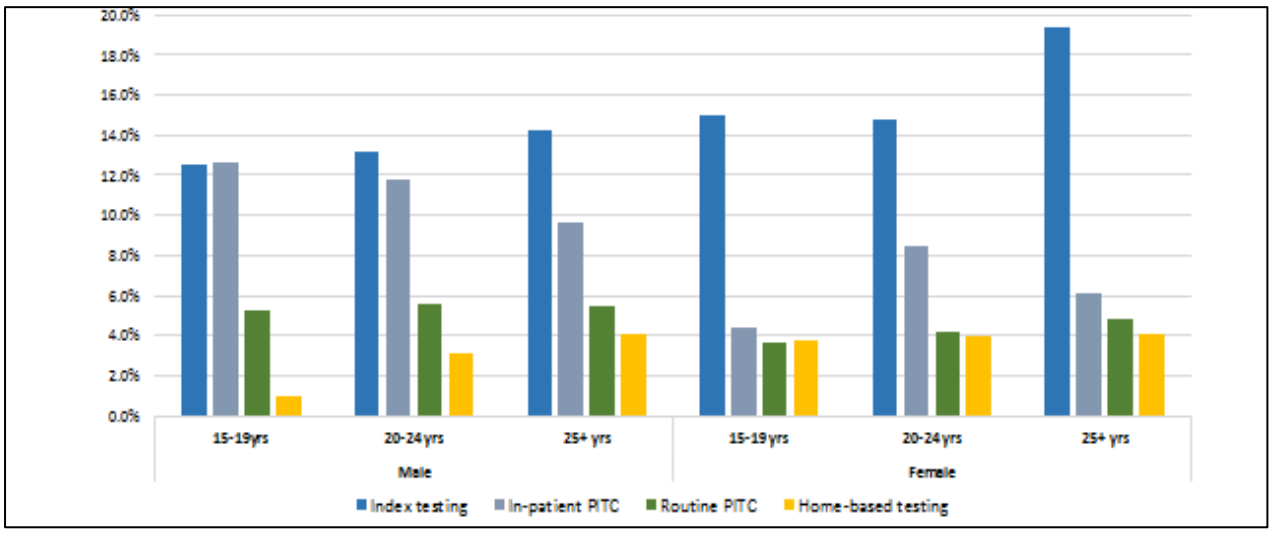
Target populations: Men aged 10-49 years, Couples and sexual partners and Adolescents and Young People (10-15 years)

Situation Analysis

HIV Testing is the entry point to HIV prevention, treatment care and support. HIV Testing Services represent a prerequisite for access to ART care and support, and for most biomedical interventions such as PMTCT and VMMC. Couple-based or individual HTS with partner testing can also assist in identifying sero-discordant couples and supporting prevention of HIV transmission to HIV-negative partners. Geographical and client coverage of HTS has increased with 76% of people living with HIV diagnosed. Despite the progress made, not all people have accessed and utilised HTS. According to the NDHS 2013/14, 49 per cent of women and 38 per cent of men aged 15-49 were tested for HIV in the preceding year (last 12 months) and received their results. This is a notable increase between 2006/2007 where the 29% women and 18% men tested and received results. This trend is attributed to high uptake and increased coverage of services. However, there is low uptake of HTS by couples, men, adolescents and men having sex with men

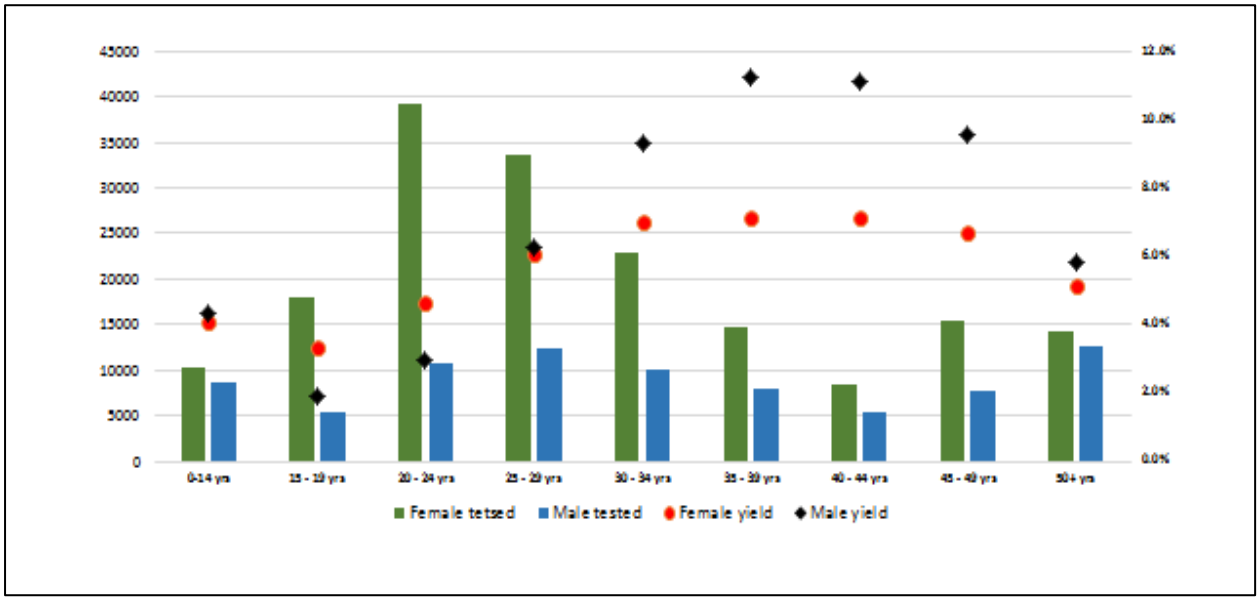
Namibia is implementing a strategic mix of HTS service delivery models which include, static health facilities, free standing VCT sites, door to door, school based and outreach/mobile delivery models have been implemented in the country with some more effective than others. This is illustrated in the figure below.

Figure 6: HIV test yield by age, sex and testing modality (October 2016)



The figure above illustrates that implementation of a mixed model discussed above, has potential to yield the desired results. Available evidence shows that Index partner testing and PITC yield higher positivity compared to door to door and other community based HIV testing models.

Figure 7: HTC Volume and Yield by Sex and Age (October 2015 to Sept 2016; N=328000)



.

The graph above shows that majority of clients who tested for HIV were females, aged 20 29 years. Men have a low uptake of HTS and as a result HIV positive men continue to be undiagnosed. This has resulted in men being linked to treatment and care late. However, the positivity yield for males above 30 years is proportionally higher than that of females in the same age groups. The yield for young women 15 to 24 years is higher than the men in the same age group as shown in the figure below.

Table 12: HTS - Gap, Challenges and Strategies

Gaps/Challenges	Strategy
Low uptake of HTS by couples (discordant couples)	• Community mobilization, interpersonal communication and mass media to encourage couples/partners and families to utilise HTS • Increase couples' and family uptake through targeted home-based HTS
Low uptake by men	• Intensify innovations such as mobile outreach to workplaces, peer-led activities, men-only days, after- hours and weekends scheduling of HTC services through public-private partnerships
HIV Testing not focused around special groups and those that are likely to be positive (higher positivity yield) for enrolment into treatment.	• Intensify incident HIV case finding using high impact mix model testing approaches including, index partner testing, facility-based PITC and community based targeted outreach/mobile testing events
Low uptake by adolescents & youth	• Mobilize and create demand for HTS services. • Social mobilization, complemented by IEC materials • Implement targeted adolescent friendly testing services

Weak systems for linking PLHIV to ART	• Strengthen innovative systems for linking PLHIV to ART
Lost opportunities to offer HTC	• Strengthen provision of PITC in the public, private and NGO sectors through integration of HTC services in routine patient care at all levels of the health delivery system

3.3.2 Provision of Antiretroviral Therapy (ART)

With adoption of test and treat, the programme will target all people diagnosed with HIV.

Programme Objective: To ensure that at least 81% of ALL PLHIV in Namibia are on Antiretroviral Therapy (ART) by 2022.

Target Population: All People living with HIV with a particular focus on young boys and girls aged 15-24 years followed by older men aged 30 years or older.

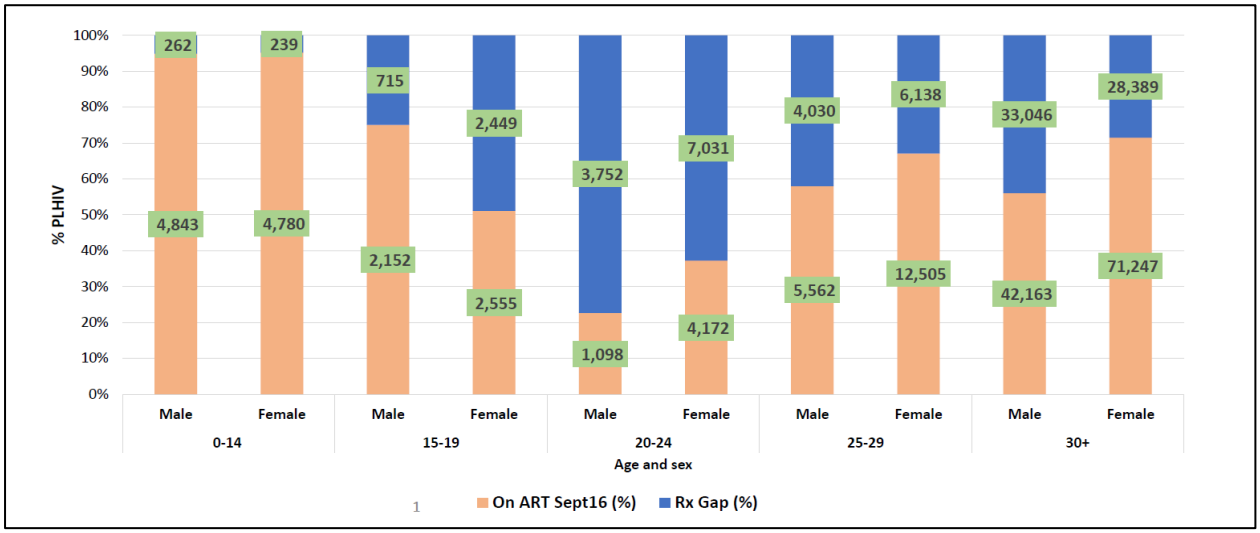
Situation Analysis

The MoHSS adopted the WHO "Test and Treat" strategy and launched the new national ART guidelines in December 2016.The "Test and Treat" is defined as the provision of lifelong ART to PLHIV regardless of their CD4 count or clinical stage of HIV for their own health. Clinical care is intended to reduce HIV related morbidity and mortality amongst PLHIV. Clinical care will include a comprehensive package consisting of HTS, ARV, periodical viral load testing, nutrition, psychosocial support, treatment of opportunistic infections and provision of related care and support in the community. Clinical care will complement efforts described in the ARV-based prevention interventions.

ART is being provided in 47 main ART sites and 147 outreach and IMAI ART sites across the country. These sites provide 80% of ART while 20% is accessed through the private sector. The private sector has introduced innovative strategies such as new health insurance options - the Health-is-Vital Risk Equalisation Fund and the Namibia Health Plan's Blue Diamond to equalise risk amongst medical schemes and to establish schemes for lower income beneficiaries. These schemes offer day-to-day medical aid benefits for employed persons who are not insured. It does include out-patient care and hospitalisation services for HIV/AIDS

Despite the gains made in ART, AIDS related deaths continue to occur. However the annual number of deaths amongst PLHIV aged 15 years and above had declined from 4200 in 2010/11 to 2900 in 2013/14 (spectrum). The annual number of deaths amongst PLHIV aged 15 year and above in 2016 was 4,671 as compared to 4,846 in 2010. Not all PLHIV have been enrolled on ART. The figure below illustrates the national ART gap by age and sex as of September 30th, 2016.

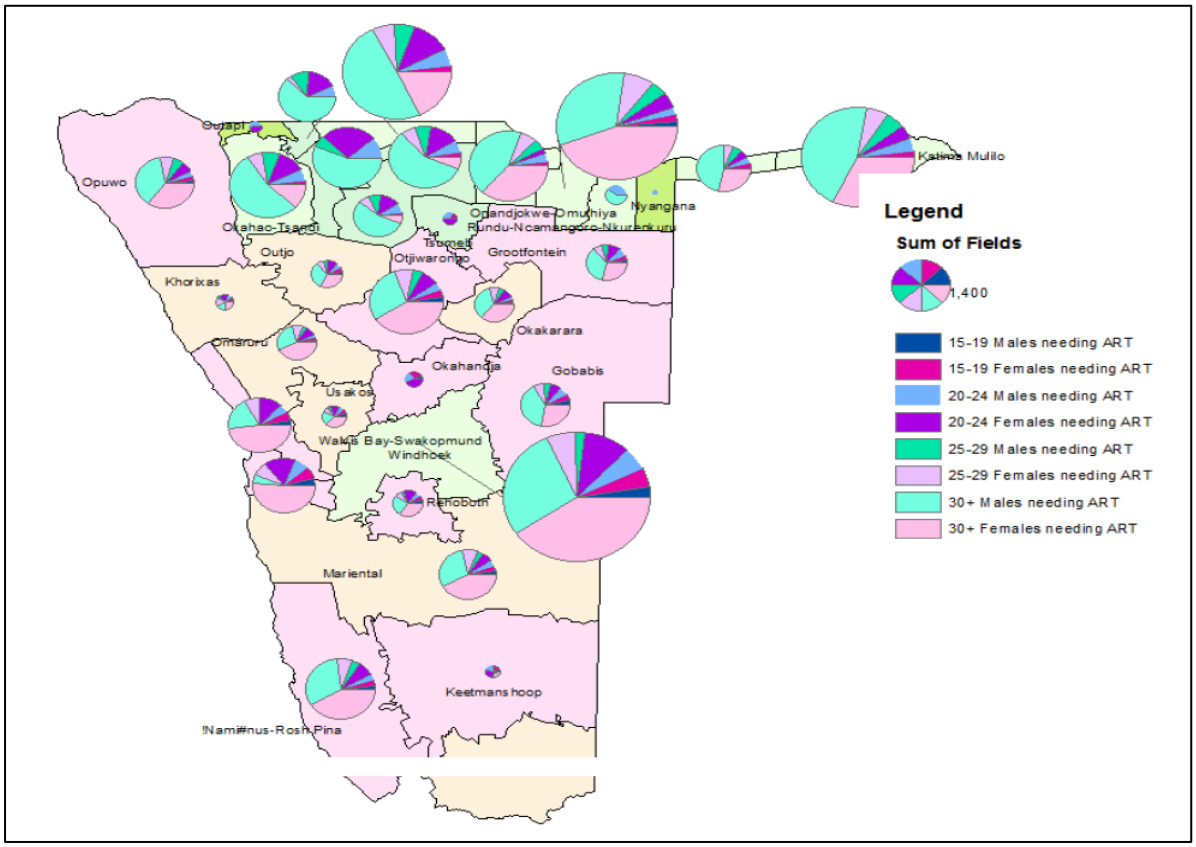
Figure 8: National ART Gap by Age and Sex



Analysis of data in the figure above indicates that the national ART coverage was 70% of All PLHIV (166 000) by 2016. The figure shows that of the estimated 237 000 PLHIV, at least 71 000 were not on ART. The figure also shows that the lowest ART coverage was among young boys and girls aged 15-24 years followed by older men aged 30 years or older. This data calls for rapid increase in ART coverage among these population sub-groups.

The figure below illustrates the distribution of ART gaps by age, sex and geographic location in all the 14 regions. Analysis show that the impact is uneven and varies from region to region with the biggest ART gaps being in Khomas, Zambezi, Kavango East and West, Ohangwena, Omusati, Oshana and Oshikoto regions. These eight (8) regions collectively account for 80% of PLIHIV in Namibia.

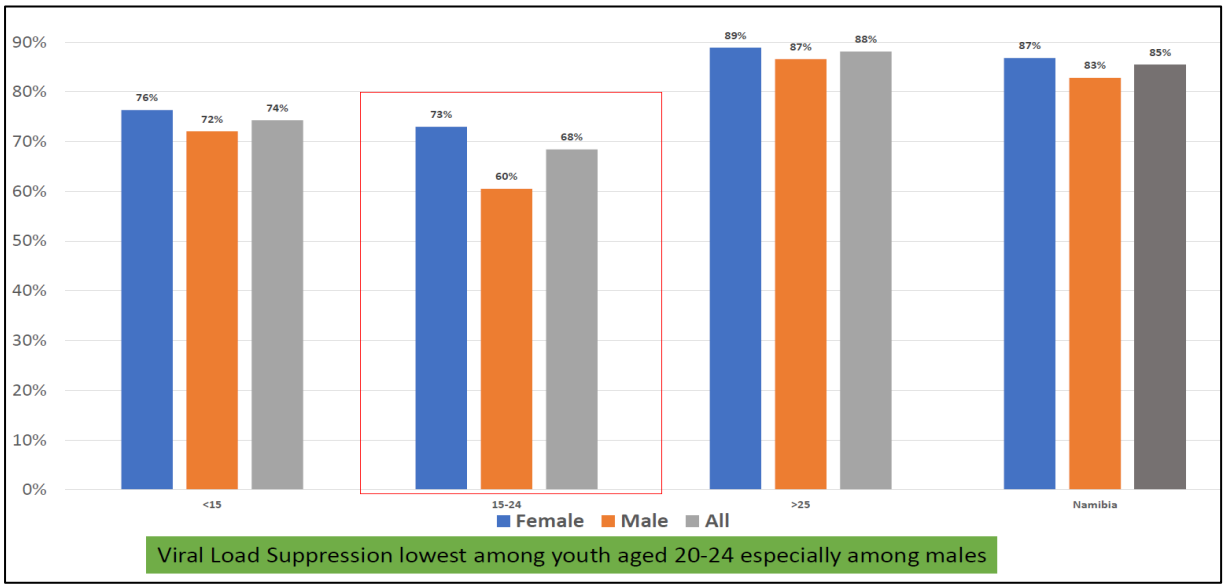
Figure 9: The ART gap by age, sex and geographical location (Sept. 2016)



It is estimated that 96.2% of adults enrolled on treatment in the public sector are on first line and only 3.7% are on second line treatment. According to NDHS (2013), 214, 956 PLHIV, 61 % (131 721) were on ART, 84% of those were retained at 12 months, and 86% of those retained were virally load suppressed. Paediatric assessed on adherence to ART by pill count scored less than 50% nationally. Furthermore by mid-2016, the proportion of patients picking up their ARVs on time countrywide stood at 71%. A major concern regarding ART adherence was that only 54% facilities reported patients achieving an adherence score of >75% in 2016.

