



Namibia

Operational Plan Report

FY 2012



Operating Unit Overview

OU Executive Summary

1. Country Context

Namibia has an estimated population approaching 2.2 million people (1 - please see end notes) with a population growth rate projected at 1.87%. In 2010, nearly 60% of the population was under the age of 24, two-thirds of which was estimated to be under the age of 18. (2)

Namibia is classified as an upper-middle income country, with an estimated gross national income per capita of US\$6,206 in 2010. (3) However, substantial income inequalities exist (Namibia's Gini coefficient, an international measure of income and wealth distribution, ranks among the highest in the world). (4) The poorest 10 percent of households command just one percent of the country's total income whereas the wealthiest 10 percent control more than half. Current World Bank estimates suggest that up to 38% of Namibians live in poverty. (5) National estimates for adult unemployment exceeded 50% in 2010. (6)

Namibia experiences a generalized HIV epidemic with an estimated 180,000 HIV-infected adults and children. (7) During 2010, HIV prevalence among 15-49 year old adults was estimated at 13.1% (8), with approximately 6,310 AIDS-related deaths (estimated 23% of all deaths during the same time period); while an estimated 16 new infections occur every day. (9)

Approximately 250,000 children aged 18 years old or younger were orphans or vulnerable children (OVC) in Namibia in FY 2008/09; around 28% of these OVC (69,000) had been orphaned by AIDS. (10)

According to the MOHSS Report on the 2010 National HIV Sentinel Survey, HIV prevalence among pregnant women stabilized at 18.8%, with the HIV prevalence in this population being approximately the same in rural and urban areas. While HIV prevalence is highest among women aged 30-34 years (29.6%) and 35-39 years (29.7%) (11) and has increased in this group during the previous three rounds of sentinel surveillance, the prevalence declined among 15-19 and among 20-24 year old women. This is indicative of a maturing epidemic with fewer new infections.

In 2009, Namibia published a report on the behavioral and social drivers of the epidemic, which vary across the country's geographic regions. (12) The study highlighted the following social, cultural and economic risk factors: Multiple and concurrent partnerships, inconsistent condom use, low HIV risk perceptions, varying levels of male circumcision, alcohol misuse, intergenerational and transactional sex, mobility of populations, and emerging pockets of "most-at-risk populations" (MARPS).

Namibia has one of the highest levels of treatment coverage in sub-Saharan Africa. In 2009, when the eligibility threshold for ART enrolment was at CD4 count cell of less than 200, an estimated 88% of Namibians in need of treatment were receiving it. (13) In 2011, Namibia changed the CD4 ART enrolment eligibility threshold to less than 350 cells per ul3. Because of this sudden increase in the denominator of patients eligible for ART, treatment coverage was estimated to have declined from its peak near 90% to approximately 76%. (14)



Tuberculosis (TB) is a major contributor to HIV-related mortality. With a TB notification rate of 598 cases per 100,000 population (of which 50% are co-infected with HIV), Namibia is faced with one of the largest national TB epidemics in the world. Namibia's 2008 TB drug resistance survey (DRS) showed MDR-TB prevalence rates of 3.8% and 16.5% among new and previously treated TB patients respectively. TB is the leading cause of death for people with HIV/AIDS in Namibia.

2. Health Sector Financing and Human Resources

The latest National Health Account report (2008/09) found that Namibia spent approximately US\$550,686,599 on healthcare, which equates to US\$268 per capita (including public, private and donor spending), or, 6.8 % of the country's GDP. In real terms, spending on health has more than doubled since 2001/02.

The public sector aims to provide universal coverage for health services, financed predominantly through general taxation and is the lead provider of healthcare. The public health sector consists of one national referral hospital, three intermediate hospitals, 30 district hospitals, 44 health centers, 265 clinics and 6 faith-based health facilities (5 district hospitals and 1 health center). The not-for-profit sector plays a significant role in health promotion and service delivery. These include hospitals, primary care clinics, health centers, pharmacies, specialist practices and offices of private practitioners. The majority of private healthcare services are provided in urban areas. While an estimated 51% of formally employed workers are covered by health insurance policies, in net numbers this accounts for 16-18% of the total Namibian population. Financed largely by external aid, NGOs are mostly involved in the delivery of community-based services. In 2006, there were 844 private health facilities registered with the MOHSS.

According to the most recent National Health and HIV/AIDS Resource Tracking Report, financing for healthcare is driven principally by the public sector (44% of total health expenditures (THE)), followed by donors (20% of THE), households (13% of THE), and lastly companies (13% of THE). As a proportion of total spending on health, the national HIV/AIDS expenditures accounted for 28.5% of total health expenditures in 2008/09. Donor contributions to the HIV/AIDS expenditures accounted for 51.1% of the HIV/AIDS response budget in 2008/09. (15)

Approximately 84% of all HIV/AIDS expenditures are health related. HIV/AIDS health spending per PLWHA is USD\$900 in 2008/09. The Cabinet has created an HIV/AIDS response sustainability task force, and assessment into the sustainability of HRH, procurement and logistic systems (including condoms and ARVs) are underway, as are efforts to mobilize additional resources from the private sector. Unlike general health care, where private firms contribute to 12% of all health expenditures, private firms only contribute to 0.5% of HIV/AIDS health expenditures, while donor contributions have increased thirteen-fold since 2001/02, largely due to USG and Global Fund contributions to the HIV/AIDS response. HIV/AIDS Civil society Organizations (CSO) is almost entirely donor-dependent in terms of financing. This financing in turn has influenced the types of services



provided by CSO. Given anticipated declines in donor funding, CS in Namibia is at a critical cross-road - to define its core competencies going forward, its value-added contributions, and how these services will be sustained in the long run.

In 2008, a review of Namibia's health and social service sector found that while Namibia has more HCW (three per 1,000 persons) than most of its neighbors in sub-Saharan Africa, the majority work in the private sector (8.8 HCWs per 1,000 persons). (16) Chronic staff shortages exist, especially in the MOHSS, where the overall job vacancy rate stands at approximately 27%, and many clinical staff are expatriates. There are marked human resource disparities between urban and rural settings. Only 24% of doctors and 39% of nurses practice in rural areas. This is significant considering that over 65% of Namibia's population resides in rural settings. In addition, the public sector loses up to 5% of its healthcare professionals to attrition each year.

3. PEPFAR Namibia Focus in FY 2012 – Sustainable Transition and High Impact Access

The 2012 COP for Namibia supports the Partnership Framework signed in 2010 and the GHI strategy for Namibia, currently under final review by the GHI Operations Committee. Given the projected decline in PEPFAR and Global Fund resources for the HIV/AIDS response in Namibia in the coming years, the USG has prioritized activities that support the sustainable transition of donor-supported activities to country ownership and ensures that high impact prevention, treatment, and care interventions are accessible to those most in need. The PEPFAR Namibia team aims to ensure that Namibia has the body of country-specific data, technical capacity, human resources, and coordinating mechanisms required to manage and direct its HIV/AIDS response. In line with Government of Namibia priorities, integration of HIV/AIDS and health services will be explored and supported by the USG as will efforts to find efficiencies in the service delivery model in Namibia. COP12 continues the shift along the continuum from direct service delivery to technical assistance and collaboration with a focus on the transfer of \$8.7 million in clinical staff (doctors, nurses, etc.) from USG salary support to full GRN ownership. USG support for the purchase of ARV medicines will phase out completely in COP12, as part of a multi-year transition. Close collaboration between the PEPFAR Namibia program, the Global Fund and key Namibian stakeholders, including the Government, civil society, the private sector and other development partners, remains critical to ensuring that the donor supported portion of the HIV response in Namibia is responsible and at a pace of transfer that Namibia can absorb. During the first half of 2012 a joint transition and sustainability plan will be developed in order to ensure that programs are effectively targeting critical gaps over the next 5 to 10 years. The PEPFAR Namibia team and Namibian stakeholders are in a continuing dialogue on transition and predictability of funding for the HIV response through 2020. In order to aid in country planning, the USG has provided planning estimates through the end of the GRN-USG Partnership Framework. A recent sustainable financing report issued by the MOHSS with the support of UNAIDS and key Namibian stakeholders extrapolates key donor contributions through 2020.



3.1 Key Priorities for COP12

Key transition and access priorities for the PEPFAR Namibia team in COP2012 are supportive of the Namibia GHI strategy, and include the following areas of focus;

- Increasing domestic health financing
- Equitable and Efficient Use of Funds
- Strengthened Human Resources for Health
- Increasing use of Strategic Information, including M&E surveillance and operational research for evidence-based decision-making
- Increasing health service efficiency
- Increasing multi-sectoral coordination and programming
- Increasing availability of integrated HIV/AIDS (e.g. PMTCT) and maternal, reproductive, neonatal and child health services
- Increasing availability of integrated TB/HIV services
- Improving the continuum of care, including referral linkages
- Increasing the availability of community-based prevention/health promotion and care and treatment services, including gender-based violence prevention
- Increasing male involvement in family-related health care decisions

As the PEPFAR Namibia program continues to shift to a technical assistance and collaboration model key areas of TA support have emerged. The areas below were identified during development of the GRN-USG Partnership Framework and Implementation Plan and remain priorities in COP2012;

- Support the transition by providing support to GRN and other local institutions on long-term Human Resource (HR) planning processes and to building the capacity of health care providers;
- Support to institutions of higher learning to strengthen their capacity in terms of producing quality health care providers;
- Support to GRN on quantification and other aspects of supply chain management;
- Supporting local partnerships through capacity building of Namibian partners to lead, manage and implement components of the national HIV/AIDS response;
- Civil society sustainability through capacity building of local and community-based organizations to diversify their funding sources, especially via partnerships with the GRN and the private sector and through organizational development support;
- Private sector engagement through supporting the GRN with strategies and development of public-private sector partnerships and other domestic financing arrangements beyond one-off contributions;

Additional detail on key priorities and areas of focus in COP2012 are provided below by Technical Area.



3.2 Prevention COP12 Priorities

With limited resources, the USG will continue to prioritize high impact, evidence-based prevention interventions and approaches, as well as the strengthening of integration of behavioural and biomedical prevention activities to ensure effective linkages and further coverage of programs. In COP12 the Prevention portfolio of programs is approximately 34% of program budget funding, compared to approximately 32% in COP11. Within Prevention of mother to child transmission (PMTCT), voluntary male circumcision, and condoms and other prevention increased as a percentage of prevention funding while funding for abstinence and be faithful programming declined. The blood safety and injection safety programs continued on their planned transition trajectory with reduced resources in COP12 and planned phase out of USG direct support before 2015. USG prevention program priorities in COP 12 include:

- Alignment with the NSF and the new USG prevention guidance;
- Support to key GRN national and regional offices for high impact, combination prevention interventions linking behavioral, biomedical and structural interventions;
- PMTCT Elimination by 2015;
- MC scale-up for public health impact with an emphasis on regional saturation;
- Achieving a high coverage of Provider Initiated Counseling and Testing (PICT) HCT services in public and FBO facilities;
- Exploring mixed models of HCT service delivery to improve access and availability for populations experiencing challenges;
- Expanding comprehensive positive prevention in the community and health care facilities;
- Systematic coverage of sex workers and men who have sex with men (MSM) with the minimum package for Most At Risk Populations (MARPs);
- Strengthening current behavioral interventions to expand coverage and incorporate evidence-based approaches that address known drivers while building active links to biomedical interventions;
- Increased focus on gender issues that contribute to HIV transmission;
- Strengthening M&E to better track performance of prevention services;
- Addressing human resource issues, capacity development and sustainability, in order to transition USG-funded community programs to local partners;
- Incorporation of new prevention technologies as they become available;
- Coordination with other stakeholders to maximize impact and leverage resources

3.3 Treatment COP12 Priorities

PEPFAR Namibia support to Namibia's national treatment program will partially change in scope in COP12 as the shift from direct service delivery support to technical assistance and collaboration continues. Examples of this shift include complete phase out of USG funding for ARV medicines and a



reduction of \$8.7 million in health care worker salary support for doctors, nurses, and other clinical staff in 6 priority regions identified by the MOHSS in its 2012 Medium Term Expenditure Framework (MTEF) request to Ministry of Finance. Due to this salary support reduction, indicative of strong country ownership in this area, the proportion of the Treatment portfolio within the program budget has gone from roughly 27% to 24% from COP11 to COP12. Within the Treatment portfolio, all budget areas have been reduced except for TB/HIV, which has been prioritized and increased from a little over 3% of the program budget in COP11 to 5% in COP12. The USG will continue to provide high quality TA to the GRN as Namibia determines its approach to implementing new Treatment as Prevention priorities. Although treatment coverage is relatively high in Namibia, service delivery gaps remain. USG will support activities to address these gaps especially through systems approaches. USG treatment program priorities in COP 12 include:

- Support to smart integration of services, including pilot implementation and evaluation of new service delivery models such as ART in general out-patient services, ART in integrated ANC/PMCT settings, and one-stop TB/HIV services;
- Increased focus on decentralization of services, point of care (POC) and outreach testing;
- Strengthening procurement systems, including improved forecasting and quantification, inventory control systems and pharmaceutical and logistics management information systems;
- Improving adherence and retention within the context of the continuum of care;
- Strengthening pediatric and adolescent HIV programs, including data collection, analysis, and use, disclosure to adolescents and sexual and reproductive health counselling;
- Provision of TA for health workforce planning, modelling and assessment;
- Scale up of the 3 Is for TB/HIV and early initiation for ART for all TB patients and strengthening community-based TB care.

3.4 Care and Support COP12 Priorities

Approaches and priorities in the PEPFAR Namibia COP12 Care and Support portfolio are reflective of Namibia's maturing epidemic and are based on a family-centered approach to the continuum of care. Overall, this portfolio of activities has decreased as a percent of the program budget from approximately 20% in COP11 to 18% in COP12. Programs focused on strengthening systems and protection for orphans and vulnerable children (OVC) are prioritized and represent a little over 11% of prevention, treatment and care programming and just under 9% of the total program budget. USG care and support program priorities in COP 12 include:

- Promote the continuum of care through family-centered programming, strengthening bi-directional linkages and building the health extension worker (HEW) program;
- Improve civil society capacity in provision of community home-based palliative care targeted at pre-ART and ART clients;



- Building health worker capacity for improved care and nutrition and HIV service integration;
- Increase PLWHA engagement and quality of life through Positive Health Dignity and Prevention programming;
- Facilitate linkages of nutrition beneficiaries to economic strengthening activities;
- Strengthen protection systems to mitigate child vulnerability to HIV, violence and poverty
- Build the social sector workforce to address child vulnerability;
- Strengthen civil society sustainability through organization capacity building in resource mobilization and management;
- Strengthen care and support for victims of gender based violence (GBV);
- Support development and roll out of national guidelines on care and support for adolescents living with HIV.

3.5 Governance and Systems COP12 Priorities

3.5.1 Health Systems Strengthening

The Health Systems Strengthening portfolio goes beyond the OHSS budget code in the PEPFAR Namibia program. The interagency team includes laboratory strengthening as part of core HSS activities and beyond these two areas systems strengthening activities are increasingly embedded across all areas and budget codes. This is reflective of the shift in emphasis from direct service delivery to technical assistance and collaboration. COP12 resources in the core HSS portfolio (OHSS and HLAB) have increased slightly from 13% in COP11 to close to 14% of the program budget but the PEPFAR Namibia team estimates that systems strengthening activities represent approximately 30% of all COP12 activities. The portfolio is aligned with the WHO Health Systems Strengthening building blocks.

In COP 12, PEPFAR Namibia will work to improve greater partnerships, particularly among domestic stakeholders who can contribute to the sustainability of the response (e.g. the public sector beyond MOHSS – e.g. MOF, and the private sector). Relatedly, to address financial sustainability, COP 12 will support the GRN to develop informed budget submissions related to the HIV/AIDS response and health system, support upcoming national funding mechanisms that have the potential for financing some civil society services, and work with NGO partners to develop innovative resource mobilization plans (that may for example include marketing services to the private sector). Another major GHI thrust for systems strengthening in COP 12 is the USG's support for "smart integration" approaches in Namibia. This will include the provision of various costing and workload scenario models to inform the integration process; along with direct funding to the MOHSS to implement (including the broadening of trainings to target more staff, such as from PHC, than those working in HIV/AIDS clinics only) the selected integration model. This work builds upon past COP investments that have expanded the availability of commonly prescribed non-ART medicines in ART pharmacies, and developed curricula to train nurses on the WHO Integrated Management of Adult (and Child) Illness (IMAI/IMCI) strategies, which the government is rolling-out to health clinics nationwide.



3.5.2 Strategic Information

Strategic information activities in COP12 have been prioritized within the overall program budget and have moved from approximately 6% of the program budget in COP11 to just over 8% in COP12. This prioritization is reflective of the critical gaps that still exist in Namibia's ability to conduct core M&E, surveys and surveillance, Health Management Information Systems (HMIS) and operational research activities. USG support focuses on operationalization of the National HIV/AIDS M&E Plan by developing and harmonizing sustainable information systems, improving data quality, and strengthening SI human resource capacity. A strong emphasis lies on advocating for increased prioritization and funding of M&E, surveillance, and research activities and for inclusion of M&E staff on the MoHSS establishment list. Long-term training and mentoring will be needed. USG strategic information program priorities in COP 12 include:

- Increasing data use to inform policies and decision-making, including harmonizing routine reporting, strengthening linkages between technical programs and M&E, strengthening data dissemination, triangulation, interpretation and use by GRN, civil society and donors;
- Development of M&E plan for program transition (as part of broader transition and sustainability planning);
- Support to comprehensive surveillance, M&E and HMIS strategies;
- Improvement of data quality through conduct of in-depth data quality assessments, particularly for ART and PMTCT programs, and routine data quality reviews;
- Capacity building through development of short and long-term training courses and a cadre of public health informatics experts;
- Increased evaluations and operational research, including outcome and impact evaluations of program scale-up (ART, PMTCT especially), assessing the TB/HIV program and comparison of PMTCT data and ANC surveillance data.

5. Central Initiatives

Team Namibia is in different stages with the three centrally funded initiatives: TB/HIV Prevention, Treatment and Care Activities, SI and Global Fund Collaboration Proposal.

5.1 Global Fund Collaboration

Namibia's HIV/AIDS response is still highly reliant on donor support, despite its status as an upper-middle income economy. According to the National Health Account (2008/09) donors finance 51% of the total health expenditure on HIV/AIDS, while Government contributed 45% with the balance being funded by households and private companies. Of the donors' contribution, the majority was funded by the US Government (33.07%) and the Global Fund (14.68%). With the anticipated decline in donor funding over the next few years, the need to improve coordination between the USG and the Global Fund is critical.



The vision for this initiative is to maximize the efficient use of the limited resources in Namibia and prevent duplication, with the following goals to be achieved: efficient use of limited resources, reduction in duplication of funding, improvement of planning at national and regional levels, ensuring that changes in programming are coordinated to prevent shortfalls in activities that are jointly funded, reduction in the reporting burden of organizations receiving funding from multiple donors and efficient use of resources by standardizing and streamlining on-site monitoring and evaluation visits. Collaboration activities have been defined and some agreements have been reached with the portfolio management team. A survey is being developed for Principle and Sub-Recipients to inform strategies for streamlining systems and maximizing efficiencies. A joint transition plan for PEPFAR and GFATM resources in Namibia is envisioned and is in the early stages of conceptualization. Work plans will be finalized with PRs, SRs and the NaCCATuM members.

5.2 TB/HIV Prevention Proposal

As stated above, Namibia has a high rate of HIV positive TB patients. This serves as the reason for this centrally funded TB/HIV proposal. The overall goal is to reduce HIV related morbidity and mortality through strategically implementing and scaling-up innovative TB/HIV Prevention, Treatment and Care Activities in selected regions in Namibia. The following objectives are being proposed: strengthening coordinating bodies at national and sub-national levels, expanding phased implementation of TB intensified case finding and TB Isoniazid preventive therapy for PLWHA in community settings and laboratories, expanding community awareness and implementation of TB infection control in HIV care settings and laboratories, strengthening tiered TB diagnostic networks, expanding coverage and timeliness of HIV counseling, testing, care and treatment services for all TB patients as well as monitoring and evaluation of TB/HIV collaborative activities. The final revised work plan has been submitted to PEPFAR Namibia management for review input and possible approval before submission to OGAC. A follow up meeting is to be held by the Technical Working Group to finalise and discuss the best way for resource allocation to the different implementers in the four districts proposed.

5.3 Strategic Information Proposal

The Namibian SI Proposal's overall goal is to enhance ownership and sustainability. It still is in a very early planning stage and its submission is only planned at end of March 2012. Members of the SI ITT and MoHSS attended a planning and revision meeting in South Africa at the end of 2011. Critical is the alignment of the proposal to ongoing and planned activities such as the new HIS Directorate and consultation with senior leadership addressing crucial issues like sustainability and transition. Technical revisions still have to be made with regard to the following issues: timeline, cost, linkages within the proposal with other USG activities and other partners. Furthermore the implementing partners will have to be determined and some of the proposal is under revision. Next steps will include the Health Information Systems Technical Working Group (HISTWG) to broaden their understanding of the SI proposal and to

sensitize the MoHSS Executive Leadership as well as consulting the broader Ministry of Health-Management Development Forum (MDF) and other stakeholders.

End Notes:

- (1) Central Bureau of Statistics Population Projections, 2010
- (2) Population Division of the Department of Economic and Social Affairs of the UN Secretariat, World Population Prospects: The 2010 Revision. <http://esa.un.org/undp/wpp/index/html>. Accessed October 27, 2011.
- (3) UNDP, source: <http://hdrstats.undp.org/en/countries/profiles/NAM.html>
- (4) The United Nations Development Programme estimated Namibia's Gini Coefficient at 0.63 (out of 1.00) in 2007
- (5) The World Bank: <http://data.worldbank.org/country/namibia>.
- (6) 2010 Labour Force Survey
- (7) www.unaids.org (information from 2009)
- (8) Worldbank data and statistics on <http://web.worldbank.org>
- (9) Estimates and Projections 2009, source: Ministry of Health and social Services, 2010 Review of Universal Access Progress in Namibia, p.7
- (10) Ministry of Health and Social Services, EPP/Spectrum 2009 estimates
- (11) Ministry of Health and Social Services, Report of the 2010 National HIV Sentinel Survey, November 2010
- (12) HIV/AIDS in Namibia: Behavioral and Contextual Factors Driving the Epidemic, 2008, MOHSS
- (13) MOHSS, August 2011: EPP/Spectrum estimate
- (14) MOHSS, August 2011: EPP/Spectrum estimate
- (15) MOHSS, August 2011: EPP/Spectrum estimate
- (16) Ministry of Health and Social Services, Health and Social Services System Review, 2008

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	160,000	2009	UNAIDS Report on the global AIDS Epidemic 2010	148,781	2012/2013 high bound	Estimates Report 2008/9
Adults 15-49 HIV Prevalence Rate	13	2009	UNAIDS Report on the global	13	2012/2013 high bound	Estimates Report 2008/9

			AIDS Epidemic 2010			
Children 0-14 living with HIV	16,000	2009	UNAIDS Report on the global AIDS Epidemic 2010	14,298	2012/2013 high bound	Estimates Report 2008/9
Deaths due to HIV/AIDS	6,700	2009	UNAIDS Report on the global AIDS Epidemic 2010	13,623	2012/2013 high bound	Estimates Report 2008/9
Estimated new HIV infections among adults	4,400	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Estimated new HIV infections among adults and children	5,800	2009	UNAIDS Report on the global AIDS Epidemic 2010	7,786	2012/2013 high bound	Estimates Report 2008/9
Estimated number of pregnant women in the last 12 months	59,000	2009	State of the World's Children 2011, UNICEF.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	8,000	2010	Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011	8,959	2012/2013 high bound	Estimates Report 2008/9
Number of people	180,000	2009	UNAIDS Report	186,498	2012/2013	Estimates Report



living with HIV/AIDS			on the global AIDS Epidemic 2010		high bound	2008/9
Orphans 0-17 due to HIV/AIDS	70,000	2009	UNAIDS Report on the global AIDS Epidemic 2010	102,883	2012/2013 high bound	Estimates Report 2008/9
The estimated number of adults and children with advanced HIV infection (in need of ART)	98,000	2010	Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011			
Women 15+ living with HIV	95,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

In what way does the USG participate in the CCM?

Voting Member

What has been the frequency of contact between the Global Fund Secretariat (Fund Portfolio



Manager or other Geneva-based staff) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.

7+ times

What has been the frequency of contact between the Local Fund Agent (LFA) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.

1-3 times

Has the USG or is the USG planning to provide support for Round 11 proposal development? Support could include staff time, a financial contribution, or technical assistance through USG-funded project.

CCM is not planning to submit proposals

Are any existing HIV grants approaching the end of their Phase 1, Phase 2, or RCC agreement in the coming 12 months?

Yes

If Yes, please indicate which round and how the end of this grant may impact USG programming. Also describe any actions the USG, with country counterparts, is taking to enable continuation of any successful programming financed through these grants.

The HIV RCC grant is approaching the phase 2 renewal phase. While Phase 2 will not begin until July 2013, guaranteed funding for Phase 1 ends in June 2012. Given the new Phase 2 counterpart financing requirement for Upper Middle Income Countries, the CCM and other stakeholders have engaged with GFATM Secretariat to more fully understand the implications of this new policy. Also, given the challenges with late disbursements and CPs for both PRs on this grant, the CCM is considering undertaking a reprogramming of the grant in the lead up to Phase 2 negotiations in order to further streamline the program. Given the anticipated decline in PEPFAR funding in Namibia over the next 2-5 years, the difficulty in accessing and predicting Global Fund grant disbursements will cause significant gaps. The GRN is leading an HIV AIDS sustainability Task Force in order to address, plan and manage these issues.



In your country, what are the 2-3 primary challenges facing the Global Fund grant implementation and performance (for example, poor grant performance, procurement system issues, CCM governance/oversight issues, etc)? Are you planning to address those challenges through any activities listed in this COP?

Redacted

Did you receive funds for the Country Collaboration Initiative this year?

Yes

Is there currently any joint planning with the Global Fund?

Yes

If Yes, please describe how the joint planning takes place (formal/informal settings; the forums where it takes place (CCM?); timing of when it takes place (during proposal development, grant negotiation, COP development, etc.); and participants/stakeholders). Also describe if this joint planning works well and its effects (has it resulted in changes in PEPFAR programming, better anticipation of stock-outs and/or TA needs, better communication with PR, etc.)

Redacted

Has the USG stepped in to prevent either treatment or service disruptions in Global Fund financed programs in the last year either during or at the end of a grant? Such assistance can take the form of providing pharmaceuticals, ensuring staff salaries are paid, using USG partners to ensure continuity of treatment, , or any other activity to prevent treatment or service disruption.

Round	Principal Recipient	Assistance Provided	Value of Assistance (If Known)	Programming Impact	Causes of Need
5	Support to the Ministry of Health and Social Services Support to the Ministry of Health and	Support to TB-Round 5 in the including incentives for field promoters, trainings; review meetings; costs associated with	750,000	USG programming impacted by implementing partner(s) shifting resources to cover	

	Social Services	tracing of defaulters/treatment interrupters; running costs for DOT Points; supportive supervision/mentoring and salary support for ministry and community-based staff.			
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Public-Private Partnership(s)

Created	Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
2012 COP	Media Cost Share	13448:Prevention Alliance Namibia	TBD, Namibian Broadcasting Corporation	Redacted	Redacted	Cost share for health communication
2012 COP	Sponsorship of helpline	12721:Strengthening HIV/AIDS Responses in Prevention and Protection (SHARPP)	MTC Namibia, Leo, Telecom Namibia	15,714	53,571	Provide calls to the Child Helpline, which we operate free of charge to all their customers.
2012 COP	Support for vocational training	13120:Self-Development and Skills for Vulnerable	ELMA Foundation, Namibia Training Authority	24,000	117,142	The ELMA Foundation supports Economic Opportunities for

		Youth	(NTA)			Youth (EOY). For KAYEC, ELMA are interested in vocational training and jobs for youth graduates. NTA is a Namibian state-owned entity that funds KAYEC for the delivery of vocational training services.
2012 COP	Training providers to delivery HIV services	14296:Capacity Plus	Oshakati Pharmacy, Sanofi Aventis, RanBx	50,000	10,000	Support to HIV clinicians society to train and build capacity of private and public providers to provide quality services to PLWHA. Includes training, annual conference, meetings, speakers, and updates.
2012 COP	PPP for Health Systems	13253:Global Development Alliance	Containers to Clinics, Global Alliance for Improved Nutrition,	340,000	288,011	Aims to strengthen the Namibian public health system and its capacities for

			Synergos Institute			achieving its maternal and child health and nutrition targets.
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Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
N/A	Alcohol counseling intervention outcomes	Evaluation	General Population	Implementation	N/A
N/A	Alcohol use estimation	Population-based Behavioral Surveys	General Population	Publishing	N/A
N/A	ANC sentinel surveillance	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Publishing	N/A
N/A	ANC Sentinel Surveillance Survey	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Development	N/A
N/A	AND and PMTCT data comparison	Evaluation of ANC and PMTCT transition	Pregnant Women	Development	N/A
N/A	ART outcomes	Evaluation	General Population	Implementation	N/A
N/A	Behavioral surveillance survey	Population-based Behavioral Surveys	Female Commercial Sex Workers, Male Commercial Sex Workers, Men who	Implementation	N/A

			have Sex with Men		
N/A	Blood donor hemovigilance study	Other	General Population	Implementation	N/A
N/A	Blood donor incidence survey	Recent HIV Infections	General Population	Implementation	N/A
N/A	Capacity Building for Country Owned HIV/AIDS services	Evaluation	General Population	Planning	N/A
N/A	Care Assessment	Evaluation	General Population	Development	N/A
N/A	Community Counselor Evaluation	Evaluation	General Population	Development	N/A
N/A	Community Reach	Evaluation	General Population	Planning	N/A
N/A	Evaluation of Door-to-Door HIV Testing and Counseling Pilot	Evaluation	General Population	Implementation	N/A
N/A	Evaluation of Mobile Outreach HIV Testing and Counseling Pilot	Evaluation	General Population	Planning	N/A
N/A	HIS Assessment	Evaluation	General Population	Other	N/A
N/A	HIV drug resistance monitoring	HIV Drug Resistance	General Population	Implementation	N/A
N/A	HIV Drug Resistance Threshold Survey	HIV Drug Resistance	Pregnant Women	Development	N/A
N/A	HIV formative assessment among military personnel	Surveillance and Surveys in Military Populations	Uniformed Service Members	Publishing	N/A
N/A	HIV prevalence survey among military personnel	Surveillance and Surveys in Military Populations	Uniformed Service Members	Other	N/A
N/A	Improving Clinical Outcomes	Evaluation	General	Implementation	N/A

	through Patient Education - NA.09.0251		Population	n	
N/A	Multi Country PHE: Development, Implementation, and Evaluation of a Comprehensive Prevention Intervention for HIV Care and Treatment Settings - NA.07.0199	Evaluation	General Population	Data Review	N/A
N/A	OVC & TB Care Services	Evaluation	General Population, Other	Planning	N/A
N/A	Palliative Care for People Living with HIV/AIDS	Evaluation	Other	Planning	N/A
N/A	PHE: Changing Gender Norms that Support HIV Risk Behaviors among Young Men in Namibia - NA.07.0214	Evaluation	General Population	Publishing	N/A
N/A	PHE: Compliance to Guidelines and Evaluations of Medicines Prescriptions - NA.08.0097	Other	Other	Development	N/A
N/A	PHE: Evaluation of the Impact of Adherence Interventions - NA.08.0098	Evaluation	Other	Data Review	N/A
N/A	PHE: Understanding and Reducing Sexual vulnerability of Adolescent OVC - NA.09.0222	Other	Other	Other	N/A
N/A	PMTCT Impact Evaluation	Evaluation	Pregnant Women	Planning	N/A
N/A	Population size estimation	Population size estimates	Female Commercial Sex Workers, Male	Implementation	N/A

			Commercial Sex Workers, Men who have Sex with Men		
N/A	Quality Management Systems Assessment	Qualitative Research	General Population	Data Review	N/A
N/A	STI Etiology and Prevalence Survey	Other	General Population	Implementation	N/A
N/A	Strengthening HIV Prevention - MARPS	Evaluation	Other	Planning	N/A
N/A	Strengthening HIV Responses in Prevention and Protection	Evaluation	General Population	Planning	N/A
N/A	TB MDR Survey	Other	General Population	Planning	N/A
N/A	TB/HIV surveillance	TB/HIV Co-Surveillance	General Population	Planning	N/A
N/A	Venue-based risk estimation	Population-based Behavioral Surveys	Female Commercial Sex Workers, Men who have Sex with Men	Implementation	N/A
N/A	Youth HIV	Evaluation	General Population	Planning	N/A



Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHP-State	GAP	GHP-State	GHP-USAID	
DOD			2,360,738		2,360,738
HHS/CDC		1,500,000	40,676,514		42,176,514
HHS/HRSA			5,022,955		5,022,955
PC			1,530,000		1,530,000
State			511,900		511,900
State/AF			318,500		318,500
USAID			38,388,574		38,388,574
Total	0	1,500,000	88,809,181	0	90,309,181

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency								Total
	State	DOD	HHS/CDC	HHS/HRSA	PC	State/AF	USAID	AllOther	
CIRC		121,914	2,498,869	412,703			2,714,254		5,747,740
HBHC	18,223	120,000	1,011,868	558,750	111,661	43,500	3,629,869		5,493,871
HKID	39,627				148,755	50,000	6,882,964		7,121,346
HLAB		120,957	2,496,508				12,397		2,629,862
HMBL			660,220						660,220
HMIN							325,000		325,000
HTXD			0						0
HTXS		343,914	8,381,001	1,540,000			2,688,375		12,953,290
HVAB	17,644		104,422		107,540		735,000		964,606
HVCT		334,871	4,445,746	105,000			2,372,570		7,258,187
HVMS	396,200	100,788	3,270,600		992,300		2,998,258		7,758,146
HVOP	20,826	882,552	2,269,497	140,000	169,744	25,000	4,750,681		8,258,300



HVSI		132,871	4,964,911	920,000			1,798,811		7,816,593
HVTB		80,957	2,484,097	290,000			1,237,190		4,092,244
MTCT			2,930,989	379,240			1,914,973		5,225,202
OHSS	19,380	121,914	3,264,384	56,025		200,000	5,107,982		8,769,685
PDCS			1,346,604	247,063			817,441		2,411,108
PDTX			2,046,798	374,174			402,809		2,823,781
	511,900	2,360,738	42,176,514	5,022,955	1,530,000	318,500	38,388,574	0	90,309,181



National Level Indicators

National Level Indicators and Targets

Redacted



Policy Tracking Table

(No data provided.)



Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	5,493,871	0
HKID	7,121,346	0
HVTB	4,092,244	0
PDCS	2,411,108	0
Total Technical Area Planned Funding:	19,118,569	0

Summary:

1. Overall Programmatic Strategy in Care

1.1 Major Accomplishments in the last 1-2 years

Namibia has made steady progress towards providing access to high quality clinical and community-based HIV care services. Over 250, 000 adults and children were provided with at least one care service. By September 2011, 57,430 were enrolled in Pre-ART care and 97,983 in ART, 76,450 were orphans and vulnerable children (OVC). Of the PLHIV reached approximately 88% were adults and 12% were children. Cotrimoxazole Prophylactic Therapy (CPT) coverage was 93%. These services were provided at service outlets including 181 health facilities, military settings and community organizations to all pre-ART clients, ART clients, and affected family members including OVC. With Namibia's implementation of the revised 2010 guidelines on ART using the CD4 count of 350 as a cut off there was a steep enrolment of Pre-ART clients into ART services over the first two quarters of FY 11 with stabilization by the end of the second quarter.

In the past two years clinical care programs have concentrated on rolling out Integrated Management of Adult and Adolescent Illnesses (IMAI) as part of decentralized services towards achievement of universal access, quality improvement (QI) and ensuring maximal adherence to care and minimal loss to follow-up of clients in care. The HIVQUAL program continued to build the capacity of regional health supervisors and training centers to support clinical QI activities in all district-level facilities with particular focus on promoting increased screening for TB, improved provision of opportunistic infections (OI) prophylaxis, improved screening for nutritional status and alcohol use among people living with HIV (PLHIV) attending for clinical services. HIVQUAL also conducted a program evaluation, and the findings were disseminated and informed program refinement. Caregiver tools for disclosure for HIV+ children were piloted.

Care for adults and children has continued focusing on improving prophylaxis and treatment of OI, promoting nutrition assessment, counseling and support (NACS) with food supplementation, improving palliative care (particularly pain management), as well as provision of positive health dignity and prevention (PHDP) intervention messages within clinical and community home-based care settings. Community-based activities have been implemented through training and supportive supervision of more than 2500 volunteers. Efforts to address the challenges around the issues of sexual reproductive health for the increasing numbers of vertically infected adolescents living with HIV (ALHIV) were initiated with the



establishment of ALHIV technical working group (TWG) which has developed a draft strategy and guidelines for programming. Additionally, providing a structured social support within teen clubs for ALHIV attending two of the largest ART clinics is being piloted.

Operational guidelines for NACS, a national nutrition strategic plan with nutrition clearly integrated in to HIV care were launched. Development of job aids and manuals as well as training for health care workers (HCWs) in NACS, prevention with PLHIV in Care and treatment settings, cervical cancer screening, IMAI, Integrated Management of Neonatal and Childhood Illness (IMNCI); Palliative Care specifically pain management were supported. NAC with food supplementation for eligible PLHIV, pregnant women (irrespective of their HIV status) and malnourished children has been commenced in 9 out 34 health districts covering about 90 health facilities. To ensure a continuum of care, community-based volunteers have also been trained in NACS to enhance early identification and referral to healthcare services for malnourished children and pregnant women.

Following training of HCWs cervical cancer screening for HIV positive women has since commenced and has been supplemented with early identification at community level within a local partner's home-based palliative care programs by community-based palliative care nurses. Full immunization coverage and other child health services for HIV positive children including appropriate infant and young child feeding (IYCF) practices were ensured. The national roll out of the facility and community-based PHDP interventions commenced with the completion of training curricula and training of trainers (TOT). With PEPFAR and GFATM support, guidelines for implementing the Community Based Health Care Policy (2008) have been developed. Training manuals for Community Home-Based Care (CHBC) based on the new National Home based Care (HBC) standards were finalized, and trainings of HBC organizations started with GFATM funding.

The USG has continued its support to MOHSS efforts on Tuberculosis (TB) control, resulting in a downward trend in both TB Case Notification Rates (CNR) and absolute numbers of TB cases. USG support contributed to the country's attainment of the national and global target for TB with the achievement of a treatment success rate of 85.3% among patients with infectious TB in the 2009 cohort. Regarding TB/HIV collaborative activities, the USG has supported the National TB/HIV TWG and the regional TB review quarterly meetings. Encouraging results on TB/HIV support obtained in the last 1-2 years includes: an increase in provider initiated HIV counseling and testing (HCT) among TB patients reaching 76%. To optimize the clinical management of TB/HIV co-infected patients, in 2010 Namibia developed and disseminated mutually complementary TB/HIV clinical care guidelines based on the latest WHO recommendations. A total of 13,581 patients had been commenced on Isoniazid Preventive Therapy (IPT) as of December 2010. Intensified Case Finding (ICF) for TB continues to be scaled up in facilities through enhanced training for HCP in the implementation of the standardized simplified symptom screen algorithm adapted from the WHO 2010 TB Infection Control (TBIC) and ICF guidelines.

More than 80% of facilities offering TB services routinely referred newly diagnosed TB patients for HIV testing. As of September 30th 2011, 5051 HIV positive patients attending HIV care were started on TB treatment. Similarly, 37% of TB patients who are HIV positive are on ART. Training workshops for HCP on the advanced HIV module, which includes TB/HIV, has been supported. The USG worked with the Namibia Business Coalition on HIV and AIDS (NABCOA) to strengthen workplace TB/HIV programs. Also medical associations and HIV clinician associations have been supported to engage private medical practitioners and nurses through training aimed at improving the quality of TB/HIV management in this sector. PEPFAR has continued to leverage resources and support MOHSS efforts to improve the surveillance, management and control of drug resistant TB. TB infection control (TBIC) guidelines have been developed and targeted training of health workers commenced in 2010; 65 focal persons have been trained to date. The USG continues to provide technical assistance (TA) for the guideline operationalization in terms of administrative, environmental and personal TBIC strategies in all public health care facilities including faith-based facilities.



USG resources have contributed to strengthening the planning and budgeting processes of the Ministry of Gender Equality and Child Welfare (MGECW). A comprehensive framework for children was developed (National Agenda for Children {NAC} 2012 – 2016). Scale and work flow processes for the cash transfer system for orphans was improved due to task shifting and a review of administrative bottlenecks. TA was provided to initiate processes required to standardize and adequately resource Early Childhood Development (ECD) programs. Tools for registering and grading Residential Child Care Facilities were tested.

With USG support, CSO provided psychosocial, nutritional and educational support services to vulnerable children in addition to facilitating referrals to health and other education services. Vocational training for older OVC, child head of households and OVC caregivers has been expanded. A microfinance activity (Village Savings and Loans) has been introduced targeting OVC caregivers in conjunction with parenting training. Other economic strengthening (ES) measures supported include a broad range of income generating activities. A child witness support program, which provides comprehensive support to prepare child survivors of violence to testify in court, has been piloted, and the first successful convictions have been made.

Vulnerability assessments of PLHIV (pre-ART and ART) as well as ES and livelihood opportunities appraisals have been undertaken to inform interventions to refer NACS beneficiaries to. TOT workshops on micro-gardening techniques to enhance food security for infected and affected individuals have been supported by PEPFAR. Also community initiatives to provide income for HIV affected communities and households have been initiated and expanded with USG resources.

1.2 Key priorities and major goals for the next two years

The key elements of the care and support program in Namibia are:

- Early identification of HIV-infected persons; referral to and retention in care
- Reduction of HIV-related morbidity and mortality (e.g. TB, malaria, nutrition)
- Improved quality of life through appropriate pain management psycho-social and spiritual support
- Reduction in the further transmission of HIV to the uninfected or re-infection of positive persons
- Strengthen social protection systems to mitigate child vulnerability to HIV, violence and poverty
- Build the social sector work force of the MGECW
- Strengthen caring capacities of families to care for OVC
- Reduce the burden of TB in PLHIV

During FY 2012, the USG expects to provide care to 253,087 eligible clients including 100,446 OVC. Additionally 8543 co-infected clients will receive TB HIV services. In FY 2013 proposed targets for adults receiving care are 290,967 and 80,157 OVC.

Efforts will focus on a family-centered approach to provide a continuum of care equitably to women, men and children from the facility to the community; continuing quality improvement initiatives in facility-based care; improving access through training of the new community-based cadre of health extension workers (HEW); strengthening organizational and technical capacities of indigenous CSOs for CHBC, child protection and OVC services; strengthening health systems by integrating palliative care; expanding the NACS, including Food by Prescription (FBP) to reach more health facilities and districts.

Further integration of PHDP messages including safe water and hygiene and activities into CHBC and enhancing quality of care by strengthening bi-directional linkages will be supported. For sustainability and to prevent relapse in NACS beneficiaries, USG resources will facilitate new and reinforce existing linkages to community based livelihood and ES opportunities to improve food security. Improving linkages and patient flow especially pre-ART clients between clinical and community-based services to reduce loss to follow-up and improve retention in care will be prioritized.

Based on previous COP years' efforts to institute a unique identifier for pre-ART and ART clients and the success of the bi-directional referral network pilot, clients in care will be monitored appropriately.



Adherence initiatives established in FY 11 will be expanded. Sustainability which is pivotal in the PF/PFIP and GHI strategies will be addressed through continuous TA to GRN and civil society to understand needed complementarity between government and civil society, each with comparative advantages and distinct but important roles and responsibilities.

1.3 Alignment with government strategy and priorities

In COP 12 and in the subsequent year PEPFAR Namibia will support the implementation of years three and four of the GRN-USG Partnership Framework (PF) and Implementation Plan. The PF is in close alignment with the National Operational plan, which is the implementation template of Namibia's National Strategic Framework for HIV/AIDS. The PF and PFIP recognize that PEPFAR investments will be shifted to further strengthen Namibian capacity and ownership, especially in the areas of human resources. To increase access and utilization of services, some of the key activities that link to the GHI strategy include expanded task shifting, service integration to lower client costs and expansion of community-based services.

1.4 Contributions from or collaboration with other development partners

USG collaborates actively with other development partners in Namibia to harmonize efforts, leverage combined expertise and establish joint strategies for engagement with the GRN to strengthen the national HIV/AIDS response. The USG in collaboration with GFATM support more than 90% of the community-level CHBC programs implemented by NGOs and civil society. Clinton HIV/AIDS Initiative (CHAI) and UNICEF have supported the Integrated Management of severe acute malnutrition (SAM), which created a platform for the PEPFAR-supported NACS program. CHAI has continued to donate ready-to-use therapeutic foods (RUTF) to support treatment of SAM in children less than five years and PLHIV who are severely malnourished. An anticipated Public Private Partnership (PPP) will impact on the wellbeing of mothers and children living with HIV. UNICEF supports advocacy on child and social protection and child poverty analysis, and collaborates with USG on capacity building to the MGECW. GFATM will provide resources to regional Child Care and Protection Forums and training on psychosocial support for social workers.

1.5 Policy advances / challenges

The PF/PFIP identified policy gaps in the areas of access to medications and services for effective care and support for PLHIV such as access to oral morphine for appropriate pain relief and a review of relevant health policies to enable task shifting. Further policy and systemic challenges include the need to ensure that the community home based care guidelines reflect the current realities of Namibia's HIV response with high levels of ART coverage as well as integrating the therapeutic and supplementary food commodities in to the more cost efficient GRN pharmaceutical supply chain. For improved protection of children affected by the epidemic, the enactment of the Child Care and Protection Bill and development of regulations governing many aspects of child protection will be prioritized. Further, a review of eligibility of vulnerable children for child welfare grants is envisaged. A national vulnerability framework to enhance food security for vulnerable households is being contemplated. Priority actions such as integration of HIV services, decentralization and the transition of funding for commodities and human resources reflects greater country ownership (government, private sector and local civil society) of the care and support program to ensure sustainability.

Continuing challenges include expansion of the IMAI and Integrated Management of Pediatric Illnesses (IMPI) to more primary health facilities in support of decentralization, addressing the sexual and reproductive health and transitioning care needs of ALHIV; providing systematic coverage of community-based care and support, and establishing functional, bi-directional referral linkages between community and clinic-based services. Engaging males at the community-level also remains a challenge. Human and organizational capacity to implement programs at the regional and local level remains limited. Additionally, required PEPFAR indicators are of limited utility, in monitoring partner performance, community-based information systems for a harmonized reporting are fragmented. Optimal



implementation of the revised complementary TB/HIV guidelines that addresses the restrictive eligibility criteria for HIV + TB patients accessing ART needs to be addressed

1.6 Efforts to Achieve Efficiencies

In COP 12 and subsequent years joint planning with GRN entities and other development partners involved in Care and support will minimize duplication of efforts. In previous years the USG purchased HBC kits for USG supported volunteers but in efforts to create efficiencies this support has been directed to strengthening the logistics systems of MOHSS, which now procures and distributes these kits to all CHBC service organizations. Further support is ongoing to streamline the procurement and storage of food commodities for the NACS program. USG support to the implementation of the HEW cadre after a successful pilot with FY10-11 resources will enable smarter integration through prevention education, illness detection and referral services. This will facilitate better access to remote communities and allow review use of volunteers in community interventions to ensure optimal effectiveness and efficiency.

1.7 Efforts to build evidence base

An assessment of the CHBC programs supported in FY 2011 will inform the revision of the CHBC guidelines and guide further programming as the USG competitively awards a follow-on agreement to an indigenous community-based care partner. A NACS program evaluation will support the evidence base to refine the implementation and ensure that the program improves outcomes of PLHIV clients. Further strengthening of the palliative HBC program will be informed by a FY 11 funded end-of-life preferences street survey. Most USAID supported care partners will undergo mid-term evaluations. Program implementers consistently rely on efficient and accurate health information systems that capture important programmatic information and are readily available to enable evidence-based programmatic decision making for program improvement. The USG will build capacity for health information systems and the skills for providers to be able to collect analyze and utilize program data as evidence base for planning and performance improvement.

1.8 Cross-Cutting Program Elements

In alignment with NSF which calls for the reduction of the vulnerability to HIV infection and mitigating the impact of HIV and AIDS on women and children, USG efforts will address the gender issues intrinsic to Care and Support as well as OVC. In Namibia, more females are infected with HIV than males and the burden of caring for those with AIDS-related illnesses falls almost exclusively on women. All partners' activities will prioritize the health and well being of women and girls while striving to maintain gender equity. Given that fewer men access HIV, care and treatment services, activities in care will link closely to efforts in HCT such as male testing days to maintain equity. Involving men in care activities will be prioritized as much as possible through male-focused volunteer groups, community sensitization events targeting men on gender based violence to have men not only share in the burden of care at the community level but also agents of changes in mitigating HIV related GBV. As gender inequality and GBV are key drivers of the epidemic. Care and support resources will supplement Namibia's Gender Challenge Fund (GCF) resources in providing support for GBV survivors in Hardap and Kavango regions of Namibia.

2. Adult Care and Support

Namibia has made substantial progress in providing access to HIV treatment and care as indicated in the UNAIDS/ MOHSS Universal Access report. As at March 2010, coverage of people in need of treatment and consequently care (adults 88% and children 95%) had exceeded Namibia's 2010 Universal Access targets (adults 70%, children 90%). CHBC was also being provided in all 13 regions of the country as reported in the NSF.

The adult care program offers a comprehensive package of clinical and family-centered community home-based palliative care for infected adults and their households comprising: i) Regular clinical follow-up and bio-clinical monitoring including CD4 counts; ii) PHDP interventions within treatment and community settings; iii) Adherence interventions; iv) Defaulter tracking; v) NACS with FBP for eligible clients; vi) Cotrimoxazole Preventive therapy (CPT); vii) OI prevention, diagnosis and treatment and viii)



Pain assessment, management and psychosocial and spiritual support.

PEPFAR assists the GRN at all levels to strengthen facility and community based care for adults living with HIV. USG will continue to support training and supportive supervision of HCP for HIV care, task shifting efforts to implement the IMAI/IMNCI strategies at primary health facilities to bring HIV care and treatment services nearer to remote communities; integration of nutrition into HIV care through the NACS program; training for the newly instituted community based cadre of HEW as well as strengthening local training institutions to integrate palliative care into their curricula. There will also be continued focus on QI at all ART sites in the 34 health districts. In close linkages with efforts to increase access to HCT as described in the prevention TAN through provider initiated counseling and testing, mobile testing and point of care CD4 testing, more clients will be enrolled in care as appropriate.

The USG in collaboration with GFATM support more than 90% of the community-level CHBC programs implemented by NGOs and civil society. Community-based programs provide an avenue for the continuum of care for PLHIV and their households utilizing a family-centered approach whilst ensuring strong linkages to HCT programs both at integrated or stand-alone and mobile sites. A high priority for USG has been to transition most community-based programs to indigenous partners, and to build their technical and organizational capacity to become direct recipients of USG assistance. USG has also been moving to consolidate community-level programs in order to achieve more systematic coverage.

USG will realign its community and home-based palliative care programs to meet the current context in which most PLHIV are accessing ART as well as provide community based support for Pre-ART clients a priority area of the NSF within Care and Support. Community-based volunteers and field officers will support adherence for PLHIV; facilitate tracking of clients lost to follow-up and provide PHDP for PLHIV. PLHIV in pre-ART care will be referred to support groups and through organizational strengthening of a nascent network regional network of PLHIV it is anticipated that more PLHIV will remain in care. The community-based palliative care nurses will provide mentorship and supportive supervision to the volunteers, appropriate pain management and targeted care for the few bedridden PLHIV clients especially those with co-morbidities and HIV related cancers as well pediatric HIV clients. Also baseline and routine cervical cancer screening for all HIV infected adult women has been introduced and is being scaled-up with provision of tools such as speculums, slides, lamps, cervico-brushes, etc and trained HCWs as well as functional referrals.

The PHDP intervention both in facilities and community settings address risk reduction, condom promotion and distribution, partner and family disclosure and testing, sexually transmitted infections (STI) management and family planning (FP)/safer pregnancy counseling. Through USG support, most facilities providing HIV care are now providing FP services and this support will continue in COP 12 and beyond. Information on appropriate pain management and measures to achieve adequate mental health for PLHIV will be integrated into the community PHDP toolkit also described in the Prevention TAN. Following successful piloting of the bi-directional referral system, expanding it to cover all ART facilities and incorporating referrals to community-based livelihood and food security interventions for NACS graduates will be prioritized.

3. Pediatric Care and Support

The comprehensive care, treatment and support needs of HIV-infected children are key focus areas in the Partnership Framework (PF) between the USG and the Government of the Republic of Namibia (GRN). The package of pediatric care services being supported by USG includes: early identification of HIV-infected persons and referral linkages to and retention in care; CPT for HIV exposed infants for and infected infants; support for treatment adherence.

- Regular clinical follow-up and bio-clinical monitoring
- IYCF counseling and food supplementation
- Linkages to immunization and other child survival services



Of the 155,413 PLHIV in care 12% are children and in COP 12 and 13 targets will be 63,425 and 68,761 respectively.

In COP 12 USG will facilitate curriculum development in pediatric palliative care and the training of facility based and community-based HCWs on the peculiarities of pediatric palliative care. Integration of the sensitivities of pediatric palliative care into the PHDP and training of PLHIV support groups (regional PLHIV network) will be supported. Following expansion of the tracking of HIV exposed infants activity in COP 11, USG support will further strengthen bi-directional referral between the facilities and community based activities for tracking HIV exposed infants and ensuring their retention in care; improving the continuum of palliatives care for infected children especially pain management, death and bereavement, as well livelihood and ES opportunities for families of infected children who are NACS beneficiaries.

Addressing the key needs of adolescents will continue to be a focus with support provided for the implementation of the national strategy developed with FY 11 resources. Critical activities to be supported will include program review for the pilots established in FY 11, annual program review and scale-up of the community component of this strategy. This will incorporate peculiar psychosocial support (PSS) such as disclosure issues and adherence supporting measures for adolescents enrolled in HIV care and support.

4. TB/HIV

USG support over the next two years will focus on supporting the MOHSS efforts to scale up HIV Provider initiated Counseling and Testing (PICT) and ensure early ART initiation in TB patients, and expand coverage of the WHO "Three-I's" interventions, including intensified TB case finding (ICF), isoniazid preventive therapy (IPT), and infection control (IC). With regard to TB PICT, the goal is to reach the national target of 95% from the current 765% through the identification of missed opportunities within TB services and related settings such as PMTCT and ART. Namibia, in line with international guidance, reviewed its TB and ART guidelines to ensure early ART initiation within eight weeks of commencing anti-TB therapy for TB patients who are HIV positive irrespective of their CD4 count. USG support over the next 1-2 years is required to support the scale-up ART uptake in TB patients from the current low off 37%. [Note; this low figure partially reflects a reporting error whereby this indicator is captured with initial TB case reporting, not the outcome reporting). Addressing key obstacles to timely referrals of TB/HIV patients to ART services, while ensuring timely and accurate reporting, will be prioritized. Furthermore, training of key HCWs on the revised guidelines to increase the number of TB patients receiving ART will be another area of USG support. Scale up and robust monitoring and evaluation of ICF/IPT is a GRN and USG priority. While reports reflect high number of PLHIV in care being screened for HIV, compliance with the existing screening tool is unclear given the apparent low proportion of patients screening positive and referred for further evaluation. In addition, of those eligible for IPT only ~10% received it and there are no data regarding outcomes or impact. The USG support will continue to strengthen efforts to increase IPT uptake and reliable reporting on this intervention. TBIC guidelines have been developed and implementation of TBIC in health care in TB care facilities is gradually gaining momentum. USG will continue TA towards this intervention focusing in particular on trainings for health workers in ART facilities regarding administrative IC controls, targeted support for environmental IC controls, and expanding TBIC education to PLHIV support groups in the communities.