Figure 10, below illustrates adherence and viral load suppression outcomes by specific age and sex bands. The lowest rates of ART outcomes are among young males and females aged 15-24 years followed by older men aged 30 years or older. The implementation of the NSF will specifically target these age groups.

Figure 10: Viral load suppression by age and sex (Oct 2015- March 2017)



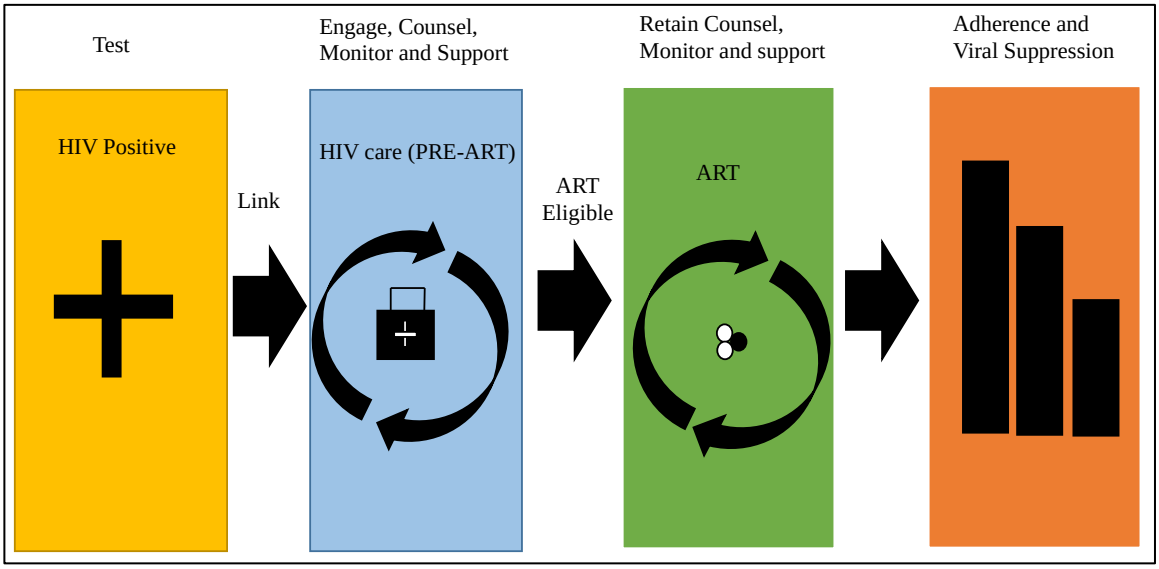
While ART remains the foundation for treatment of PLHIV, adherence, retention and viral suppression are also dependent on the comprehensive and quality care and support including nutrition, psychosocial support, and treatment of opportunistic infections (OI).

To ensure quality of services Systematic Continuous Quality Improvement (CQI) programs have been introduced, and is currently being implemented in 37 facilities in 34 districts. Namibia has also introduced a clinical mentoring programme for doctors and other health care providers servicing PLHIV in the public sector. An experienced HIV physician is assigned per region to provide expert support to health care providers in up to four districts in the provision of high quality HIV and AIDS care and treatment. These physician mentors and supports health care providers to manage complex HIV cases which otherwise would ordinarily had been referred to higher clinical care centre. Similarly, at district level an experienced HIV nurse is assigned as a nurse mentor to provide support to nurses and other health care providers working in the district.

Since November 2014, MoHSS has been piloting Project ECHO® (Extension for Community Health Outcomes), an HIV tele-mentoring program. The project aims to strengthen capacity for health care providers to treat complex and chronic health conditions in underserved communities by linking less-experienced providers with subject experts. The ECHO project offers virtual training and mentoring. Task shifting, scaling up trainings and fostering professional confidence amongst medium and lower level health care cadres is critical in decentralising ART services to peripheral facilities.

The 2016 National ART Guidelines, adopted differentiated models of care depending on the needs of patients in different contexts. These models include strategies to reduce frequency for clinical appointments for stable patients on ART, multi-month scripting and fast track pill pick up and implementation of various community-based ART delivery models (both patient-led and health care provider facilitated models). These strategies will be scaled up with the aim of decongested health facilities, improved retention; adherence and achievement of sustained viral load suppression. It is anticipated that this will also improved the quality of services, better patient satisfaction and improved morale for HIV health care providers. Provision of ART will follow the Treatment, care and support cascade illustrated below.

Figure 11: Framework for the Treatment Cascade



Based on the Figure above, retention in care after testing for HIV and starting on ART is dependent on interlinked factors, including accessibility of services, nature of ART regimens used, services provided, competing priorities. stigma and discrimination .

Table 13: ART - Gaps, Challenges and Strategies

Gap/Challenge (Behavioural/Structural/Biomedical)	**Key Interventions**
Uneven ART coverage by age and sex	Provide ART to all PLHIV sub-groups to ensure that ALL age/sex groups achieve minimum 81% coverage by 2022
Uneven ART coverage by geographic location	Scale up ART coverage to ensure that ALL health districts achieve minimum 81% ART coverage by 2022
Low retention; adherence and viral load suppression rates particularly among children, young males and females	• Implement Adolescent Adherence Clubs, Community Adherence Clubs (CACs) • Decentralize ART service provision to communities including youth and adolescent friendly environments • Develop systems for adherence and retention specific to age and sex groups
Limited Human Resource Capacity	• Recruit and retain adequate staff to provide ART Services • Implement Task Shifting • Strengthen the capacity of service providers – including Training, Mentorship and periodical suppervision
Limited access to ART services	Scale up Differentiated Service Delivery Models - including Community-Based ART delivery

3.4 Prevention and Management of Opportunistic Infections

Programme Objective:

To ensure that by 2022 at least 95% of all PLHIV enrolled in care are provided with preventive and curative services for Opportunistic Infections and STIs

Target population:95% of All PLHIV

To achieve the above objective the programme will identify all PLHIV at the highest risk of developing Opportunistic Infections and acquiring STIs. The program will support provision of preventive and curative services for OIs and STIs, aimed at reducing HIV and AIDS related morbidity and mortality. Special attention will, be paid to the most common OIs which include TB/HIV co-infection, Cryptococcal Meningitis and other preventable OIs such as PCP. This is in addition to providing routine screening, diagnosis and management of STIs among PLHIV, and addressing malnutrition and food insecurity among PLHIV. Referral to other essential services and sectors will also be strengthened.

Table 14: Opportunistic Infections – Gaps, Challenges Strategies

Gap/Challenge (Behavioural/Structural/Biomedical)	Key Interventions
Malnutrition and food insecurity negatively impacting on PLHIV, compromising treatment of OI, retention and ART adherence	Ensure meaningful involvement and linkages with the Ministry of Agriculture *(Refer to Section 4.2.2 HIV Mainstreaming)*
Inadequate routine screening; diagnosis and treatment of OIs in health facility and community settings	Provide routine screening and diagnosis of OIs at facility and community levels
	Provide OI prophylaxis and Treatment at facility and community levels
	Implement Continuous Quality Improvement systems to improve routine screen for OIs
	Improve access to laboratory services for routine screening and diagnosis of OIs
	Ensure routine availability of medicines for OI prophylaxis and treatment
Inadequate implementation of TB/HIV collaborative	Develop and operationalise an implementation guide for TB/HIV activities
	Strengthen district and regional TB/HIV QI project implementation.

3.4.1 TB/HIV Co-infection

Situation Analysis

The percentage of TB patients with known HIV status increased from 89% in 2012 to 92% in 2014. Eighty one percent (81%) of PLHIV with new smear-positive TB were successfully treated in 2013. Approximately 87% of HIV positive persons were screened for TB at their most recent visit. The number of HIV infected persons who are getting Isoniazid Preventive Therapy (IPT) has increased in most regions. Coverage of cotrimoxazole preventive therapy (CPT) also increased from 92% in 2010 to 99% in 2014. Coverage of antiretroviral therapy among TB/HIV patients increased from 43% in 2010 to 84% in 2014. HIV testing for TB patients improved from 76% in 2010 to 92% in 2014. The use of Gene Xpert diagnostic technology has been introduced and is expected to result in improved TB case finding among PLHIV

The Namibian Guidelines recommend that all PLHIV should be screened for TB at each clinical visit. Those with presumptive TB should be referred for Gene Xpert as a first line test for TB diagnosis. Those found to be negative for active TB should be provided with at least a nine (9) month course of Isoniazid Preventive Therapy (IPT). All PLHIV with CD4 less than 350 or advanced clinical stages (3/4) should be provided with Cotrimoxazole (CTX) prevention therapy in all district hospitals. The ART guidelines also recommend that HIV-positive adults with CD4 count <200 cells/mm^3 should be screened for Cryptococcal antigenaemia and managed appropriately according to the guidelines.

Table 15: TB/HIV Co-Infection - Gaps, Challenges and Strategies

Gaps and Challenges (Behavioural, Structural and Biomedical)	Key Strategies
Measurement of IPT uptake remains low	Strengthen processes of capturing IPT completion
Low implementation of TB/HIV collaborative efforts	Increased service integration

3.4.2 Prevention of Sexually Transmitted Infections (STIs) in general population

Situation Analysis

Treatment, care and control of STIs is based on the syndromic management approach. STI services are integrated into other HIV related programmes such as clinical care for PLHIV, VMMC, Condoms and ARV based prevention programmes. Epidemiological evidence support that the presence of other sexually transmitted infections, influence acquisition and transmission of HIV. It if for this reasons that early case detection and effective management of STIs is crucial in controlling HIV infection.

The latest studies and local data demonstrates that STI amongst general population is higher amongst women by 12% compared to men (10%) (NDHS 2013). The STI-co-infection amongst PLHIV is high confirming the STI prevalence of 16.3% (2015). Furthermore the syphilis prevalence in Namibia amongst pregnant women is at 1.8% with some having higher prevalence among young women aged 20-24 years and lower among adolescents 19 years and younger. While consistent use of condom is essential in

preventing STI infections, only 15% of women were likely to have consistently used condoms in the last six months. Unprotected sex among women was estimated at 63% compared to men at 37%.

STI screening amongst PLHIV needs to be re-enforced and intensified especially among population groups at higher risk.

Table 16: Prevention of Sexually Transmitted Infections - Gaps, Challenges and Strategies

Gap/Challenge (Behavioural/Structural/Biomedical)	**Key Interventions**
Inadequate access and utilisation of SRH services	Improve access to integrated SRH services by PLHIV
STI guidelines out of date	Update guidelines and job aids
Lack of information on resistance patterns to STI treatment	Conduct Etiological study
Lack of Point of Care (POC) services	Expand provision of STI POC in Health Facilities

Section 4: Systems Strengthening, Capacity Strengthening and Development of Synergies

Sustainability of quality delivery of high quality HIV and AIDS services is dependent on the existence of a functional and effective health system. Strong health systems ensure equitable distribution of health services, including availability and accessibility of comprehensive health and social services, that are necessary to support the national multi-sectoral HIV and AIDS response. Strong health systems are premised on adequate infrastructure, human and financial resources, health commodities, and increased use of evidence-based information to inform planning, allocation of resources and services delivery. Similarly robust community systems support community participation and engagement with health services and promote community mobilisation and demand creation.

4.1 Resilient Sustainable Systems for Health

Programme Objective

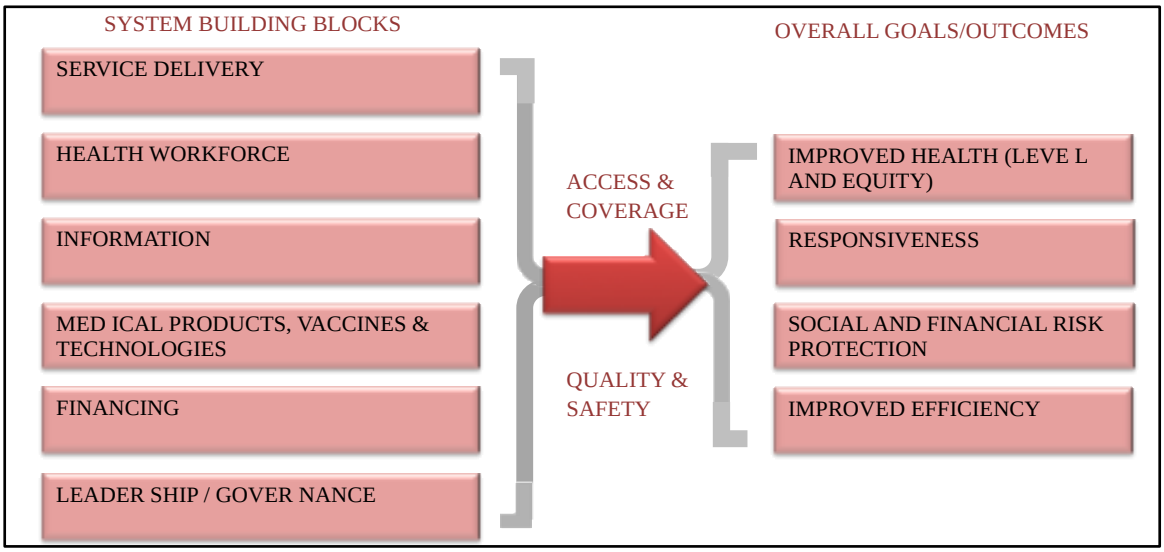
The objective is to strengthen sustainable systems for health in order to improve the efficiency and effectiveness of service delivery, and increase resource mobilisation to support the overall health system performance, and the HIV and AIDS multi-sectoral and decentralised response in all 14 regions by 2022.

Overview

Developing resilient sustainable systems for health (RSSH) demands sustained and adequate investments in critical areas outlined in figure 12 below. Strong health systems not only supports equitable distribution and delivery of quality services, but also strengthens inter-sectoral collaboration, makes sure that the systems are able to cope with any future shocks. Systems for health include all components of the health system as well as community systems.

Figure 12: WHO Health systems building blocks

.



In the next five years, the focus will be to develop resilient sustainable systems for health (RSSH). Strategies for RSSH strengthening will be based on identified gaps and priority areas, and guided by frameworks outlined in figure 12 above, as well as the Global Fund's (GF) seven priorities areas of RSSH. The key areas of focus include: - service delivery, human resources for health, information, medical

products, vaccines and technologies, sustainable financing, leadership and governance. These areas correspond to the Global Fund's seven priorities for systems strengthening that include:

i. Strengthen community responses and systems
ii. Service integration and support for reproductive, maternal, new-born, child and adolescent health
iii. Strengthen global and in-country procurement and supply chain systems
iv. Strengthening data systems, and capacity for analysis and use of data
v. Leveraging critical investments in human resource for health
vi. Strengthen and align to robust national strategies and national disease-specific strategic plans
vii. Strengthen financial management and oversight

Strengthening these areas will improve equitable distribution of service delivery, availability, accessibility and utilisation of services. Over the years, Namibia has made significant progress strengthening its systems. The Multisectoral response has been well resourced, services delivery is relatively strong, and Namibia has demonstrated good governance and leadership. The use of evidence-based information have also significantly improved. Despite the progress made, there is still an urgent need to strengthen the health and community systems.

During the implementation of the NSF, strategies for strengthening RSSH will aim to improve efficiency, unlock synergies, and explore options for additional resources. The following areas will be prioritised for RSSH strengthening:

- Community systems strengthening
- Resource mobilisation and financing
- Procurement and Supply Chain Management
- Health Information and Data Systems
- Human Resources for Health and Health Services
- Human Rights and Gender Equality

Resource mobilisation and sustainable financing of the response are addressed in Section 6. Other issues including human rights, gender equality and human resources for health have been contextualised and integrated in the relevant sections of the NSF.

The following section of the NSF only provides a high-level overview and strategic direction.

4.1.1 Community Systems Strengthening

The primary objective of community systems strengthening (CSS) is to promote participation and active engagement of communities in health sector interventions. This strategy provides greater opportunities for communities to partner with the health system in determining their health priorities, implementing community driven solutions, and ensure accountability of the health system.

Situation Analysis

Namibia has a well established community structures and systems that support the implementation of the HIV response. A review of the National Coordination Framework (NCF) for HIV/AID, identifies the Regional AIDS Coordinating Committees (RACOCs) and the Constituency AIDS Coordinating Committees (CACOCs) as key institutions that support community planning and service delivery. The committees are multisectoral with diverse participation from different stakeholders including the communities themselves, community based CBOs, FBO, support groups of PLHIV and other NGOs.

Despite the progress made participation of key populations, adolescent girls and young women and other vulnerable groups have been identified. Lack of adequate financing has been cited as the key obstacle to communities realising their potential. The work of most community-based organisations is largely funded by donors on a project-by-project basis, compromising long term sustainability. Inadequate experience and skills in governance and leadership also remains a critical challenge. Despite the challenges CBOs and other CSOs remains well placed to find and link people to care who are hard to reach for facility based/initiated health care interventions.

Strengthening community systems will ensure improve community outreach, sustained demand creation, adherence and retention.

Strategies for community systems strengthening

i. Strengthen community skills and competencies in key areas.
ii. Strengthen coordination and leadership
iii. Support community-led interventions especially those target key populations and other vulnerable populations such as people with disability, migrants workers, people living in informal settlements.
iv. Provide financial support
v. Train community leaders on strategies to address negative socio-cultural practices and norms.

4.1.2 Procurement and Supply Chain Management

The objective of the procurement and supply chain management (PSCM) system is to ensure sustained availability of pharmaceutical and other commodities to support the provision of comprehensive and quality HIV services.

Situation Analysis
Namibia operates a public sector pharmaceutical supply system whereby medicines and medical consumables are procured and distributed by the government-owned Central Medical Store (CMS) via one integrated supply system. The MOHSS currently manages a supply chain that serves approximately 350 public health facilities, including 29 hospitals, four intermediate hospitals, and one national tertiary hospital as well as 335 primary health care facilities (39 health centres and about 296 clinics). In addition to the CMS, there are two Regional Medical Depots (RMDs) that also act as intermediate stock holding points: the Oshakati RMD located 700km to the northwest of Windhoek, and the Rundu RMD, located 700km to the northeast[29].

The Government of the Republic of Namibia has been successful in providing the bulk of funds required for procurement of essential medicines and clinical supplies, and in driving the operations of the PSCM system. Despite the strong ownership, a review[30] of the PSCM system highlighted some challenges. These include inadequacies in storage facilities, human resource limitations (skills and numbers), distribution challenges, and poor inventory management and forecasting. These challenges apply to CMS, RMDs and health facilities.

In 2014, delayed receipts of stock, and erratic ordering from health facilities resulted in stock-outs and shortages of pharmaceutical products, including ARVs. Improved enrolment of PLHIV on ART and uptake in other services such as PMTCT, HTC, Condoms, and VMMC have equally increased the work load of

[29] NSF End of Term Report 2011 – 2016. Review of the 2011-2016 HIV National Strategic Framework
[30] MOHSS (2014) Consolidated Report on the Current Status of the Namibian Public Health Supply Chain: A Desk Review

the PSCM by almost 300% between 2007 and 2012. (NSF ETR Report, 2011-2016). The Namibian Medicines Regulatory Council (NMRC) experiences backlogs of pharmaceutical product registration. This is primarily caused by shortage of skilled manpower and financial constraints. NMRC currently has a backlog of 490 application dossiers, of which 10 are ARVs.

Since the review of the PSCM systems, the government has worked to strengthen the PSCM. By 2015, performance indicators for PSCM had started to improve[31]. Despite these, the systems needs continuous improvement to ensure timely procurement and distribution of pharmaceutical and commodities for HIV/AIDS, and avoid stock outs.

Strategies for strengthening the PSCM

The following strategies will be used to strengthen the PSCM.:

i. Strengthening human resource capacity for PSCM
ii. Improving storage, and distribution of pharmaceutical products
iii. Improving standard operating procedures
iv. Commence timely tendering procedures for pharmaceuticals
v. Utilize Pharmaceutical dashboard to track stock
vi. Resource allocation and mobilization to NMRC

4.1.3 Health Information and Data Systems

The objective of this component is to ensure, availability and use of empirical evidence to inform decision-making, planning, resource allocation, governance, leadership and governance of the multisectoral HIV response.

. **Situation Analysis**

Strategic information and empirical data have increasingly become the most valuable assets in the management of the HIV multisectoral and decentralised response. The adoption of the Investment Framework, and the results-based management (RBM) approaches have influenced and increased demand for evidence-based information. This has become a pre-requisite for decision making, planning and programming, resource allocation and service delivery in the national multisectoral HIV response.

Response Monitoring and Evaluation (RM&E), Sub-division within the Directorate of Special Programmes (DSP) is responsible for coordinating the NSF National M&E. DSP coordinates the M&E systems for TB and Malaria. The M&E systems is a sub-set of the MOHSS, broader health sector M&E system managed by the MOHSS Health Information and Research Directorate (HIRD). The HIRD Directorate has the overall mandate to oversee and coordinate different health sector-based data systems.

The RM&E division continues to develop and set up necessary data management mechanisms, tools and instruments. A key function has been the development of data collection and reporting tools for implementing partners at national, regional and community levels. This has entailed facilitating harmonisation and standardisation of tools and systems.

The complex nature of the M&E, and the diverse and many stakeholders involved in the HIV response at different levels, makes data quality assurance a daunting challenge. At the health facilitate level, despite the existence of electronic systems, surveillance and reporting is mostly paper-based. This is even more

[31] NSF End of Term Report 2011 – 2016. Review of the 2011-2016 HIV National Strategic Framework

challenging for non-health sector stakeholders where paper-based system is in common use. Across all sectors there is a severe lack of M&E skills and competencies. Most people are not M&E experts, but people who have learned the art of M&E on the job. Also, there is limited funding for research and evaluation activities.

With multiple and diverse stakeholders involved in M&E, and in the absence of a standardised M&E coordination framework, coordination has been compromised. At the patient level, the lack of a unique patient identifier number for the entire health system also exacerbates the challenges of linkages and coordination across data systems.

Despite the challenges the electronic patients monitoring system for HIV patient care and the electronic dispensing tool for ART commodity tracking and patient management in pharmacies have been a success story for data management. However, the systems lack interoperability resulting in data gaps and inconsistencies between the two. Non-prioritisation of ART data entry, partly resulting from competing demands of health facility staff has led to significant data gaps.

It is evident that a robust data management system that provides reliable and timely data is a critical component of a strong, resilient and sustainable health system. During the implementation of the NSF, the M&E system will be reviewed and strengthened, with a focus on key areas including ensuring availability and use of appropriate tools for data collection and reporting, storage and dissemination of data. Capacity of M&E personnel will be strengthened with a focus on appropriate M&E competencies and skills. Capacity development will revolve around the twelve components of a functional M&E system.

Strategies

Over the next five years, the following strategies will be prioritised in order to strengthen health data systems:

i. Integration of health data systems and enforce reporting requirements
ii. Develop a universal unique patient identifier number
iii. Develop human resource capacity in relevant skill areas
iv. Advocate for additional budgetary support to strengthen capacity of the RM&E division and HIRD

4.1.4 Human Resources for Health

Programme Objective

The objective is to ensure sustained availability of a competent and skilled work force necessary to support an efficient and effective HIV and AIDS planning, implementation and service delivery, across the sectors, all 14 regions and the country by 2022.

Situation Analysis

(a) Human Resources for Health: Namibia faces a serious shortage of skilled and competent health workforce in the world. While the number of health workers per capita (3.7 per 1,000 population) is above the WHO benchmark of 2.9 health workers per 1,000, there is marked disparity between the public and private sectors and between urban and rural areas. The private sector has 8.8 health workers per 1,000 population, while the public sector has barely 2.0 health workers per 1,000 population. The vast majority of registered physicians and pharmacists work in the private sector serving only about 15% of the population, and over 75% of doctors, 68% of pharmacists, and 61% of registered and enrolled nurses work in urban areas. Meanwhile, there are high vacancy rates in the public sector, especially in rural

areas, with the average public sector vacancy rate for medical doctors at 36% and for pharmacists at 41%. Overall, staff shortages are most profound for doctors and pharmacists[32]. Both the intermediate and district hospitals have only one-third of the doctors that they require based on workload. The shortage of pharmacists is even more severe. The challenge of staff shortage in Namibia has been exacerbated by the increase in hospital visits of people suffering from opportunistic infections as a result of HIV and AIDS. Shortage of doctors and pharmacists in particular is likely to affect the HIV and AIDS response negatively given the increased number of PLHIV likely to be enrolled on ART; and the associated increase in volume and hospital visits of people suffering from opportunistic infections, as a result of HIV/AIDS. Nevertheless, the GRN remains committed to strengthening HRH and in exploring opportunities to increase the supply of HRH and in developing the capacity of existing staff.

The Government of Namibia opened the first School of Medicine for the country at the University of Namibia in 2011. The school trains doctors and pharmacists, with the long term aim of contributing to addressing the critical shortage of health professionals in the country. Other strategies such as task shifting, the use of Health Extension Workers, and community health workers are being implemented to stretch available resources and ensure adequate health service coverage. During the implementation period of the NSF these strategies will be strengthened and scaled up.

Strategies

The GRN will continue to:

i. Review and revise staffing norms; improving staffing equity across regions and types of facilities; and ensuring an appropriate skill mix at each level, including estimating workforce requirements for new cadres
ii. Strengthen the skills and competencies of existing health work force and develop a plan to address the gaps.
iii. Accelerate recruitment of strategic competent and skilled technical staff to support the national response (Doctors, nurses, and pharmacists)
iv. Accelerate expansion of task shifting for qualified nurses.
v. Undertake recruitment and training of new health workforce
vi. Leverage skills and resources in the private sector
vii. Decentralise HIV services

4.1.5 Service Delivery

Programme Objective:

The objective is to ensure availability, equitable distribution, access and utilisation of comprehensive HIV and AIDS services.

Situation Analysis

HIV and AIDS services are currently available country-wide. However uptake of some services by some population sub groups (i.e. men, key populations, adolescents) have been low. Low uptake of services has been associated with a number of reasons including lack of awareness, poor access, socio-cultural, policy and structural barriers. The NSF aims to catalyse, support and strengthen innovative strategies to intensify demand creation, increase client and geographical coverage, ensure sustained access and utilisation of services. Strategies will aim at promoting services integration, user-friendliness, efficiency

[32] NSF End of Term Report 2011 – 2016. Review of the 2011-2016 HIV National Strategic Framework

and effectiveness. Community-based strategies (i.e. community conversations) will enable positive changes by addressing social and cultural norms and practices, values, and religious believes that influence risk behaviours. Linkages and synergies between health, community and social systems will also be improved.

Strategies

i. Train stakeholders on critical service delivery strategies, especially for community-based interventions, and in particular those targeting key populations, including adolescents girls and women, and men in general.
ii. Review and improve synergy between different service delivery systems with the aim to improve integration and efficiency.
iii. Harmonise service delivery systems between the various stakeholders
iv. Strengthen the capacity to use appropriate medical technologies to improve serivice delivery

Indicators and results for service delivery

4.2 Human Rights and Gender Equality

Programme Objective

The objective is to ensure no person is discriminated or stigmatised against on the basis of their HIV status, in addition to ensuring gender equality among men and women.

Situation Analysis

The Constitution of Namibian guarantees the fundamental rights and freedom of all people. The constitution outlaws any form of discrimination on the grounds of sex, race, colour, ethnic origin, religion, creed or socio-economic status. The National HIV and AIDS policy also criminalises all of forms of stigma against people living or affected by HIV and AIDS. The constitution further provides for the right to fair and reasonable access to public facilities including health. The constitution also guarantees equality among men and women.

While Namibia has made significant progress in addressing HIV and AIDS, some social-cultural, policy and legal barriers prevent access and utilisation of services by some population groups. Gender inequality, and some negative sociocultural practices and norms dis-empowers women and young girls and increases their risk and vulnerability to HIV/AIDS. Gender based violence (GBV) and HIV are mutually reinforcing epidemics with GBV being both a risk factor for HIV infection as well as a consequence of being infected with HIV, and a by product of gender inequality. In fact, fear of violence may hinder individuals from getting an HIV test, disclosing their HIV status, and seeking HIV treatment and care. Gender inequality has been a major obstacle for women in negotiating safe sex[33]. According to the NDHS 2013, 28% of women between the ages of 15 and 49 agree that a husband is justified in beating his wife for at least one specified reason. In 2014, up to 32% of women between the age of 15 and 49 indicated having experienced GBV at least once since the age of 15 (NSF ETR Report 2011-2016). Other factors such as low levels of knowledge of HIV and AIDS, and STI prevention contribute to this challenge. The high prevalence of adolescent pregnancy (15%) underscores the gender imbalance in decision-making and choices around sexual activities.

[33] NSF End of Term Report 2011 – 2016. Review of the 2011-2016 HIV National Strategic Framework

Discrimination, stigma and marginalisation have equally affected key populations groups (i.e. FSW, MSM, LBGTI community,) and other vulnerable groups such s PWD, nomadic groups and people in correctional facilities, including other places such as Police holding cells and migrant workers.. The marginalisation results from various reasons such as lack of supportive legislation, perceived cultural or traditional taboos, access to building, lifestyle cultures and high mobility due to work and others. A key challenge has been inadequate implementation and compliance with existing policies and legislation.

Anecdotal evidence suggest that some healthcare providers deny health services to children that do not require the consent of a parent or guardian, due to unfamiliarity with legal provisions. The Child Care and Protection Act 2015 stipulates that a child may consent to a medical intervention in respect of himself or herself if -

(i) The child is 14 years of age or older; and

(ii) A medical practitioner concerned is satisfied that the child is of sufficient maturity and has the mental capacity to understand the benefits, risks and implications of the medical intervention

This provision also covers HIV testing and counselling as well as surgical operations.

Strategies

i. Intensify advocacy to empower women and promote behaviour change for men, using community-led structures
ii. Conduct routine training of health service providers on relevant legal provisions.
iii. Support development of support structures for women and adolescent girls
iv. Advocacy for human rights approach to provision of health care to LBGTI, FSW, MSM, people in holding cells
v. Develop a HIV prevention & education strategy targeting people in congregate settings
vi. Strengthen provision of mobile health (in particular HIV) care services targeting mobile populations.

Indicators and Results for Human rights and gender equality

4.3 HIV Mainstreaming in Development Sectors

Programme Objective

The programme objective is to expand the scope and coverage of the national HIV multisectoral response by galvanising and catalysing development sectors to undertake HIV mainstreaming in their internal and external programmes and projects.

HIV mainstreaming in the development sectors will enable the national multisectoral response to reach 90% of the public and private workforce with HIV, health and wellness services by 2022

Situation Analysis

It is evident that HIV prevention and treatment strategies alone will not overcome deep-rooted social-cultural and economic causes of risk and vulnerability associated with HIV, or reduce the impact of AIDS on PLHIV and their households. It is important that the national response also addresses the social and structure drivers of the epidemic. Available evidence shows that the epidemic is spreading along the socioeconomic development fault lines such as poverty, gender inequality, GBV, unemployment, inadequate social protection and food insecurity among others. The impacts of the epidemic are being

felt across all sectors of the economy and society where they are manifesting in different ways ranging from loss of productivity, decline in personal savings, reduction in investments and purchasing power for products and services, to increased cost of health care and labour. All these circumstances increase the risk and vulnerability to HIV infection for many people, and also impact on sectors productivity.

The social and economic impacts of the epidemic transcend sector and institutional boundaries, and demand for a multisectoral response based on institutional mandate and comparative advantage. It is for this reason that Namibia has adopted the policy[34] that all sectors mainstream HIV in their internal and external programmes and projects. The process of HIV mainstreaming will also strengthen synergies within and between different development sectors. Development synergies are defined as investments in other sectors that can have positive effect on HIV outcomes. They tend to have a broad range of impacts across health and development sectors.

HIV mainstreaming will depend on how individual sectors perceive, analyse and address HIV and AIDS risk factors and in particular how the epidemic is likely to affect delivery of their development objectives. To facilitate effective mainstreaming, individual sectors will consider the following questions -

i. How is the epidemic (risk factor) likely to affect the goals, objectives and programmes of the sector?.
ii. How the sectors development programmes and projects are influencing the spread of HIV?
iii. Where does the comparative advantage of the organisation lie in responding to those causes and effects?

4.3.1 Internal HIV Mainstreaming

Internal HIV mainstreaming will focus on improving the quality of health of the sector employees by mitigating the impacts of HIV and AIDS. HIV mainstreaming will be provided as part of the sector's wellness programme for three reasons. First, with the advent of ARV, ART has changed HIV and AIDS from being a life-threatening disease to a chronic illness. Second, services offered within the wellness programmes are beneficial to PLHIV, and finally the integration will increase efficiency in services delivery and provide an opportunity to address other non-communicable diseases such as diabetes, and hypertension affecting PLHIV. This strategy will also improve adherence and retention in care.

Sectors are encouraged to conduct rapid (simplified) sector HIV and AIDS assessment.

4.3.2 External HIV Mainstreaming

External mainstreaming of HIV will seek to ensure that development and capital projects don't fuel the spread of HIV among the communities around the geographical locations where development is taking place. External mainstreaming will also enable sectors address structural drivers of the epidemic. For Ministry of Agriculture could address issues of national and household food insecurity in HIV vulnerable households, and improve nutrition for PLHIV. Food security and nutrition contribute to retention and adherence to treatment and care by PLHIV. In the case of preventing new infections among adolescents and young women, Ministry of Education, could ensure availability of relevant policies and programmes to keep them is schools. For economic development sectors, mainstreaming HIV in capital projects could facilitate mitigating the impacts of HIV among sex workers and communities living around such capital projects..

[34] Note: National HIV Mainstreaming Guidelines have been developed.

To ensure that development projects consider the likely impact of HIV and AIDS, Namibia has included HIV and AIDS assessment as part of the National Environmental Impact Assessment Guidelines for all large capital projects.

Gaps and Challenges – for both internal and external mainstreaming

i. Lack of relevant skills, experience and institutional capacity in HIV mainstreaming – especially external mainstreaming.
ii. The National Mainstreaming Guidelines have not been disseminated adequately,
iii. HIV mainstreaming initiatives are under-funded
iv. Indicators for mainstreaming are not clearly defined.

Implementation Strategies

The process of HIV mainstreaming will follow the six-steps described below. The stepwise process provides an incremental benefit from one step to another. Both step 1 and 2 are intended to generate the strategic information and data needed to inform mainstreaming strategies in Step 3. While addressing step 3, sectors are encouraged to prioritise interventions based on the evidence provided in steps 1 and 2, in addition to the efficacy of the proposed actions. Costing is undertaken in step 4, and will determine financial and other resource needs necessary to implement sectors HIV mainstreaming. Step 5 outlines the implementation strategies, while step 6 focuses on monitoring and evaluation of the mainstreaming initiative. All mainstreaming interventions should be gender and human rights sensitive and responsive.

Sectors should ensure that mainstreaming action plan is an integral component of the sectors overall strategic plan.

To operationalize mainstreaming sectors are advised to refer to the National Mainstreaming Guidelines for detailed step-by-step planning for internal and external mainstreaming.

4.4 Coordination and Management of the multisectoral response

Coordination and Management Objective

The objective is to improve and strengthen efficiency and effectiveness of coordination across all stakeholders, sectors and regions.

Situation Analysis

Namibia has a well established HIV and AIDS coordination mechanism, and structures. In 2010, Namibia developed the National Coordination Framework (NCF) to guide and inform coordination and management of the national multisectoral and decentralised response. The NCF is premised on the three-One principles of having one national coordination authority, one national strategic framework and one national M&E plan.

The development of the NCF was necessary given the many and diverse stakeholders involved in the multisectoral response at national, regional and community level. Most of the stakeholders have different mandates, roles and responsibilities, governance structures and accountability lines. The need to strengthen coordination was also necessitated by the increase and expansion of services, geographical and client coverage.

Despite the existence of the national coordination guidelines coordination remains complex and demanding. It is for this reason that during the implementation of the NSF, capacity will be strengthened to ensure efficiency and effectiveness, good governance and leadership of the national response.