Monitoring and Evaluation (M&E) of TB/HIV collaborative activities are aligned and integrated into the indicators in the National TB and HIV Control Programs Strategic plans of both TB and HIV programs, WHO-PEPFAR harmonized indicators, Universal access as well as the PEPFAR next generation indicators. Therefore, the scale up of the 3 I's is informed by the latest program data detailed above. Key TB/HIV indicators are integrated in the respective program M&E systems, including EPMS and facility level quality improvement activities (HIVQUAL/Healthqual). Furthermore, the same staff members conduct planning and implementation of TB and HIV activities at sub-national level. USG has continued to provide support to the Electronic TB Register (ETR) which is currently implemented at ~80% of health



facilities with TB services [source: NTLCP]. The paper-based TB surveillance system the primary source of TB surveillance data due to incomplete ETR reporting; USG will continue to support MOHSS efforts to fully enable ETR and ensure reliable data. TB laboratory-based surveillance (also addressed in the Laboratory section) is also critical to informing program gaps and progress, particularly for multi-drug resistance (MDR) TB.

USG supported activities for TB/HIV are aligned to the priorities in the national TB and HIV programs strategic plans. To avoid duplication priorities are determined at the national TB/HIV technical working groups meetings. The TB and HIV programs undertake complementary resource mobilization efforts based on clear delineation of responsibilities between the two programs in order to avoid duplication of support while aiming at ensuring geographic coverage. Finally, the scope of TB/HIV activities in COP 2012 has also been developed in a manner to avoid duplication and promote complementarity with the centrally-funded TB/HIV proposal.

5. Food and Nutrition

PEPFAR in 2011 supported the expansion of NACS program from 62 health facilities in 9 districts to an additional 90 in 13 health districts and provided NACS to 28,371 eligible clients. USG in COP 12 will continue expansion and refinement of the NACS program within HIV/AIDS care and treatment programs. This is closely aligned to USG Namibia's GHI goal of reducing morbidity and mortality amongst vulnerable persons especially pregnant women, under-fives and PLHIV. As food and nutrition interventions improve HIV treatment outcomes and are an important component of care, nutrition indicators have been included into the revised patient care booklet for PLHIV and will be monitored with TA from USG.

For continued expansion of NACS to additional districts and health facilities USG resources will support: assessing human resource and logistical capacity and the need for anthropometric equipment and NACS training; TA to improve the sites' capacity to implement NACS; Training of HCWs in assessed sites; Training of community based volunteers to provide support for NACS clients and community detection and referrals of malnourished children; Procurement of food supplements which will be transitioned to the GRN in line with the draft PFIP by 2016; and Strengthening referral links between clinical nutrition services for pediatric HIV clients and community-based nutrition, and livelihood services for caregiver

USG will continue to train HCWS in antenatal (ANC) and Maternal and Child Health (MCH) clinics on the revised 2010 IYCF practices. Formative research on social behavior changes issues influencing IYCF practices in Namibia supported in 2011 will aid MOHSS to design a communication strategy on food and nutrition and refine existing and/or develop new take-home client materials on IYCF addressing current realities.

To ensure sustainability and prevent dependency USG will support TA to ensure strengthened linkages for adult and pediatric PLHIV graduates of NACS, their affected households and OVC with livelihood and food security interventions of GRN and other development partners including Millennium Challenge Corporation activities where feasible.

6. Orphans and Vulnerable Children

USG support to vulnerable children and their families will be guided by Namibia's new NAC, which aims to provide an accountability framework for different line ministries and sectors to address child vulnerability, including, but not limited to, HIV related causes of child vulnerability. USG will continue to provide TA to MGECW to strengthen systems for service delivery to women and children, especially with regard to full decentralization of management, human resources (HR) and finance functions to the regions. Support will also be provided to increase the ministry's capacity to coordinate line ministries and CSOs as demanded by the NAC.

PEPFAR will support the roll-out of key components of child protection outlined in the Child care and protection, bill to be enacted in 2012, such as improvement of child grants administration, development of an integrated approach to alternative care (kinship/foster care, adoption, residential child care), and



institutionalization of a support system for child survivors of violence and abuse. Social sector work force development components will include support to operationalization of the MGECW HR Strategic Plan developed with USG support, and targeted measures to fill social worker vacancies, including management of government bursary support to social work students.

USG aims to intensify its brokering role for collaboration of government with civil society involved with service delivery for children by providing TA and financial resources to strengthen MGECW outsourcing capabilities to select NGOs. CSO partners will be supported to strengthen the capacity of families to care for OVC through ES, building of caregiver skills as well as community capacity building through promotion of community initiatives linked to advocacy through faith-based congregations. ES interventions will focus on vocational training of OVC caregivers and adolescent OVC as well as micro-finance for caregivers (Village Savings and Loans Groups). Caregiver skills will be built through child health and development education, as well as training on psycho-social support techniques. Small grants provision to community initiatives for advocacy and OVC support will be enhanced. All civil society partners will also provide information to caregivers on government services available to OVC and track access to services in health (immunization), education (including waiver of school development fund contribution) and child welfare grants. In an exploratory activity with the government's Social Security Commission, a mechanism will be developed for the Commission's Development Fund to earmark and disburse funds to CSOs for critical community services to vulnerable children.

USG support in OVC embraces a life cycle approach. Early childhood development (ECD) has previously received very little emphasis and resource allocation by both government and donors, thus PEPFAR started in 2011 to provide TA to the MGECW to roll out an ECD implementation plan. Under COP 12, assistance will be provided to MGECW to finalize and administer a subsidy structure to ECD centers. For children aged 7-16, retention in school will be emphasized through after-school programs with homework support and PSS. Out-of-school who did not manage to complete secondary education will access PEPFAR-supported vocational training.

7. Cross Cutting Areas

7.1 Public-Private Partnerships

The USG supports a global development alliance (GDA) that leverages domestic and international public and private resources to the amount of \$1,343,499 over three years. This PPP focuses on strengthening the Namibian public health system and its capacities for achieving its maternal and child health and nutrition targets. This initiative brings new contributory partners to the health sector in Namibia; it includes the Synergos Institute, Ministry of Health and Social Services (MOHSS), Containers to Clinics (C2C), the Global Alliance for Improved Nutrition (GAIN) and the First National Bank (FNB) Foundation. Activities which have national and regional level focus builds the capacity senior leaders to implement strategies and establish a clear direction for the Namibian public health system to more effectively achieve national maternal and child health and nutrition goals. It also builds regional capacity to design and implement innovative, frontline projects for addressing maternal and child health and nutrition. Based on the success of this the USG will continue to explore options of developing, more PPS with local entities in Namibia.

7.2 Gender

Results from the 2011 APR (63 % females and 37% males) indicate that more women are accessing care services and engaging males at the community level remains a challenge. Activities will focus on reaching out to men through male engagement workshops, building the capacity of men only PLHIV organizations like Namibia Men's Network (NAMEN+) to advocate for male involvement in HIV care services and facilitating the formation of male-only volunteer groups providing care and support for PLHIV and OVC thus learning to share in the burden of care and promoting gender equity. Care activities will be linked with HIV counseling and Testing (HCT) such as male-testing days. USG will increase gender equity in all HIV/AIDS services, and is committed to a family-centered approach for providing a continuum of care



equitably to women, men and children from facility to community level.

In COP12 Pre-ART, ART, STI management and FP counseling for female and especially male clients will be made more accessible through community-based support; cervical cancer screening for HIV Positive women will continue to be provided; community-based volunteers are trained and will identify and refer malnourished children and pregnant women for NACS with food supplementation to reduce morbidity and mortality amongst vulnerable persons especially pregnant women, under-fives and PLHIV.

GCF resources will be addressing gatekeepers and community sensitization to promote zero tolerance of GBV in two regions of Namibia and abused children and women will be getting comprehensive care services. - PEPFAR's strategy to increase women's and girl's access to productive resources will include microfinance and micro-gardening for ES and food security. Implementation will be guided and monitored through partners' work and performance monitoring plans, partner reviews and site visits.

7.3 MARP

Most at risk populations (MARP), specifically those self-identifying as sex workers and men who have sex with men, face barriers to care and support including punitive laws, stigma and discrimination. Such barriers are often poorly recognized by partner country and civil society program managers' thus making care services by these populations inaccessible. Sex workers complain of harassment by uniformed services. Re-enforcing linkages and referral between the MARP project implemented under Prevention and facility and community-based services will be in focus.

7.4 Human Resources for Health (HRH)

For Namibia to be able to meet the increased service demand for comprehensive and quality HIV care and support services, the USG will continue to support GRN efforts for task shifting and decentralization of services. This will require continued TA to both pre-service and in-service training institutions to enhance the skills and capacity for more HCWS to provide these services. Furthermore, in line with the draft PFIP, the USG will provide assistance the GRN to explore novel and innovative delivery models of care and support which lessen the workload burden on the limited HR while ensuring maximum program quality and improved sustainable program and clinical outcomes.

To begin to address inequalities in the health sector and to better implement primary health care, the MOHSS is piloting a community health extension program that will utilize a new cadre of community extension workers. These HEW will provide integrated prevention education, illness detection and referral services and facilitate better linkages between health facilities and the communities. The USG is assisting the MOHSS to pilot this program. Continued support for roll out after successful pilot, is anticipated, to increase access to integrated sustainable quality healthcare services.

7.5 Laboratory

During the next 1-2 years USG support to the MOHSS will continue to strengthen TB laboratory capacity with a particular focus on the diagnosis of TB in PLHIV so as to respond to the revised TB and HIV treatment guidelines as well as the technological advances in TB diagnostics, particularly the development of the Xpert® MTB/RIF test. Development of a laboratory strategic plan to reflect phased implementation of the Xpert where appropriate will be supported. To support efforts towards early identification of TB in PLHIV USG will support the use of MTB/RIF test as the primary diagnostic test for all HIV positive TB suspects. Conventional TB C/DST remains relevant as a follow- on test for Rifampicin resistant patients to guide better second line regimens. Similarly, standard First line drugs surveillance testing as well as the newer HAIN's test will be strengthened. The TB laboratory QA program will be supported to achieve full coverage of all TB diagnostic centers. Laboratory TBIC measures in the identified laboratories will also be strengthened.

7.6 Strategic Information (SI)



As stated in the Governance and Systems Strengthening TAN, several activities are underway that will provide data and information for evidence based-planning for care services. At the facility level, pre-ART registers track PLHIV enrolled in care. M&E tools are being piloted for the GRN nutrition program targeting PLHIV. Care for OVC is tracked through an M&E system developed with the MGECW. A DHS+ is being planned for 2012 and will provide intervention, outcome and impact data for care programs including OVC. Strengthening of M&E of TB/HIV activities will be a priority in the coming year.

Many care programs are implemented at the community and household level and challenges remain for measuring the quality and impact of interventions and for efforts at the district, regional, and national level to bring all of this information together. Such challenges include nascent community-based information systems (a priority in SI); limited capacity within MGECW to manage the OVC database; identification of MARPS being served by care interventions; measuring the progress, outcomes, and impact of CHBC interventions in addition to gaps in implementation and limited capacity of the national non-facility based M&E system to characterize the national care response and provide information for program planning. Moreover poor data linkages between TB and HIV settings and non-alignment of national ART Registers and TB Registers still persist.

7.7 Capacity building

Capacity development activities will include and integrate systems approaches with individual/workforce measures. Priority objectives will be to: 1) Enhance country leadership at national and sub national levels on sustaining and coordinating HIV related care and integration with the larger health system and with other sectors; 2) Improve the continuum of care/referral system between facilities and communities and 3) Increased sustainability of community-based care

New capacity building initiatives under COP 12 include support to a civil society funding 'vehicle' being established under the auspices of an NGO umbrella organization, as well as to Namibia's new training institution for public servants that was established by an Act of Parliament in 2010. USG will also support the capacity of the National Health Training Centre. The new HEW cadre training will receive PEPFAR support.

Ongoing capacity building measures will include USG participation in the HRH taskforce and TWG and technical advisory committees provided for in the NSF. Lastly, leadership building will focus on MGECW, MOHSS and MRLGHRD as well as the network of Namibia's civil society AIDS Service Organizations.

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	2,629,862	0
HVSI	7,816,593	0
OHSS	8,769,685	0
Total Technical Area Planned Funding:	19,216,140	0

Summary:

- 1. Overview
 - 1.1 Major actors



The major financing actors in the health system are largely the Government (accounting for 54 percent of all health expenditures), followed by donors—largely USG and GFATM (22%), households (12%), and employers (12%). The majority of household and employer health payments are made to medical aid (health insurance) premiums. The medical aid industry covers 16-18% of the population or approximately half of the formal workforces. An emerging actor with respect to achieving universal health coverage is the Social Security Commission, which by law, will be developing and rolling out the Namibia Medical Benefits Fund with the intent of widening the initiative to become a national health insurance scheme. In terms of service delivery, the majority of the population access services through the Ministry of Health and Social Services (MOHSS). A substantial proportion receives care via faith-based facilities (that are in large part financed by the MOHSS, with the exception of the HIV/AIDS program. While private facilities serve a relatively smaller section of the population, the majority of health care workers are found in the private-for-profit facilities. The total health care facility network (excluding consultation rooms which have not yet been quantified) now includes 46 hospitals (district, intermediate; including public, faith-based and private), 49 Health Centers, and approximately 350 clinics and other healthcare service points (1 - see End Notes) , including the military which has 1 main hospital and a health centre and smaller clinics and sick bays at each of the military installations across the country. Facilities are distributed across all 13 regions; however, specialist services are concentrated in hospitals, which lie in urban areas. Under the Namibia Institute of Pathology, a robust network of diagnostic laboratories provides laboratory services to public and private healthcare facilities.

1.2 Health system constraints

In terms of health systems constraints, findings from a 2008 comprehensive review (2) show a number of challenges facing the health sector. With respect to governance, the Review found leadership challenges within the MOHSS and that leadership capability is not systematically nurtured; moreover, “clarity of direction fades at lower levels.” The public sector is still largely centralized despite the 2000 national Decentralization Act. The 2008 Review also found weaknesses in coordination ,particularly between HIV and RH, education, vertical and community based interventions, the private sector, and among donors. In addition, the report noted fragmentation, ‘verticalization’ and duplication of information systems and responsibilities within the MOHSS. In terms of HRH, the Systems Review found that while Namibia has more HCW (three per 1,000 persons) than most of its neighbors in sub-Saharan Africa (3) the majority work in the private sector (8.8 HCW per 1,000 persons) with two HCW per 1,000 population in (4) the public healthcare system. HR constraints in the public sector include high vacancy rates (at 27%), recruitment and retention challenges, and an outdated staffing establishment that places considerable emphasis on the roles and responsibilities of clinical staff, particularly medical officers. At the service delivery level, public health care services are based on an outdated minimum district services package that is largely facility based (with minimal outreach and mobile health services). There are also considerable challenges with ensuring access to care given the geographic size of Namibia and many poor Namibians’ lack of transportation. Despite all of these mentioned constraints, the MOHSS is systematically working to address these issues based on recommendations in the Systems Review and much of the USG SS support targets these nationally led efforts to strengthen the health system.

1.3 Context from which the country team engages with the health system

The USG country team engages the health system through multiple mechanisms and levels; bilaterally with specific line ministries and other donors, through the GFATM Namibia Coordinating Committee for AIDS, Tuberculosis, and Malaria (NaCCATuM), through the new NSF coordination structures (while some structures are operational—such as select Technical Advisory Committees (TACs), many higher level structures are not yet fully operational), and through umbrella bodies such as NANASO and the Namibian Association of Medical Aid Funds. Because many health systems issues are dependent on and influenced by Government entities beyond the MOHSS, the USG team also engages with the Ministry of Finance (MOF), Office of the Prime Minister, Public Service Commission, Ministry of Regional Local Government Housing and Rural Development (MRLGHRD), Ministry of Gender Equality and Child



Welfare (MGECW), Ministry of Defense (MOD), Ministry of Safety and Security and Social Security Commission (SSC).

2. Global Health Initiative

Namibia's Global Health Initiative Strategy is built around the central idea that PEPFAR support for the national HIV/AIDS response, coupled with investments in cross-cutting areas such as strategic information, gender, financial sustainability, and human capacity development, can have profound ripple effects on broader health indicators, such as maternal and child survival, infants' nutritional status, human resources for health, and the use of data for evidence-based health programming. The Systems Strengthening portfolio directly supports the Namibian GHI objectives and principles of transition, access, and sustainability. The "Transition" objective is designed to "increase government and civil society capacity to manage, coordinate and finance the health and social sectors through improved systems." Specifically, key priorities for the USG Namibia team, as described in its GHI strategy, include --

- Increasing domestic health financing
- Equitable and Efficient Use of Funds
- Strengthened HRH
- Increasing use of Strategic Information, including M&E surveillance and operational research for evidence-based decision-making
- Increasing health service efficiency
- Increasing multi-sectoral coordination and programming

The "Access" objective seeks to "accelerate/expand access to quality health services in underserved areas." USG agencies will develop and implement existing and new programs to achieve the following key intermediate results (as described in the country's GHI strategy)

- Increasing availability of integrated HIV/AIDS (e.g. PMTCT) and maternal, reproductive, neonatal and child health services
- Increasing availability of integrated TB/HIV services
- Improving the continuum of care, including referral linkages
- Increasing the availability of community-based prevention/health promotion and care and treatment services, including gender-based violence prevention
- Increasing male involvement in family-related health care decisions

PEPFAR Namibia's COP 12 funding for Governance and Systems Strengthening target both objectives. Because most USG health funds in Namibia flow through PEPFAR, GHI-focused activities will require innovative thinking about the way investments in HIV/AIDS and TB may have maximum impact across the GHI principles. In COP 12, the USG team will work to improve greater partnerships, particularly among domestic stakeholders who can contribute to the sustainability of the response (e.g. the public sector beyond MOHSS – e.g. MOF, and the private sector). Relatedly, to address financial sustainability, COP 12 will focus will support the GRN to develop informed budget submissions relating to the HIV/AIDS response and health system, support upcoming national funding mechanisms that have the potential for financing some civil society services, and work with NGO partners to develop innovative resource mobilization plans (that may for example include marketing services to the private sector). Another major GHI thrust for systems strengthening in COP 12 is USG's support for "smart integration" approaches in Namibia. This will include the provision of various costing and workload scenario models to inform the integration process; along with direct funding to the MOHSS to implement (including the broadening of trainings to target more staff, such as from PHC, than those working in HIV/AIDS clinics only) the selected integration model. This work builds upon past COP investments that have expanded the availability of commonly prescribed non-ART medicines in ART pharmacies, and developed curricula to train nurses on the WHO Integrated Management of Adult (and Child) Illness (IMAI/IMCI) strategies, which the government is rolling-out to health clinics nationwide.

3. Leadership and Governance and Capacity Building



The Namibia GHI strategy is based on a number of critical assumptions around the government's current and future commitment to governance and leadership in the health sector. Notably, the Namibia GHI strategy assumes that the Government of Namibia will remain "committed to health sector priorities as outlined in the National Development Plan, the National Health Policy Framework, and the National Strategic Framework for HIV and AIDS." The USG will work to strengthen 1) the Government, 2) the private sector, and 3) civil society capacity to design, manage, and monitor HIV programs at various levels.

3.1 Government

For the GRN, the USG in COP 12 will support the strengthening of country-led processes, including greater alignment to GRN budgeting cycles. As mentioned before, the USG will work with a broader range of GRN stakeholders – akin to a Namibian 'whole of government' approach-- who are and can be influential in the sustainability of the response and health system (in addition to the MOHSS and MGECW); this includes the MOF, MRLHRD, and Social Security Commission. In addition, USG governance activities in COP 12 will support and inform the restructuring/ reform efforts of the MOHSS and the MGECW to be more responsive and effective in meeting their national mandates. It should be noted that in keeping with the GHI principles, the USG support to the MOHSS on HSS goes beyond the Directorate of Special Programs (that houses the Ministry's HIV/AIDS program) to also target other directorates dealing with primary health care, central medical stores, policy planning and human resource development, and tertiary care.

3.2 Private Sector

For the private sector, the USG in COP 12 will support a number of initiatives including high-impact activities, such as the expansion of an innovative public-private mobile primary healthcare initiative (that can serve as a model for similar activities in the public sector). USG efforts will focus on mobilizing sustainable private sector contributions-through price reduction efforts for ARV to promote low-cost health insurance uptake by employers for low-wage income earners, strengthening private sector links to and financing of civil society, strengthening private sector provision and financing of male circumcision (5), and supporting greater GRN-private sector coordination through upcoming new structures such as the PPP unit within the MOHSS. An area of particular interest over the next five years will involve increased USG engagement with the Social Security Commission and private insurance companies as these entities debate wide-ranging reforms with respect to the development and roll-out of national health insurance and steps for achieving universal health coverage.

3.3 Civil Society

For Civil society, the USG will build upon previous efforts to garner greater involvement and engagement by civil society and PLWHIV in the HIV/AIDS. With respect to civil society, the USG will continue to offer organizational development support to help civil society become more focused in their mandates, clearer in articulating their value, strategic in resource mobilization and in diversifying revenue streams, and accountable in delivering services.

5. Service Delivery

Central to its approach to improve service delivery systems, the USG in COP 12 is focusing efforts on strategic integration and formalizing referral systems and links—such as those between facilities and communities as well as between services provided by various line ministries (such as those of the MOHSS and MGECW).

Specifically, the USG is addressing the key features of the continuum of the Response in the following manner:

- The USG is working to improve upon the sustainability of services—through both GRN and private sector resource mobilization.

- The USG is also working to improve access and distribution of services, through better targeting of financial resources (through the development of an equitable resource allocation formula), increased support for mobile services, and better use of data to identify those in need of services.
- In addition, the USG is working to reduce HIV transmission through greater linkages and more targeted efforts in behavior change, male circumcision, counseling and testing, PHDP, and MTCT.
- To improve retention and adherence of HIV+ clients in care/treatment programs, the USG is working to strengthen better information systems for tracking patients on ART; to improve outreach and mobile ART services; to increase capacity building for health care workers to promote adherence; and to pilot new, evidence-based technology and community based adherence promoting interventions.
- To improve client, family, and community health outcomes, the USG is supporting the development of the health extension worker cadre to improve access to care by communities; the strengthening of bi-directional referrals and linkages; promoting family centered approaches to the continuum of care; and various economic strengthening efforts for affected families.

To foster such linkages in the Continuum, the USG is working to support greater data-use for decision making. In this regard, the GRN recognizes that effective programming necessitates the need for the production of appropriate data for evidence-based planning. Targeted survey and M&E activities for areas such as PMTCT and MC and for populations such as MARPs and PLWHA are being prioritized for the coming years to provide baseline, mid-term and end term evaluation data to plan and track progress of these initiatives. As the urgency of scaling up life-saving programs wanes, and as new initiatives are implemented for target populations, the focus for data will go beyond routine M&E. Process, outcome, impact evaluations and studies will be incorporated into prevention, care and treatment programming.

6. Human Resources for Health

COP 12 resources for HRH will be focused on the transition of relevant donor staff (in a phased approach (6)) to the pay-roll of domestic stakeholders, including the GRN. In addition, HSS projects funded in COP 12 will focus on capacity building, along with workforce planning, development, and management.

In 2010/2011, USG helped launch an inter-agency, inter-ministerial, and multi-sectoral task force on Human Resources for Health. This task force is chaired by the Deputy Permanent Secretary of the MOHSS and includes senior representatives from the National Planning Commission, the Ministry of Finance, other line ministries, civil society and the private sector. The task force has established a technical working group (TWG) to manage and implement the current transition of USG-supported positions to the MOHSS staff establishment. This TWG is also charged with supporting the on-going development of staffing norms and other HR strategies (e.g., recruitment and retention in under-served areas) required to expand and restructure the MOHSS workforce. In August 2011, the TWG supported the submission of a US\$29 million "motivation" letter from MOHSS to the Ministry of Finance. This motivation seeks funds over a three year (Medium Term Expenditure Framework MTEF period) period to create 1,455 new clinical and non-clinical positions within the MOHSS workforce. Workers in these positions are currently providing HIV/AIDS services to the MOHSS, however all of their salaries are paid by the USG and the Global Fund. Historically, the USG has invested up to 30% of its annual COP budgets in direct salary support.

The three-year transition request submitted in August is the cornerstone of USG efforts to transition these costs to the GRN in a structured way that will not interrupt service delivery. In addition, the MOHSS has agreed to take on donor supported medical officers as contract staff until the results of the MTEF budget submission is known in April 2012. In this regard, the TWG has successfully managed the transition of 35 (out of 37) medical officers from USG supported mechanisms to the GRN.

For COP 12, USG will reduce its salary support budget by \$USD 8.7 million. This reduction will cover 1) all medical officers (to be absorbed by the GRN) with the exception of those involved the time-limited male circumcision scale-up (7) campaign, 2) clinical positions in 6 MTEF priority



regions (namely nurses, pharmacists, and pharmacist assistants), and 3) the phase-out of several salary supported posts (which the MOHSS has decided to not absorb). USG will continue to work with the MOHSS to ensure that follow-up motivations are made for subsequent fiscal years and will work to remove funding for remaining health care workers in future COPs in collaboration and discussion with the GRN.

Beyond the HRH Task Force and TWG within the health sector, USG has worked closely with implementing partners to begin discussions with government institutions such as the University of Namibia to begin motivating for additional resources to absorb HR positions that are currently funded by the USG. Since 2009, for example, UNAM and the National Health Training Centre (NHTC) have successfully motivated for additional GRN funding to absorb over half a dozen positions that were previously funded through USG implementing partners I-TECH and MSH.

Pre-service and in-service training have been overshadowed by direct salary support as a proportion of total USG funding for HRH. However, support for the development of a highly-trained and well-led health workforce is a priority for the USG team. USG investments in nursing, public health, and laboratory science programs at UNAM and the Polytechnic of Namibia will contribute to PEPFAR's "140,000 health care worker" target, and strengthen coordinated and standardized health care curricula in Namibia. Graduates from these programs will fill critical gaps in the health workforce. Importantly, over time these graduates will allow Namibia to reduce its dependence on expatriate health care workers. In-service training will build on historical USG investments to strengthen the HIV/AIDS response scale-up, and expand into cross-cutting areas such as maternal and child health, health promotion, and monitoring and evaluation. Moreover, as the MOHSS restructures its service delivery approach and considers the strategic integration of HIV/AIDS services within primary health care, the USG will offer training support for HCWs in non-HIV/AIDS units to care for HIV+ patients and also support HIV/AIDS-focused HCWs refresher courses for non-HIV/AIDS health services.

The USG Namibia team recognizes the importance of expanding task-shifting and deploying new cadres of facility-based and community-based health workers to reduce the work burden on what will continue to be a limited number of medical officers and registered nurses. The USG in collaboration with UNICEF is offering support for the pilot of the GRN's new "health extension worker" cadre, which will work to bring health care services to the communities themselves – helping to address the geographic barriers to accessing current facility-based care. Moreover, this cadre will serve as a career growth possibility for currently funded USG supported community workers and volunteers, who would be viable candidates for HEW pre-service training.

Finally, the USG is supporting broader HRH workforce planning and management through a number of initiatives. For example, building upon its earlier support to introduce an Human Resource Information System the USG will focus efforts on greater data use by managers and on broadening the system to include faith-based staff (in addition to public sector staff), and the private sector. In addition, the USG will support efforts to link HRIS with data from academic institutions that show the numbers of students being trained in various health care related fields. Doing so will help inform projections and identify deficiencies in the anticipated number of health care workers for a particular cadre. In addition, the USG, will support HRH planning, projection, and analysis workshops for the MOHSS and MGECW along with supporting HRH-related assessments to inform the revision of Ministry staffing norms. Finally, the USG will provide technical assistance on possible the HRH impact/needs arising from various integration strategies.

7. Laboratory Strengthening

COP 12 funds will focus activities on strengthening coordination through the public health network, launching point-of-care testing to strengthen efficiencies, strengthening quality of lab services, and training the next generation of Namibian laboratorians.

Following a Cabinet decision, the Namibia Institute of Pathology (NIP) was established to provide and sustain quality medical laboratory diagnostic services throughout Namibia. NIP operates a two-tier laboratory system through a network of 37 laboratories that extends up to district level though not



covering all districts. The NIP operates a good system for specimen referral to ensure countrywide coverage for laboratory services. However, the referral system faces the challenges of specimen collection, transportation and long turn-around times for test results.

Moreover, laboratory services need to be organized and properly regulated at the national level in order to meet the priority needs of the healthcare and public health systems and assure the quality of testing.