The current coordination and management framework includes the structures-.

i. **The Cabinet**: Cabinet is the highest policy making body on HIV/AIDS in Namibia. The membership is composed of sitting Ministers. The function of the Cabinet is to approve the National HIV/AIDS Strategic Framework, the National HIV/AIDS Policy, and the M&E plan.

ii. **Meeting of Senior Civil Servants.** This is a monthly meeting of Permanent Secretaries (PS). It has the responsibility of ensuring harmonization and alignment of the national response with government policy frameworks, in addition to overseeing the HIV mainstreaming in different public sectors. This platform also provides policy guidance; institutional leadership and resource mobilisation and will receive and review periodical progress reports on the HIV response. At individual sector level, Permanent Secretaries are responsible for reviewing and approving sector specific HIV mainstreaming action plans and budgets.

iii. **National AIDS Executive Committee** (NAEC): The composition is multisectoral with representation from all stakeholders drawn from public and private sectors, civil society and development partners with a mandate to provide technical leadership, facilitate programme development and planning, oversee capacity development and technical assistance, partnership strengthening and management of strategic information. The committee also reviews programme coordination, policies and legislation and makes recommendations to Cabinet for approval and meets on a quarterly basis and reports to the Meeting of Senior Civil Servants and to Cabinet if required. NAEC work through technical advisory committees, sector steering committees, programme and specialised committees that may be established from time to time.

iv. **Regional AIDS Coordinating Committees (RACOCs):** RACOC's are multisectoral committees whose membership is drawn from all stakeholders operating within a specific region with the mandate is to facilitate and coordinate regional level response. RACOCs are chaired by the Chairpersons of the Regional Councils and deputised by the Chief Regional Officer and Regional Health Director or a Member of Management Committee appointed by the Regional Council. They operate under the auspices of the Ministry of Urban and Rural Development (MURD). Part of their responsibility is to facilitate demand creation for HIV services, and ensure that services are delivered on time. Each region has Regional Operational Plan that is aligned to the NSF. Although public sectors at regional level participate in the RACOCs, they don't usually contribute to the development of the Regional Operational plans (ROPs). They argue that their budgets are centralised and will not have significant impact for the regional operational plans.

v. **Constituency AIDS Coordinating Committees (CACOCs):** The CACOCs are responsible for coordinating community-based response and operate under the auspices of their Constituency Councils. CACOCs are chaired by the Regional Councillor of that particular constituency and deputised by the District Primary Health Care Supervisor and Control Administrative Officer Communities are encouraged to develop and implement their own HIV/AIDS action plans with technical support from RACOCs and other stakeholders. Their core responsibilities are to ensure meaningful participation and engagement of community members, support demand creation, and advocate for increased access, and utilisation of available services. CACOCs are coordinated by volunteers and most regions are not able to offer paid positions or adequate incentives to retain

volunteer coordinators. Several engagements took place between MoHSS and MURD to create a permanent position for the CACOC Coordinators on the Regional Councils staff establishment but the negotiations are still on-going.

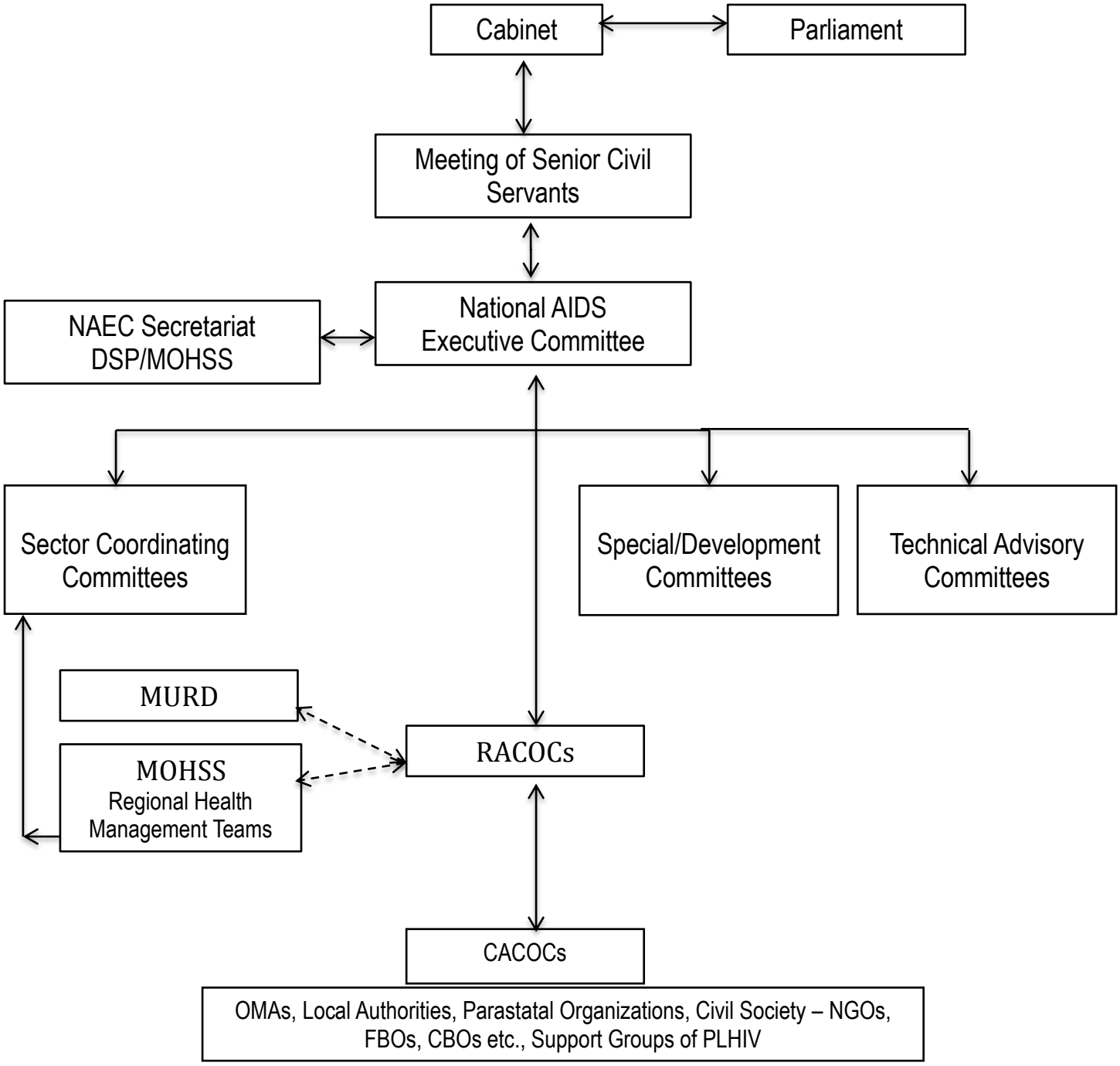
vi. **Sector Steering Committees:** Sector Steering Committees are responsible for facilitating the development, coordination and implementation of sector responses. The sector responses are premised on HIV internal and external mainstreaming. The current sectors are listed in Annex 4. Sectors are comprised of public and private institutions and enterprises, civil society and development partners.

Although CSO, private sector and development partners are represented in most of the committees described above, they also have independent self-regulating coordination structures and umbrella organisations. Namibian Network of AIDS Service Organisations (NANASO) coordinates the involvement and participation of the civil society organisations. Health Works Business Coalition coordinates the participation and engagement of the private sector and Walvis Bay Corridor Group also plays a key role in implementing interventions for long distance truck drivers and communities along transport corridors. The Participation of the UN agencies is coordinated by UNAIDS, through the UN Joint Team on HIV/AIDS among others.

The coordinating structures

The figure below illustrates the current coordination structure and the respective institutions at different levels. The mandates, terms of reference, roles and responsibilities of these structures are further articulated in the National Coordination Framework (NCF).

Figure 13: The National Response Coordination framework



The terms of reference (TOR) for the different structures are outlined in the National Coordination Framework

Gaps and Challenges

i. **Coordination and Management**: Coordination remains weak and fragmented despite the establishment of coordination structures. Some (i.e. CACOCs and CSOs) structures are underfunded

ii. **Inadequate use of empirical evidence to inform decision making and planning:** Empirical evidence is not adequately being used to inform decisions and planning for HIV and AIDS
iii. **Funding:** Although funding levels have improved, the national response remains underfunded. With the adoption of test and treat, and introduction of PrEP more resources will be needed. Namibia also needs to improve on service delivery efficiencies, and create value for money.
iv. **Policies and Laws**: Inadequate enforcement and due to lack of capacity and monitoring.
v. **Poor coordination efficiency and effectiveness:** Although Namibia has applied the "investment approach" and have used results-based management approaches, efficiency and effectiveness of the response service delivery remains inadequate.
vi. **Community Participation, Engagement and Ownership:**. Community mobilisation strategies remain weak and fragmented, and often driven by external persons other than communities themselves.
vii. **Inadequate human resource capacity:** Inadequate (numbers) and experienced (skilful) human resources, coupled with a poor retention strategy.
viii. **Inadequate use of evidence-based information management**: Inadequate management of strategic data, information and HIV/AIDS related knowledge.
ix. **Inadequate HIV Mainstreaming in Development Sectors**: HIV mainstreaming remains weak, with only a few sectors having adequate mainstreaming plans and strategies. Mainstreaming has not gained the desired momentum.
x. **Stigma and Discrimination**: Stigma and discrimination continue to be barriers for services uptake.

Implementation Strategies

The following strategies will be used to strengthen coordination and management of the national response.

i. Stakeholders will be oriented on coordination, leadership and governance, monitoring, reporting and feedback strategies.
ii. Capacity of the coordinating structures and the Technical Advisory Committees (TAC) will be strengthened.
iii. Advocacy will be intensified to increase financial support for RACOCs, CACOCs and CSO coordinating structures including funding to recruit basic personnel. In the case of CACOCs, funding would also include operational budgets.

Section 5: Strategic Information and Knowledge Management

5.1 Programme Objective

The objective of the M&E system is to ensure availability of comprehensive and quality data and strategic information, and its use to inform policy, planning, service delivery and resource allocation by 2022.

To achieve this objective, the M&E system will focus on -

- Systematically tracking the progress of the disease in achieving programme objectives
- Tracking inputs, outputs, outcomes and impact results, based on agreed indicators and targets.
- Providing timely and accurate information to meet national and international reporting requirements
- Serve as an instrument of accountability among stakeholders
- Strengthen the multi-sectoral response and the national commitments to HIV/AIDS

5.2 Situational Analysis

The Monitoring and Evaluation system of the Namibia HIV/AIDS response is guided by a set of indicators, compiled in the NSF Results Framework with details that includes indicator definition, targets, data sources, information products and assigned responsibilities. There is also a prioritised HIV/AIDS research agenda that supports the effective generation of strategic information to guide the multisectoral HIV and AIDS response.

The national HIV Multi-Sectoral Monitoring and Evaluation Framework 2017/18 – 2021/22 sets out the mechanism of monitoring the results of the NSF at the Impact, Outcome and Output levels. It provides relevant information to program managers and policy makers to help them make relevant and informed decisions. It is therefore used by the various M&E functions of all implementing stakeholders who have a responsibility to collect data and report through DSP to other stakeholders.

There are about 340 public health facilities that report consistently on the HIV/AIDS response through the various programmes to the national level in the various directorates. HIV related data is then sourced through to the RM&E subdivision of the DSP, and utilised to support the work of stakeholders including the M&E function at DSP, Civil Society, private sector and development partners.

5.3 The NSF Monitoring, Evaluation and Research Agenda

The NSF M&E evaluation and research agenda identifies and prioritises key monitoring and evaluation activities for the next 5 years covered by the program. The agenda closely supports the production of key information products that will communicate feedback to the different stakeholders. Research, surveys and surveillance are the source of the required baselines on public health trends, denominators for RM&E indicators. The evaluation and research agenda (See annex 3) is informed by the following factors:

Table 17: Factors influencing the M&E Research Agenda

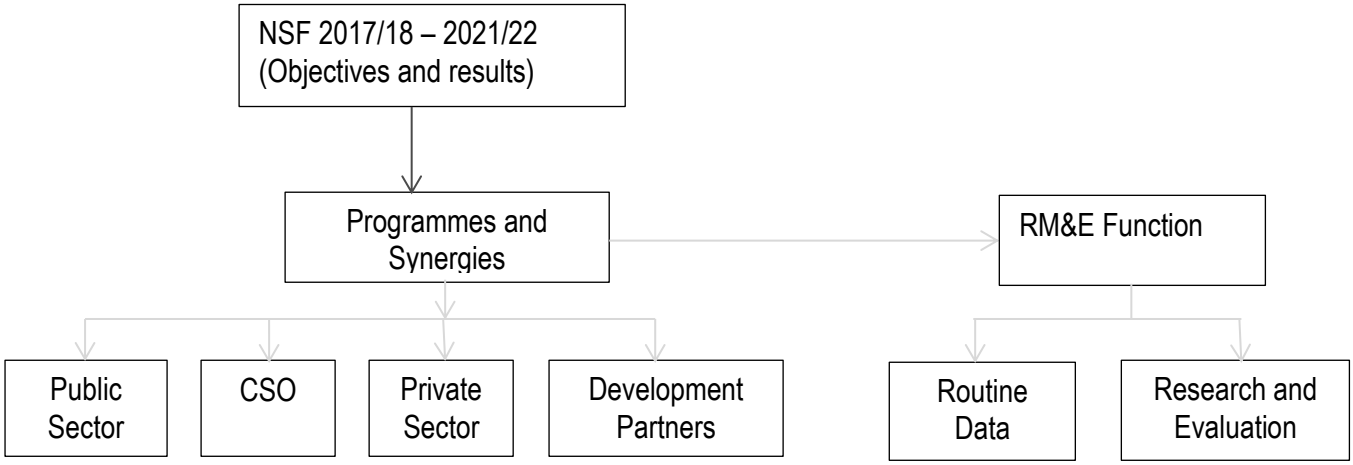
Area	Agenda over the next 5 years
Monitoring Agenda	
Strengthen routine monitoring data collection (health facility-based data, multisectoral response data)	Ensure increased reporting by civil society, private sector and community-based interventions to ensure a comprehensive coverage of the progress on the national response. Strengthened capacity in Integrated Health Systems. Strengthened system to capture community-level interventions.
Data quality improvement	An agreed data quality framework is specified for the program. The strategy is based on On-site-data verification to be conducted by RM&E on a quarterly basis and Annual Independent Data Quality Audits to support improvements in quality.
Services quality and delivery	Indicators are specified that target services quality ad services delivery for the program.
Services delivery among Key populations and gender	Indicators and tools are specified that keep track of services delivery and coverage of Key Populations and vulnerable groups that are key drivers of the epidemic. Information is important for program planning, resource allocation and improved monitoring.
Evaluation & Research Agenda	
Strategic investment in Population-based surveys	Surveys are implemented in a cost efficient manner through good planning, improved design and coordination. Reduction in duplication through integration and joint program evaluations. Priority investment from donors to target disease incidence, prevalence key predictors of risky sexual behaviours.
Invest in capacity strengthening for improved strategic information generation	New and innovative approaches to collecting, integrating and archiving data and information. Capacity strengthening in data collection, analysis

	and interpretation for improved decision-making. A Bi-Annual high level stakeholder reviews.
Fund strategic evaluations	Periodic program progress reviews to complement existing information and data for informed decision-making. Focus will be on outcome and impacts and specific areas such as gender, equity, quality of services and services coverage among key populations and MARPS.
Operations Research	Periodic research to answer specific program implementation questions

5.4 The NSF M&E Conceptual Framework

Figure 14 below provides the conceptual framework linking the NSF programmes to the monitoring and evaluation function. NSF will focus on achieving the results set through the programmes, and the programmes in partnership with other sectors will be responsible for implementing the strategies. Data generation will be provided to the RM&E and Health Information Systems (HIS) Programme for central storage, management and reporting.

Figure 14: Conceptual framework for the national M&E framework



5.5 Data Sources

Routine Data: Routine monitoring is an important source of data based on tracking selected outputs and outcomes to provide information on the status of interventions and expenditures. It checks whether outputs are resulting into desired outcomes. The NSF monitoring will be an on-going process and will be conducted at national, regional, district and community levels. In order to ensure the quality of data collected, common indicators and pre-designed standard tools will be used. Reporting will be based on standardised reporting formats.

Routine monitoring will focus on:

- **i.** Ascertaining the extent to which planned activities are being implemented and contributing to the achievement of the desired results.
- **ii.** Identify any emerging barriers/bottlenecks that may negatively impact or compromise the implementation of national HIV/AIDS response.
- **iii.** Ensure sustained availability and equitable coverage of services
- **iv.** Track the use of financial resources earmarked for the HIV and AIDS response across programmes, sectors and regions.

v. Monitoring the levels of capacity development, knowledge and skills transfer, improvement of service delivery systems, use of best practices and strategic information.

Research and Evaluation: Although programme monitoring is an integral part of tracking NSF programme results, it is not sufficient to measure higher-level impacts or to learn lessons from implementation that can be applied to future interventions. Consequently, research and evaluations of activities are important to provide deeper measurement of results.

Mid and end term evaluation of the NSF will be conducted. The Evaluation will focus on the assessing the effectiveness and efficiency of the response towards achieving planned results and the impact the response has made.

5.6 Data Flow, Reporting and Feedback Lines for the NSF

The data flow system, reporting and feedback channels (Figure 15) are largely based on the coordination framework of the HIV/AIDS response in Namibia. Data flow, reporting and feedback takes place as follows:

1. **Local level:** Implementers, including health facilities, CACOCs, non-health sector entities, CBO, CSOs, FBOs, municipalities, private organizations, etc. submit copies of their respective data sheets and reports to the regional level offices for consolidation.

2. **Regional level:** The designated officers at the region for the local level entities receive the reports, aggregate the reports and submit them to the national level

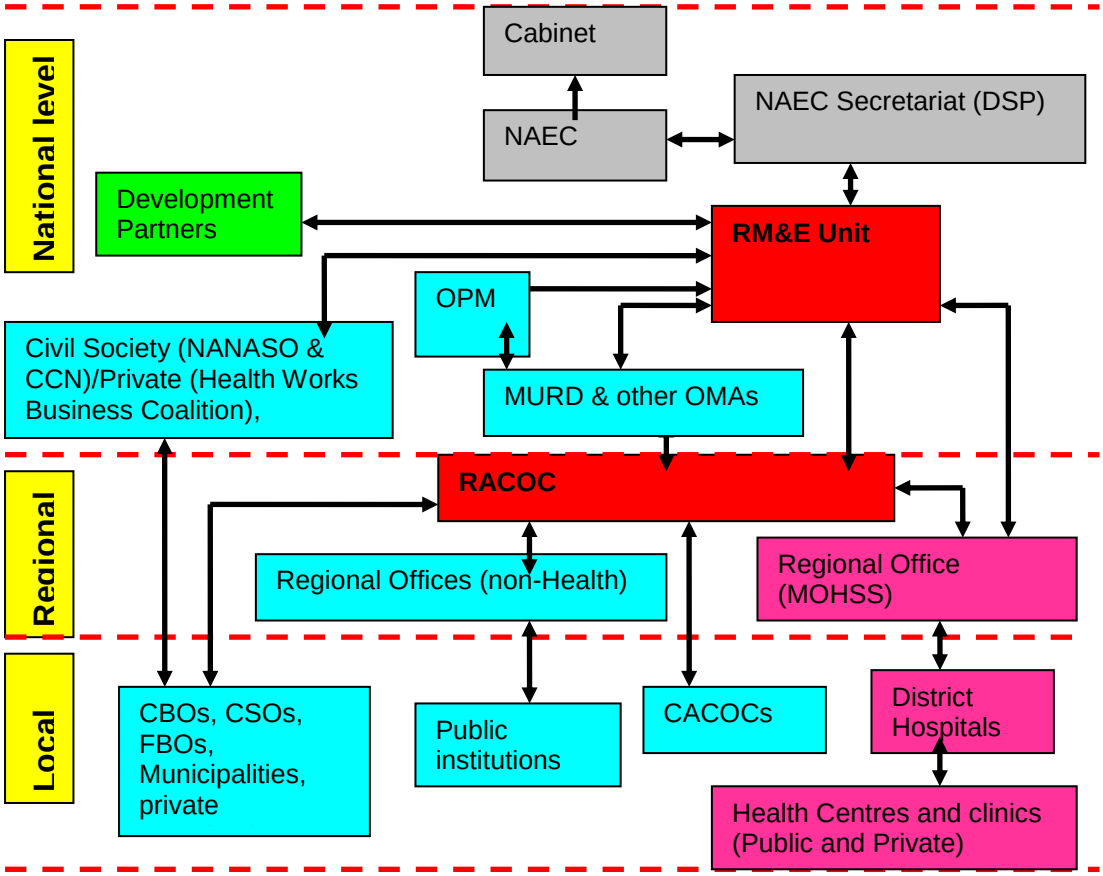
3. **National level:** At the national level, the respective M&E officers or focal points persons collate, analyse the data received from their subnational entities and submit what is relevant to stakeholders and the RM&E sub division of the Directorate of Special Programmes.

The reporting upwards is also accompanied by horizontally sharing information to partners within the various levels. Feedback on data and reports received by the respective higher levels are sent back to the levels below.

Information is sent to the Ministry of Health and Social Services on a quarterly basis and consolidated in various databases including the Multisectoral Information Management System (MIMS), electronic patient monitoring system (ePMS) and the District Health Information System (DHIS2). Data will be sent to MoHSS on a quarterly basis using the customised forms through an electronic system.

Health sector data from health facilities to the District Health Information Managers are checked and reported further to the Regional Health Information Managers then to the RM&E.

Figure 15: Data flow, reporting and feedback lines for the NSF



5.7 Information Products

Qualitative and quantitative data is generated from various sources, ranging from programme data, patient files, surveys and surveillance reports, service registers, and routine monitoring and evaluation reports. It is disaggregated by, sex, age, population groups, education, occupation, and geographical location (rural or urban) among others. The M&E Plan therefore prioritises the production and dissemination of strategic information by proposing the following priority strategic information products:

Table 18: Prioritised Information Products for the Namibia AIDS Response

Information Products	Description/Purpose
Integrated Health Information Systems	Routine monitoring data for both health facility interventions and multisectoral response (programme outputs, outcomes)
Modelling & Projections Estimates	Modelling will be used to generate data that is not readily available from existing data sources. The EPP software and Spectrum enables modelling of different scenarios based on input data from the ANC Sentinel Surveillance, DHS+, Namibian Demographic data and other programme data. The MOHSS conducts Sentinel Surveillance every two years. Demographic data is obtained from Namibia Statistical Agency (NSA).
NDHS	The surveys targets information on the impact of the combined national HIV response, the change in HIV prevalence, the change in HIV incidence. Funds will be requested to contribute to the preparation and the implementation of the study.

Workplace Surveys	Workplace surveys are conducted with a view to gathering information that allows Namibian stakeholders to understand the extent to which HIV programmes have been mainstreamed internally by organisations. The survey targets both private sector and public sector employees. Private sector employers are mainly large corporate entities and will be selected on the basis of the size of the labour force. Public sector employers include government ministries, parastatals and other government agencies in Namibia.
HIV Drug Resistance Surveys	Studies provide information on among other things resistance to HIV drugs which provides crucial information on the need for switching to new regimens
Key Population Surveys & Studies	This targets and provides information on services coverage and programme impact among key populations, and size estimates.
NASA	This assessment will collect financial data to inform the national indicators about national government allocation and expenditures on HIV programmes. As per the NSF, the MOHSS is expected to conduct NASA every second year
National Commitments and Policy Instruments	The NCPI is a questionnaire based tool used in the UNGASS report to assess progress in a number of areas such as Policy, Strategic Planning, Structures, Resources, M&E (including research), Legal environment, Human Rights, Civil Society Participation, Prevention, Treatment, Care and Support, Impact Mitigation. This tool requires that a composite index be generated to provide information to decision-makers. The NCPI questionnaire is administered to key informants. The answers will then be reviewed and validated by a group of stakeholders, participating in the Joint Annual Review.
HIV/TB/STI Drug Stock Survey	Drug shortages and stock outs hamper effort to control STIs, TB and HIV. It is therefore critical to keep track of the extent to which health facilities that offer ART, STI and TB treatment keep enough stock of critical drugs and not run out of stock. To assess stock availability, heath facilities offering STI, ART and TB treatment will be assessed on the basis of experiencing stock out for more than 1 week in the last 12 months. This will be done through a drug stock survey
National Sentinel Sero-Survey	Biological surveillance of HIV and STIs has been primarily tracked through surveillance of sentinel populations. In Namibia, HIV surveillance targets pregnant women attending Ante natal clinic as a sentinel population. Frequency Responsibilities for data compilation and analysis lie with the RM&E subdivision of the DSP within the Ministry of Health and Social Services. Sentinel surveillance is conducted on a Biennial basis.
Health Facility Census/Assessment Reports	The study provides essential information on the quality of services being provided by the MOHSS.
NAMPHIA	The study was formally called the AIDS Indicator Survey and is planned to continue, this study will be useful to reinforce the end term evaluation of the National Strategic Framework in 2022.
NSF MTR & ETR	The Ministry of Health and Social services will conduct in-depth Mid Term review and end term review of the NSF to among other things determine the efficiency and effectiveness of the national response as the basis for programmatic recommendations on how to obtain more value-for-its-HIV investment and also to determine the implementation progress made during the implementation of the NSF.
Independent Data Quality Audit Reports	Data quality reviews will address the following (among others): The prerequisites of data quality (i.e., legal framework, resources, relevance, and quality management), Assurances of integrity, Methodological soundness and serviceability
On-site Implementation Verification Visits Reports	The Data verification visits and data verification meetings are purposed to ensure that data reported is of a good quality and that program implementation actually took place. These will be used as an opportunity by RM&E team to mentor and empower regional and community-level data people on data management. This will target both the MOHSS and implementing partners' M&E officers, Senior Data Clerks at the Regional level to carry out regional level data auditing.
HIV Stigma Index Study	The study will provide much needed data to help understand the dynamics of HIV related stigma in Namibia. This will help in the formulation of policies and programmes to address stigma towards PLHIV.

5.8 Data Quality Assurance

Data quality assurance is important to ensure that all data collected from implementers, surveys, government agencies or other sources are reliable, accurate, and consistent enough to support the various functions of Monitoring and Evaluation. The quality of the national response is as good as the data collected and hence the need to ensure data quality assurance. The following is proposed -

i. ***First***, data collection tools will be standardised. Stakeholders will be encouraged to use the standardised tools for data collection.

ii. ***Second***, Capacity of M&E personnel will be strengthened, and during the implementation periodical supervision and mentorship will be provided.

iii. ***Data verification:*** Data verification will be done on a routine basis. All data will be verified before it is reported or entered online. Initial verification will be done by, implementers before entering data online. RM&E will conduct follow-up verifications with selected implementers on a quarterly basis. Data will be verified to ensure the following:

- ***Data completeness***: whether the data captured is complete, and if disaggregated appropriately. Disaggregation elements may include but not limited to sex, age, service providers, and where possible the level of education among others.
- ***Reliability***: Checking whether the data is reliable and does not have biases, or technical flaws.
- ***Accuracy:*** Where data elements require mathematical calculations, that they are done correctly using the right process and formulas.
- ***Relevance***: Whether data collected is relevant to the NSF stakeholders needs.
- ***Timeliness*****:** whether data is available when it is needed for reporting or decision-making.

5.9 Independent Data Quality Audits

The MoHSS will undertake Data Quality Reviews and audits regularly, including ex-ante and ex-post reviews of all surveys and all indicators in the monitoring component. Data quality reviews will address the following (among others):

- The prerequisites of data quality (i.e., legal framework, resources, relevance, and quality management)
- Assurances of integrity
- Methodological soundness (e.g., concepts and definitions, approaches/study design, and sampling methodologies)
- Validity, reliability, timeliness, and precision of all data (including data collection instruments and procedures, data entry and storage, and data analysis)
- Serviceability (i.e., periodicity and dissemination standards, consistency, and revision policies and practices) Data quality reviews on the indicators in the M&E Plan and the data reported against them will take place prior to the MTR and ETR of the current NSF

Table 19: M&E and Research: Gaps, Challenges and Strategies

Gap/Challenge (Behavioural/Structural/Biomedical)	Key Strategies
Late reporting from sub national to national levels	Intensify advocacy to improve commitment to report on time
Human Resources Capacity Constraints	Recruit M&E staff, and build M&E capacity of all staff responsible for M&E functions
Weak linkages between HIV M&E system and the overall MOHSS HIS and other sectoral systems	Develop and operationalize a framework on M&E linkages with MOHSS, and National Statistics Agency
Limited use of M&E data for improved planning, resource allocation and decision making	Conduct orientation among key stakeholders on the use of M&E data and strategic information
Data gaps coupled with irregular and untimely reporting	Conduct research and or studies to generate new data
Limited infrastructure and connectivity for improved data transmission and reporting	Intensify advocacy with Government to strengthen ICT infrastructure in all regions
Coordination challenges, duplication and vertical reporting	Intensify implementation of the national coordination Framework
Fragmentation of sector and or institutional data. This makes it difficult to access data timely.	Strengthen linkages with the MOHSS database and M&E system

5.10 M&E Implementation Strategy

The following strategies will address the gaps and challenges highlighted above and strengthen strategic information and knowledge management during the implementation NSF:

a) **Create an enabling environment for M&E systems**: Appropriate policy and technical guidelines developed, revised, and disseminated. The M&E plan developed, indicators harmonized and aligned to the national core HIV/AIDS indicators. An indicator protocol developed that describes all indicators appropriately. Improve **M&E** coordination **among** the various stakeholders.
.

b) **Generate accurate, timely and relevant HIV data;** Training in routine data collection, primary analysis and reporting provided. Standardised tools and indicators developed and disseminated. Resources mobilised to support planned studies, surveys and surveillance, routine monitoring and periodic evaluations.

c) **Support for HIV research and evaluation:** A HIV and AIDS research agenda developed and reviewed periodically in the course of the NSF implementation. Research will aim at validating existing data, generating missing baselines. This will improve knowledge of HIV and AIDS. The capacity of the National Scientific and Ethics Committee strengthened to ensure efficient review of research protocols in a timely manner. New data from surveys, research, monitoring and evaluations disseminated using a variety of communication channels and information products.

d) **Increased use of HIV M&E data and information for planning decision-making and reporting:** Advocacy intensified among policy and decision-makers to create demand for strategic information coupled with capacity strengthening. Information packaged and made available in formats appropriate for the intended purpose.

e) **Improve linkages of MOHSS M&E System with program level systems**: Efforts made to link MOHSS M&E system to other systems including national statistics, and National Planning Commission (NPC) databases. Collaborative efforts will be established with Education Management Information System (EMIS), the OVC and Gender M&E system, and youth.

f) Capacity development: The capacity of M&E officers across sectors strengthened. Short-term courses, workshops, study tours, mentorship, supervisory visits and more formal institutional training for career progression**.** Advocacy will be intensified to fill vacant M&E positions**.**

g) Data Storage, Backup and Restoration: Data management strengthened at all levels. Appropriate equipment procured and placed at national regional and district levels to facilitate data management and storage Data generated through the response transformed into strategic information, and where applicable documented as part of advancing knowledge in the respective geographical areas. Strategic information used in improving programme design, implementation strategy, and to inform resource allocation

5.11 The Results Framework

Detailed information on indicators, including definitions, timing and frequency of reporting, units, level, classification, source, and responsible parties for reporting, has been compiled in the results framework in Annex 2. Efforts will be made to ensure that every indicator has a baseline, which should ideally be established prior to the start of the NSF. All indicators also must have annual targets whenever appropriate. It should also be noted that even if the frequency of an indicator's target is annual, reporting on that indicator may be more frequent, to provide up-to-date information on progress; in many cases, the indicator will be reported on a quarterly basis.

Table 20: RM&E Indicators and Targets

Indicator kind	Indicator description	Period (years)					Data sources
		1	2	3	4	5	
Outcome	% of NSF Core indicators providing data at Mid-term and End term evaluations (disaggregated by Impact, outcome, output level)			75%		90%	
Output	NSF Mid-term and NSF End-Term reports produced			Yes		Yes	
	Number of M&E reports produced						
	HR and Capacity enhancement						

Section 6: NSF Costing, Resources Mobilisation and Sustainability

6.1 NSF resource mobilisation and costing

Project Objective

To ensure increased domestic funding for the needs of the national multisectoral HIV response to 80%

Situation Analysis

Government spending on HIV and AIDS has been within the context of relatively high government allocation to the health sector. Government health expenditure as a percentage of total government expenditure in 2014 was approximately 14%. Public health expenditure as a percentage of GDP was estimated at 5.4% in 2014[35]. In comparison with other upper middle-income countries in Africa, government expenditure in health is relatively high[36]. Despite high government allocations to the health sector, sustainability of HIV/AIDS financing remains a major challenge and HIV/AIDS services are still significantly dependent on external funding from donor funding.

The last National AIDS Spending Assessment (NASA) was conducted in 2014. According to the report 65% of the funding for the HIV/AIDS response came from domestic sources including 1% from private sources. Thirty five percent (35%) of resources came from international sources. The Government of Namibia (GRN) has been the largest contributor (64%) of HIV/AIDS funding followed by PEPFAR (27%), Global Fund (6%), and private sector (1%). The remaining funding came from a variety of sources including German Development Cooperation (GIZ), UN agencies, and other international sources. The HIV spending in Namibia was US$ 201,060,024 (approximately N$ 2.07 billion[37]) in the period 2012/13 and US$ 213,346,629 (approximately N$ 2.2 billion) in the period 2013/14 respectively. The NASA report shows an increase in the funds spent by 6% percent from 2012/2013 to 2013/2014. Most of the expenditure on HIV/AIDS funding went to the provision of ARTs.

Both Global Fund and PEPFAR resource envelopes in Namibia are expected to significantly reduce during the period of the NSF (2017/18 – 2021/22). The Global Fund allocation to Namibia for 2018-20 representing only 20% annually of the 2016/17 commitment.

Other factors that cause immediate sustainability concerns include:

- Namibia's classification as an upper middle-income country (UMIC) means the country is not considered a priority by donor agencies as lower-middle income countries and low-income countries.
- Recent historical weaknesses in currency exchange as the Namibia Dollar is linked to the South African Rand.
- HIV Treatment policy changes that have significantly increased the target population for treatment. Sustainability analysis conducted in 2011 suggested that the funding gap for HIV/AIDS has been projected to be over N$500,000[38].

[35] UNDP 2016, Human Development Report
[36] Data sources from World Bank Open Data Base
[37] Using spot exchange rate for 11 December 2013: US$ 1 = N$ 10.3
[38] NSF 2017-22 Operational Plan Costing 2017 (MoHSS)

In 2012/13 financial year, the private health sector in Namibia accounted for 41% of total health expenditure (medical schemes 30%; household out-of-pocket payment 11%). However, private sector expenditure on HIV/AIDS is less than 2% of total HIV/AIDS expenditure.

The Resource Mobilisation and Development Coordination (RMDC) sub-division in the MOHSS is tasked with coordinating and facilitating donor support, for HIV/AIDS, TB and Malaria programmes. However, the work of the RMDC sub-division is constrained by:

a) Lack of dedicated budget, and hence the sub-division is mainly dependent on donor funding..
b) Shortage of human resources (HR) and skills in key financial management areas.
c) Financial and procurement policies and procedures that are not well-aligned with GRN procedures for effective functioning.

Analysis of the funding landscape shows that the current financing trajectory is not sufficient to adequately fund the national HIV/AIDS response. However efforts are being made to improve efficiencies in services delivery – that include strengthening health systems, strengthening linkages with communities and improving on the enabling environment (coordination and management).

Table 21: Resource Mobilisation - Gaps, Challenges and Strategies

Gap/Challenge (Behavioural/Structural/Biomedical)	Key Strategies
a) In adequate use of strategic information to inform funding and resource allocation for HIV and AIDS, and in resource mobilisation efforts.	Strengthen i. The capacity for resource mobilisation ii. Review and update relevant policies related to HIV and AIDS Financial management iii. Intensify resource mobilisation, including expansion of the donor base.
b) Shortage of competent and skilled HR in key financial management areas in GRN implementers and Civil Society	
c) Inadequate alignment of financial and procurement policies and procedures with the GRN procedures	
d) Lack of effective mobilisation of domestic (especially private sector) resources for NSF responses	Intensify advocacy with government to increase domestic funding for HIV and AIDS, including from the private sector
e) Lack of updated information for financial gap planning and resource tracking	Undertake efforts to improve efficiency and effectiveness of resource utilization in the disease responses
f) Inefficient resource utilisation	

6.2 Sustainability Strategies

International financial assistance has declined steadily over the past several years, and this situation is expected to continue. As a result it is expected that the GRN will assume more responsibility for funding the national response. However, for long-term sustainability of the response, a viable sustainable financing strategy will therefore need to be developed and implemented within the broader context of health systems financing and HIV mainstreaming in development programmes. Prioritizing high impact interventions and investing in the most effective strategies is not an option, but a requirement for Namibia

and in particular for the NSF.