Recognizing that the Laboratory services are critical for proper delivery of health care services and provides data for policy formulation and informed decision making, the MOHSS with USG support has embarked on developing a national laboratory policy and strategic plan to address the gaps in laboratory service delivery. The national public health laboratory policy supports priority goals as defined by the MOHSS, sets standards for establishment of public and private laboratories, regulates them and guides training and certification of laboratory personnel and for quality laboratory practice in Namibia.

This policy defines the laboratory governance, coordination and collaboration structures and provides an environment and infrastructure that will assure the delivery of quality laboratory services to all and support the priority health initiatives of the national health plan. The national public health laboratory policy is a key element of the MOHSS operational resources for supporting effective national health priorities.

Laboratory personnel at the Ministry of Defense (MOD) facility have been trained in line with national laboratory guidelines. The establishment of a comprehensive laboratory Quality Management System (QMS) has progressed well with the development of a Quality Manual and Standard Operating Procedures (SOPs), and training of staff on Quality Systems Essentials. The laboratory receives technical assistance from the Namibia Institute of Pathology (NIP), which also serves as the reference laboratory for the Ministry of Defense. The Laboratory continues to participate in an External Quality Assurance (EQA) program with Thistle QA and efforts are underway to ensure that the laboratory is accredited to the South African National Accreditation System (SANAS).

8. Health Efficiency and Financing

In COP 12, the USG will support improved and informed host country budgeting and planning through the production of better expenditure and costing data, cost-benefit analyses, and efficiency analyses. These activities are critical for developing viable financial sustainability strategies.

First, to strengthen health care financing capacity in Namibia, the USG is supporting the institutionalization and policy use of national resource tracking efforts (National Health Accounts, National AIDS Spending Assessments) to routinely estimate expenditures by the public, private, and donor stakeholders for health care, HIV/AIDS, reproductive health, and other priority areas. Institutionalization activities include the development of a donor and NGO expenditure database. In addition, the USG will be linking such efforts to strengthening GRN capacity to conduct needed costing studies (as opposed to hiring external consultants and not retaining information on assumptions, methodology and cost data within the GRN) and to strengthening financial management practices.

The USG is also supporting a number of economic analyses to inform efficient, equitable, and effective use of health funds. For example, efforts are underway to garner sufficient data and analysis to develop an equitable resource allocation formula for the MOHSS to use in future budgeting decisions. This would shift allocation decisions from being largely based on historical allocations to being based on need, utilization, facility competencies, and burden of disease. Also, a number of analyses are underway to inform ways to strengthen private sector involvement in health care. For example, the USG is supporting analyses to determine the cost savings to the GRN and private sector if ARVs are procured through the public sector for purchase by the private sector (currently the private sector uses alternative procurement mechanisms and due to low-volume purchases, it pays twice the price as the public sector). Other examples include assessments to determine the viability of public-private partnerships to sustainably finance the development of upcoming primary health care mobile initiatives.

Furthermore, following a recent analysis by UNAIDS on financial sustainability, the USG will support follow-up studies as needed. Principal findings describe the need to address inefficiencies within the health care system. To inform the national health insurance initiative, the USG will also support



economic and actuarial analyses to make low-cost health insurance options more viable for employers and employees. If health insurance is expanded within the formal sector, the financial burden on the public sector will be reduced significantly. Preliminary assessments conducted by USG partners indicate that the GRN would save USD \$1,000,000 per year for every percentage increase in the population covered by health insurance.

9. Supply Chain and Logistics

To strengthen the national health supply chain system, the USG will continue its capacity-building efforts to forecast, procure, store, distribute and generate logistics information of pharmaceuticals and other related commodities for the prevention, testing, treatment and care of HIV and AIDS in all regions of Namibia.

Enhancing the MOHSS supply chain system will be done by (1) strengthening warehousing operations and quality assurance capacity in Central Medical Stores (CMS); and inventory management at the two Multi-Regional Medical Depots in Rundu and Oshakati. (2) Providing supply chain-related technical assistance to MoHSS to accelerate the roll-out of male circumcision (MC) interventions.

In addition, USG will contribute to an adequately trained and well-performing supply chain workforce, including capacity building activities and transitioning roles and responsibilities to partner government counterparts. This will be done in part through support of UNAM and networks to provide health-related supply chain management training.

To improve coordination and leverage among other donors, the USG will support (1) capacity building of the National Medicines Policy Coordination (NMPC) sub-division in the Division: Pharmaceutical Services to provide overall coordination and supervision in the supply chain management activities; (2) strengthen long-term quantification and budgeting of public-health program commodity needs including strengthening linkages between program commodity forecasts, supply planning and procurement actions and institutionalizing long-term forecasting and budgeting of commodity needs into MoHSS systems; and (3) provide technical assistance to the Project Management Unit of MoHSS to coordinate procurement of Global Fund-funded Therapeutic and Supplementary Foods (TSFs).

Finally, the USG will improve the availability and use of information within the supply chain system for decisions making by (1) Enhancing CMS and Regional Medical stores' performance monitoring using Pharmacy Management Information System (PMIS) and utilization of data from Syspro as well as the fleet management system for decision-making. (2) Supporting the Primary Health Care directorate to monitor implementation; and evaluate the performance of the CHBC kit system and the TSFs logistics system. (3) Strengthening systems for data collection, validation, analysis and reporting of HIV counseling and testing (HCT)-related commodities to generate information for evidence-based managerial decision-making and policy recommendations.

10. Gender

Various strategic frameworks and national policies represent the Government of Namibia's (GRN) commitment to achieving gender equality and the empowerment of both men and women in Namibia. to create a society in which women and men enjoy equal rights and equal access to basic services, as well as opportunities to participate in and contribute towards the political, social, economic and cultural development of Namibia. The National Gender Policy recognizes that women in Namibia face increased prevalence of HIV/AIDS, high rates of gender-based violence (GBV) and continued pervasive gender and intra-household inequalities. USG resources will support implementation of the GRN GBV Action Plan in two focus regions working mainly to promote zero tolerance of GBV at the community level, strengthening national and regional GBV coordination structures along with GBV data management. Namibia adopted the National Strategic Framework for HIV/AIDS 2010/11-2015/16 (NSF) which highlights the importance of women and the girl child and calls for the reduction of the vulnerability to HIV infection and mitigating the impact of HIV and AIDS on women and children. Namibia participates in the annual 16 Days of Activism Against Gender Violence.

Gender inequalities within the family setting continue to undermine women's



decision-making powers around their health resulting in delays in seeking appropriate health care and rising maternal mortality in Namibia. USG Partners report that low levels of male utilization and involvement and most treatment and care services are weak on utilizing a family-centered approach. The Namibia GHI strategy focuses on investments that will help the GRN and civil society partners accelerate and expand access to quality health services particularly for women, children and other underserved populations. The Namibia GHI strategy highlights increasing community awareness about gender issues, especially gender-based violence and male involvement in family health decisions. A key tenet of the HIV/AIDS Partnership Framework of the GRN and the USG is to support advancement of policies to address gender-related norms and practices that hinder equitable access to services and increase the vulnerability of women and girls to HIV infection.

End Notes

- (1) Ministry of Health and Social Services (MoHSS) [Namibia] and ICF Macro. 2010. Namibia Health Facility Census 2009. Windhoek, Namibia. MoHSS and ICF Macro.
- (2) Ministry of Health and Social Services. 2008. Health and Social Services System Review. 2008
- (3) 3 HCW/1000 population is above the WHO benchmark of 2.28 specified in the WHO 2006 report.
- (4) Ministry of Health and Social Services, Health and Social Services System Review, 2008.
- (5) With COP10 funds, USG support to the private sector produced an important measurable output, notably the creation of an affordable national tariff (that outlines fees and services) for insurance schemes to offer male circumcision benefits as a prevention measure for HIV/AIDS. Previously, MC was only covered under insurance for medical reasons and was considered too expensive to offer for HIV prevention purposes.
- (6) It should be noted that the USG will continue to provide salary support for some positions, particularly in the non-clinical cadres (as these do not always have readily identifiable counterpart cadres on the GRN staffing structure) and technical adviser positions (the latter is critical for evolving into a TA model).
- (7) MC medical officers will not be included as part of the transition to GRN.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	7,758,146	
Total Technical Area Planned Funding:	7,758,146	0

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	5,747,740	0
HMBL	660,220	0
HMIN	325,000	0
HVAB	964,606	0
HVCT	7,258,187	0



HVOP	8,258,300	0
MTCT	5,225,202	0
Total Technical Area Planned Funding:	28,439,255	0

Summary:

1. Overview

HIV/AIDS remains a significant source of morbidity and mortality, and a major drain on national and international resources for health. In 2008/09, the national HIV/AIDS response consumed 27.5% of total national expenditures on health (1 - see End Notes). The HIV/AIDS epidemic is mature, generalized, and driven by heterosexual and mother-to-child transmission. The Government of the Republic of Namibia (GRN) identified prevention as one of four national HIV/AIDS priorities in the National Strategic Framework (NSF) 2010/11-2015/2016. With continued support from its partners, Namibia has made considerable achievements in this area, achieving high PMTCT and HCT coverage and adopting the Voluntary Medical Male Circumcision (VMMC) policy. However, to achieve high-impact sustainable prevention efforts there is still a need to address many challenges including the key drivers of the epidemic, e.g. multiple sexual partnerships, alcohol, inconsistent condom use etc.

In addition, cross-cutting issues related to human resources for health, systems strengthening, capacity building, gender, and strategic information remain a significant challenge. The USG prevention portfolio has already been moving towards a more strategic mix of target populations, geographic coverage and approaches. Using combination prevention, the focus is on supporting Namibia to achieve a sustainable and country-owned mix of evidence-based high-impact prevention approaches integrated with and complemented by appropriate behavioral activities to create demand for these approaches.

The bulk of current USG support for Health Systems Strengthening activities in the prevention program area is targeted at Human Resources for Health (HRH). USG support for permanent staff within the Ministry of Health and Social Services (MOHSS) will progressively decline over the coming years and the transition of clinical staff is underway. USG, GRN, and civil society are in continuous dialogue regarding the HRH transition. For non-clinical staff, a plan is being formulated. It is predicated on the resource mobilization and on working with GRN to create cadres within the government staff establishment (e.g. M&E staff, health extension worker).

1.1 HIV Prevalence

HIV prevalence in Namibia has never been measured through a national population-based survey. National estimates are derived from bi-annual surveillance of pregnant women attending antenatal clinics (ANC). The 2010 ANC Surveillance Report indicates HIV prevalence among pregnant women attending ANC was 18.8%, a decline from the peak ANC prevalence estimate of 22.5% reported in 2002 (2) Amongst 15-24 year olds, the ANC prevalence rate was 15.2% and 10.3% in 2004 and 2010 respectively (ANC Sentinel Survey 2010). These reductions in HIV prevalence, giving a proxy for trends in recent infections, could indicate a reduction in incidence. Additionally, updated estimates derived from the Estimates and Projections Package (EPP) and SPECTRUM software show a steep decline in probable incidence from between 2002 and 2011. A new Namibian Demographic and Health Survey (DHS) is planned for 2012 and is expected to include bio-markers with HIV testing high on the list.

Although a significant downward trend was observed among young pregnant women aged 15 to 29, HIV rates increased for all five-year age cohorts of pregnant women between 30 and 49, perhaps reflecting a “cohort effect” owing to improved survival of previously infected women as they move into older age cohorts, given the high coverage of ART. Very limited data are available on HIV rates among men. A 2011 survey of 9,800 private sector employees found similar HIV rates for men and women, about 10%.

Although HIV prevalence does not differ significantly between urban and rural areas



within Namibia, it varies greatly across regions. HIV prevalence is highest in the North along the Angolan border, where roughly 60% of the population resides. In 2010, ANC prevalence ranged from 4.2% in Rehoboth to 35.6% in Katima Mulillo. HIV rates are also high in Walvis Bay in the west and Karasburg and Luderitz in the south. Although overall prevalence estimates are declining, troubling increases were observed in several sites.

Data for most-at-risk populations (MARPs) are limited. Key informants estimate HIV rates among sex workers (SW) to be high, and the total population of SW is estimated to be around 10,000-12,000. SW are concentrated where there are transport routes and a high presence of truckers, miners and sailors. These occupational groups typically spend long periods away from home and seek out paid sex. In these "hot spots," the high prevalence of sex work increases the risk of HIV for both mobile workers and surrounding communities, as SW clients serve as a 'bridge' from their commercial to their regular partners. In a small 2008 study in Windhoek, HIV prevalence among men having sex with men (MSM) was 12.4%.

1.2 Alignment to the Government of Namibia's Prevention Planning and Priorities
Prevention is one of four national HIV/AIDS priorities in the NSF developed by the GRN. The NSF supports a combination prevention approach including behavioral, biomedical and structural interventions and a focus on the key epidemic drivers. During preparation of the NSF, the GRN identified the following weaknesses that have undermined prevention efforts: inadequate targeting of key epidemic drivers and populations; inadequate coverage and intensity; and fragmented coordination and a lack of synergy resulting from a lack of capacity among regional and community level GRN structures.

Since 2008, the USG and the GRN have worked together to formalize HIV Prevention within the GRN through support to planning and coordination and support to the technical Advisory Committee (TAC). Key GRN stakeholders in prevention include: the MOHSS; Ministry of Information, Communication, and Technology (MICT); Ministry of Education (MOE); Ministry of Defense (MOD); the Namibian Defense Force (NDF); Ministry of Gender Equity and Child Welfare (MGECW); and Ministry of Regional and Local Government, Housing and Rural Development (MRLGHRD), civil society organizations (CSO) and other donors.

The NSF combination prevention strategy focuses on reducing the risk of HIV transmission by promoting changes in sexual behavior, underlying social and cultural norms, poverty, and gender inequalities. Biomedical interventions, including male circumcision (MC), prevention of mother to child transmission (PMTCT), HIV counseling and testing (HCT), increased male and female condom use, control of sexually transmitted infections (STI), and blood and injection safety. Creating an enabling policy and legal environment is also needed to support the successful implementation of these strategies.

Consensus drivers of the HIV epidemic in Namibia include: low male circumcision rates; multiple and concurrent partners (MCP); inter-generational and transactional sex; mobility/migration; excessive alcohol use; declining marriage and co-habitation rates; inconsistent condom use; inadequate personal risk perception; and lack of HIV testing/awareness of HIV status.

Specific factors driving the epidemic vary by region and group so much that Namibia has multiple drivers occurring simultaneously. International borders (Caprivi) and ports (Walvis Bay) are homes to large groups of migrant men and widely available commercial sex which were found to be significant in the spread of HIV in these regions.

The social, economic and gender issues underlying these drivers are mutually reinforcing. Many Namibians share deep-rooted traditions of polygamy, bride-wealth exchange and patriarchal authority. These in turn form a strong cultural backdrop for societal tolerance of multiple concurrent partners (MCP) and transactional and cross-generational sex. For women, high unemployment, low access to resources, the fluidity of relationships, poverty and food insecurity all contribute to their vulnerability and dependence on transactional sex.

1.3 Evaluation of Prevention Efforts
Monitoring and evaluation efforts to build evidence-based programming continue. There are surveys and impact evaluations planned that go beyond routine program M&E:

- A population-based sero-prevalance survey (DHS+) remains under discussion with the partner country and is expected for 2012.
- An Integrated Biological and Behavioral Surveillance Survey (IBBSS) with Population Size Estimation focusing on SW and MSM in Namibia is being implemented in 2012. A randomized control trial examining the effectiveness of alcohol-HIV risk reduction intervention for men in a standalone VCT setting in Windhoek is also underway.
- A randomized control trial examining the effectiveness of prevention for persons living with HIV.

1.4 Funding For HIV Prevention

There are two major donors providing financial assistance to the partner country: The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the USG. Technical assistance is provided by GIZ and the UN. The GFATM Rolling Continuation Channel (RCC) is providing \$169.4 million from July 2010 to 2016 and includes a range of HIV prevention activities with the exception of medical male circumcision.

Currently, MOHSS depends heavily on external resources to assure core services for HIV/AIDS. External support from the two largest donors is expected to decline significantly in the future. Community-based and civil society groups implementing HIV prevention receive almost zero funding from domestic resources.

1.5 PEPFAR/Namibia COP12 Priorities in Prevention

USG/Namibia has a mandate to substantially reduce funding levels in Namibia over a period of five years. The process of transitioning USG-funded activities to the GRN began in COP11 and will accelerate in COP12. Given diminishing resources, USG priorities in COP12 include:

- Alignment with the NSF and the new USG prevention guidance.
- Support to key GRN national and regional offices for high impact, combination prevention interventions linking behavioral, biomedical and structural interventions.
- PMTCT Elimination by 2015.
- MC scale-up for public health impact with an emphasis on regional saturation
- Achieving a high coverage of Provider Initiated Counseling and Testing (PICT) HCT services in public and FBO facilities.
- Exploring mixed models of HCT service delivery to improve access and availability for populations experiencing challenges.
- Expanding comprehensive positive prevention in the community and health care facilities.
- Systematic coverage of SW and MSM with the minimum package for MARPs.
- Strengthening current behavioral interventions to expand coverage and incorporate evidence-based approaches that address known drivers whilst building active links to biomedical interventions.
- Increased focus on gender issues that contribute to HIV transmission.
- Strengthening M&E to better track performance of prevention services.
- Addressing human resource issues, capacity development and sustainability, in order to transition USG-funded community programs to local partners
- Incorporation of new prevention technologies as they become available.
- Coordination with other stakeholders to maximize impact and leverage resources

USG achievements, challenges and future priorities in each area of prevention are elaborated below. Cross-cutting issues relating to human resources for health, systems strengthening, capacity building, gender, and strategic information are integrated into the discussion in each technical area.

2. Prevention of mother to child transmission (PMTCT)

2.1 Achievements and Challenges

USG contributes to the national program through technical assistance in guideline development, training and salary support for Health Care Workers (HCW). Achievements include assistance to implement rapid HCT service; delivering a more efficacious ARV regimen to sero-positive pregnant women, post-partum mothers and HIV exposed infants; CD4 screening and nutritional counseling that encourages exclusive



breastfeeding for six months.

Challenges include a shortage and high turnover of HCW; population mobility and long distances to health facilities; links between community-clinic services due to suboptimal referral systems; integration of ANC/PMTCT with sexual and reproductive health (SRH), antiretroviral therapy (ART) and follow-up of mother-infant pairs and HIV exposed infants. Namibia continues to experience poor data quality.

2.2 COP12 Priorities

Namibia has made considerable progress in scaling up access to ARVs for PMTCT (Prong 3) and treatment, care and support for HIV positive mothers, their infants and families (prong 4) therefore a greater focus will be placed on quality improvement in prong 3 & 4; and strengthening integration and linkages to interventions aimed at prevention of HIV infections among reproductive age groups (prong1) and prevention of unintended pregnancies among HIV positive women (prong 2) through increasing access to family planning services among HIV positive women as well as improving couple counseling and testing. A specific area of emphasis is to continue strengthening mother-baby pair follow-up as well as improve access and availability to early infant diagnosis (EID). Resources will strengthen interventions on maternal mortality, including assistance to Health Extension Worker (HEW) program to identify pregnant women with complications, address the 3 "delays" in service delivery (seek, reach, receive) experienced by pregnant women and stronger community systems including support to the adaptation of mother-to-mother models designed by the MoHSS. An impact evaluation of the program using a cohort analysis to follow-up HIV-exposed infants at six weeks, nine months and 18 months to determine baselines for monitoring progress towards E-MTCT is underway.

USG will transition HCW salary support and commodities. Resources will support in-service training and technical assistance, including reviewing various service delivery models to strengthen linkages between PMTCT, ART, maternal and child health (MCH) and SRH (sexual and reproductive health). PEPFAR does not support family planning (FP) commodities procurement but service integration will increase access to commodities through referrals. USG will support country efforts to implement the MTCT national elimination agenda (eMTCT by 2015). Resources will enhance quality of services through implementation of revised national guidelines, protocols and strategies. Resources will be directed to improving current integration, service linkages and patient flow between PMTCT and ART services.

3. HIV Testing and Counseling (HTC)

3.1 Achievements and Challenges

In the 2006/7 DHS, 55% of women and 34% of men reported ever having had an HIV test. However, current program data corroborates increasing uptake of HTC. The majority of HTC occurs in the public sector. Over 80% of health facilities provide HTC services. Women account for approximately 70% of HTC in health facilities, reflecting high rates of testing in PMTCT settings. Services nonetheless remain poorly accessed by population segments including men and specifically defined MARP.

Namibia adopted a mixed model of service delivery through integrated sites in health facilities, stand-alone clinics, mobile/outreach, home-based testing, and institutional testing in prisons and military settings. Based on findings from the pilot in COP11, implementation of door-to-door testing will be scaled up in COP12. Namibia utilizes lay counselors to implement the majority of HTC services. Provider Initiated Counseling and Testing (PICT) is widely implemented in ANC and TB clinics. Efforts to scale-up PICT beyond ANC and TB are underway, though experiencing delays. The HTC program is dependent on external financing, especially for salary supports, the procurement of commodities, testing campaigns, and quality assurance.

3.2 COP 12 Goals and Priorities

The USG will initiate a multi-year transition of salary support, commodity and service costs. USG assistance will focus on improving HCT data analysis, accelerating PICT implementation, incorporating



private sector, and strengthening supply chain management for public and non-governmental HTC activities. Efforts to identify sero-discordant couples and family members will be renewed. Other priorities include: the coordination of mobile services, increasing the number of males and couples who access HCT services, and improving linkages to care.

4. Male and Female Condoms

4.1 Achievements and Challenges

The NSF outlines distribution of 50 million condoms annually by 2015/16. MOHSS supports a public sector procurement and distribution model resulting in free condom distribution. Partial or unsubsidized condom products have been largely crowded out of the market. Since 2004 the GFATM has funded 80 percent of condom procurements; financed the capital costs for a local organization to repackage and trade condom products and establish a quality assurance laboratory. In 2010 a dispute between GFATM and Prime and Sub-Recipients resulted in procurement delays using GFATM resources. The dispute is unresolved. In late 2011 the MOHSS announced intent to finance 100 percent of condom requirements with domestic resources. In 2012/13, MOHSS targets distribution of 30 million condoms.

Since 2009 USG procured \$1.2 million worth of condoms for MOHSS, a total of 16 million condoms and \$0.2 million for the Namibian Defense Force (NDF), approximately four million condoms. The USG supports HR salary costs for Condom Logistics Officers. An internal USG condom quantification was conducted in 2011 providing information to stakeholders on standard forecasting and costing of condoms. The USG does not procure female condoms. Concerns over adequacy of national and regional condom supply remain due to an unresolved dispute between GFATM and grant recipients. Regional distribution patterns are often inconsistent with population needs.

4.2 COP12 Priorities

During COP12 the USG will initiate a transition from procuring condoms and salary support though current timelines remain undefined. Technical assistance requirements of the MOHSS and NDF will be reviewed to increase efficiencies in the system.

5. Voluntary Medical Male Circumcision (VMMC)

5.1 Achievements and Challenges

In 2009 voluntary medical male circumcision (VMMC) was piloted. A national VMMC policy was endorsed by MOHSS in 2011. Approximately 9,000 adult males were circumcised between 08/2009 and 11/2011 in integrated facilities. Some facilities have long waiting lists; at others, demand is weak. Currently, all USG-supported VMMC services in Namibia take place in government facilities although there are neonatal and adult VMMC procedures implemented in the private/commercial sector. The current public sector program remains physician-centered as of 11/2011, despite USG efforts to advocate for task-shifting to nurses by host country stakeholders. Namibia utilizes forceps-guided methods and electro-cautery devices. The MOVE model is not currently practiced.

USG resources support a MOHSS-based VMMC coordinator; development of MC strategy and costed implementation plan, dedicated MC services providers; supplies, equipment and M&E related materials, community outreach and client education materials. USG resources support VMMC in faith-based and military hospitals, training private providers and implementing a health insurance tariff for private health insurers.

The USG currently provides 100 percent of VMMC resources. MOHSS indicated in 2011 that it will not pursue a GFATM targeted grant for VMMC. A USG costing in 2010 estimated \$24 million to reach 80 percent of Namibia's males by 2015, 15- 49 using current models.

5.2 COP12 Priorities

USG assistance will support multiple streams: 1. Accelerated implementation, using a regional saturation approach, in high burdened regions to achieve 50 to 80 percent coverage among eligible males; 2. technical assistance to MOHSS to implement a national VMMC program; and 3. technical assistance in



preparing a neonate component of the VMMC program. Resources will support stream one, specifically deploying dedicated HCW teams; adoption of MOVE; continue to advocate for task shifting; service delivery models in both health facilities and mobile units; targeted multi-channel community mobilization and health communication to generate demand. Demand creation will be linked to other prevention programs.

The ongoing challenge of mobilizing adequate financial and human resources has yet to be resolved. There is an urgent need to identify alternative funding sources for VMMC. A plan to cost the implementation of the VMMC policy is underway. To ensure sustainability and transitionability of USG investments in this area, the USG will use the costed implementation plan to work with the GRN to determine their specific contributions and their commitment to take over as USG support declines.

6. Positive Health Dignity and Prevention (PHDP)

6.1 Achievements and Challenges to Date

Prevention among PLHIV is a component of the response and includes health promotion, interpersonal counseling on behaviors and adherence, enhanced access to health and social services to support partner disclosure, partner referral, counseling and referral on FP/RH and STI; alcohol assessment and brief advice service for hazardous drinking. A centrally funded evaluation of facility-based PHDP was completed in 2011. Community-based PHDP is implemented through local PLHIV-led organizations by delivering the intervention package to existing PLHIV support groups, community and home-based care programs, and post-test clubs where available. Obstacles include: 1. Stigma: few women live openly with HIV and even fewer males disclose their status; 2. Support groups in Namibia are fragmented and do not cover the majority of the HIV positive population; 3. Gaps in linkages and referral systems between the community and health facility; and 4. M&E: project structures capture and report activities but do not inform the national response.

6.2 COP12 Priorities

PHDP is a growing component of Namibia's combination HIV prevention. Coverage of HIV positive Namibians receiving this intervention will increase with the integration into facility and the expansion of community-based efforts. Technical assistance to strengthen linkages and referrals between community and facility-based services is essential to increase the potential impact of PWP. Efforts to increase coverage of sero-discordant partners, pre-conception planning for sero-positive women and adolescents living with HIV remains a priority for USG.

7. Most at Risk Populations (MARP)

Namibia maintains discriminatory laws against sex workers and homosexuals which impede the roll-out of services for MARP. Despite this political environment, MARP such as sex workers (SW), clients of SW and men who have sex with men (MSM) figure prominently in the NSF. The USG supports uniformed services to implement a comprehensive program to control the epidemic.

7.1 Achievement and Challenges

USG is a majority financier of MARP interventions and maintains assistance to civil society or CSOs working with and representing SW, MSM, and clients of SW. Several of these CSO are MARP-led organizations focused on delivering a core set of targeted HIV prevention interventions and promoting enabling environment for MARP. Activities implemented by the CSO include single and multi-session risk reduction counseling with themes of risk perception, alcohol and substance abuse, violence, targeted condom/lubricant distribution, linkages to VCT/FP/RH/STI/ART and MC. In addition, peer outreach, community-level activities and outreach to HCW will reduce barriers to treatment and care. Policy and advocacy activities, in collaboration with UN agencies, are expected to achieve improvements in the enabling environment. Namibia does not have a conducive legislative or policy environment to work with SW and MSM, as both face punitive laws and social stigmatization. An IBBSS with Population Size Estimation among female SW and MSM will be implemented in 2012.



7.2 COP12 Priorities and Goals

USG will continue to support MARP-led organizations to expand coverage of a core package of interventions and enhanced access to ART for SW, their clients, and MSM. Longer-term transition goals present a challenge, as the GRN is unlikely to directly support MARP-led organizations.

8. General Population

Namibia has made substantial progress in HIV prevention in the general population. Successive NDHS (1992, 2000 and 2006) exhibit improvements in comprehensive HIV knowledge and reductions in multiple partners among married/cohabiting respondents and an increase in condom use, especially in high-risk sexual encounters and delays in sexual debut.

8.1 Achievement and Challenges

With support from USG, the National Prevention Coordinator leads the Prevention Technical Advisory Committee (TAC), which facilitates coordination across stakeholders. Recent engagement with the Ministry of Regional, Local Government, Housing and Rural Development (MRLGHD) strengthens sub-national coordination structures under the NSF, specifically Regional Councils. Engagement of MICT and MOD/NDF strengthened Namibia's whole of government approach to HIV prevention.