One of the strategies for strengthening sustainability is improving efficiency through a mix of strategies including services integration, and focus on comparative advantage. Namibia will explore the possibilities for efficiency gains through services integration and mainstreaming in development sectors. Efficient financial resource management will also require an effective resource tracking and reporting mechanism that is currently not in place.

Innovative sustainability strategies will go beyond financial sustainability to cover organisational, service delivery and human resources. While strategies to achieve sustainability in these areas are distinct they are also intertwined and complementary. Table 37 below presents some of the suggested sustainability area, the challenges to be addressed and associated strategies.

Table 22: Framework for strengthening Sustainability

Issue	Challenge	What needs to be done
Financial sustainability	• A small donor base • Very little contributions from the private sector • Contribution by CSO not accounted for • Efficiency strengthening strategies lacking	• Develop a sustainability strategy • Expand donor base in the short term • Advocate for increased domestic funding • Develop exit strategies for all donor funded initiatives • Improve on efficiencies, and invest available resources smartly. • Develop a resource mobilisation strategy
Service Delivery	• Weak health and community systems	• Support strengthening resilient and sustainable systems for health (RSSH)
Human resources	• Inadequate HRH, • Poor retention, • Inadequate skills, competencies and experience	• Recruit and train essential staff, - qualified and competent • Strengthen skills and competencies, • Accelerate task shifting to complement key skills.
Organisational Sustainability	• Weak organisational operational, governance and administrative systems • No strategic organisational development strategies • Poor use of ICT technologies	• Develop an organisational development strategy • Periodically review organisational mandate, vision, mission and comparative advantage. • Strengthen strategic partnerships and alliances

Section 7: Operationalizing The NSF

Overview

The following NSF implementation strategies are premised on the multisectoral and decentralised nature of the response. NSF provides guidance on the national response and identifies the priority programmes, social and programmatic enablers necessary to achieve the desired health outcomes i.e. prevention of new HIV infections and reduction of AIDS related deaths.

NSF implementation will take different forms i.e. policy, advocacy, planning, monitoring and direct service delivery. Implementation will take place at national, regional, district and community levels. The key service providers include public sector institutions and in particular the MOHSS, the private sector and civil society organisations. Communities are both beneficiaries and key actors in service delivery. Participation will be premised on the individual organisational mandate, organisational capacity and expertise, and its comparative advantage.

Using a Combination Prevention Approach

The implementation of the HIV prevention, treatment, care and support programmes will be premised on the Combination Prevention Approach (CPS). The approach aims at ensuring effective synergies and complementarity between programmes and between specific interventions. The approach will be premised on the "National Combination Prevention Approach" plan. The CPS will -

i. Provide a strategic framework for the core prevention programmes elaborated in the NSF in order to: enable more effective coordination, management and alignment between these programmes; maximise efficiencies; avoid duplication; and address the challenges that have been created by the legacy of vertical prevention programming
ii. Provide guidelines on the NSF strategic planning process, the strategic planning cycle, and operational planning, and how they should be applied by, the core prevention programmes.
iii. Provide a summary of the scientific evidence relating to each of the NSF core prevention programmes, which can be used by stakeholders to inform the design, development and implementation of their respective HIV prevention interventions
iv. Offer guidance on how the coordination and management of combination prevention should be strengthened at the national, regional and community levels
v. Outline ways in which combination prevention strategies should be scaled up, prioritised and targeted to maximise the impact they will have in preventing new HIV infections

Catalysing Action Planning

It is anticipated that implementing partners will develop their organisational strategic or operational plans that are inspired and informed by the NSF. Thematic programmes such as eMTCT or VMMC will also develop their specific action plans guided and aligned with NSF (Annex 1 – NSF Operational plan Guide).

Intensifying Communication and Advocacy

Advocacy will be intensified to ensure that stakeholders focus on prioritised programmes, the critical social and programmatic enablers. These are prioritised because of their efficacy and potential to realise the desired results and targets (Annex 2 - Results Framework)

Advocacy will also aim at influencing the choice of HIV prevention behaviours and changes in lifestyles to those that support prevention of new infections – These may include but not limited to male circumcision, the use PrEP, condoms, HTC, and reduction of MCP, stigma and discrimination. Advocacy will aim to influence changes in service delivery to bridge the gaps between availability, access and utilisation.

At community level advocacy will focus on galvanising communities to initiate local responses to change risk environment and promote HIV prevention. The approach will also promote community-centred design and delivery of services.

Strengthening Strategic Partnerships and Alliances

The implementation of NSF transcends beyond sectoral, region and organisational boundaries and hence calls for strategic partnerships and alliances. Efforts will be made to consolidate existing partnerships and alliances, and establish new ones as the need arises. Strategic partnerships will be expected to advance innovative ideas, leverage technical assistance and resource flows, facilitate transfer of skills, knowledge, and best practices. Effective health systems will enable collaborating partners to scale up service delivery innovations, increase client and geographical coverage; access and utilisation of services; and improve client retention on services. The partnerships are anchored on the principles of shared and common interests, shared resources (time, money, expertise, and people), risks and benefits

Mobilising Communities for Demand Creation

Community mobilisation will be intensified and scale up. This strategy will focus on demand creation, facilitating community participation and engagement, and as part of promoting adherence and retention in treatment and care. It is through community mobilization that communities have been able to mobilize key populations such as sex workers, MSM and other vulnerable groups including survivors of gender-based violence, women and girls, orphans and vulnerable children. Effective community mobilisation will enhance efforts in building trust and transparency with the respective communities.

Monitoring the Implementation of the response

Routine monitoring of the national response will be undertaken by, all stakeholders involved in the implementation. The process will be guided by the national M&E plan, and the programme specific (i.e. HTC) guidelines.

Data from non-health facility based programmes, implemented by the private sector, civil society or government organisations, ministries and agencies (OMAs), will be reported through the Multisectoral Information Management System (MIMS), housed by the DSP. The process requires programme implementers operating in regions to submit data through Regional Aids Coordinating Councils (RACOCs), where an initial approval will be made, before the data reaches the RM&E unit. In addition institutions operating at a national level and contributing programmatically to the epidemic response – such as government ministries and umbrella organisations – report programme data directly into MIMS.

Engaging Communities, Civil Society Organisations, and PLHIV

Communities are the cornerstones of the national response implementation. Their partnership with CSO has helped to expand the scope of the response, increase uptake of services through demand creation, and facilitate development of community solutions that address negative socio-cultural norms and

practices, including GBV. In the past, communities have supported PLHIV through community-based support groups.

HIV integration in the Health Care System

Service providers and in particular MOHSS will provide the leadership necessary for the integration of HIV services with mainstream health care including non-communicable diseases. Integration will not only improve on service delivery efficiency but will also increase uptake and utilisation.

Integrating and implementing critical social and programmatic enablers, and developing synergies

Specific social and programmatic enablers have been addressed or infused in the relevant sections of the prioritised basic/core programmes. Stakeholders will be oriented / trained on HIV mainstreaming and implementation of the critical enablers.

Strengthening Coordination, Management and Networking

Stakeholders will be trained on coordination and management of the response, including networking. Improvements in coordination will result in efficient delivery of services, and will narrow the gap between demand and supply of HIV and AIDS services. It will facilitate harmonisation and alignment of service to avoid duplication, rationalize resource use, and ensure equitable distribution of HIV services. This process is characterised by shared responsibility, defined mandates and responsibilities and a functional monitoring and evaluation system

.

Section 8: Annexes

Annex 1: NSF Costed Operational Plan – Summary by Module (In NAD)

		2017/18	2018/19	2019/20	2020/21	2021/22	Total	%
1.0	**Prevention (inc contingency)**	**598,574,778.69**	**645,676,818.87**	**707,595,073.83**	**730,568,828.03**	**828,715,889.26**	**3,511,131,388.68**	**29.9%**
1.1	AGYW	189,412,385.92	225,130,512.60	221,560,427.72	244,924,275.29	251,938,705.22		9.6%
1.2.1	MSM	88,104,484.00	76,868,675.88	100,407,139.23	88,006,947.02	114,956,133.71		4.0%
1.2.2	FSW	88,160,484.00	76,928,595.88	100,471,253.63	88,075,549.42	115,029,538.28		4.0%
1.3	Condoms	51,034,631.96	54,874,556.20	65,298,950.13	74,280,031.44	82,625,544.06		2.8%
1.4	VMMC	74,229,207.00	95,809,999.97	90,156,427.69	96,467,377.62	105,407,603.53		3.9%
1.5	PrEP	402,767.42	2,515,794.70	4,831,717.36	4,579,834.36	4,900,422.77		0.1%
1.6	PMTCT	66,954,393.08	69,064,442.09	75,732,205.08	84,102,123.50	95,803,705.44		3.3%
	Contingency	40,276,425.30	44,484,241.57	49,136,952.99	50,132,689.37	58,054,236.26		2.1%
2.0	**HIV Testing, Treatment, Care and Support**	**842,846,452.10**	**1,092,458,196.18**	**1,153,534,263.46**	**1,340,446,345.82**	**1,582,314,727.33**	**6,011,599,984.89**	**51.2%**
2.1	HTS	243,857,892.14	252,497,354.40	268,844,085.21	287,966,442.82	307,684,977.15		11.6%
2.2	ART	566,265,944.33	746,330,229.09	804,327,864.82	964,724,228.70	1,158,054,226.57		36.1%
2.3	TB/STI	17,005,544.00	66,015,628.43	60,019,972.45	65,809,090.58	91,071,057.62		2.6%
	Contingency	15,717,071.63	27,614,984.26	20,342,340.99	21,946,583.72	25,504,465.98		0.9%
3.0	**Systems Strengthening, Capacity Strengthening and**	**208,681,122.98**	**222,131,233.86**	**254,422,087.04**	**295,680,175.50**	**345,079,053.25**	**1,325,993,672.64**	**11.3%**

	Development of Synergies							
3.1	RSSH	103,789,144.00	110,352,357.08	124,839,922.88	142,435,529.50	163,639,672.80		5.5%
3.2	CSS	1,184,745.00	637,051.25	-	-	-		0.0%
3.3	Coordination	93,907,383.17	100,761,218.59	117,687,949.32	139,227,656.89	164,795,436.86		5.2%
	Contingency	9,799,850.82	10,380,606.94	11,894,214.83	14,016,989.11	16,643,943.59		0.5%
4.0	**HIV Mainstreaming in Development Sectors**	**3,204,750.61**	**21,172,458.56**	**35,031,602.44**	**4,898,987.82**	**9,073,483.13**	**73,381,282.56**	**0.6%**
5.0	**Strategic Information and Knowledge Management**	**245,646,295.92**	**107,207,261.84**	**80,076,340.52**	**273,568,822.94**	**55,321,270.23**	**761,819,991.45**	**6.5%**
6.0	**Resources Mobilisation and Sustainability**	**8,700,429.80**	**7,252,106.15**	**9,248,798.16**	**17,414,495.06**	**20,612,893.81**	**63,228,722.98**	**0.5%**
		1,907,653,830.09	2,095,898,075.47	2,239,908,165.45	2,662,577,655.17	2,841,117,317.00	**11,747,155,043.19**	**100%**

Annex 2: NSF Results Framework

Indicator number	Indicator description	Numerator	Denominator	Disaggregation	Baseline	Target 2017/18	Target 2018/19	Target 2019/20	Target 2020/21	Target 2021/22	Data Source	Responsible Institute	
1. National Impact Level Indicators													
1.1	**New infections** Number of new HIV infections per 1000 uninfected population	Number of new HIV infections in one year	Total uninfected population	Age, Sex, Region	4.3 (2016)	3.8	3.2	2.9	2.2	0.9	EPP, HIV Estimates and Projections	MoHSS	
1.2	Number of AIDS related deaths per 100 000 population		Total Population	Age, Sex, Region	17.2 (2016)	16.9	14.5	12.2	10.0	3.9	HIV Estimates and Projections	MOHSS	
1.3	% of HIV infected infants born to HIV positive mothers	Number of HIV infected infants born to HIV positive mothers	Total number of infants born to HIV positive mothers	Region	4% (2014)	4%	3.5%	3%	2.5%	2%	Programme data, HIV Estimates	MoHSS	
1.4	**ART retention** % of adults and children living with HIV known to be on antiretroviral therapy 12 months after starting	Number of adults and children who are still alive and receiving antiretroviral therapy 12 months after initiating treatment	Total number of adults and children initiating antiretroviral therapy within the reporting period, including those who have died since starting antiretroviral therapy, those who have stopped treatment and those recorded as lost to follow-up at month 12	Age, Region, 24 and 36 month	Adult: 77% Children: 86% (2016)	Adult 80% Children 90%	Adult 83% Children 94%	Adult 85% Children 95%	Adult 88% Children 97%	Adults 90% Children 98%	Routine program data	MoHSS,	
1.5	TB/HIV mortality rate per 100,000 population	Number of HIV-positive new and relapsed TB patients who died	Total population	Sex	36/100,000 (2015)	31	28	26	23	21	Programme data	MOHSS	

		before or during TB treatment											
1.6	**Domestic finance** National HIV expenditure	HIV domestic public expenditure	Total HIV expenditure	Domestic and Internatio nal	Domestic 65% (2014) Internationa l 34%	Domestic 70% (2014) Internatio nal 29%	Domestic 75% (2014) Internatio nal 24%	Domestic 85% (2014) Internatio nal 19%	Domestic 85% Internatio nal 14		NASA NHA	MOHSS	
2. National Outcome Level Indicators													
3.1.2. Adolescent Girls and Young Women													
3.1.2.1	Number of New HIV infections among adolescents girls and young women			Age: 10 – 19 15 - 24	1,000 (2016) 2,323 (2016)	900 2,200	800 1,900	700 1600	600 1,400	400 1,000	Spectrum Estimates	MOHSS	
3.1.2.2	Number of AIDS related deaths among adolescents girls and young women			Age: 10 – 19 15 - 24	132 (2016) 176 (2016)	120 170	100 150	80 130	60 120	50 100	Spectrum Estimates	MOHSS	
3.1.2.3	Adolescents girls and young women on ART who have achieved virus suppression			Age: 10 – 19 15 - 24	74% (2014) 74% (Proxy 2014)	78% 78%	80% 80%	84% 84%	87% 87%	90% 90%	NIP Lab	MOHSS	
3.1.2.4	% Adolescents girls and young women tested for HIV and know their status			Age: 10 – 19 15 - 24	29% (2015 NIP Lab)	78%	80%	84%	87%	90%	DHS/PHIA	MOHSS	
3.1.2.5	Adolescents girls and young women enrolled and retained on ART			Age: 10 – 19 15 - 24	74% (2013)	78%	80%	85%	90%	95%	EDT	MOHSS	
3.1.2.6	% of women of reproductive age (15–49 years old) who have their demand for family planning satisfied with modern methods			Age: 15 – 49	88% (2013)	90%	92%	94%	96%	98%	DHS/PHIA	MOHSS	

3.1.2.7	% of women and men 15–24 years old who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission			Sex, Age	61% (2013)	68%	70%	75%	80%	90	DHS/PHIA	MOHSS	
3.2.1 Male Involvement in the HIV/AIDS response													
3.2.1.1	Percentage of pregnant women attending antenatal care (ANC) whose male partner was tested for HIV in the last 12 months	Number of pregnant women attending antenatal care whose male partner was tested in the last 12 months	Number of pregnant women attending antenatal care	None	4% (2013 PMTCT ANC Data)	10%	20%	30%	40%	50%	DHS/PHIA	MOHSS	
3.2.1.2	% men who had sexual intercourse with more than one partner in the last 12 months	Number of men who had sexual intercourse with more than one partner in the last 12 months	Total number of men who answered the question	Sex	Male: 6.5% Female: 2.2%	20%	30%	40%	55%	60%	DHS/PHIA	MOHSS	
3.2.1.3	% men 15 – 49 who had sexual intercourse with more than one partner in the last 12 months	Number of men who consented to having sex with more than one partner in the last 12 months	Total numbers of men who answered the question	Age	10.4% (2013)	40%	45%	50%	55%	60%	DHS/AID Indicator Survey/PHIA	MOHSS	
3.3.1 Key Populations (Men who have Sex with Men (MSM), Sex workers, etc.)													
3.3.1.1	HIV Prevalence among key populations	Number of People in the specific key population who tested positive	Number of People in the specific key populations tested for HIV	 MSM FSW	Averages across sites: 11.9% (2013) 39.9% (2013)	 12% 41%	 12% 41.5%	 12.5% 42%	 13% 42%	 13.5% 42.5%	Sentinel Survey/IBBS	MOHSS	

3.3.1.2	Percentage of key populations who know their HIV status	Number of People in the specific who answered yes to knowing their HIV status	Number of People in the specific key populations who answered to the question	MSM FSW	Diagnosed: 23% (2013 IBBS) Diagnosed: 53% (2013 IBBS)	50% 70%	60% 75%	70% 80%	75% 85%	80% 90%	Sentinel Survey/IBBS	MOHSS	
3.3.1.3	Percentage of people living with HIV in the a key population receiving ART in the past 12 months	Number of respondents living with HIV who report receiving ART in the past 12 months	Number of respondents living with HIV	MSM FSW	85% (2013 IBBS) 72% (2013 IBBS)	86% 80%	87% 84%	90% 87%	95% 95%	95% 90%	Sentinel Survey/IBBS		
3.3.1.4	% Of people in the key population reached with HIV prevention program	Number Of people in the key population reached who said yes to the question	Total number people in in the key population who answered the question	MSM FSW	Average across sites: 63.65% (2013 IBBS) Average across sites: 59.93 (2013 IBBS)	70 60%	70% 70%	80% 80%	85% 85%	90% 90%	Sentinel Survey/IBBS	MOHSS	
3.3.1.5	Percentage of people in the key population reporting using a condom with their most recent client	Number of people in the key population reporting using a condom with their most recent client	Total number of respondents	MSM FSW	Average across sites: 70% (2013 IBBS) Average across sites: 86.05 (2013 IBBS)	75% 89%	80% 90%	85% 95%	90% 98%	95% 98%	Sentinel Survey/IBBS	MOHSS	
3.3.5 Condom Promotion and Distribution													
	Percentage of respondents who say they used a condom the last time they had sex with a non-marital, no-cohabiting partner in the last 12 months	Number of respondents who report using a condom the last time they had sex with a non-marital, no-cohabiting partner in the last 12 months	Total Number of respondents who report they had sex with a non-marital, no-cohabiting partner in the last 12 months	Sex, Age (15 – 49)	Male: 72.1 (2013) Female: NA Male: 76.1% (15-19) 80.7% (20-24) 67.6% (25 -49)	80%	85%	90%	95%	98%	DHS/PHIA	MOHSS	

	Number of Male and female condoms distributed			Male Female	26m (2013) 0.18 (2013)	31.1M 251250	34,9M 251,250	38.7M 251,250	39.5M 251,250	40M 251,250	Programme Data	MOHSS	
3.3.6 Voluntary Medical Male Circumcision (VMMC)													
	Percentage of men 15–49 that are circumcised	Number of male respondents aged 15–49 who reported that they are circumcised	Number of all male respondents aged 15–49 years	By age	25.5% (2013)	40%	50%	60%	70%	80%	DHS/PHIA	MOHSS	
	% of HIV-positive men identified in VMMC settings successfully linked to HIV Treatment	Number of HIV-positive men identified in VMMC settings successfully linked to HIV Treatment	Total number of HIV positive men identified in VMMC settings	By age	NA	70%	80%	85%	90%	95%	Programme Data	MOHSS	
	Number of male circumcisions performed according to national standards during the past 12 months			By age	53,820 (2016)	55,000	60,000	60,000	65,000	65,000	Programme Data	MOHSS	
3.3.7 Pre-Exposure Prophylaxis (PrEP)													
	Number of people receiving oral PrEP for the first time during the reporting period			FSW, MSM, Discordant Couples	NA	500	500	500	500	500	Programme Data	MOHSS	
3.3.8 Prevention of Mother to Child Transmission (PMTCT)													
	Infant HIV case rate (cases/100,000 live birth)			None		500	400	300	200	150	ANC Sentinel Surveillance/ HIV Estimation	MOHSS	
	Estimated percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in	Estimated number of children newly infected with HIV from mother-to-child transmission among	Estimated number of children delivered by women living with HIV who delivered in the previous 12 months	None	4.1% (2015)	4%	3.5%	3%	2.5%	2%	Programme Data/Estimates	MOHSS	

	the past 12 months (MTCT rate)	children born in the previous 12 months to women living with HIV											
	% of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV	Number of pregnant women living with HIV who delivered and received antiretroviral medicines during the past 12 months to reduce the risk of the mother-to-child transmission of HIV during pregnancy and delivery.	Estimated number of women living with HIV who delivered within the past 12 months	None		95%	96%	96%	97%	97%	DHS/Estimates	MOHSS	
	Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth	Number of infants who received an HIV test within two months of birth during the reporting period	Number of pregnant women living with HIV giving birth in the past 12 months	None		95%	95%	95%	96%	96%	Lab and Estimates	MOHSS	
	% of HIV exposed infants receiving HIV DNA PCR test within 12 months					95%	95%	95%	96%	96%	Lab and Estimates	MOHSS	
	% of pregnant women who were tested for HIV and know their results												
	HEI receiving ARV prophylaxis												
	HEI receiving CTX prophylaxis												

3.2.1 HIV Testing and counselling													
	People living with HIV diagnosed	Number of people living with HIV who know their HIV status	Number of people living with HIV	Sex Age	77% (Estimates 2016)	80%	83%	86&	88%	90%	Estimates	MOHSS	
	% Of women and men 15-49 who received an HIV test in the last 12 months and know their results	Number of women and men 15-49 who received an HIV test in the last 12 months and know their results	Number of women and men 15-49 who received an HIV test in the last 12	Sex	Male: 38.1% (2013 DHS) Female: 49.1% (2013 DHS)	50% 55%	60% 65%	70% 70%	78% 78%	80% 80%	DHS/PHIA	MOHSS	
	% Of PLHIV diagnosed with HIV linked to ART by 2022	Number of PLHIV diagnosed with HIV linked to ART	Total number of PLHIV diagnosed	Sex Age	NA	80%	85%	90%	95%	95%	Programme Data	MOHSS	
3.4.3 Treatment Care and Support targets													
	Currently on ART % of PLHIV receiving ART for treatment	Number of people on antiretroviral therapy at the end of the reporting period	Estimated number of people living with HIV	Sex Age	Adult 64% Children 66% (Estimates 2016)	70%	76%	80%	86%	90%	Estimates	MOHSS	
	Viral Suppression % Of PLHIV on ART with suppressed viral load	Number of PLHIV on ART in the reporting period with suppressed viral loads (≤1000 copies/mL)	Estimated number of people living with HIV on ART	Sex age	87% (2016)	87%	88%	89%	90%	90%	Clinical and programme data, nationally representative surveys	MOHSS	
	People with HIV	Number of people living with HIV	Population	Sex, age, location, key population, pregnancy	Male: 10.9 (2013) Female: 16.9 (2013)	(All: 11.0)	11.0	10.9.	10.9	10.8	PHIA, DHS	MOHSS	

				status, TB patients	Pregnant women: 17.2 (2016) TB patients: 45(2013)								
3.4.4 Treatment of TB/HIV Co-infection among PLHIV													
	Percentage of estimated HIV-positive incident tuberculosis (TB) cases (new and relapse TB patients) that received treatment for both TB and HIV	Number of HIV-positive new and relapse TB patients started on TB treatment during the reporting period who were already on antiretroviral therapy or started on antiretroviral therapy during TB treatment within the reporting year	Estimated number of incident TB cases in people living with HIV	Sex Age	Male: 1843 Female: 1567 (2016)	84%	90%	95%	95%	98%	Programme Data	MOHSS	
	% Of Adult PLHIV with CD4< 200 screened for Cryptococcal Antigen			Sex		95%	100%	100%	100%	100%	Programme Data	MOHSS	
STI Indicators and Targets:													
	Gonorrhea among men	Number of men reported with laboratory-diagnosed gonorrhoea in the past 12 months	Number of men 15 years and older	None	NA					TBD	Programme Data	MOHSS	
	Proportion of people starting antiretroviral therapy who were tested for hepatitis B	Number of people started on antiretroviral therapy who were tested for hepatitis B during the reporting	Number of people starting antiretroviral therapy during the reporting period	Sex Age	NA	50	60	70	80	90	Programme Data	MOHSS	

		period using hepatitis B surface antigen tests											
	Proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV)	Number of adults and children starting antiretroviral therapy who were tested for hepatitis C during the reporting period using the sequence of anti-HCV antibody tests followed by HCV polymerase chain reaction (PCR) for those who are anti-HCV positive.	Number of adults and children starting antiretroviral therapy during the reporting period	Sex Age	NA	40	50	55	60	70	Programme Data	MOHSS	
	Proportion of women living with HIV 30–49 years old who report being screened for cervical cancer using any of the following methods: visual inspection with acetic acid or vinegar (VIA), Pap smear or human papillomavirus (HPV) test	Number of women living with HIV 30–49 years old who report ever having had a screening test for cervical cancer using any of these methods: VIA, pap smear and HPV test.	All women respondents living with HIV 30–49 years old.	30-49 yrs	NA	40	50	55	60	70	Programme Data	MOHSS	
4.1.4	**Human Resources for Health and Service Delivery**												
4.1.5	**Human Rights, Gender Equality, Stigma and Discrimination**												
	Existence of HIV friendly services for different population groups			AGYW MSM FSW						Yes for all groups			
	% Health service providers trained on legal provisions and human rights												

	Percentage of Women and Men 15 – 49 years who report discriminatory attitude towards people living with HIV	Number of respondents (15–49 years old) who respond no to either of the two questions	Number of all respondents (15–49 years old) who have heard of HIV	Sex	71.9%	80%	85%	90%	95%	98%	DHS, PHIA	MOHSS	
	Proportion of ever-married or partnered women 15–49 years old who experienced physical or sexual violence from a male intimate partner in the past 12 months	Women 15–49 years old who have or have ever had an intimate partner and report experiencing physical or sexual violence from at least one of these partners in the past 12 months.	Total number of women 15–49 years old surveyed who currently have or have had an intimate partner	Age	31% (2013)	50%	55%	60%	65%	70%	DHS/PHIA	MOHSS	
4.2 HIV Mainstreaming,													
	# of government ministries, (OMAs) & Private sector organisations providing health and wellness service for employees (Disaggregated by sector												
4.3 Coordination and Management of the multisectoral response													
	Number of coordination meetings held			NAEC, Prevention TAC,	3 (2016 NAEC meeting)	4	8	12	16	20	Programme Data	MOHSS	
	# of coordination structure personnel trained on governance and leaderships			Coordination structures							Programme Data	MOHSS	
5.0 Strategic Information and Knowledge Management													

	% of NSF Core indicators providing data at Mid-term and End term evaluations	Number of NSF Core indicators providing data at Mid-term and End term evaluations	Total number of core indicators	Impact, Outcome	NA	50%	65%	75%	80%	90%	Programme Data	MOHSS	

Annex 3: NSF Research and Evaluation Agenda

Research Area	Priority Research Questions	Type of Study	Specific Studies Planned	NSF Programmes Areas	Planned Year
HIV SURVEILLANCE	What is the HIV incidence? What is the HIV Prevalence? What is the impact of the National Response on HIV in Namibia?	Population-based Study	Namibia Demographic and Health Survey (DHS+)	AGYW, condoms, VMMC, PrEP, PMTCT, ART	2019
			NAMPHIA	AGYW, condoms, VMMC, PrEP, PMTCT, ART	2022
			ANC PMTCT comparison study	PMTCT	
			HIV Sentinel Surveillance Survey	PMTCT	2018
			Multiple Indicator and Cluster Survey (MICS)	AGYW	2019
	What are the drivers of the HIV epidemic?	Population-based Study	HIV Modes of Transmission Study	All	2018
	What are the changes in behavioural and risk factors for HIV over time? What are the key determinants of risky sexual practices among KPs?	Key populations	National Population Size Estimation of Sex Workers, MSM and IDU	Key Populations (MSM, FSW, and IDU)	2018, 2022
			Integrated Bio-behavioural surveillance survey among Sex workers, MSM and IDU	Key Populations (MSM, FSW, and IDU)	2018
	How well does the ART programme in Namibia prevent HIVDR? What proportions of persons have HIVDR at ART initiation?	HIV Drug resistance Survey	Surveillance of HIVDR in children less than 18 months of age	ART	2018
			Transmitted drug resistance surveys (TDR)	ART	2018

	How does the pattern of HIVDR predict response to first-line regimens? What proportions of persons on ART have virological failure? How does the pattern of HIVDR in persons with virological failure predict response to 2nd-line ART? HIV		Cross-sectional surveys of acquired HIVDR (ADR) in adults and children on ART at nationally representative ART clinics	ART	2018
			Cross-sectional surveys of HIVDR in adults prior to ART initiation (PDR) at representative ART clinics	ART	2019
			Early Warning Indicators	ART	2018
		HIV Incidence Studies	Sentinel Incidence Surveillance to Evaluate the Response (SISTER)	ART	2018
			Drug resistance surveillance	ART	2019
			Incidence and HIVDR testing of DHS specimens	AGYW, PrEP, PMTCT, ART	2019
			Incidence testing of ANC specimens	AGYW, PrEP, PMTCT, ART	2019
		Special Studies	Microbiological Surveillance for Sexually Transmitted Infections	AGYW, PMTCT, Key Populations	
			A pilot study of Hepatitis B virus infection in HIV infected children in Namibia	AGYW, PMTCT, ART	2020
			Survey of non-communicable diseases among PLWHA	All	2010
HTC	What are optimal models for effective referral/follow-up mechanisms from HCT to prevention, care and treatment?	Impact/Outcome	Effectiveness evaluation of HCT delivery models in identifying new HIV infections, discordant couples and linking HIV positive clients to care and treatment	HTS	2020
	What are the key predictors of HCT services uptake and use by couples? How can MARPS/KPs be effectively	Implementation/processes	Evaluation of the Mixed method of Provider Initiated Testing & Counselling	HTS	2019
			Community Counsellor evaluation	HTS	2020

	reached with HCT services? What are the key determinants for HCT services uptake/use among Men?		Couples counselling and testing assessment	HTS	2019
VMMC	What effect does male circumcision have on sexual behaviour and risk behaviour?	Impact/Outcome	Study on the behaviour change among men who undergo circumcision for HIV prevention	VMMC	
	How can MC service delivery be improved to improve acceptability, quality, and reach?	Implementation/processes	Male circumcision evaluation	VMMC	2020
General Prevention	What is the efficacy and cost effectiveness of the rollout of PrEP	Implementation/Cost	Conduct operational research on PrEP implementation in various groups (Cost effectiveness)	PrEP	2019
		Impact/Outcome	Demonstrate population level impact of PrEP	PrEP	2022
	How effective is the has PrEP implementation been	Implementation/Process	Evaluate the predictors of PrEP adherence	PrEP	2020

	What is the effectiveness and quality of prevention programs? What is the impact of the scale up of ART on risk behaviour?	Impact/Outcome	Evaluation of the TCE programme in Namibia	All	
	Are prevention programs effective in reducing risk behaviours in order to decrease HIV incidence?	Impact/Outcome	Condom Impact Assessment Study	Condoms	2020

Annex 4 NSFs Sectors and Membership

Sector	Lead Agency
Cluster 1: Agriculture, Fisheries and Environment	• Ministry of Agriculture, Water and Forestry • Ministry of Land Reform • Namibia Farmers Union • Namibian Agricultural Union • Agricultural Bank of Namibia • AGRA • Meat Board of Namibia • MEATCO • NamWater • Ministry of Environment and Tourism • Ministry of Fisheries and Marine Resources • Namibia Tourism Board • Namibia Wildlife Trust • Federation of Community Based Tourism Assistance • Hospitality Association of Namibia • Namibia Community Based Tourism Assistance Trust (NACOBTA) • Namibia Nature Foundation committed to Conservation • Hunters Association • Desert Research Foundation Namibia • Save the Rhino Trust • Travel Agencies • Representatives of relevant development partners • Private Fishing Companies • Community-based Aquaculture • Ministry of Poverty Eradication and Social Welfare
Cluster 2: Education, Youth and Employment Creation	• Ministry of Labour, Industrial Relations and Employment Creation • Ministry of Education, Arts and Culture • Ministry of Higher Education, Training and Innovation • Ministry of Gender Equality and Child Welfare • Ministry of Health and Social Services • Ministry of Information and Communication Technology • Ministry of Sport, Youth and National Service • National Youth Council • Institutions of Higher Learning • Representatives of relative development partners • Representatives of Commercial Banks • KAYEC • Vocational Training Centre • Labour Advisory Council • Trade Union Congress of Namibia (TUCNA) • International Labour Organisation • Ministry of Industrialisation, Trade and SME Development • Ministry of Public Enterprises • Ministry of Sport, Youth and National Service • University of Namibia • International University of Management • Namibia University of Science and Technology • Namibia College of Open Learning

Cluster 4: Communication, Transport, Industrialisation; Trade and SME Development	Ministry of Information of Communication Technology • Telecom Namibia • Mobile Telecommunication • NAMPOST • Media Institute of Southern Africa • Namibia Press Agency • Namibia Broadcasting Corporation (TV and Radio) • One Africa Television • Multi-choice Namibia • Film Commission • Communications Regulatory Authority of Namibia (CRAN) • Representatives of relative development partners • Ministry of Mines and Energy • NAMPOWER • Mine Workers Union of Namibia • Chambers of Mines • National Petroleum Corporation of Namibia • Shell Namibia • Petroleum Companies • Electricity Control Board • Namibian Renewable Energy Programme • Diamond Board of Namibia • Offshore Development Company • Representatives of relevant development partners • Ministry of Trade Industrialisation and SME Development • Ministry of Poverty Eradication and Social Welfare • Ministry of Labour, Industrial Relations and Employment Creation • Ministry of Higher Education, Training and Innovation • Ministry of Finance • Ministry of Public Enterprises • Ministry of Sport, Youth and National Service • National Youth Council • Business Information Providers Union (BIPA) • Namibia Competition Commission • Ministry of Finance: Customs • AfriYaN • Ministry of Works and Transport • Walvis Bay Corridor Group • NAMPOST • Air Namibia • Roads Construction Companies • Trans Namib Holdings • Motor Vehicle Accident Fund • Namibia Airports Company • Namibian Port Authority • Namibia Bus and Taxi Association • Trade Unions • Representatives of Relevant Development Partners
Cluster 5: Health Social Welfare and Gender	Ministry of Health and Social Services • Ministry of Gender Equality and Child Welfare • Council of Churches of Namibia • Health Professional Council • Namibia Network of AIDS Service Organisations

	• Namibian Association of Medical Aid Funds • Traditional Healers Association • Women Action for Development • Out right Namibia • Health Works Business Coalition • Namibia Nursing Association • Namibia Nurses Union • Namibia Institute of Pathology • OYO • DAPP • NAPPA • Society for Family Health • Organisations of People living with disabilities • Social Security Commission • Government Institute Pension Fund • Representatives of relevant development partners • FAWENA • Khomas Women in Development • AfriYan • Namibia Red Cross Society • Council Of Churches in Namibia • Women Action for Development • National Association for Women in Business • Gender Based Violence Protection Units • Legal Assistance Centre • Ministry of Industrialisation, Trade and SME Development • Organisations of People living with HIV • Lifeline Childline • Representatives of relevant development partners
Cluster 6: Uniformed Services	**Ministry of Defence** • Namibia Police Force • Namibia Marine Services – Marine Police • Ministry of Finance – Immigration Officials • Ministry of Home Affairs and Immigration –Customs • Society for Family Health • Namibia Correctional Services • Ministry of Veterans Affairs • United Nations Development Programme • United Nations Joint Programme on AIDS • United States Agency for International Development