A high priority for USG is to transition most community-based programs to indigenous partners, and to build their technical and organizational capacity to become direct recipients of USG assistance. USG has also been moving to consolidate community-level programs in order to achieve more systematic coverage.

Support for alcohol-related HIV prevention activities, including the MOHSS Coalition for Responsible Drinking (CORD) and interventions seeking to reduce hazardous drinking in drinking establishments, will be continued in 2012.

Preventing HIV among youth remains critical to the epidemic's trajectory, since 39% of the population is under age 15. Yet USG's youth prevention portfolio is scattered and lacks a strategic approach. Although the education sector has a key role to play in HIV prevention, the USG does not provide direct support to the Ministry of Education for school-based HIV prevention programming. Outside of the school setting, PEPFAR supports various partners with youth prevention activities. Programs work to support positive parenting practices and effective adult-youth communication. Other USG partners support life skills in selected schools; radio programs for children; and afterschool programs for youth 10-18, as well as vocational training for youth 18-25. A faith-based partner is supporting outreach to youth through communities and congregations, using the Stepping Stones curriculum.

8.2 COP12 Priorities

USG will seek to further transition public sector salary support to the GRN in a phased manner, to complete the shift in community-based activities to local partners, and to build the capacity of community based organizations to deliver high quality interventions. More broadly, the USG seeks to achieve adequate dosage and coverage of behavioral and biomedical interventions that address the known drivers of the epidemic.

9. Medical Transmission

The HMBL and HMIN budget codes have been identified as "mature" areas that may be phased out over the next three years. Support to the Blood Transfusion Service of Namibia (NAMBTS) through the HMBL budget code will be reduced by approximately 30% a year until phased out. In COP12, NAMBTS will complete the absorption of clinical and non-clinical staff onto its own payroll. Reductions in future COP years will focus on commodities (e.g. blood bags), and, ultimately, support for infectious disease testing of donated blood. While funding to NAMBTS is scheduled to be phased out under the HMBL budget code, NAMBTS may receive funding through the OHSS budget code for health systems strengthening activities that contribute to Global Health Initiative objectives, such as training for physicians in the appropriate use



of blood, and technical assistance to strengthen blood transfusion services in Emergency Obstetric Care (EMOC). In a similar fashion injection safety activities are being transitioned to the MOHSS after a successful intervention and evaluation. COP12 funds subsequently will support action on evaluation findings, transition and system strengthening activities in consultation with MOHSS.

10. Gender

COP 12 gender priorities will continue to address gender-related HIV transmission drivers. There is substantial evidence that gender-based violence (GBV) is common and acceptable in Namibia and often associated with alcohol misuse. Poverty, food insecurity, unemployment and women’s inferior status increase women’s vulnerability for transactional and intergenerational sex and contribute to very high estimated HIV rates among sex workers. USG resources will strengthen GRN efforts to promote zero tolerance to GBV and to mitigate the negative impacts of alcohol abuse. USG will allocate limited resources to provide technical assistance to strengthen post-exposure prophylaxis (PEP) integration into the routine package for those experiencing sexual violence and to promote follow-up and program evaluation.

To increase the number of men accessing HCT services, mixed models of HCT service delivery will be scaled up, specifically mobile vans, door-to-door home-based HCT. In addition, male engagement workshops, male-only testing days, and mobile testing in male-dominated workplaces will be organized.

PEPFAR Namibia will strengthen the capacity of the NDF gender focal person and will provide limited support to a MARP-led organization to improve transgender advocacy and prevention efforts.

USG will support voluntary medical male circumcision (VMMC).

In COP12, USG PHDP programming will prioritize clinic-based and community-based PHDP interventions. Efforts to engage more men will be strengthened. The majority of beneficiaries of post exposure prophylaxis are related to sexual violence. As a result, USG will allocate limited resources to provide technical assistance to strengthen PEP integration into the routine package for those experiencing sexual violence and to promote follow-up and program evaluation.

(1) Government of Namibia, Health Systems 20/20 Project, World Health Organization, and UNAIDS. December 2010. Namibia Health Resource Tracking: 2007/08 & 2008/09. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

(2) Ministry of Health and Social Services: Report on the 2010 National HIV Sentinel Survey. Windhoek. 2010

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	0	
HTXS	12,953,290	0
PDTX	2,823,781	0
Total Technical Area Planned Funding:	15,777,071	0

Summary:

1. Adult treatment section

Namibia has made remarkable progress towards the goal of providing universal access to high quality comprehensive HIV treatment services. With PEPFAR support, free comprehensive HIV care and



treatment with Highly Active Antiretroviral Treatment (HAART) started in the public health sector in 2003 on a pilot scale in 2 districts and was rapidly rolled out to all 34 health districts by March 2007. Rapid scale and service decentralization has been a key focus and pursued over the last few years through the IMAI as well as outreach ART service delivery (including in the faith and military based facilities). The Ministry of Health and Social Services (MOHSS) reported that 97,983 patients were receiving ART by end of September 2011.

In COP12 the USG will continue working through the Partnership Framework Implementation Plan (PFIP) and collaborate with the Government of the Republic of Namibia (GRN) in implementing several key strategic focus areas as described in the National Strategic Framework for HIV/AIDS Response 2010/11-2015/16 (NSF), Partnership Framework (PF) and the implementation plan (PFIP) aligned to the Global Health Initiative (GHI) principles. The overarching strategy will be to reduce overall unit costs through maximizing efficiencies, reducing human resources (HR) foot print while improving ART coverage as well as strengthening technical assistance (TA) in HR and institutional capacity building for service delivery, ART commodities supply, and ART bio-clinical monitoring.

Adherence to treatment by individual patients and communities will be further enhanced in order to minimize treatment defaulters as well as development of HIV drug resistance (HIVDR) over time. These adherence-promoting interventions will incorporate implementation of treatment literacy activities; piloting of novel and innovative delivery models, e.g. chronic disease care model with active participation, as well as strengthening of community based evidence-based adherence promoting interventions. Additional key focus areas will be aimed at enhancing compliance to quality of care standards (ART guidelines) and particular focus will also be directed on refining and further strengthening the national HIVDR monitoring strategy. Linked to this will be TA for reviewing, strengthening and developing of more reliable monitoring and tracking systems for ART patient management. Finally, the Minister of Health has repeatedly affirmed the strategic importance of Treatment as Prevention (TasP) in reducing the number of new HIV infections in Namibia. USG will continue to provide technical assistance and support capacity building in this area to help enable this goal via stronger laboratory services, strategic information, and health systems. This goal is closely tied to the GRN's commitment to eMTCT using a WHO Option "B+" approach, which will be supported in a similar manner.

1.1 Access and integration

Access to ART in Namibia has increased dramatically over the past years reaching 85% of those in need at CD4 cell count of 200 by year 2009. This was achieved through scale-up of C&T and decentralization of services (Outreach, IMAI). Furthermore, with support from USG and other stakeholders, the GRN reviewed and updated the national ART treatment guidelines in line with the WHO 2010 guidelines, which recommended treatment initiation at CD4 of ≤ 350 cells/ μ l in adults and treatment for all children less than 2 years regardless of the CD4 count. This is likely to maintain high access to ART despite an increase in number of those in need. Point of Care technology for CD4 testing was piloted in FY11 and it is anticipated that it will be taken to scale over the next few years and will equally contribute to improve access and reduce costs of CD4 testing.

The NSF set ambitious treatment targets and has projected that the country would achieve ART coverage of 95% by 2016. The guidelines launched in September 2010 resulted in a huge shift of people previously ineligible for treatment being started on ART in the first half of FY2011, resulting in a doubling of the average new patients uptake during the past year. Similar demands were noted in terms of ARV drug consumption and laboratory monitoring demands.

As in many public health emergencies, the ART program in Namibia was introduced as a vertical program. Currently, efforts to integrate treatment care, prevention, family planning, Reproductive Health, and TB/HIV services remain a core principle of national ART programming. However, the best model for a smart integration of the various services still has to be developed and currently various levels and models of integration are operational at facility level. Relatedly, systems strengthening activities in this area will focus on costing for the various service integration models. The GRN is also working on defining the minimum district service package that details service availability at each level of the care system.



The GRN recognizes that external funding from both PEPFAR and Global fund will continue to decline over the next few years and has started making contingency measures to ensure that the scale-up is not negatively impacted by the declining external support. For instance, the GRN has committed to start transitioning donor-supported clinical staff into the government pay roll and has included proposals for increased government budgetary support for other treatment related costs such as ARV drugs and laboratory monitoring costs in its 3 year rolling Medium Term Expenditure Framework (MTEF) budget proposal for the period 2012/13 to 2014/16. The final funding levels approved will however remain unknown until sometime in the first quarter of 2012.

Within the military settings, the Fountain of Hope (FOH) HIV care and treatment clinic at the Grootfontein military base has been operational since 2009, providing comprehensive HIV and related diseases services, including Anti-Retroviral Therapy (ART). This clinic is currently the only health facility providing treatment for PLHIV in the military.

1.2 Quality & Oversight

The USG continues to value quality of care as it transitions from service delivery model to a TA model. Throughout the transition, the USG will continue to strengthen mechanisms which ensure that the quality of care provided through PEPFAR support is not compromised. In COP12, the USG will continue to support the GRN and FBO in strengthening ongoing supportive supervisory mechanisms, in-service and pre-service training, and clinical mentorship as well as structured quality improvement (QI) programs (HIVQUAL) to ensure sustainability of quality treatment, care and support services in both the public (including the military settings) and private sector. The national quality management program has a dedicated national program officer currently PEPFAR-funded who supports the regional and district level supervisory structures in systematic quality monitoring and improvement. Regular regional quality management forums are convened, where providers review their clinical performance data and devise customized QI strategies. In addition, TA for standardizing treatment and care practices through periodic updates of the standard national HIV treatment and care guidelines in response to emerging evidence will continue to be a priority of USG in enhancing quality of care.

The USG has supported the establishment of a national therapeutic information and pharmacovigilance system (TIPC), which tracks adverse events to ART and other medications. PEPFAR continues to have a role in strengthening this program further through provision of technical assistance.

Additionally, staff at the FOH military site mentioned above, have been mentored in various areas of HIV treatment, care and support, and 41 health care workers (HCW) were trained in Integrated Management of Adolescent and Adult Illness (IMAI) and Medicine Adherence Counseling (MAC) to equip them with the necessary skills to provide quality and comprehensive HIV care to military personnel living with HIV at their respective health facilities. A total number of 22 peer educators and support group members from the Northern bases were trained in film facilitation to facilitate the "Remember Eliphaz" ART film to promote HIV treatment, care and support in the military and to sensitize and encourage military members to seek HCT, treatment, care and support within the military health facilities.

1.3 Sustainability and Efficiency

In line with the Namibia GHI strategy and as described in further detail in the Governance and Systems TAN, several activities are planned in COP12 to promote efficiencies within the health system and for the sustainability of the HIV response. The USG will support "smart integration" approaches in Namibia. This will include the provision of various costing and workload scenario models to inform the integration process; along with direct funding to the MOHSS to implement (including the broadening of trainings to target more staff, such as from PHC, than those working in HIV/AIDS clinics only) several integration models, including ART in general out-patient department, one-stop TB-HIV services, and ART in integrated ANC/PMTCT services. This work builds upon past COP investments that have expanded the availability of commonly prescribed essential non-ART medicines in ART pharmacies, and developed curricula to train nurses on the WHO Integrated Management of Adult (and Child) Illness (IMAI/IMCI) strategies, which the government is rolling-out to health clinics nationwide. In order to scale up access

and adherence to ART in the context of limited physician staff, the MOHSS intends to decentralize services using task-shifting to nurses. USG will support policy development, implementation and ongoing evaluation of this. Efforts to improve cost effectiveness and sustainability of bio clinical monitoring for treatment include the implementation and evaluation of point of care testing (POC) for CD4 counts. POC services will increase access to testing, decrease cost of laboratory testing and increase quality of care and support services. Newer POC technologies such as for early infant HIV diagnosis (EID) will be explored as they become available. GRN has gradually taken up an increasing proportion of the procurement of ARV and currently procures approximately 65% of national ARV needs. In order to sustain ARV procurement, especially in face of increasing national needs, the government adopts the treatment as prevention policy. USG will provide technical assistance in ARV costing, forecasting, supply planning and pharmaceutical management to improve efficiencies within the supply chain.

2. Pediatric HIV treatment section

2.1 Background

In the context of a generalized epidemic, Namibia has rapidly scaled-up HIV treatment in the public sector since 2003, for both the adult and pediatric patients. According to 2008/9 MOHSS Spectrum estimates, 8,143 people will be newly infected in 2011/12 and in 2011/12, 11 218 children under 15 will be in need of ART. By September 2011, 97,983 people were on ART treatment, of which 8,939 were children under 15, representing 9% of the total population on ART. The table below shows the number of children currently on ART and ever enrolled, by age group.

Age	Currently on HAART	Ever enrolled on HAART
0-<5	2623	3814
5-14	6316	8279
Total	8939	12093

Source: ePMS

2.2 National Strategy and Priorities

Building on the gains made by the national HIV program, the NSF strategic orientation for Treatment, Care and Support for all clients emphasizes the need to scale-up comprehensive quality services that encompass the continuum of care, at both community and health facility settings. The specific treatment goal as stated in the NSF for pediatrics includes reaching 86% of children (age 0-14) eligible for ART in FY 2012/13 and 95% in FY 2015/16.

To meet this goal the NSF outlines strategies directed to both adult and pediatric treatment and include: i) To improve ART coverage as well as the service provision environment including HR and infrastructure capacities; ii. To encourage adherence to treatment schedules to minimize defaulters and drug resistance over time; iii) To enhance quality of care by managing treatment standards; iv) To strengthen linkages across key response areas for treatment, care and support, particularly referral to the ART program and the management of Opportunistic Infections (OI); v) To develop more reliable monitoring and tracking systems for ART patient management; and vi) To strengthen the pharmaceutical supply system throughout all levels. As USG was actively involved with the development of the NSF, and in the PF and draft PFIP, PEPFAR priorities are well aligned with the strategic direction in the NSF.

2.3 Treatment Guidelines and Service Delivery

The 2010 National guidelines reflect the WHO 2010 pediatric treatment guidelines, which include treatment initiation for all HIV infected children under the age of two years, regardless of the CD4 cell count/percentage. Alongside with the change in pediatric treatment eligibility criteria, Prevention of Mother to Child transmission (PMTCT) services have scaled up in Namibia aiming to reduce by 90% new infant HIV infection. The early infant diagnosis (EID) using dried blood spot (DBS) polymerase chain reaction (PCR) testing has also been rolled out to 224 health facilities. Currently, ART services are offered at 181



fixed health facilities and outreach sites across the country. Pediatric care and treatment, integrated with adult services, is offered at a majority of these sites. Dedicated pediatric services exist only in Windhoek at Katutura hospital and in Onandjokwe Lutheran Medical services with a dedicated pediatric HIV staffing. Pre-service and in-service training has been supported by PEPFAR and with the National Health Training Center (NHTC) to improve the capacity of Health Care Workers (HCW) who provide pediatric HIV treatment. In addition, clinical mentors provide ongoing support for clinicians providing pediatric HIV treatment.

In the same way as for adult treatment, task shifting for pediatric treatment is being expanded in order to mitigate the challenge of on-going HR shortages.

Decentralization of ART services will improve access to pediatric treatment, but the challenge remains to deliver quality pediatric care to this unique population. The increased numbers of children and adolescents in care and treatment programs have created additional challenges for supportive and communication interventions, related to disclosure at all ages and positive prevention and counseling on sexual and reproductive health for adolescents. In response, MOHSS with PEPFAR support is in the process of rolling out an HIV-disclosure to children module for doctors, nurses, and community counselors. To address challenges of HIV care and treatment for adolescents, the MOHSS has tasked a TWG to develop a national approach to the management of adolescents living with HIV (ALHIV) and to develop ALHIV guidelines for HCW including facilitating the transitioning of HIV positive youths from pediatric to adult HIV care. Other efforts to improve pediatric HIV treatment include the development of a pediatric care booklet which will include essentials such as growth charts, HIV disclosure etc.

2.4 Monitoring and Evaluation (M&E):

Monitoring for pediatric HIV treatment is integrated within the MOHSS Electronic Patient Management System (ePMS) and the pharmaceutical EDT. Although there are ongoing problems with system programming, data quality, limitations to data access, analysis at both facility and management levels, a recent use of EDT data provided a useful trend of pediatric update per region. This data, showing regional disparity in pediatric ART coverage, will be used for future care and treatment programming. PEPFAR will continue to support efforts to strengthen overall HIV M&E as described in the governance and system TAN.

To date, the quality of the national ART program has not been formally assessed. MOHSS has requested USG support to develop a protocol for the formal evaluation of the ART outcomes in Namibia to better understand the quality and effectiveness of the national ART program. This evaluation may be expanded to include the pediatric population since the outcomes will be critical for future programming, especially given the environment of declining donor support from both PEPFAR and the Global fund and as the GRN takes a greater role in financing the sustainability of the national ART program.

2.5 Pharmaceutical management:

The national HIV program collaborates with the division of pharmaceutical services within the MOHSS and other partners, including USG and Global Fund. During GFATM rounds preparation, USG through SCMS has supported quantifications and forecasts of ARV, based on Spectrum estimates of new and ongoing adult and pediatric patients in need of ARVs as well as quarterly consumption data. The recommended first line treatment for pediatrics is stavudine-lamivudine-and-nevirapine which is available as fixed dose triple and double combinations in two different strengths to cater for varying weight bands of pediatric populations. It has been a challenge for the MOHSS to procure other fixed dose combinations (FDC) because of limited availability of pre-qualified suppliers. Given a relatively good procurement and distribution system, there have not been reports of stock out in any of the ART sites or pediatric formulations. The EDT captures data on pediatric dispensing and allows analysis of national and regional trends of pediatric uptake.

2.6 COP12 priorities:



In line with national priorities USG will continue to focus on assisting the government to maintain high pediatric ART coverage while reducing the number of new infant infections as per eMTCT and to provide cost efficient, evidence based and decentralized quality services to pediatric populations. USG will continue to build HCW capacity through clinical mentorship and support to pre-service (University of Namibia, NHTC) and in-service training to include pediatric ART training. Special attention will be provided through TA to address the unique needs of ALHIV and strengthening treatment adherence support strategies as well as exploring ways for optimizing national HIV DR surveillance to include the pediatric population

3. Cross cutting priorities

3.1 Supply Chain

The USG has supported and will continue to focus on activities to enhance existing GRN systems in order to promote supply chain information sharing and improved procurement, warehousing and inventory controls systems. These activities include strengthening the capacity of the National Medicines Policy Coordination (NMPC) sub-division in the Division: Pharmaceutical Services to provide overall supervision in the supply chain management aspects; strengthening long-term quantification and budgeting of public-health program commodity needs, including strengthening linkages between program commodity forecasts, supply planning and procurement actions and institutionalizing long-term forecasting and budgeting of commodity needs into the MHSS systems. Additionally, technical assistance will be provided in evaluating interventions for improving cost-effectiveness of transport and distribution services; enhancing CMS performance monitoring using Pharmacy Management Information System (PMIS); supporting the establishment of a new state-of-the-art CMS and strengthening the public sector supply chain management practices by benchmarking the private sector supply chain models in Namibia.

This technical assistance will be extended to the two multi-regional medical depots to strengthen their pharmaceutical and related medical supplies inventory management, warehousing and distribution. As per GRN request, the USG will also support the Department of Logistics in the Directorate of Finance in the review and harmonization of the MOHSS transport guidelines and supply chain SOP that impact on the supply and logistics of HIV-related commodities. The USG supply chain expertise will also be landed to strengthen the capacity of NIP to procure, warehouse, and distribute lab commodities. In other to ensure sustainability in supply chain, the USG will work with the GRN to strengthen human resources capacity for supply chain management and support local tertiary education institutions to provide health-related supply chain management training.

3.2 ARV Drugs: Pediatric section

Same as for adult treatment section above

3.3 Laboratory

All laboratory-based testing for the public sector in Namibia is offered by the Namibia Institute of Pathology (NIP) for clinical diagnosis and patient management through a network of 37 laboratories. Laboratory services are delivered through a two tiered laboratory system based on level of care delivery, volume of testing and a strong referral system.

To provide basic laboratory services for the military, Ministry of Defense (MOD) has established a Lab at the army basis in Grootfontein to complement NIP services.

The national public health laboratory policy supports priority goals as defined by the MOHSS, sets standards for establishment of public and private laboratories, regulates them and guides training and certification of laboratory personnel and quality laboratory practice as well as bio-safety issues in Namibia.

The national Laboratory strategic plan, developed for the implementation of the policy, includes quality management system and bio-safety.

The Namibia Institute of Pathology is implementing a quality management system and has currently three ISO 17025 accredited laboratories and is preparing four more laboratories for accreditation with USG support.



Laboratory personnel at the MOD facility have been trained in line with national laboratory guidelines. The establishment of a comprehensive laboratory Quality Management System (QMS) has progressed well with the development of a Quality Manual and Standard Operating Procedures (SOP), and training of staff on Quality Systems Essentials. The laboratory receives technical assistance from the NIP, which also serves as the reference laboratory for the Ministry of Defense. The laboratory continues to participate in an External Quality Assurance (EQA) program with Thistle QA and efforts are underway to ensure that the laboratory is accredited to the South African National Accreditation System (SANAS). The NIP's mandate to generate income from the private sector is a model for sustainability. The MOHSS introduced HIV RT testing in 2005 as part of its strategy to scale up access to HIV testing at a lower cost and is piloting point of care CD4 testing with the same objectives.

NIP has a centralized procurement system for all laboratory supplies. The main store keeps a minimum of four weeks supply on hand, due to vendor ability to deliver supplies from Europe and South Africa. Logistic data from the Meditech system can be used for action. SCMS has been working with NIP to strengthen their logistics management systems, improve forecasting and use Meditech for informed decision making.

3.4 Gender

In Namibia, like in other countries in sub-Saharan Africa, women and girls bear the burden of HIV/AIDS disproportionately. As at September 30, 2011 97,983 (64% Females, 36% males) were on ART. This reflects almost a 2:1 ratio and the low levels of male involvement in HIV prevention, care and treatment services. Fewer males are known to test for HIV and within PMTCT services couple testing rates are very low. With FY11 resources a gender assessment supported by the USG, provided a clearer understanding of the barriers that women and men selectively face in accessing care and treatment services. The assessment reported that most PEPFAR-supported programs are gender accommodating and do not address the gender-based constraints that limit access to services. Furthermore, the assessment recommended the need to consider gender transformative messaging in HIV programs that consider the gendered nature of inequalities that drive individual risks and vulnerabilities.

USG supported treatment programs employ a family-centered approach though limited HR and pediatric expertise impacts on service provision for infected children at the rural clinics. Ongoing attention to gender issues guarantees women and men's equitable access to treatment and care, including reproductive health services. These efforts are channeled towards increasing early access to treatment for more males, as they are known to access treatment late in the disease. Integration of family planning (FP) activities into ART clinics through the Positive Health, Dignity and Prevention (PHDP) interventions in treatment settings will be supported. Activities that target reducing stigma and discrimination around HIV/AIDS include male engagement workshops, male-only testing days at stand-alone HCT sites and outreach to male dominated work places (sea farers, miners, etc.) described in prevention TAN. Outreach services and mobile HCT units that are integrated with primary health care services will enable services to the hard-to-reach and the migrant workers in farms in the south of Namibia.

With Gender-based Violence (GBV) being rife in Namibia and a key driver of the epidemic, access to post exposure prophylaxis (PEP) is keenly promoted as part of a comprehensive package offered to survivors of sexual GBV. Adequate data collection on the numbers of GBV survivors provided with PEP is limited. Given the constraints of existing punitive and discriminatory laws against MARP, training HCW to provide a friendly atmosphere for service provision to these vulnerable populations is a focus.

3.5 Strategic information

USG Namibia has worked closely with the MOHSS and other stakeholders to develop and implement necessary treatment related strategic information activities including surveys and surveillance, monitoring and evaluation, health management information systems (HMIS), and operational research. In FY12, USG and its partners will continue working to expand the treatment information base, strengthen treatment information systems, and improve treatment information use at all levels of program



implementation. Several small-scale data quality assurance (DQA) activities that took place during FY11 at MOHSS health care facilities will inform large scale DQA exercises for ART in FY12. Also, in FY12, USG will work with MOHSS in conducting a national ART outcomes evaluation to assess the success of the ART program. An ART cohort analysis workshop was conducted in FY11 with national and regional staff to understand how to use data for ART program planning; USG will continue to provide technical assistance in ART cohort analysis for ART program use in FY12.

An HIV drug resistance threshold survey will be incorporated into the biennial ANC based HIV sentinel survey; results from this survey will provide important information for refining and further strengthening the national HIV drug resistance monitoring strategy. HIV drug resistance monitoring in ART sites will be prioritized for FY12. Early warning indicator monitoring will continue and be increasingly incorporated into routine M&E.

In HMIS, the USG will continue to support the Electronic Patient Management System (EPMS) - which maintains a database of patients on pre-ART and ART, and the Electronic Dispensing Tool which manages ART medicine pickup at pharmacies. USG will also provide technical assistance on developing prototypes for linking MOHSS databases (including EPMS) into a national M&E data warehouse and developing plans for data standards and assessments for EPMS and other MOHSS systems.

Capacity building is a priority for the USG strategic information program across budget code areas, including treatment. The USG provides continuous in-service and refresher trainings for data clerks, analysts and M&E staff that support monitoring and evaluation of the ART program at the national and sub-national level.

3.6 Capacity building

In line with the capacity building objectives of GRN, CSO, and the private sector, as spelt out in the National Strategic Framework (2010/11-2015/16) and the Partnership Framework, the USG has supported and will continue to support institutional, system and individual level capacity building for the programming and delivery of quality HIV health care services. The institutional capacity building support by the USG will be directed at bridging the capacity gaps in the national, regional and district level health program management levels to better plan, implement, manage and evaluate programs for the provision of quality treatment, care and support services. This support will be provided through direct and indirect technical assistance to these institutions in evidence-based planning, implementation, monitoring and evaluation of quality assured treatment, care and support services. The USG will continue building the national capacity for service delivery systems of HIV care and treatment, including strengthening of quality of care management strategies such as clinical mentorship, supportive supervision and structured quality improvement programs. In addition, institutional capacity building will continue to be provided to the pre-and in-service health training network in human capacity development to enable the training institutions to provide quality training for the health workforce who administer HIV care services. At individual level the USG will also continue direct support for both pre-service and in-service training (including refresher trainings) of the health care workforce in the provision of quality HIV treatment, care and support services.

The capacity building initiatives will be measured at mid-term and end-of-term reviews of the NSF through the various relevant indicators defined in the Results Framework for the HIV and AIDS Response in Namibia 2010/11-2015/2016.

3.7 Public Private Partnerships (PPP)

The USG worked with the Namibia Business Coalition on HIV and AIDS (NABCOA) to strengthen workplace TB/HIV programs. The USG supports the MOHSS efforts to reach out to the private health sector on TB/HIV interventions. To date, a link exist between the MOHSS, the Namibian Association of Medical AIDS Funds (NAMAF) and its PEPFAR-supported partners in working with the Medical AIDS and HIV Clinicians Society to engage medical insurance, private medical practitioners and nurses through training aimed at improving the quality of TB/HIV management in this sector and collaborating for better reporting. In addition, as described in the Governance and Systems TAN, PSEMAS, the GRN medical



insurance for civil servants will be assisted in finding efficiencies in ARV procurement and distribution.

3.8 MARPS

Namibia has existing laws and policies against sex work and sodomy. These policies impede the roll-out of prevention, care, and treatment services for these groups. However, for the first time, MARPS and other vulnerable populations figure prominently in the new NSF with clear targets and priority areas for implementation.

3.9 Human Resources for Health (HRH)

For Namibia to be able to meet the increased service demand for comprehensive quality HIV care and support services, the USG will continue to support GRN efforts for task-shifting and decentralization of services. The policy directive on task-shifting has been recently approved at the MOHSS management meeting. Support to this policy will require continued technical assistance to both pre-service and in-service training institutions to enhance the skills and capacity for more health care providers to be able to provide quality HIV care and support services. Furthermore, in line with the draft PFIP, the USG will provide assistance to the GRN to explore novel and innovative delivery models of care which lessen the workload on the limited HR while ensuring maximum program quality. Additionally, in beginning to address inequalities in the health sector and to better implement primary health care, the MOHSS is piloting a community health extension program that will utilize a new cadre of community health extension workers (HEW). These HEW will provide integrated prevention education, illness detection and referral services and facilitate better linkages between health facilities and the communities. The USG is assisting the MOHSS to pilot this program. Based on the outcomes of the pilot, the USG will continue to support the program's roll-out to increase access to integrated sustainable quality healthcare services.



Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
P1.1.D	P1.1.D Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	n/a	Redacted
	Number of pregnant women who were tested for HIV and know their results	63,650	
P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	90 %	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	10,300	
	Number of HIV-positive pregnant women identified in	11,500	

	the reporting period (including known HIV-positive at entry)		
	Life-long ART (including Option B+)	3,600	
	Newly initiated on treatment during current pregnancy (subset of life-long ART)		
	Already on treatment at the beginning of the current pregnancy (subset of life-long ART)		
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	0	
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery)	6,200	
	Single-dose nevirapine (with or without tail)	500	
NA.387	The total number of whole blood units collected by the NBTS network that have been screened for all	10	Redacted

	four transfusion-transmissible infections and are available for transfusion, times 1,000		
P4.1.D	P4.1.D Number of injecting drug users (IDUs) on opioid substitution therapy	n/a	Redacted
	Number of injecting drug users (IDUs) on opioid substitution therapy	0	
P5.1.D	Number of males circumcised as part of the minimum package of MC for HIV prevention services per national standards and in accordance with the WHO/UNAIDS/Jhpiego Manual for Male Circumcision Under Local Anesthesia	18,350	Redacted
	By Age: <1	0	
	By Age: 1-9		
	By Age: 10-14		
	By Age: 15-19		
	By Age: 20-24		
	By Age: 25-49		
	By Age: 50+		
P6.1.D	Number of persons provided with	480	Redacted

	<p>post-exposure prophylaxis (PEP) for risk of HIV infection through occupational and/or non-occupational exposure to HIV.</p> <p>By Exposure Type: Occupational 0</p> <p>By Exposure Type: Other non-occupational 0</p> <p>By Exposure Type: Rape/sexual assault victims 0</p>		
P7.1.D	<p>P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions</p> <p>Number of People Living with HIV/AIDS reached with a minimum package of 'Prevention of People Living with HIV (PLHIV) interventions</p>	<p>n/a</p> <p>42,709</p>	<p>Redacted</p>
P8.1.D	<p>P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention</p>	<p>n/a</p>	<p>Redacted</p>

	interventions that are based on evidence and/or meet the minimum standards required		
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	122,205	
P8.2.D	P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are primarily focused on	27,325	

	abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required		
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	17,475	
	By MARP Type: CSW	3,000	
	By MARP Type: IDU	0	
	By MARP Type: MSM	700	
	Other Vulnerable Populations	13,775	
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	267,610	Redacted

	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		
	By Age: <15	0	
	By Age/Sex: 15+ Female		
	By Age: 15+	0	
	By Age/Sex: 15+ Male		
	By Sex: Female	159,166	
	By Sex: Male	108,444	
	By Test Result: Negative		
	By Test Result: Positive		
C1.1.D	Number of adults and children provided with a minimum of one care service	253,087	Redacted
	By Age/Sex: <18 Female		
	By Age/Sex: <18 Male		
	By Age: <18	97,891	
	By Age/Sex: 18+ Female		
	By Age: 18+	155,196	
	By Age/Sex: 18+ Male		
	By Sex: Female	155,186	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	170,858	Redacted
	By Age/Sex: <15		

	Female		
	By Age/Sex: <15 Male		
	By Age: <15	15,378	
	By Age/Sex: 15+ Female		
	By Age: 15+	155,480	
	By Age/Sex: 15+ Male		
	By Sex: Female	111,058	
	By Sex: Male	59,800	
C2.2.D	C2.2.D Percent of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	35 %	Redacted
	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	59,800	
	Number of HIV-positive individuals receiving a minimum of one clinical service	170,858	
C2.3.D	C2.3.D Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	n/a	Redacted
	Number of clinically malnourished clients who received therapeutic and/or supplementary food	3,000	

	during the reporting period.		
	Number of clients who were nutritionally assessed and found to be clinically malnourished during the reporting period.		
	By Age: <18		
	By Age: 18+		
C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	95 %	Redacted
	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	162,315	
	Number of HIV-positive individuals receiving a minimum of one clinical service	170,858	
C2.5.D	C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	5 %	Redacted
	Number of HIV-positive patients in HIV care who	8,543	

	started TB treatment		
	Number of HIV-positive individuals receiving a minimum of one clinical service	170,858	
C4.1.D	C4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	95 %	Redacted
	Number of infants who received an HIV test within 12 months of birth during the reporting period	10,884	
	Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positive at entry)	11,457	
	By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months	0	
	By timing and type of test: virological testing in the first 2 months	8,665	
C5.1.D	By Age: <18	25,613	Redacted
	By Age: 18+	30,502	
	Number of adults and children who received	56,115	

	food and/or nutrition services during the reporting period		
	By: Pregnant Women or Lactating Women	8,660	
T1.1.D	By Age/Sex: <15 Female	180	Redacted
	By Age/Sex: <15 Male	540	
	By Age/Sex: 15+ Female	12,240	
	By Age/Sex: 15+ Male	5,040	
	By Age: <1	0	
	By: Pregnant Women	0	
	Number of adults and children with advanced HIV infection newly enrolled on ART	18,000	
T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)	113,353	Redacted
	By Age/Sex: <15 Female	5,668	
	By Age/Sex: <15 Male	5,668	
	By Age/Sex: 15+ Female	66,878	
	By Age/Sex: 15+ Male	35,139	
	By Age: <1	0	
T1.3.D	T1.3.D Percent of adults and children known to be alive and on treatment 12	85 %	Redacted

	months after initiation of antiretroviral therapy		
	Number of adults and children who are still alive and on treatment at 12 months after initiating ART	15,300	
	Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.	18,000	
	By Age: <15	0	
	By Age: 15+	0	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	38	Redacted
H1.2.D	Number of testing facilities (laboratories) that are accredited according to national or international standards	8	Redacted
H2.1.D	Number of new health care workers who graduated from a pre-service training	617	Redacted

	institution or program		
	By Cadre: Doctors	23	
	By Cadre: Midwives	233	
	By Cadre: Nurses	224	
H2.2.D	Number of community health and para-social workers who successfully completed a pre-service training program	47	Redacted
H2.3.D	The number of health care workers who successfully completed an in-service training program	9,711	Redacted
	By Type of Training: Male Circumcision	296	
	By Type of Training: Pediatric Treatment	247	



Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
6459	U.S. Department of State	Other USG Agency	U.S. Department of State/Bureau of African Affairs	GHP-State	318,500
7443	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	1,316,710
9869	Blood Transfusion Service of Namibia	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	796,539
9872	Potentia Namibia Recruitment Consultancy	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	7,583,099
9874	U.S. Department of Health and Human Services/Health Resources and Services Administration (HHS/HRSA)	Other USG Agency	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	199,174
9876	Namibia Institute of Pathology	Parastatal	U.S. Department of Health and	GHP-State	831,386

			Human Services/Centers for Disease Control and Prevention		
9940	Development Aid from People to People, Namibia	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	2,140,841
10163	Society for Family Health	NGO	U.S. Department of Defense	GHP-State	871,595
10164	University of Washington	University	U.S. Department of Defense	GHP-State	1,224,000
10181	U.S. Peace Corps	Other USG Agency	U.S. Peace Corps	GHP-State	50,000
10382	FHI 360	NGO	U.S. Agency for International Development	GHP-State	957,600
10386	IntraHealth International, Inc	NGO	U.S. Agency for International Development	GHP-State	3,400,000
10389	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	2,223,077
10397	KNCV Tuberculosis Foundation	NGO	U.S. Agency for International Development	GHP-State	1,000,000
10780	University of Washington	University	U.S. Department of Health and Human Services/Centers for Disease Control and	GHP-State	600,000



			Prevention		
11572	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention (HHS/CDC)	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	896,253
12705	Ministry of Health and Social Services, Namibia	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	19,377,769
12721	Lifeline/Childline Namibia	NGO	U.S. Agency for International Development	GHP-State	2,826,389
12752	Ministry of Health and Social Services, Namibia	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,494,230
12860	Ministry of Regional, Local Governments, Housing and Rural Development (MRLGHRD)	Host Country Government Agency	U.S. Agency for International Development	GHP-State	100,000
12997	African Palliative Care Association	NGO	U.S. Agency for International Development	GHP-State	1,104,831



13042	Central Bureau of Statistics	Host Country Government Agency	U.S. Agency for International Development	GHP-State	150,000
13090	Project HOPE	NGO	U.S. Agency for International Development	GHP-State	900,000
13110	TBD	TBD	Redacted	Redacted	Redacted
13120	Kayec Trust	NGO	U.S. Agency for International Development	GHP-State	761,014
13166	Abt Associates	Private Contractor	U.S. Agency for International Development	GHP-State	1,000,000
13207	Polytechnic of Namibia	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	350,000
13209	Church Alliance for Orphans	FBO	U.S. Agency for International Development	GHP-State	1,131,638
13227	ITECH	NGO	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	4,823,781
13253	New Partner	TBD	U.S. Agency for International Development	GHP-State	340,000
13289	TBD	TBD	Redacted	Redacted	Redacted
13420	Ministry of Gender	Host Country	U.S. Agency for	GHP-State	180,000



	Equality and Child Welfare	Government Agency	International Development		
13448	Nawa Life Trust	NGO	U.S. Agency for International Development	GHP-State	1,000,000
13479	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	800,000
13601	Society for Family Health	NGO	U.S. Agency for International Development	GHP-State	2,035,754
13605	FHI 360	NGO	U.S. Agency for International Development	GHP-State	200,000
13676	FHI 360	NGO	U.S. Agency for International Development	GHP-State	339,675
13752	TBD	TBD	Redacted	Redacted	Redacted
14285	TBD	TBD	Redacted	Redacted	Redacted
14296	IntraHealth International, Inc	NGO	U.S. Agency for International Development	GHP-State	400,000
14304	TBD	TBD	Redacted	Redacted	Redacted
14305	TBD	TBD	Redacted	Redacted	Redacted
14306	TBD	TBD	Redacted	Redacted	Redacted
14307	TBD	TBD	Redacted	Redacted	Redacted
14312	TBD	TBD	Redacted	Redacted	Redacted
14317	TBD	TBD	Redacted	Redacted	Redacted
14334	TBD	TBD	Redacted	Redacted	Redacted
14340	TBD	TBD	Redacted	Redacted	Redacted
14341	TBD	TBD	Redacted	Redacted	Redacted
14371	JHPIEGO	University	U.S. Agency for International Development	GHP-State	450,000



14385	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention (HHS/CDC)	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	996,672
14389	TBD	TBD	Redacted	Redacted	Redacted
14390	TBD	TBD	Redacted	Redacted	Redacted
14391	University of California at San Francisco	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	350,000
14746	USAID Central Commodity Fund	Other USG Agency	U.S. Agency for International Development	GHP-State	350,000



Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 6459	Mechanism Name: Department of State/African Affairs
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: USG Core
Prime Partner Name: U.S. Department of State	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A
Total Funding: 318,500	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	318,500

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The State Department Public Diplomacy and Ambassador's Self-Help Program PEPFAR activities are continuing. These programs directly support PEPFAR Namibia's GHI strategic goals of transition and access by supporting capacity building and country ownership, leveraging resources, and focusing on women and girls. Focusing on youth and community-based activities, PAO and Self-Help directly support the increase of access to and utilization of services for underserved populations. Self-Help will encompass all of Namibia, with special attention to vulnerable populations (women, children, disabled persons and other minorities). The Self-Help program is committed to effective project monitoring with M&E visits prior to the release of second disbursements and after the conclusion of project implementation. The activities are focused on Namibian youth, using grants to various cultural, civil society, and educational groups in Namibia to create and support programming in following areas: prevention, reduction of stigma/discrimination and prevention outreach to youth. Also, the USG sends Namibian HIV/AIDS professionals to the US for training and training local media to improve reporting on Namibian trends in the epidemic. The Self-Help Program will directly reach about 50 community members



per community-based project. Cost savings and sustainability are attained through leveraging resources from other PEPFAR programs. Building capacity of youth contributes to sustainability. Appropriate indicators and target for M&E have been selected.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	30,000
Education	7,500
Food and Nutrition: Commodities	20,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID: 6459			
Mechanism Name: Department of State/African Affairs			
Prime Partner Name: U.S. Department of State			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	43,500	0
Narrative:			
The Ambassador's HIV/AIDS Self-Help Program will directly reach an average of 50 community members per project through 10 to 15 community-based initiatives that are supported through small			



grants. These initiatives aim to: 1) provide care and support for adults and children who are infected with, and affected by, HIV/AIDS; and 2) prevent further spread of the disease.

Specifically, the program will: Reduce HIV infection rates among vulnerable populations, as well as encourage risk prevention behaviors among PLHIV, through vocational skills training that increases access to income and productive resources for these target groups.

This funding will directly contribute to: 1) Developing project guidelines, promotional materials, applications, and other documents; 2) Soliciting and accepting applications, qualifying projects, and dispersing funds; and 3) Monitoring and evaluating projects.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	50,000	0

Narrative:

The Ambassador's HIV/AIDS Self-Help Program will directly reach an average of 50 community members per project through 10 to 15 community-based initiatives that are supported through small grants. These initiatives aim to: 1) provide care and support for adults and children who are infected with, and affected by, HIV/AIDS; and 2) prevent further spread of the disease.

Specifically, the program will: 1) Provide critical support to OVC, including assistance with food, clothing and school supplies; and 2) Equip PLHIV and OVC caregivers with income-generating skills that foster sustainable livelihoods.

This funding will directly contribute to: 1) Developing project guidelines, promotional materials, applications, and other documents; 2) Soliciting and accepting applications, qualifying projects, and dispersing funds; and 3) Monitoring and evaluating projects.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	200,000	0

Narrative:

The State Department Public Diplomacy and PEPFAR Coordination Office activities are primarily focused on Namibian youth, using grants to various cultural, civil society, and educational groups in Namibia to create and support programming that focuses on the following areas: prevention, reduction of stigma and discrimination, and prevention outreach to youth. In addition, the USG develops programs focused on sending Namibian HIV/AIDS professionals to the US for training and training local media to improve



reporting on Namibian trends in the epidemic. This mechanism has the following components;

The International Visitor Leadership Program (IVLP) trains leaders in the field of HIV/AIDS prevention, care and treatment through the State Department's IVLP short-term professional exchange program. The IVLP is a three week international exchange program which aims to expose Namibians in key areas of the HIV/AIDS community to clinical and outreach activities in the United States.

The Performing Arts Outreach program provided grants to fund the Living Positive tour with Vocal Motion 6 (VM6) and Herlyn Uiras in 2007, 2008, and 2009. The five young male musicians and the young female HIV/AIDS positive speaker/counselor are uniquely positioned to reach Namibia's students with prevention and anti-stigma messages, and have conducted outreach to students in regions across Namibia. This task will be re-competed in COP12.

The Community Radio Outreach program represents a mix of media-oriented initiatives that will continue to build capacity among community radio journalists, improve access to information and increase outreach to Namibian youth who are vulnerable and at risk in Windhoek, particularly in the Katutura neighborhoods. USG is discussing ways in which a debate program might be made a regular component of Windhoek-based radio station Base FM as well as stations outside of Windhoek.

The USG funds speakers from the United States with HIV/AIDS expertise via the US Speaker Program and has leveraged funds from the wraparound program, often supplementing the IIP speakers that the Department of State supports.

The Committed Artists of Namibia (CAN) provides HIV/AIDS outreach through drama. Within a short timeframe in 2008, CAN wrote an original play with a focus on Namibian students, aiming to change attitudes on HIV/AIDS prevention, risky behavior, PMTCT, and testing. USG will re-compete the activity in COP12.

The Diversity Tour is in collaboration with Peace Corps Volunteers and focuses on raising HIV/AIDS awareness, prevention and behavior change to young Namibians who are selected in different regions. They will explore the diversity within Namibia while the participants will be exposed to a multifaceted understanding about HIV/AIDS in a socio-cultural manner.

The Book Donation for Libraries and Schools provided resource books on HIV/AIDS to libraries around Namibia in COP08. In COP12 our focus will be on providing reading materials for primary school students.

USG supports the provision of HIV/AIDS publicity materials and equipment such as press material, advertising, outreach, among others to the general public.

A portion of this funding will support new grants to explore new creative, innovative and informative activities which target youth.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
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Prevention	HVOP	25,000	0
Narrative:			
Specifically, the program will:			
1) Facilitate peer education and awareness-raising through individual, small group and community-level interventions that reduce stigma and discrimination, and that promote sexual and other behavioral risk prevention; and 2) Reduce HIV infection rates among vulnerable populations, as well as encourage risk prevention behaviors among PLHIV, through vocational skills training that increases access to income and productive resources for these target groups. This funding will directly contribute to: 1) Developing project guidelines, promotional materials, applications, and other documents; 2) Soliciting and accepting applications, qualifying projects, and dispersing funds; and 3) Monitoring and evaluating projects.			

Implementing Mechanism Details

Mechanism ID: 7443	Mechanism Name: Supply Chain Management System (SCMS)
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A
Total Funding: 1,316,710	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	1,316,710

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Supply Chain Management System (SCMS) is implemented by Management Sciences for Health in Namibia and focuses on three objectives: 1) Strengthening the supply chain for HIV/AIDS commodities; 2) Enhancing existing systems to strengthen forecasting and improve efficiencies; and 3) Improving



procurement management systems within governance and systems, prevention, care and treatment. SCMS contributes to four strategic areas of the Partnership Framework: governance, systems, prevention and care and treatment. SCMS works with the Ministry of Health and Social Services (MOHSS) to improve supply chain management of HIV/AIDS commodities in all regions of Namibia and targets all ART-users.

For cost effectiveness, SCMS will transition from direct commodity procurement services to the use of capacity building strategies, provision of technical assistance to the MOHSS and other partners, using in-country expertise. SCMS will reduce program delivery costs by sharing operational costs and leveraging synergies of other IMs managed by MSH.

To enable transition to local institutions, SCMS will continue capacity development and systems strengthening for its partners. SCMS will work with its partners to facilitate skills transfers through mentoring local supply chain staff to ensure program ownership and sustainability. This is in line with the GHI strategy that focuses on transition and increased access.

SCMS has developed measurable indicators to track the progress of the project. A comprehensive performance management plan has also been implemented. The project will document progress and project outcomes and disseminate lessons learned and case studies. An end-of-project evaluation will also be conducted.

No vehicle purchases envisaged.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	330,000
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TBD Details

(No data provided.)

Motor Vehicles Details

N/A



Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: 7443			
Mechanism Name: Supply Chain Management System (SCMS)			
Prime Partner Name: Management Sciences for Health			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	165,000	0
Narrative:			
<p>This is a continuing activity through which Supply Chain Management Systems (SCMS) will continue to support the Ministry of Health and Social Services (MOHSS) Primary Health Care (PHC) Directorate in the design and implementation of a community home-based care (CHBC) kit system and the integration of this system into the existing pharmaceutical supply chain for sustainability.</p> <p>Support will be provided to the PHC Directorate to monitor implementation and evaluate the performance of the integrated CHBC kit system. This will include strengthening the monitoring and evaluation tools and procedures (for example the daily activity register and reporting forms) used by CHBC providers that were developed, implemented and handed over to MOHSS in COP11. The enhanced monitoring and evaluation system will facilitate the entry, aggregation and analysis of CHBC data at all levels (district, regional and national) to generate information for evidence-based policy and managerial decision-making.</p> <p>Support will also be provided to facilitate the integration of the therapeutic and supplementary foods supply chain activities into the existing MOHSS pharmaceutical supply chain thus ensuring harmonized procurement, warehousing, distribution and inventory control procedures at all levels of the health system. This will include developing a monitoring and evaluation tool that will enable data entry, aggregation and analysis of nutrition assessment counseling and support data at all levels (district, regional and national) to generate information for evidence-based policy and managerial decision-making. SCMS will provide technical assistance to the Project Management Unit of MOHSS to coordinate procurement of GFATM-funded therapeutic and supplementary food.</p>			



This activity focuses on strengthening the national-level system, which will have an impact on the delivery of CHBC kits and therapeutic and supplementary foods throughout the country.

This narrative is linked to activities under HVCT, CIRC, HBHC and PDCS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	33,000	0

Narrative:

This is a continuing activity through which Supply Chain Management System (SCMS) will continue to support the Primary Health Care (PHC) directorate of the Ministry of Health and Social Services (MOHSS) in the design and implementation of a logistics system for therapeutic and supplementary foods (TSF). This activity is linked to and compliments MOHSS activity in PDCS, PDTX related to support to food commodity logistics for Nutrition Assessment, Counseling and Support programs

With COP12 funding, SCMS will: 1) Facilitate the integration of the TSF supply chain activities into the existing MOHSS pharmaceutical supply chain, harmonizing quantification, procurement, warehousing, distribution and inventory control procedures to ensure availability of pediatric rations of TSF at all levels of the health system; and 2) Build capacity of the PEPFAR-supported commodity logistics officer within MOHSS to take over these tasks with time.

This activity focuses on strengthening the national-level system, which will have an impact on the delivery of therapeutic and supplementary foods throughout the country.

This narrative is linked to activities under HVCT, CIRC, HBHC and PDCS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	925,737	0

Narrative:

This is a continuing activity through which Supply Chain Management System (SCMS) will focus on enhancing existing systems to promote supply chain information sharing and improve procurement and supply chain management systems.

SCMS will strengthen the capacity of the National Medicines Policy Coordination (NMPC) sub-division in the Division of Pharmaceutical Services at the Ministry of Health and Social Services (MOHSS) to provide overall supervision in the supply chain management aspects.

In addition, activities will be conducted to strengthen long-term quantification and budgeting of public-health program commodity needs including strengthening linkages between program commodity forecasts, supply planning and procurement actions and institutionalizing long-term forecasting and budgeting of commodity needs into the MoHSS systems to ensure commodity security. This is closely linked to supply chain and commodity logistics activities described in HBHC and PDCS addressing adult and pediatric care and support program commodity needs.

SCMS will also enhance capacity in Central Medical Stores (CMS) by strengthening warehousing operations, quality assurance and enhance CMS performance monitoring using the Pharmacy Management Information System (PMIS) and utilization of data from Syspro as well as the fleet management system.

Activities will strengthen inventory management of the two Multi-Regional Medical Depots and use of Syspro and PMIS data for decision-making. SMCS will also provide technical assistance for pharmaceutical waste disposal.

To strengthen human resources capacity for supply chain management SCMS will support local tertiary education institutions and networks to provide health-related supply chain management training.

This activity focuses on strengthening the national and regional level commodities system.

This narrative is linked to activities under HVCT, CIRC, HBHC and PDCS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	100,000	0

Narrative:

Under this budget code, Supply Chain Management System (SCMS) will utilize COP12 funding to provide supply chain-related technical assistance to the MOHSS to accelerate the roll-out of medical male circumcision (MMC) interventions.

In 2011, the World Health Organization has undertaken the process of prequalification of a number of MC devices for adults.

SMCS will provide technical assistance in product selection for medical male circumcision devices and related supplies by sharing experience from other SCMS countries and assisting in defining product specifications with the aim of achieving standardization. SCMS will also build capacity for forecasting and quantification of MMC commodity requirements and strengthen inventory management and systems for data collection and reporting on the use of MMC-related commodities.



<p>SCMS, in collaboration with other USG partners, will also undertake limited procurement of selected MC devices and supplies required for program roll-out at demonstration sites and share MC supplies market information and intelligence with the Central Medical Stores.</p> <p>This narrative is linked to activities under HVCT, OHSS, HBHC and PDCS.</p>			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	92,973	0
Narrative:			
<p>Under this budget code, Supply Chain Management System (SCMS) will utilize COP12 funding to strengthen the capacity of the Ministry of Health and Social Services (MOHSS) Directorate of Special Programs and Central Medical Stores (CMS) for long term forecasting, inventory control systems and budgeting for rapid test kits (RTK) and related supplies to ensure commodity security.</p> <p>Supply Chain Management System (SCMS) has been procuring RTK and related consumables needed for the HIV counseling and testing (HCT) services for USAID-supported standalone HCT sites. In COP12, SCMS will end procurement and will work to strengthen systems for data collection, validation, analysis and reporting of HCT-related commodities to generate information for evidence-based policy and managerial decision-making.</p> <p>This narrative is linked to activities under OHSS, CIRC, HBHC and PDCS.</p>			

Implementing Mechanism Details

Mechanism ID: 9869	Mechanism Name: Cooperative Agreement 1U2GPS002715
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Blood Transfusion Service of Namibia	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A
Total Funding: 796,539	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount



GHP-State	796,539
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Sub Partner Name(s)

(No data provided.)

Overview Narrative

This partner's main goal is to manage the safety and adequacy of the Namibian blood supply. NAMBTS is legally mandated to be the sole provider of blood and blood products to Namibian hospitals. NAMBTS collects blood from fixed and mobile sites; all infectious disease testing is performed by the South African National Blood Service through a unique contract mechanism. NAMBTS training in the appropriate use of blood is a health systems strengthening activity that reduces wastage and contributes to improved access to blood transfusion services within the primary healthcare (PHC) system, which is a GHI and PF objective. NAMBTS provides blood to 48 transfusion centers in all 13 regions in Namibia. NAMBTS is a "mature" partner with a functional cost-recovery system to sustain future operations. Starting in COP12, USG Namibia will begin phasing out funding to NAMBTS through HMBL over a three year period. Limited support to NAMBTS will continue through OHSS and HLAB for cross-cutting activities linked to GHI goals for improving access to PHC services and developing human capacity in blood transfusion laboratory science. As the sole provider of blood to public and private hospitals, NAMBTS has a responsibility to ensure that blood is affordable. Since most transfusions are paid by the Government, cost control is a critical part of the MOHSS's overall sustainability plan. NAMBTS actively seeks private contributions to off-set costs. In 2011 NAMBTS also began selling excess plasma to a South African pharmaceutical company, adding to its cost-recovery revenue stream. The partner maintains a robust electronic data system which contributes information to PEPFAR, WHO and GRN indicators. NAMBTS also operates one of Africa's only adverse transfusion reaction surveillance systems.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

Custom



N/A

Key Issues

Child Survival Activities
 Safe Motherhood

Budget Code Information

Mechanism ID: 9869			
Mechanism Name: Cooperative Agreement 1U2GPS002715			
Prime Partner Name: Blood Transfusion Service of Namibia			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	136,319	0
Narrative:			
<p>Building Namibian technical capacity is an essential component in the USG strategy to promote country ownership and the sustainability of services provided by local partners. NAMBTS will work with Polytechnic and UNAM to identify Namibian students in the laboratory science program and the Medical School, and assist them to attain post-graduate qualifications in blood transfusion medicine or blood transfusion laboratory science. NAMBTS currently relies on expatriate experts to fill high-level positions within the blood service and in facility-based blood bank laboratories. The intent of this funding is to build Namibian capacity to fill these senior-level positions. Currently all training in blood transfusion medicine and laboratory science must be conducted outside of Namibia. On this note, NAMBTS is investigating twinning arrangements with universities in the UK and South Africa. If funds are available in the future, this budget code could be used to support curriculum development in these areas at Polytechnic and UNAM. See the HMBL narrative for additional information.</p> <p>This is the first time the NAMBTS cooperative agreement has been funded through a program area other than HMBL. CDC believes this is an appropriate evolution of the PEPFAR-NAMBTS relationship in light of the sustainability issues described above, and the importance of safe blood transfusion services to maternal and child health, as well as systems strengthening objectives described in the Namibia GHI Strategy.</p>			



Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	660,220	0

Narrative:

NAMBTS will continue to implement the comprehensive blood safety program described in prior years. A major change since COP11: 1) In COP12 NAMBTS will absorb the salary and benefit costs all of the employees previously funded by PEPFAR. This absorption is the first step of a three year phase-out plan for blood safety funding under HMBL. Given the continuing systems strengthening needs related to the delivery of safe transfusion services, PEPFAR funding for NAMBTS will continue at a reduced rate under the OHSS and HLAB program areas.