Annex 5 Mandates, Roles and Membership of the National Coordinating Structures

Name of Structure	Mandate	Roles	Membership
The Cabinet	Cabinet is the highest policy making body on HIV/AIDS in Namibia. The membership is composed of sitting Ministers. The function of the Cabinet is to approve the National HIV/AIDS Policy and National HIV/AIDS Strategic Framework.	✓ Ensure periodical review of the National HIV and AIDS Policy and other national, and sector policies to mainstream HIV and AIDS. ✓ Ensure that the multisectoral HIV and AIDS response in Namibia is aligned to the long-term social and economic development goals articulated in Vision 2030, NDPs and Global and Regional targets. ✓ Ensure equitable distribution, availability, access, and utilisation of HIV and AIDS services. ✓ Ensure enforcement and compliance with relevant HIV and AIDS policies and legislation. ✓ Ensure adequate and sustained funding of the national HIV and AIDS multisectoral response. ✓ Maintain HIV and AIDS agenda on the national socioeconomic and political development agenda.	➢ All Cabinet Ministers ➢ Director – General National Planning Commission ➢ Auditor General ➢ Attorney General ➢ Ombudsperson
Meeting of Senior Civil Servants	This is a monthly meeting of Permanent Secretaries (PS). It has the responsibility of ensuring harmonization and alignment of the national response with government policy frameworks, in addition to overseeing the HIV mainstreaming in different public sectors. At individual sector level, Permanent Secretaries are responsible for reviewing and approving sector specific HIV mainstreaming action plans and budgets.	✓ Ensure alignment of the national HIV and AIDS response with government policies and legislation ✓ Provide leadership, support and facilitate resource mobilisation and allocation for internal and external mainstreaming of HIV and AIDS response in the sector development plans. ✓ Receive and review reports from NAEC. The Committee can approve recommendations by NAEC, unless in their opinion the decision is required from Cabinet. ✓ Ensure strengthening synergies between the sectors and the	➢ All permanent Secretaries, ➢ Director General – National Planning Commission

		national HIV and AIDS response.	
National AIDS Executive Committee (NAEC)	The composition is multisectoral with representation from all stakeholders drawn from public and private sectors, civil society and development partners with a mandate to provide technical leadership, facilitate programme development and planning, oversee capacity development and technical assistance, partnership strengthening and management of strategic information. The committee also reviews programme coordination, policies and legislation and makes recommendations to Cabinet for approval and meets on a quarterly basis and reports to the Meeting of Senior Civil Servants and to Cabinet if required. NAEC work through technical advisory committees, sector steering committees, programme and specialised committees that may be established from time to time.	✓ Ensure harmonisation and alignment of stakeholder's priorities with the national priorities. ✓ Ensure the existence and availability of an updated National HIV and AIDS policy. ✓ Ensure joint (multisectoral) development and implementation of the National Strategic Frameworks (NSF), sector and regional plans, and the National Operational Plan (NOP). ✓ Monitor compliance by stakeholders with existing policies, legislation and technical programme guidelines and protocols. ✓ Commission Joint mid-term review and end term evaluation of the NSF. ✓ Ensure effective monitoring and reporting on the implementation progress of the NSF. ✓ Facilitate research to generate new knowledge or data to fill in strategic policy and programme gaps. ✓ Facilitate resource mobilisation, investments in high impact interventions and tracking of resources for HIV and AIDS.	➢ All Deputy Permanent Secretaries ➢ Chairperson – Chamber of Mines ➢ Chairperson – Chamber of Commerce and Industry ➢ Director – AMICCALL ➢ Country Director - CDC ➢ Country Director - GIZ ➢ UNAIDS Country Coordinator ➢ Country Coordinator – PEPFAR ➢ Director - Association of Local Authorities' Declaration on HIV/AIDS (ALAN) ➢ Director – GFATM Programme Management Unit ➢ Director - NABCOA ➢ Director – NANASO, (also representing NANGOF) ➢ Representative, Outright Namibia ➢ Representative, Rights Not Rescue ➢ Director General – Electoral Commission ➢ Namibian National Women's Association ➢ National Union of Namibian Workers (NUNW) ➢ Representative of a Faith Based Organisations ➢ Representative of Organisations of people living with HIV ➢ Representative of the National Youth Council ➢ Representatives of UN Agencies ➢ Representative of other Development partners (EU, DFID etc.) ➢ Representative – Regional Association of Councils ➢ Sector Coordinators
The Combination Prevention TAC	The mandate of the CPS–TAC is to provide strategic technical support to NAEC and participating implementing partners in planning and implementation of integrated HIV prevention, treatment, care and support interventions within the context of the multi-sectoral HIV and AIDS response.	✓ Provide technical guidance to NAEC and NSF implementing partners in the planning and implementation of high impact prevention interventions. ✓ Ensure that the NSF strategies, policies, programmes and services are evidence-based and	➢ All Prevention Programme Coordinators ➢ Representatives of civil society, including faith-based organisations ➢ Representative of private sector ➢ Representative of key development partners involved in prevention activities ➢ A representative of human rights organisation ➢ Coordinator of the public sector workplace HIV

		are adapted to the Namibian context. ✓ Provide oversight on the implementation of combination prevention interventions. ✓ Facilitate the identification of policy and programme gaps in HIV prevention, treatment, care and support. ✓ Facilitate the development and revision of prevention targets for the NSF implementation. ✓ Have an oversight responsibility to ensure the quality, relevance, cultural and national sensitivity of prevention messages and interventions.	and AIDS / Wellness programmes
Response Coordination and Management TAC	The mandate of the RCM–TAC is to provide strategic technical support to national and decentralised coordinating structures, in-order to enhance efficiency and effectiveness in all aspects of the response.	✓ Ensure effective coordination and management of the many and diverse implementing partners at national, regional and community levels. ✓ Provide technical guidance and support in developing and strengthening the capacity of coordinating structures at all levels. ✓ Provide technical assistance in developing and implementing sustainable financing strategies for the national response. ✓ Ensure strengthening of strategic partnerships and alliances with development partner's communities and community-based organisations.	➢ Office of the Prime Minister – Coordinator for the Workplace /Wellness programmes ➢ Representative of MURD ➢ UNAIDS Country Coordinator ➢ Director PEPFAR ➢ Director Global Fund PMU ➢ Director CDC ➢ Director USAID ➢ All HIV Sector Coordinators ➢ Chairs of the CPS and RM&E TACs ➢ Director Health Works Business Coalition ➢ Director NANASO ➢ Walvisbay Corridor Group ➢ WHO ➢ UNFPA ➢ UNDP ➢ UNICEF
M&E and Research TAC	The mandate of the M&ER-TAC is to support NAEC efforts in strategic information generation, management and dissemination of new knowledge on HIV and AIDS, in addition to advocacy on the use of evidence-based information for planning and resource mobilisation and allocation.	✓ Support efficient and effective routine data collection, and reporting by all stakeholders ✓ Support periodical reviews and evaluation of the national HIV and AIDS response.	➢ M&E Personnel from implementing partners ➢ M&E Officer – Global Fund PMU ➢ UNAIDS Strategic Information Adviser ➢ Officers M&E officers from CDC, PEPFAR, GIZ, ➢ M&E officer – National Planning Commission

		✓ Ensure harmonisation and alignment of indicators, targets, data collection and reporting tools, ✓ Facilitate the development and implementation of the national HIV research agenda, ✓ Advocate for increased access and utilisation of empirical data by stakeholders and in particular decision and policy makers. ✓ Advocate for the development and implementation of M&E and research capacity. ✓ Advocate for the establishment and maintenance of national HIV and AIDS database linked with other relevant databases such as the Health Information Systems (HIS)	➢ M&E Officer – MOLG ➢ M&E Officer – Office of the Prime-Minster ➢ M&E Officer – TB programme ➢ M&E Officer Khomas Regional Council
Permanent Task Force for Children	The mandate of PTF is to advocate, promote and support child welfare interventions, promote social protection, and impact mitigation for children. PTF has also assumed the responsibility of coordinating impact mitigation efforts of the NSF that were previously coordinated by the Impact Mitigation TAC. Strengthen synergies with other coordinating structures such as the NAFIN for food security and nutrition, and the National Gender Task Force, for interventions on gender-based violence.	✓ Coordinate the national multisectoral planning and programming for children. ✓ Facilitate the development and implementation of the National Agenda for Children and the accompanying National M&E Plan for children ✓ Facilitate networking among the key stakeholders and service providers at national, regional and community levels to provide services to children. ✓ Ensure stakeholder accountability for service to children based on the legal and social obligations of the duty bearers' and rights holders. . ✓ Mobilise resources to support interventions targeting children.	➢ OMAs ➢ Representatives from UN Agencies ➢ Lifeline Childeline ➢ Women and Child Protection Units ➢ Relevant Non-Governmental Organisations ➢ Private Sector Representatives
Regional AIDS Coordinating Committees (RACOCs)	RACOC's are Multisectoral committees whose membership is drawn from all stakeholders operating within a specific region with the mandate to facilitate and coordinate regional level response. RACOCs are chaired by the Chairpersons of the Regional Councils and deputised by the Chief Regional Officer and Regional	✓ Coordinate joint and participatory planning and implementation of strategies aimed at mitigating HIV and AIDS.	➢ Regional representatives of Government agencies, ministries and organisations ➢ Regional representatives of civil society organisations – NGOs, FBOs, CBOs

	Health Director or a Member of Management Committee appointed by the Regional Council. They operate under the auspices of the Ministry of Urban and Rural Development (MURD).	✓ Facilitate resource mobilisation for regional responses. ✓ Advocate for stakeholders accountability and good governance of the response. ✓ Provide technical, financial and material support to CACOCs in developing and implementing their own operational plans. ✓ Identify capacity needs, develop and implement strategies to address capacity gaps. ✓ Compile quarterly regional reports for submission to the MURD through the Regional Councils and to NAEC.	➢ Regional Coordinator of the Child Care and Protection Forum ➢ Representatives of Support Groups of PLHIV ➢ Chairpersons – CACOCs ➢ Representatives of private sector institutions ➢ Regional Commandants of the Namibian Police Force, the Army and Prisons Services ➢ Regional Development Planner/Economic Planner, ➢ Regional representative of the National Planning Commission ➢ A representative of regional women's organisations ➢ A representative of the Traditional Authorities ➢ A representative of local authorities ➢ Sector HIV and AIDS Coordinators
Constituency AIDS Coordinating Committees (CACOCs)	The CACOCs are responsible for coordinating community-based response and operate under the auspices of their Constituency Councils. CACOCs are chaired by the Regional Councillor of that particular constituency and deputised by the District Primary Health Care Supervisor and Control Administrative Officer Communities are encouraged to develop and implement their own HIV/AIDS action plans with technical support from RACOCs and other stakeholders.	✓ Coordinate community-based HIV and AIDS response planning, implementation and monitoring. ✓ Facilitate establishing and strengthening of strategic partnerships and alliances between communities and other stakeholders ✓ Support strengthening of linkages between health facilities and community structures. ✓ Facilitate community surveys and mapping to identify key populations and vulnerable groups in the communities and address their challenges. ✓ Coordinate capacity development for community-based organisations (CBOs), and support groups of PLHIV. ✓ Facilitate resource mobilisation to support community initiatives.	➢ Community based NGOs, FBOs and CBOs ➢ Support Groups of PLHIV ➢ Constituency Youth Committee ➢ Person in charge of the constituency health facility / health services ➢ Private Sector Representatives ➢ Local Authorities ➢ Public servants representing their respective sectors. ➢ Representatives of Traditional Authorities ➢ Religious leaders ➢ Representatives of Constituency Child Care and Protection Forum
Sector Steering Committees	Sector Steering Committees are responsible for facilitating the development, coordination and implementation of sector responses.	✓ Appoint a sector coordinator, and provide logistical support including operational space	➢ Chairs of the TACs ➢ Director – NABCOA ➢ Director of NANASO ➢ Director of NANGOF

	The sector responses are premised on HIV internal and external mainstreaming.	and basic equipment to support sector coordination. ✓ Mobilise resources for the sector coordination and networking services. ✓ Convene sector coordination meetings and maintain records of such meetings. ✓ Facilitate joint planning and reviews of sectoral action plans for HIV and AIDS. ✓ Promote and support inter-sectoral collaboration and synergies. ✓ Identify and facilitate opportunities for sectoral capacity development. ✓ Support networking and information sharing within the sector and with the wider HIV and AIDS stakeholders in Namibia. ✓ Coordinate sector research initiatives (including sector specific surveys) around HIV and AIDS, as proposed in the NSF or suggested by the membership from time to time. ✓ Ensure that HIV is mainstreamed in their core mandates to mitigate its effects ✓ Provide quarterly sectoral reports to NAEC.	➢ National Planning Commission ➢ Sectoral Focal Persons ➢ OMAs ➢ Private Sector Representatives ➢ Civil Society Organisations

Annex 6: Glossary of Terms used in the NSF

Coordination	The process of bringing together and supporting stakeholders to efficiently and effectively coordinate and plan their activities in a manner that enhances synergy, reduces duplication, increases skills and knowledge transfer
Duty bearer	The person or institution with a legal mandate to provide certain services to another person in need.
Effectiveness	The extent to which an intervention objective was achieved or is expected to be achieved
Efficiency	A measure of how economically resources / inputs are converted to results
Empowerment	Action taken to overcome obstacles arising from inequality between people and between gender – male and female.
Evidence Based	A process that allows planners to use available evidence to inform their choices and decisions on interventions and strategies to achieve specific desired results.
Gender	Refers to the social conceptualization of males and female based on social differences and relations between them that are learnt, changeable over time, and have wide variations across cultures. They are context specific and can be modified.
Gender equality	Entails the concept that all human beings, both men and women are free to develop their personal abilities or make choices without limitations set by stereotypes, rigid gender roles and prejudices; so that their rights, responsibilities, and opportunities do not depend on whether they are born male or female.
Gender equity	It is fairness of treatment (distribution) of females and males according to their respective needs, rights, benefits, obligations and opportunities. Equity is the means to reach equality.
Gender-based violence	Gender-based violence is a form of violence derived from the unequal power relationship between men and women. It is the type of violence where either a man or a woman exerts his or her power over the other with the intention to harm, intimidate, and control the other person.
Human rights	The universally agreed upon rights with regard to the right to life, social and economic welfare, which should be enjoyed by all human beings irrespective of their sex, colour, or creed.
Impact Mitigation	Alleviating social and economic negative forces on the lives of people and society and contributes to lessening the burden of HIV/AIDS, poverty and income inequalities.
Impact result	Long-term positive changes in the lives of people, condition or organisation arising from an intervention.
Input	Pre-requisite resources (human, information, finance) required to support activity implementation to produce outputs.
Multiple and concurrent sexual partners	A term used to describe Sexual relationships involving more than
Outcome	A change in behaviour (values, attitudes, practices etc.) of, or the use of new capacities (laws, policies etc.) by target group (people and institutions).
Output:	Operational changes or new capacities (knowledge, skills and equipment, products and services), which result from the completion of activities within a specified intervention in a given time.
Poverty	Poverty is multi-dimensional including shortage of income and deprivation in access to basic social services (education, health and water), food security, shelter, credit and employment. It can be defined in absolute and relative terms. Absolute poverty refers to inability to attain a minimum standard of living measured by a range of economic and social indicators such as household incomes, expenditure per capita, health status, life

	expectancy, access to basic social services, infant mortality rate, nutritional status and literacy.
Region	An administrative geographical area with clearly defined boundaries. Namibia has 13 administrative regions.
Result	A measurable or describable change in the lives of people or organisations resulting from a cause and effect relationship or programme intervention.
Results based planning	A planning process that uses empirical evidence to inform planning and prioritising of interventions
Results chain	The causal sequence for an intervention to achieve impacts, moving from inputs and activities to outputs outcomes and impacts
Results Framework:	A diagrammatic illustration of the logical chain of results that will lead to strategic objectives being achieved.
Rights Holder	A person who has a human and or legal right to claim for services from another person or institution with the mandate to provide such services
Risks	The probability that a person may be affected negatively by a condition or behaviour i.e. acquiring HIV infection
Sector	A section of society that has common characteristics or interests.
Sex	A biological construct defining the physical differences that males and females are born with
Terminology	Definition
Three Ones principle	Three Ones principle means a country having one national coordinating authority, one national strategic framework and one national M&E framework.
Vulnerability	Results from a range of external factors39 that are often beyond the ability of a person to control that increases the possibilities of their exposure to HIV infection

[39] This may include personal factors such as lack of knowledge and skills required to protect oneself, and others; factors pertaining to the quality and coverage of services such as inaccessibility of services due to distance, cost etc., and societal factors such as social and cultural norms, practices beliefs and laws that stigmatize and disempower certain populations such as women and girls.

Annex 7: Abbreviations

ADT	Antiretroviral Dispensing Tool
AIDS	Acquired Immuno-deficiency Syndrome
ANC	Ante-natal Clinic
ARV	Antiretroviral (drug)
CACOC	Community AIDS Coordinating Committee
CBO	Community Based Organisation
CLO	Condom Liaison Officer
CPT	Contrimoxazole Preventive Therapy
CSO	Civil Society Organisation
CSS	Community Systems Strengthening
DNA	Deoxyribonucleic acid
DOTS	Directly observed therapy
DSP	Department of Special Programmes
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother To Child Transmission
EPMS	Electronic Patient Management System
FSW	Female Sex Worker
GARPR	Global AIDS Response Programme Report
GF	Global Fund
GRN	Government of Namibia
HCT	HIV Counselling and Testing
HEW	Health Extension Worker
HIV	Human Immune Virus
HTS	HIV Testing Services
IBBSS	Integrated Biological and Behavioural Surveillance Survey
IC	Investment Case
IDU	Injecting Drug User
IPT	Isoniazid Preventive Therapy
IYCF	Infant and Young Child Feeding
LTC	Linkage to Care
M&E	Monitoring and Evaluation
MCP	Multiple and Concurrent Partnership
MDR-TB	Multiple Drugs Resistance Tuberculosis
MIMS	Multisectoral Information Management System
MNCH	Maternal New Born Child Health
MOHSS	Ministry of Health and Social Services
MURD	Ministry of Urban and Rural Development
MTCT	Mother to Child Transmission (of HIV)
NAEC	National AIDS Executive Committee
NANASO	Namibia Network of AIDS Service Organisations
NASA	National AIDS Spending Assessment
NASOMA	Namibia Social Marketing
NCF	National Coordinating Framework
NDHS	Namibian Demographic and Health /survey

NSF	National Strategic Framework
OMA	Organisations, Ministries and Agencies
OVC	Orphans and Vulnerable Children
PCR	Polymerised Chain Reaction
PEP	Post Exposure Prophylaxis
PEPFAR	Presidents Emergency Plan For AIDS Relief
PITC	Provide Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child Transmission
POC	Point of Care
PrEP	Pre-Exposure Prophylaxis
PS	Permanent Secretaries
PSCM	Procurement and Supply Chain Management
RACOC	Regional AIDS Coordinating Committee
RM&E	Response Monitoring and Evaluation
RSSH	Resilient and Sustainable Systems for Health
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TA	Technical Assistance
TasP	Treatment as Prevention
TB	Tuberculosis
TG	Transgender
TOR	Terms of Reference
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation
XDR-TB	Extensively Drug Resistant TB