Specific activities will include:

Blood collection: NAMBTS will work to retain current blood donors, expand recruitment activities to schools, and conduct ongoing surveillance of transfusion transmissible infections (TTI) among donors to identify lowest risk sub-groups.

Blood screening: NAMBTS will maintain a contract with the South African National Blood Service (SANBS) for all infectious disease screening. This arrangement is subject to a bi-annual sustainability review, the latest of which occurred in March 2010. NAMBTS has tentatively set a five year goal to return infectious disease screening to Namibia. This objective may be limited by a lack of trained human resources to operate the expanded testing laboratory. To address this barrier, NAMBTS will work with Polytechnic to identify Namibian students in the laboratory science program and assist them to attain blood transfusion qualifications (see NAMBTS narrative in OHSS). This assistance may also include training in nucleic acid testing (NAT) through a twinning arrangement with university blood transfusion medicine programs in South Africa, the US or the UK.

Blood utilization: Equipment procured in COP12 will allow an expansion of blood group compatibility testing to a major hospital in northern Namibia. NAMBTS will also work with the MOHSS Department of Clinical Services and NIP to expand and strengthen the national network of blood banks and compatibility testing laboratories.

Policy and Sustainability: NAMBTS will continue to finance approximately 75% of its operations through an innovative cost-recovery system. Through this system, consumers of blood (the MOHSS, private insurance schemes, individual patients) pay NAMBTS a fixed cost per unit of blood consumed. To increase sustainability, NAMBTS will pursue international accreditation of the NAMBTS laboratory. This will allow NAMBTS to enter into plasma sales and export agreements with pharmaceutical companies in



South Africa and elsewhere.

Implementing Mechanism Details

Mechanism ID: 9872	Mechanism Name: Cooperative Agreement 1U2GPS002722
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Potentia Namibia Recruitment Consultancy	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A
Total Funding: 7,583,099	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	7,583,099

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Potentia performs a limited number of HRH-related services for the MOHSS. These include support for recruitment, administering payroll and timely transfers of electronic funds to the MOHSS contract staff. This mechanism encompasses a broad range of activities and objectives under the Coordination and Management thematic areas (human resources/human capacity development and monitoring and evaluation) of the Partnership Framework (PF). By linking professionals to MOHSS positions, Potentia also indirectly supports other technical areas (e.g., prevention, care and treatment). The activities under this mechanism are national in scope. In the past 12 months, good steady progress has been made in transitioning personnel from Potentia's pay roll to the GRN. As the role of Potentia evolves, the USG will support the strengthening of HR management systems within the GRN civil service. While the USG will continue to support the GRN civil service as the primary public sector employment mechanism, technical assistance will develop flexible and diverse HR mechanisms within the GRN, including outsourcing. This mechanism will contribute to HRH objectives through helping to develop transparent and flexible HR



systems within the MOHSS and GRN. Activities supported under this mechanism are integrated with CDC's technical assistance to the MOHSS, both at the national level and in the field. As Potentia's responsibilities for contract staff have declined, so have management fees. This mechanism requires submission of a detailed work plan in the yearly continuation application, monthly reports, and monthly meetings with CDC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	6,800,000
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TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

- Addressing male norms and behaviors
- Impact/End-of-Program Evaluation
- Increasing gender equity in HIV/AIDS activities and services
- Malaria (PMI)
- Child Survival Activities
- Mobile Population
- Safe Motherhood
- TB
- Family Planning

Budget Code Information

Mechanism ID: 9872



Mechanism Name:	Cooperative Agreement 1U2GPS002722		
Prime Partner Name:	Potentia Namibia Recruitment Consultancy		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	397,183	0

Narrative:

In COP12, Potentia will no longer support medical officers dedicated to ART clinics. These positions were all successfully transitioned to the MOHSS payroll between October 2011 and February 2012. Additional transitions will occur in 2012 and 2013 as the MOHSS implements an absorption program funded through its Medium Term Expenditure Framework (MTEF). In 2012, clinical staff in six regions have been slated for transition. The reduced budget in this program area compared to COP11 is a reflection of this planned transition.

Potentia will manage this scale down in accordance with local labor laws. Throughout this transition, Potentia will continue to support a declining number of the following clinical, allied professional and training positions through the HBHC program area: nurses, pharmacists, clinical mentors/advisors, and trainers.

For additional detail please see human resources for health (HRH) database.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	66,023	0

Narrative:

Potentia supports clinical and allied health care worker positions in public health facilities, as well as training staff to support the Ministry of Health and Social Services' National (and Regional) Health Training Centres (N/RHTC). Staff recruited by Potentia have labor contracts with the MOHSS, or, in limited instances with ITECH, a training partner which supports the National Health Training Center (NHTC). Potentia provides recruitment and payroll services to these contract workers, but is not the "employer." This role is filled by the MOHSS or ITECH. In the "employer" role, both partners advise Potentia on salary and benefit packages that match the government's salary scale.

Within HVTB, Potentia will provide recruitment and payroll services for an infection control specialist.

In COP12, Potentia will no longer support medical officers dedicated to ART clinics. These positions were all successfully transitioned to the MOHSS payroll between October 2011 and February 2012. Additional transitions will occur in 2012 and 2013 as the MOHSS implements an absorption program funded through its Medium Term Expenditure Framework (MTEF). In 2012, clinical staff in six regions have been targeted for transition. The actual number of positions transitioned in 2012 will be determined



by the amount of funding released to the MOHSS by the Ministry of Finance. Potentia will manage this scale down in accordance with local labor laws. Throughout this transition, Potentia will continue to support a declining number of the following clinical, allied professional and training positions: nurses, pharmacists, clinical mentors/advisors, and trainers.

For additional detail please see human resources for health (HRH) database.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	142,847	0

Narrative:

In COP12, Potentia will no longer support medical officers dedicated to ART clinics. These positions were all successfully transitioned to the MOHSS payroll between October 2011 and February 2012. Additional transitions will occur in 2012 and 2013 as the MOHSS implements an absorption program funded through its Medium Term Expenditure Framework (MTEF). In 2012, clinical staff in six regions have been slated for transition from USG to MOHSS salary support. Potentia will manage this scale down in accordance with local labor laws. Throughout this transition, Potentia will continue to support a declining number of the following clinical, allied professional and training positions: nurses, pharmacists, clinical mentors/advisors, and trainers.

Potentia supports clinical and allied health care worker positions in public health facilities, as well as training staff to support the Ministry of Health and Social Services' National (and Regional) Health Training Centres (N/RHTC). Staff recruited by Potentia have labor contracts with the MOHSS, or, in limited instances with ITECH, a training partner which supports the NHTC. Potentia provides recruitment and payroll services to these contract workers, but is not the "employer." This role is filled by the MOHSS or ITECH. In the "employer" role, both partners advise Potentia on salary and benefit packages that match the government's salary scale.

For additional detail please see human resources for health (HRH) database.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	1,492,415	0

Narrative:

Potentia supports clinical and allied health care worker positions in public health facilities, as well as



training staff to support the Ministry of Health and Social Services' National (and Regional) Health Training Centres (N/RHTC). Staff recruited by Potentia have labor contracts with the MOHSS, or, in limited instances with ITECH, a training partner which supports the NHTC. Potentia provides recruitment and payroll services to these contract workers, but is not the "employer." This role is filled by the MOHSS or ITECH. In the "employer" role, both partners advise Potentia on salary and benefit packages that match the government's salary scale.

Under HVSI, Potentia will provide recruitment and payroll services for contractors working on the MOHSS Strategic Information (SI) staff at the national and regional level.

Recruitment and payroll services will also be provided to field staff engaged to implement a MARPS rapid assessment, population size estimation, and behavioral surveillance survey.

Positions supported through this budget code will work under short-term labor agreements or long-term contracts with the MOHSS. CDC technical staff will work with MOHSS and, where relevant, UNAM, to determine if any of these study personnel could be absorbed into the MOHSS or UNAM staff establishment. If such a determination is made to build long-term study capacity within these organizations, CDC will engage with the HRH TWG to ensure that appropriate budget motivations and other workforce planning steps are taken.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	1,000,359	0

Narrative:

Potentia supports clinical and allied health care worker positions in public health facilities, as well as training of staff to support the Ministry of Health and Social Services' National (and Regional) Health Training Centres (N/RHTC). Staff recruited by Potentia have labor contracts with the MOHSS, or, in limited instances with ITECH, a training partner which supports the NHTC. Potentia provides recruitment and payroll services to these contract workers, but is not the "employer." This role is filled by the MOHSS or ITECH. In the "employer" role, both partners advise Potentia on salary and benefit packages that match the government's salary scale.

Under HVSI, Potentia will continue to support positions linked to the ITECH technical assistance program to the University of Namibia (UNAM). See details in ITECH/UNAM BCN. This project will support a lecturer and several lecturer assistants in the UNAM Nursing School.

Positions supported through this budget code will be included in an overall HRH transition plan between ITECH and UNAM. To date, this plan has already transitioned over 30 PEPFAR-funded positions to UNAM or the MOHSS's National Health Training Centre. While positions will continue to be supported by PEPFAR in COP12, this absorption process – which requires UNAM and the MOHSS to make annual



budgetary requests of the Ministry of Finance – will continue in this budget period.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	2,029,370	0

Narrative:

Potentia continues to provide recruitment and payroll support to the MOHSS, which holds the contracts and ultimate supervisory authority over these contractors. Unlike other program areas in which support for long-term salary support is slated to begin scaling-down in COP12, PEPFAR Namibia will continue to finance salaries for short-term personnel, such as MC clinicians. Furthermore Salary support for the national Male Circumcision program coordinator, a senior MC trainer, and medical officers and nurses to serve as dedicated MC teams in selected priority areas of Namibia.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	703,712	0

Narrative:

Quality Assurance Coordinators: This activity covers salary support for Regional Quality Assurance Officers (RQA) who monitor quality of HCT services in the regions. RQA officers have backgrounds in nursing and Social Work and help provide clinical supportive supervision to community counselors deployed in public health facilities. They also provide on-site mentorship so lay community counselors. This element links to support provided to National Institute for Pathology (NIP) for quality assurance testing (see NIP BCN under HVCT).

Field Staff to Conduct Basic Program Evaluations: This activity will cover the personnel costs associated with a basic program evaluation of HCT delivery models that will be conducted in COP 12. This evaluation will examine the costs and outputs associated with four HCT delivery models: facility-based integrated VCT, stand-alone VCT, home-based counseling and testing, and mobile testing. Funds to support logistics and procurements required by these study personnel are described in the TBD Local Study Procurement and Logistics mechanism BCN.

As CDC continues its engagement with the USG-GRN HRH TWG to ensure the rational and efficient transition of permanent positions receiving salary support from PEPFAR, CDC's Technical Assistance model will increasingly require short-term staff to support studies and evaluations like the one described in this BCN. CDC is working with Potentia and the Ministry of Health and Social Services (MOHSS) to develop specific standard operating procedures and agreements for short-term study staff, and will work with Potentia and the MOHSS Research Directorate to develop the Ministry's capacity to absorb and



manage short-term study staff in the future.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	50,000	0

Narrative:

Within this budget code funds will support 50% of National HIV Prevention Coordinator salary within the Ministry of Health and Social Services. This position coordinates HIV and other prevention efforts across line ministries and with other stakeholders in the national HIV/AIDS response. The prevention coordinator leads the National Prevention Technical Advisory Committee, and is leading the development of the National Prevention Strategy.

For additional detail please see human resources for health (HRH) database.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	278,320	0

Narrative:

Potentia supports clinical and allied health care worker positions in public health facilities, as well as training staff to support the Ministry of Health and Social Services' National (and Regional) Health Training Centres (N/RHTC). Staff recruited by Potentia has labor contracts with the MOHSS, or, in limited instances with ITECH, a training partner which supports the NHTC. Potentia provides recruitment and payroll services to these contract workers, but is not the "employer". This role is filled by the MOHSS or ITECH. In the "employer" role, both partners advise Potentia on salary and benefit packages that match the government's salary scale.

In COP12, Potentia will no longer support medical officers dedicated to ART clinics. These positions were all successfully transitioned to the MOHSS payroll between October 2011 and February 2012. Additional transitions will occur in 2012 and 2013 as the MOHSS implements an absorption program funded through its Medium Term Expenditure Framework (MTEF). In 2012, clinical staff in six regions have been targeted for transition. The actual number of positions transitioned in 2012 will be determined by the amount of funding released to the MOHSS by the Ministry of Finance. Potentia will manage this scale down in accordance with local labor laws. Throughout this transition, Potentia will continue to support a declining number of the following clinical, allied professional and training positions: nurses, pharmacists, clinical mentors/advisors, and trainers.

For additional detail please see human resources for health (HRH) database. CDC will remain engaged with the USG-GRN HRH TWG to ensure the planned transition of healthcare salaries continues



throughout COP12 and into the future. CDC will also support (with in-kind assistance from Namibia-based technical advisors) M&E activities within the MOHSS to monitor the impact of this massive transition on clinical service delivery. This M&E work will compliment broader workforce planning investments by USAID.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,217,209	0

Narrative:

In COP12, Potentia will no longer support medical officers dedicated to ART clinics. These positions were all successfully transitioned to the MOHSS payroll between October 2011 and February 2012. Additional transitions will occur in 2012 and 2013 as the MOHSS implements an absorption program funded through its Medium Term Expenditure Framework (MTEF). In 2012, clinical staff in six regions have been targeted for transition. The actual number of positions transitioned in 2012 will be determined by the amount of funding released to the MOHSS by the Ministry of Finance. Potentia will manage this scale down in accordance with local labor laws. Throughout this transition, Potentia will continue to support clinical and allied health care worker positions in public health facilities, as well as training staff to support the Ministry of Health and Social Services' National (and Regional) Health Training Centres (N/RHTC). Staff recruited by Potentia have labor contracts with the MOHSS, or, in limited instances with ITECH, a training partner which supports the NHTC. Potentia provides recruitment and payroll services to these contract workers, but is not the "employer." This role is filled by the MOHSS or ITECH. In the "employer" role, both partners advise Potentia on salary and benefit packages that match the government's salary scale.

As the nature of CDC's support to the MOHSS evolves, Potentia will also evolve into a technical assistance role, providing expert advice to the MOHSS on payroll systems, labor law, recruitment strategies, and general HR management.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	205,661	0

Narrative:

In COP12, Potentia will no longer support medical officers dedicated to ART clinics. These positions were all successfully transitioned to the MOHSS payroll between October 2011 and February 2012. Additional transitions will occur in 2012 and 2013 as the MOHSS implements an absorption program funded through its Medium Term Expenditure Framework (MTEF). In 2012, clinical staff in six regions



have been targeted for transition. The actual number of positions transitioned in 2012 will be determined by the amount of funding released to the MOHSS by the Ministry of Finance. Potentia will manage this scale-down in accordance with local labor laws. Throughout this transition, Potentia will continue to support a declining number of the following clinical, allied professional and training positions: nurses, pharmacists, clinical mentors/advisors, and trainers. Potentia provides recruitment and payroll services to these contract workers, but is not the “employer.” This role is filled by the MOHSS or ITECH. In the “employer” role, both partners advise Potentia on salary and benefit packages that match the government’s salary scale.

For additional detail please see human resources for health (HRH) database.

Implementing Mechanism Details

Mechanism ID: 9874	Mechanism Name: HIVQUAL
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: U.S. Department of Health and Human Services/Health Resources and Services Administration (HHS/HRSA)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A
Total Funding: 199,174	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	199,174

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The main goal is to provide technical assistance to the MOHSS to establish a Quality Improvement (QI) program that enables regular assessments of the quality of HIV care. As part of the USG contribution to the goal of “enhancing the quality of care” in the partnership framework implementation plan (PFIP), USG will provide TA to enhance quality management throughout the HIV



care and treatment system.

This mechanism has a national geographic coverage.

Building the capacity for QI and use of strategic information for program improvement, HIVQUAL contributes to efficiencies and better patient outcomes. HIVQUAL is also a model for HEALTHQUAL a broader healthcare system quality improvement initiative.

HIVQUAL's performance assessment and quality improvement modules contribute to building HRH.

HIVQUAL works through MOHSS structures, providing TA through targeted use of consultants and extensive use of USG Namibia staff. Cost reductions are also sought through training of trainer courses.

HIVQUAL is required to submit bi-annual progress reports to the HRSA project officer in Washington.

Routine monitoring meetings are held with the CDC Namibia technical advisor, financial manager and cooperative agreement manager. Evaluation is an integral component of HIVQUAL's quality

improvement strategy project officer in Washington. Routine monitoring meetings are held with the CDC

Namibia technical advisor, financial manager and cooperative agreement manager. Evaluation is an integral component of HIVQUAL's quality improvement strategy.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000
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TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

Increasing gender equity in HIV/AIDS activities and services

Child Survival Activities

Safe Motherhood

TB

Custom



Family Planning

Budget Code Information

Mechanism ID:	9874		
Mechanism Name:	HIVQUAL		
Prime Partner Name:	U.S. Department of Health and Human Services/Health Resources and Services Administration (HHS/HRSA)		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	18,750	0

Narrative:

This activity is conducted under the leadership of the MOHSS Directorate of Special Programs (DSP) in close collaboration with CDC Namibia and the US-based HIVQUAL team for technical support. The program has been rolled out to all 34 health districts of Namibia, with at least five health centers offering HIV care through the Integrated Management of Adolescent and Adult Illness (IMAI) strategy. Specific activities include;

Quality Improvement (QI) training: The USG-MOHSS HIVQUAL team will continue to build capacity for QI in public healthcare facilities and among MOHSS technical staff. Advanced in-service trainings will be provided to staff who received training in prior years. Basic training in QI will be provided to all relevant new staff. Training activities will be done in collaboration with ITECH. Specific activities will include; Training of Trainers workshops to promote decentralization of QI trainings throughout Namibia, and TA and training in support of the expanded national quality program.

Assessment of quality management programs at the participating clinics: An assessment tool to measure the capacity of the quality management program at each facility will be used to measure the growth of quality management activities as well as the quality of staff members' skills. The findings from these assessments will guide coaching interventions. Aggregated facility-specific data will provide population-level performance data to indicate priorities for national quality improvement activities. Similarly, local performance data will be used to identify facility-specific gaps in the delivery packages of care and then devise customized interventions to improve services at local facilities.

Performance measurement on selected core indicators: HIVQUAL will continue to develop providers' skills for collecting and using performance data within their own organizations to improve their HIV



treatment and care. Indicators will track the provision of the basic treatment and care package. Selected national core indicators will monitor proportions of pediatric patients receiving HAART, ART adherence, Cotrimoxazole prophylaxis, pediatric nutrition, immunizations, growth monitoring and TB screening.

Ongoing QI coaching and mentoring at participating sites: The program will continue to invest in transferring knowledge and skills to local technical advisors in the MOHSS. The transfer of QI skills will be accomplished through coaching and mentoring for MOHSS staff and health care providers. These QI skills will include performance data interpretation skills, quality program planning and design of quality improvement projects and implementation through improvement project cycles.

Promotion of consumer engagement in HIV care: HIVQUAL will provide technical assistance to the MOHSS to develop local, regional, and national strategies and programs to increase consumer (patient) involvement in HIV/AIDS programs. Increased participation by patients, pediatric patients' parents and guardians, and other "consumers" will improve HIV care and treatment services by enhancing the feed-back loop between patients, providers and the MOHSS. The plan will outline structures to ensure active participation of people living with HIV/AIDS in the development and improvement of HIV/AIDS programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	36,250	0

Narrative:

This activity is conducted under the leadership of the MOHSS Directorate of Special Programs (DSP) in close collaboration with CDC Namibia and the US-based HIVQUAL team for technical support. The program has been rolled out to all 34 health districts of Namibia, with at least five health centers offering HIV care through the Integrated Management of Adolescent and Adult Illness (IMAI) strategy. Specific activities include:

Quality Improvement (QI) training: The USG-MOHSS HIVQUAL team will continue to build capacity for QI in public healthcare facilities and among MOHSS technical staff. Advanced in-service trainings will be provided to staff who received training in prior years. Basic training in QI will be provided to all relevant new staff. Training activities will be done in collaboration with ITECH. Specific activities will include; Training of Trainers workshops to promote decentralization of QI trainings throughout Namibia, and TA and training in support of the expanded national quality program.

Assessment of quality management programs at the participating clinics: An assessment tool to measure



the capacity of the quality management program at each facility will be used to measure the growth of quality management activities as well as the quality of staff members' skills. The findings from these assessments will guide coaching interventions. Aggregated facility-specific data will provide population-level performance data to indicate priorities for national quality improvement activities. Similarly, local performance data will be used to identify facility-specific gaps in the delivery packages of care and then devise customized interventions to improve services at local facilities.

Performance measurement on selected core indicators: HIVQUAL will continue to develop providers' skills for collecting and using performance data within their own organizations to improve their HIV treatment and care. Indicators will track the provision of the basic treatment and care package. Selected national core indicators will monitor proportions of pediatric patients receiving HAART, ART adherence, Cotrimoxazole prophylaxis, pediatric nutrition, immunizations, growth monitoring and TB screening.

Ongoing QI coaching and mentoring at participating sites: The program will continue to invest in transferring knowledge and skills to local technical advisors in the MOHSS. The transfer of QI skills will be accomplished through coaching and mentoring for MOHSS staff and health care providers. These QI skills will include performance data interpretation skills, quality program planning and design of quality improvement projects and implementation through improvement project cycles.

Promotion of consumer engagement in HIV care: HIVQUAL will provide technical assistance to the MOHSS to develop local, regional, and national strategies and programs to increase consumer (patient) involvement in HIV/AIDS programs. Increased participation by patients, pediatric patients' parents and guardians, and other "consumers" will improve HIV care and treatment services by enhancing the feed-back loop between patients, providers and the MOHSS. The plan will outline structures to ensure active participation of people living with HIV/AIDS in the development and improvement of HIV/AIDS programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	100,000	0

Narrative:

This activity is conducted under the leadership of the MOHSS Directorate of Special Programs (DSP) in collaboration with CDC Namibia and the US-based HIVQUAL team for technical support. The program has been rolled out to all 34 health districts of Namibia, with at least five health centers offering HIV care through the Integrated Management of Adolescent and Adult Illness (IMAI) strategy. COP12 will focus on quality program implementation in these sites, and in additional health centers. For the first time, this



mechanism will include technical assistance to military sites providing ARV treatment.

Advanced in-service refresher trainings: Basic training in Quality Improvement (QI) will be provided to all relevant new staff. Training activities will be done in collaboration with ITECH. Specific activities will include: Training of Trainers workshops to promote decentralization of QI trainings throughout Namibia, and TA and training in support of the expanded national quality program.

Assessment of quality management programs at the participating clinics: An assessment tool to measure quality management capacity at each facility will be used to measure the growth of quality management activities and the quality of staff members' skills. Aggregated facility-specific data will include performance data to indicate priorities for national QI activities. Local performance data will be used to identify facility-specific gaps and devise customized interventions to improve services at local facilities.

Performance measurement on selected core indicators: HIVQUAL will continue to develop providers' skills for collecting and using performance data within their own organizations. Indicators will track the provision of the basic treatment and care package. Selected national core indicators will monitor proportions of pediatric patients receiving HAART, ART adherence, Cotrimoxazole prophylaxis, pediatric nutrition, immunizations, growth monitoring and TB screening.

Ongoing QI coaching and mentoring at participating sites: The program will continue to invest in transferring knowledge and skills to local technical advisors in the MOHSS. The transfer of QI skills will be accomplished through coaching and mentoring for MOHSS staff and health care providers. These QI skills will include performance data interpretation skills, quality program planning and design of quality improvement projects and implementation through improvement project cycles.

Promotion of consumer engagement in HIV care: HIVQUAL will provide technical assistance to the MOHSS to develop local, regional, and national strategies and programs to increase consumer (patient) involvement in HIV/AIDS programs. The plan will outline structures to ensure active participation of people living with HIV/AIDS in the development and improvement of HIV/AIDS programs.

HIVQUAL will coordinate and collaborate with the USAID/BLC program in at selected facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	44,174	0

Narrative:



This activity is conducted under the leadership of the MOHSS Directorate of Special Programs (DSP) in collaboration with CDC Namibia and the US-based HIVQUAL team for technical support. The program has been rolled out to all 34 health districts of Namibia, with at least five health centers offering HIV care through the Integrated Management of Adolescent and Adult Illness (IMAI) strategy. COP12 will focus on quality program implementation in these sites, and in additional health centers. For the first time, this mechanism will include technical assistance to military sites providing ARV treatment.

Advanced in-service refresher trainings: Basic training in Quality Improvement (QI) will be provided to all relevant new staff. Training activities will be done in collaboration with ITECH. Specific activities will include: Training of Trainers workshops to promote decentralization of QI trainings throughout Namibia, and TA and training in support of the expanded national quality program.

Assessment of quality management programs at the participating clinics: An assessment tool to measure quality management capacity at each facility will be used to measure the growth of quality management activities and the quality of staff members' skills. Aggregated facility-specific data will include performance data to indicate priorities for national quality improvement activities. Local performance data will be used to identify facility-specific gaps and devise customized interventions to improve services at local facilities.

Performance measurement on selected core indicators: HIVQUAL will continue to develop providers' skills for collecting and using performance data within their own organizations. Indicators will track the provision of the basic treatment and care package. Selected national core indicators will monitor proportions of pediatric patients receiving HAART, ART adherence, Cotrimoxazole prophylaxis, pediatric nutrition, immunizations, growth monitoring and TB screening.

Ongoing QI coaching and mentoring at participating sites: The program will continue to invest in transferring knowledge and skills to local technical advisors in the MOHSS. The transfer of QI skills will be accomplished through coaching and mentoring for MOHSS staff and health care providers. These QI skills will include performance data interpretation skills, quality program planning and design of quality improvement projects and implementation through improvement project cycles.

Promotion of consumer engagement in HIV care: HIVQUAL will provide technical assistance to the MOHSS to develop local, regional, and national strategies and programs to increase consumer (patient) involvement in HIV/AIDS programs. The plan will outline structures to ensure active participation of people living with HIV/AIDS in the development and improvement of HIV/AIDS programs.

HIVQUAL will coordinate and collaborate with the USAID/BLC program in at selected facilities.



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Implementing Mechanism Details

Mechanism ID: 9876	Mechanism Name: Cooperative Agreement 1U2GPS002058
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Namibia Institute of Pathology	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A
Total Funding: 831,386	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	831,386

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The main objective of this partner is to strengthen national lab systems necessary to conduct quality assured surveillance for HIV infection, sexually transmitted infections (STIs), and tuberculosis (TB), and to expand access to diagnostic and bio-clinical monitoring services. Quality bio-clinical monitoring and training is key to USG commitments related to the PF goal of “scaling up and enhancing antiretroviral treatment services (including pre-ART) [and] reducing TB/HIV co-infection.” Technical assistance aids the GRN to enhance the quality of ART care through quality assured bio-clinical monitoring, and expand access to screening for TB/HIV co-infection and other opportunistic infections. The NIP’s laboratory network coverage is national. The Namibia Institute of Pathology (NIP) is a public company established in 1999. Since then it has assumed responsibility for 37 MOHSS labs. This approach has allowed for a single lab structure within the HIV/AIDS response. NIP recovers a substantial portion of its costs through reimbursements from insurance plans. This innovative cost-recovery system is a model that could be adapted by other GRN programs. All cooperative agreement grantees must submit a detailed work plan with their annual continuation application. This work plan must be based on PEPFAR indicators and



aligned with targets set for each country. NIP also submits bi-annual status reports to CDC; these reports are shared with CDC technical advisors and the financial manager. Regular meetings between the CDC coag management team and the grantee allow for monitoring, advance planning and the identification of any redirection needs during the course of a budget period.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **No**

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

Malaria (PMI)

Child Survival Activities

TB

Budget Code Information

Mechanism ID:	9876		
Mechanism Name:	Cooperative Agreement 1U2GPS002058		
Prime Partner Name:	Namibia Institute of Pathology		
Strategic Area	Budget Code	Planned Amount	On Hold Amount



Care	HVTB	101,000	0
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Narrative:

Salary Support for NIP TB staff will be provided in COP12. The following NIP positions will be supported:
 One medical technologist for Quality Assurance (QA): The TB QA technologist is responsible for monitoring the implementation of quality assurance indicators at all NIP TB microscopy and culture labs, managing proficiency testing results, doing blind slides, rechecking, and site supervisions.
 Six laboratory assistants: The Laboratory assistants are deployed as microscopists and lab aids at district level laboratories. These are good examples of task shifting in the context of lack of qualified lab technologists.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	366,000	0

Narrative:

Procurement and maintenance of equipment: NIP will continue to strengthen its peripheral laboratories by procuring and maintaining equipment to make diagnostics and basic bio-clinical monitoring services accessible to remote areas. COP12 funds will also be used to maintain laboratory information system equipment that links remote health facilities to the main laboratory system. Increased access to laboratory services will minimize costs, delays and risk of loss associated with transporting samples to central testing facilities.

Salary support. COP12 funds will support the following NIP salaries:

- two laboratory trainers;
- one administrative assistant assigned to the training unit; and
- one program officer based at NIP.

The training positions will support the NIP training unit to leverage external TA in training provided by International partners (ASCP, ASM, CLSI). The training unit will focus on in-service training (internships), and practical training for Polytechnic of Namibia laboratory tech students. The NIP program officer together with the Corporate Affairs Manager is responsible for the management of the NIP COAG. This management team works closely with the CDC technical advisor, the CDC project manager, and the CDC finance department.



Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	364,386	0

Narrative:

Ongoing Quality Assurance (QA) for Rapid Testing (RT): These activities support the expansion of HCT through traditional and non-traditional delivery models, such as provider-initiated testing and counseling (PITC), outreach testing (e.g., mobile and door-to-door) as well as existing HCT. The MOHSS requires retesting of 5% of all rapid HIV testing done as part of external quality monitoring. All HCT facilities are enrolled in the EQA scheme and are expected to submit the 5% specimens for retesting using ELISA at NIP. Additionally, NIP provides proficiency panels and Quality Control sets to all rapid test sites and compiles EQA reports for the program.

Salary Support for Staff: QA staff will be responsible for the validation of any new RT technologies introduced in Namibia, and for making recommendations to the MOHSS on the RT algorithm and selection of test kits. These QA experts will also support training and post-training certification of all MOHSS/New Start/NGO personnel who administer rapid tests, preparation, distribution, and analysis of quality controls and proficiency panels; retesting of 5% of all rapid tests done at sites by ELISA; proficiency follow-up with rapid test sites and personnel; and; submission of reports on rapid test QA to the MOHSS HCT unit.

Support for QA staff within NIP is designed to support the national HCT strategy to diagnose and refer a greater number of newly infected patients into ART services and treatment.

CDC will continue to work with NIP and the USG-GRN HRH TWG to develop and implement rational transition plans for all staff currently supported with PEPFAR funds.

Implementing Mechanism Details

Mechanism ID: 9940	Mechanism Name: Cooperative Agreement 1U2GPS0018665166
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Development Aid from People to People, Namibia	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A



Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A
Total Funding: 2,140,841	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	2,140,841

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The main goal of this partner is to deliver HIV prevention and care interventions to individuals in household and community settings. These interventions include: home-based HIV VCT, education and behavior change counseling, counseling on ART adherence, and referrals to clinical services such as MC, PMTCT, and ART. As part of the USG contribution to the PF goal of “enhancing prevention,” USG contributions will seek to strengthen this community-based organization’s capacity to design, implement and finance comprehensive HIV prevention programs at the community level. The PF is aligned with the priority prevention areas described in Namibia’s National Strategic Framework for HIV and AIDS 2010-2016. This partner works in the regions with the highest rates of HIV in Namibia (Omusati, Oshana, Oshikoto, Ohangwena, Kavango, Caprivi, and Khomas). USG is engaging the GRN in high level discussions on how government can support essential community services such as DAPP that have direct links and referrals to facility based services. DAPP is also partially funded by the Global Fund, but these resources are declining. At the moment, there is no other known donor to fund this organization. This activity is designed to be cost efficient. Local volunteers receive a modest monthly stipend. HIV test kits are procured through the existing MOHSS system. The DAPP community-based networks are utilized for other public health activities, e.g., distribution of insecticide-treated bed nets. The partner is required to have an extensive monitoring and evaluation (M&E) plan that is linked to PEPFAR and GRN indicator that includes number of individuals reached, tested, and linked to services.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?



Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HVCT	DAPP Field Officers who support projects that are also supported by GF.	2140841	DAPP Field Officers provide door-to-door prevention counseling, HCT, referrals and other community-based health information services. As a sub-recipient of GF support, much of DAPP's work in HIV/AIDS is jointly funded by USG and GF.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	100,000
Human Resources for Health	1,800,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

- Addressing male norms and behaviors
- Increasing gender equity in HIV/AIDS activities and services
- Increasing women's access to income and productive resources
- Malaria (PMI)
- Child Survival Activities
- Mobile Population
- Safe Motherhood
- TB
- Family Planning



Budget Code Information

Mechanism ID: 9940			
Mechanism Name: Cooperative Agreement 1U2GPS0018665166			
Prime Partner Name: Development Aid from People to People, Namibia			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	255,935	0
Narrative:			
<p>DAPP will train and deploy at least 310 Field Officers (FO) to conduct door-to-door counseling and outreach sessions, as well as household-based HCT and referrals to clinical services. Additional details on these activities may be found in the HVCT and HVOP narratives. HBHC-related activities will include:</p> <ol style="list-style-type: none"> 1) Referral information and links to appropriate care, and treatment services, including HIV care and treatment services, PMTCT, FP services, as well as TB and STI treatment in cooperation with MOHSS; 2) Referral information for social and health services including alcohol, abuse support, gender-based violence, and nutrition support; and 3) Condoms, as appropriate. <p>In addition, DAPP will provide extensive training for FO on the most up-to-date, evidence-based approaches for effective prevention counseling. The TBD partner will also produce appropriate job aids and tools for the field officers, as well as supporting information, education and communication (IEC) materials for clients.</p> <p>DAPP will also be expected to conduct other community-based prevention efforts including education for traditional leaders, youth and other groups. DAPP will also establish tailored referral guides for each region, and will establish community-based resource centers. In addition, FOs will conduct public events to raise public awareness about HIV STI, and TB prevention, care, and treatment.</p> <p>CDC will work with DAPP and USAID to ensure that DAPP's continuing work at the community level is complementary with other USG-supported community-based organizations. This on-going monitoring will contribute to the identification and removal of any duplicative activities. DAPP's community-based work is designed to improve health-seeking behaviors and increase access to healthcare services for poor and traditionally underserved communities in Namibia.</p>			
Strategic Area	Budget Code	Planned Amount	On Hold Amount



Care	PDCS	17,375	0
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Narrative:

DAPP will train and deploy at least 310 Field Officers (FO) to conduct door-to-door counseling and outreach sessions, as well as household-based HCT and referrals to clinical services. Details on these activities may be found in the HVCT and HBHC narratives. PDCS-related activities will include:

Referral services (HIV, STI, and TB care and treatment, as well as preventive care) for families: FO will work with families to promote whole-family health. Emphasis will be placed on ensuring that family members of an HIV positive person (including children) are tested for HIV. Testing or referral for TB will be emphasized when at least one member may have TB disease. This program aims to increase access to cotrimoxazole prophylaxis and early initiation of ART. Adolescents will receive age-appropriate prevention messages for youth, including information on delaying sexual debut and abstinence. FO will also be vigilant to report suspected child sexual abuse.

Technical assistance to community support groups for PLWHA: FO will provide psycho-social support to community and PLWHA groups, as well as advice on small income-generating projects (e.g. community gardens), and capacity building for PLWHA to care for HIV-impacted children. Where older children and adolescents are already HIV-infected, support will be provided to facilitate the disclosure of HIV-status to infected children, adherence to OI prophylaxis and/or ART, caregivers' concerns and referrals to OVC programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	100,000	0

Narrative:

Implementation of CDC Families Matter!

Families Matter! is an intervention designed to promote positive parenting practices and effective parent-child communication about sexuality and sexual risk reduction for parents and guardians of 9-12 year olds. The Families Matter! Program (FMP) intervention is an adaptation of the US-based "Parents Matter!" curriculum which CDC has evaluated in the US and Kenya. The ultimate goal of FMP is to reduce sexual risk behaviors among adolescents, including delayed onset of sexual debut, by giving parents tools to deliver primary prevention to their children. Families Matter! is a community-based, group-level intervention delivered over five consecutive 3-hour sessions.

Costs for the program include personnel, such as an overall manager, facilitators and administration staff,



as well as miscellaneous costs, such as for project materials, travel and office supplies. To ensure sustainability, materials and trainings will be shared with other organizations such as the Ministry of Gender, Equality and Child Welfare, Lifeline ChildLine, and others with an interest in family interventions. Community-based public health interventions like Families Matter! are designed to contribute to USG Namibia’s “access” goals by improving the health-seeking behavior of youth and families. Linkages to and the sharing of materials with other public sector and civil society programs will contribute to USG Namibia’s transition goals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	414,300	0

Narrative:

The partner has trained and deployed 300 Field Officers (FO) to conduct door-to-door counseling and outreach sessions, as well as referrals, with individual households. Details on these activities may be found in the HVAB, HVOP and HBHC narratives. Field Officers will also perform the following HVCT-related activities:

Community mobilization to access MOHSS mobile and facility HCT services: FO will use their unique position in the community to mobilize demand for HCT services offered by the MOHSS. These services are delivered through four MOHSS vans, which will operate across several regions. FO will also work with the MOHSS team, community leaders, and local radio stations to promote each outreach visit. To support this activity, the partner will provide FO with salaries, transportation (e.g. a bicycle or transportation costs), printed materials (e.g. flyers and IEC materials in local languages), and support for public and MOHSS coordination meetings (e.g. tents, office space).

Delivery of HCT services during household outreach visits: In 2008, the MOHSS approved the delivery of HCT through non-traditional settings such as mobile/outreach delivery points for the first time. A subset of FO were trained in home-based HCT in COP11. In COP12, most of the remaining FOs will receive this training.

Expanding the reach of community-based HCT is a priority for the MOHSS as it seeks to raise the number of persons with new HIV infections who are diagnosed and referred to ART services for treatment. DAPP’s activities will contribute to this national access to care objective, as well as to the access objectives described in the Namibia GHI Strategy. Utilizing lay healthcare workers who are recruited from, and retained in their local areas is an important component of CDC’s investments in sustainable approaches to community-based services.



Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,128,231	0

Narrative:

DAPP has trained and deployed 310 Field Officers (FO) to conduct door-to-door counseling and outreach sessions, as well as household-based HCT and referrals to clinical services. Details on these activities are described across multiple program areas, including HVCT and HBHC. In COP12, HVOP-related activities will include:

Community Outreach: DAPP provides door-to-door, age-appropriate, education and prevention counseling to households and community members. Based on assessments conducted during the outreach visits, individually tailored packages of advice and services will be prepared. These packages will include: 1) Information on HIV counseling and testing, as well as counseling and rapid testing; 2) Information on strategies to reduce sexual risk taking behaviors (e.g., abstinence, multiple concurrent partnerships, correct and consistent condom use, responsible drinking); 3) Information and referrals for male circumcision where appropriate; 4) Tailored prevention information for PLWHA; 5) Referral information and links to appropriate care, and treatment services, including HIV care and treatment services, PMTCT, FP services, as well as TB and STI treatment in close cooperation with government health services; 6) Referral information for social and health services including alcohol, abuse support, gender-based violence, and nutrition support; and 7) Condoms as appropriate.

Training: DAPP provides extensive training for FO on the most up-to-date, evidence-based approaches for effective prevention counseling. DAPP will work with ITECH, which will produce appropriate job aids and tools for the field officers, as well as supporting information, education and communication (IEC) materials for clients.

Public Outreach to Special Groups and Public Information Campaigns: DAPP continues to conduct other community-based prevention efforts including education for traditional leaders, youth and other groups. DAPP will update referral guides for each region, and will support community-based resource centers. In addition, FOs will conduct public events to raise public awareness about HIV STI, and TB prevention, care, and treatment.

Community PWP: DAPP will continue to implement the PEPFAR-supported community PWP intervention tool kit. This tool kit will include prevention for PLWHIV messaging and referrals, but will also emphasize positive living and social support.



DAPP and CDC will work closely with USAID and Peace Corps to ensure that adequate coverage of community-based activities is achieved without overlap or duplication with other partners. By supporting increased health-seeking behaviors, DAPP's work will help more Namibians to access necessary HIV/AIDS and primary healthcare services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	225,000	0

Narrative:

Support to DAPP to strengthen community component of mother baby follow up through the use of field officers to: 1) Trace PMTCT clients as part of mother-baby follow up and; 2) Encourage/refer pregnant women and their exposed infants to PMTCT services. DAPP activities include community-based HIV prevention, HIV counseling and testing, and referral to services through door-to-door outreach. The Field Officers (FO) come from the communities they serve. Currently DAPP is working in several regions (Omusati, Oshana, Ohangwena, Oshikoto Kavango, Caprivi, Erongo, Otjozondupa and Khomas). Field officers also conduct outreach activities for youth and men and also help to organize PLWHA into support groups. DAPP has been involved in the mother-baby follow-up initiative in selected regions. This funding will enable DAPP to continue supporting the mother-baby follow-up activities and expand its support to the additional regions where they operate when MOHSS rolls out mother-baby follow-up nationwide.

CDC will work with DAPP and USAID to ensure that DAPP's continuing work at the community level is complementary with other USG-supported community-based organizations. This on-going monitoring will contribute to the identification and removal of any duplicative activities. DAPP's community-based work is designed to improve health-seeking behaviors and increase access to healthcare services for poor and traditionally underserved communities in Namibia.

Implementing Mechanism Details

Mechanism ID: 10163	Mechanism Name: Society for Family Health (SFH)
Funding Agency: U.S. Department of Defense	Procurement Type: Cooperative Agreement
Prime Partner Name: Society for Family Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	



G2G: N/A	Managing Agency: N/A
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Total Funding: 871,595	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	871,595

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism provides comprehensive HIV prevention services for the Ministry of Defense/Namibian Defense Force (MOD/NDF) to implement its HIV/AIDS workplace program, the Military Action and Prevention Program (MAPP). This mechanism is contributing to Namibian’s five year National Strategic Framework (NSF) and the Partnership Framework Agreement (PFA) and the GHI and addresses key policy and strategic issues related to sustainability and ownership of program by Namibians. The program aims to reach over 15,000 military personnel and civilians working at the 23 military bases and camps across 11 regions in Namibia. Having the military implementing their own programs through the trained peer educators, HIV/AIDS Unit Coordinators, chaplains and gender focal persons through the leadership of the base commanders will ensure that the mechanism becomes more cost effective. Ownership of the program lies with the Ministry of Defense/Namibian Defense Force. Main cross cutting issues include gender, alcohol, stigma and discrimination and human resources for health. The monitoring and evaluation plan includes PEPFAR indicators and is fully integrated into the overall US DOD M&E plan for assistance to the MOD/NDF.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	90,000
Human Resources for Health	151,000

TBD Details

(No data provided.)



Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
 Increasing gender equity in HIV/AIDS activities and services
 Military Population
 Workplace Programs

Budget Code Information

Mechanism ID: 10163			
Mechanism Name: Society for Family Health (SFH)			
Prime Partner Name: Society for Family Health			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	871,595	0

Narrative:

SFH's contribution to the implementation of the Military Action and Prevention Program (MAPP) is to develop the capacity of the Ministry of Defense/Namibian Defense Force (MOD/NDF) to take full ownership in the entire implementation of MAPP at all the military facilities. As a result, SFH has trained various MOD/NDF military personnel and has, together with MOD/NDF, created Steering Committees at base-levels to monitor and guide the implementation of HIV activities at that level. The activities are designed to also address issues related to gender and male norms and behaviors in the military and promote the participation of women in activities at the bases because the military is predominantly male and women often feel shy to participate actively. This activity will continue to further strengthen the institutional capacity of the Namibian Ministry of Defense/Namibian Defense Force (MOD/NDF) to implement an integrated HIV/AIDS prevention program in the military through:

Training: SFH provides training to military peer educators, gender focal persons, chaplains, unit coordinators and base commanders in various aspects of HIV combination prevention approaches, namely 1) Military Base Commanders on HIV Leadership and responsibilities of providing oversight to the program at the bases; 2) New recruits on basic HIV/AIDS knowledge and skills that teaches HIV prevention and the importance of consistent condom use and HIV testing as well as male circumcision; 3)



HIV Unit coordinators on program management and coordination, including monitoring and evaluation, and to better address gender, male norms and HIV/AIDS related issue, coercion, alcohol abuse, and stigma and discrimination within military settings; 4) Assist peer educators to conduct community outreach activities to continue providing HIV prevention messages; 5) Mobilize the military to participate in the Namibian Annual National HIV Testing Day, World AIDS Day, National TB Day and any other health related days to promote HIV prevention messages; and 6) Training Military Chaplains and their assistants on HIV/AIDS and spiritual counseling as appropriate. Assist peer educators and chaplains/chaplain assistants to facilitate interactive video presentations on combination prevention approaches at all military bases.

Community outreach: Procure and distribute military packaged condoms through military logistic channels and reproduce and distribute customized military specific prevention IEC materials and other HIV prevention materials.

Learning and sharing of best practices: Facilitate the participation of MOD member at Military HIV Conferences, the PEPFAR Implementers Meeting and any other one or two important national or international meeting/conference on HIV prevention.

Implementing Mechanism Details

Mechanism ID: 10164	Mechanism Name: University of Washington/International Training & Education Centre for Health (UW/I-TECH)
Funding Agency: U.S. Department of Defense	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Washington	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,224,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	1,224,000

Sub Partner Name(s)

Custom



(No data provided.)

Overview Narrative

This mechanism will continue to develop and build the institutional capacity of the Ministry of Defense/Namibian Defense Force (MOD/NDF) to strengthen ownership, leadership, management and planning capacities to ultimately provide a sustainable HIV/AIDS response in the Namibian military. The overall goal of this mechanism is to support the strategic goals and objectives of the 5 year National Strategic Framework (NSF) and the Partnership Framework Agreement (PFA) and the GHI. Approximately 15,000 MOD/NDF staff and civilian workers at the military bases and camps in 11 regions of the country. Integrating HIV services into services regularly provided at each military health facility. Strategies to transition are focusing on contributions to health systems strengthening through extensive in-service training of military health care workers in various aspects of HIV/AIDS related issues and pre-service training at both the University and Polytechnic of Namibia in laboratory and pharmacy fields and mentoring. Human resources for health are cross-cutting all programs and TB and Prevention with People Living with HIV are some of the Health Wrap-around activities. The mechanism addresses male norms and behaviors, through Positive Health Dignity and Prevention (PHDP), VCT and MC counseling. The monitoring and evaluation plan includes PEPFAR indicators and is fully integrated into the overall US DOD M&E plan for assistance to the MOD/NDF.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	24,600
Gender: Reducing Violence and Coercion	45,000
Human Resources for Health	939,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A



Key Issues

Addressing male norms and behaviors
 Increasing gender equity in HIV/AIDS activities and services
 Military Population
 TB
 Workplace Programs
 Family Planning

Budget Code Information

Mechanism ID:	10164		
Mechanism Name:	University of Washington/International Training & Education Centre for Health (UW/I-TECH)		
Prime Partner Name:	University of Washington		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	120,000	0

Narrative:

With COP12 funds, this continuing program will support the Ministry of Defence/Namibia Defence Force (MOD/NDF) to strengthen and expand high quality HIV care and support services both within and outside its health facilities. Core support activities include:

Support clinical HIV palliative care services: Provision of technical support to assist the military to expand and enhance clinical palliative care service delivery to established sites. In line with the Ministry of Health and Social Services strategy to decentralize HIV care and treatment, I-TECH will continue to provide TA to support integration of a package of HIV care into other services at other military health facilities. I-TECH will also provide necessary minor equipment and materials to allow decentralization of these services and health care workers will receive training as required to ensure they remain updated with the latest MoHSS guidelines.

Support community-centered palliative care: support groups and home-based care: Strengthen the existing support groups and in collaboration with DOD prevention partner assist the military to establish new support groups at different military bases as needed. I-TECH will continue to provide training to support group members on issues such as stress management, disclosure of status to others, etc.; promote opportunities for support group members to develop innovative strategies to support each other; promote interchange of ideas between support groups through targeted exchange visits if applicable; and



further building capacity of military health care workers to share information at support group meetings on topics such as medicine adherence, PHDP, basic nutrition, and others. I-TECH will also continue to assist MOD/NDF home-based care givers to provide effective services to military members in need. Further, I-TECH will assist military health care workers to provide refresher training to home-based care givers on relevant palliative care topics; and promote opportunities for home-based care givers to meet, exchange ideas and develop innovative ways to improve their home-based care services.

Capacity Building: Train new home-based givers and other health care workers and provide in-service training, on different topics relevant to HIV care and support services including procurement of necessary equipment for training and implementation of service provision. I-TECH will also train selected military “HIV experts” on how to train others to provide HIV care and support in a training of trainers course and will co-facilitate during their first opportunities to train. Further, I-TECH will continue to train and coach selected military HIV experts in mentoring skills to enable them to better support colleagues in the field.

Quality assurance: Provide technical assistance to the MOD/NDF to develop assessment tools for quality of HIV patient care delivered. I-TECH will also coach the military health care workers who have been trained as mentors, to review the performance of military staff in correct HIV care and support according to MoHSS guidelines through utilization of monitoring tools to do chart reviews and inform case discussions with clinic staff and continue to assist the MOD/NDF to ensure accurate recording and reporting of patient data relevant to care and support as a basis for generating accurate monthly and quarterly reports as required by the Ministry, and to monitor and evaluate their own performance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	70,000	0

Narrative:

This continuing activity will support the Ministry of Defence and the Namibian Defence Force (MOD/NDF) to further strengthen its capacity to prevent tuberculosis (TB) and to identify and correctly and successfully manage patients with TB.

Support TB prevention and treatment services: Because PLHIV are more susceptible to TB disease than those without HIV, and in accordance with World Health Organization and Ministry of Health and Social Services (MOHSS) guidelines, PLHIV should be screened for TB at each clinic visit and should be offered Isoniazid Preventive Therapy (IPT) if they meet the eligibility criteria. In addition, every patient with TB should be tested for HIV. With COP12 funds, I-TECH will continue to provide TA support during mentoring visits to ensure TB prevention in patients attending clinics for HIV care and correct identification and management of patients who have TB, including testing for HIV. I-TECH will provide



support to MOD health care workers to ensure that 100% of people with HIV accessing their MOD health facilities are screened for TB at each visit and that 100% of TB patients are tested for HIV.

Utilizing COP12 funds, I-TECH will assist the MOD/NDF to evaluate and to implement improvements in TB infection control (IC) in crowded military settings, in addition to continuing to assist in the assessment of TB IC in individual health facilities. I-TECH will also assist with minor equipment needed for the required improvements in TB IC. I-TECH will also assist the MOD/NDF to enhance military personnel's knowledge about TB and services available through collaboration in the production of appropriate IEC materials for general distribution to all health facilities and bases and for use in National and International TB Days.

Capacity building: With COP12 funds, I-TECH will continue to train health care workers from throughout the military to prevent, diagnose and manage TB in the era of HIV and drug resistant TB and to provide IPT to eligible PLHIV. Training of health care workers will include procurement of any necessary equipment for training and implementation of service provision. With a view to long-term sustainability of the program, I-TECH will continue to co-facilitate with selected military "TB experts" in training of health care workers in TB. In further support of long-term effective and quality management of TB and TB prevention, I-TECH will continue to coach selected military TB "experts" in implementation of their mentoring skills to enable them to better support colleagues in the field.

Quality assurance (QA): During mentoring support visits, I-TECH mentors, together with the MOD trained mentors, will review the performance of military staff in correct screening and provision of TB prevention (IPT) and treatment according to MOHSS guidelines through chart reviews and case discussions with clinic staff. In addition, I-TECH will continue to assist the MOD/NDF to hold regular review meetings where IPT initiation and completion rates will be determined and TB management data will be evaluated. This activity will support sustainability of quality TB prevention and treatment services in the military.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	110,000	0

Narrative:

This continuing activity will support the Ministry of Defence and the Namibia Defence Force (MOD/NDF) to further strengthen its capacity to perform high quality HIV-related laboratory services.

I-TECH has been assisting the MOD/NDF to establish a laboratory at the Grootfontein Military Hospital capable of catering for HIV-related laboratory testing. I-TECH will provide TA to ensure continuing uninterrupted quality laboratory services by 1) ensuring appropriate use and maintenance of the latest



laboratory equipment through on-site training and monitoring, assisting the MOD/NDF to maintain an effective and sustainable equipment process as new technology becomes available, and monitoring of equipment; 2) assist in the development, implementation and updating of clear and comprehensive standard operating procedures; and 3) assist the laboratory personnel to utilize and maintain an effective laboratory information system. In addition, I-TECH will assist MOD/NDF to identify which facilities might benefit from establishment of “specimen processing areas”, thus promoting safe and timely processing of specimens as well as ensuring accurate test results.

Capacity building: I-TECH will continue to assist MOD/NDF to build the human resource capacity in the laboratory services. With a view to sustainability, I-TECH will provide mentoring training to an expert laboratory technologist selected by MOD, and will coach the MOD mentor during routine mentoring support visits to give on-site training to their colleagues. To further enhance skills of laboratory staff, I-TECH will continue to facilitate in-service training through linkages with the Namibia Institute of Pathology (NIP) and Centre for Disease Control and Prevention (CDC’s) International Laboratory Branch Consortium partners. I-TECH will continue to train on safe, high quality specimen collection. Furthermore, I-TECH will assist in the establishment and implementation of a “specimen processing area” in the military including procurement of necessary equipment for training and service provision.

Noting the scarcity of military laboratory personnel, a high degree of staff “turn-over”; and in anticipation of expanding and sustaining laboratory services, I-TECH provided four bursaries to military staff to attend the Polytechnic of Namibia’s pre-service laboratory technologist 4-year degree program. Depending on funding, two students will complete their studies in 2013. With COP12 funds under OHSS program area, I-TECH will support the remaining two students for enrolment in their 3rd year of study.

Quality Assurance/Accreditation: Laboratory accreditation is a lengthy process and requires several years to be achieved when a laboratory’s services meet international quality standards. I-TECH will continue to assist the MOD/NDF Grootfontein laboratory to ultimately achieve accreditation through 1) strengthening internal quality assurance both during mentoring support visits and through anticipated collaboration with Namibia Institute of Pathology (NIP); and 2) continued enrollment in an External Quality Assurance (EQA) program that meets the requirements of the South African National Accreditation System (SANAS) and the International Medical Laboratory Accreditation Community. I-TECH will also assist MOD/NDF to monitor quality of services at the mini-laboratory at PMMHC and any specimen processing areas which are established in specific health facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and	HVSI	100,000	0



Systems			
Narrative:			
<p>The overall objective of this continuing program is to assist the military in providing effective Information and Communications Technology (ICT) support for its HIV prevention, care and treatment programs. Support implementation of effective health information systems: With COP12 funds, I-TECH will continue to provide TA support to the Defence Health Management Information System (DHMIS) Technical Working Group (TWG) and will assist with updating and further customization of HIV-related databases in response to changing programs and needs as required.</p>			
<p>Capacity building: With COP12 funds, and with a view to long-term sustainability, I-TECH will continue to build capacity of MOD/NDF information communication technology (ICT) specialists in systems management and hardware maintenance. In addition, I-TECH will work side-by-side with identified expert ICT staff to continue the transfer of IT support to the MOD/NDF's MAPP. As needed, I-TECH will use COP12 funds to continue to train more military healthcare workers in basic computer skills and use of the HIV-related databases. They will also continue to receive training on how to use their own data for planning purposes.</p>			
<p>Support monitoring and evaluation: With COP12 funds, I-TECH will assist the MOD/NDF to strengthen its capacity to monitor and evaluate HIV-related services and activities and to promote the use of data to continually improve the quality of HIV services. During mentoring support visits, I-TECH mentors together with military mentors, will assist staff to review registers and patient/client files, focusing on the quality of data collection, and will discuss strengths and weaknesses noted. With COP12 funds, and to further promote ownership and sustainability of quality assurance programs, the military mentors noted in the CIRC, HVCT, HTXS and HBHC sections will be coached to take over the quality assurance role. With COP12 funds I-TECH will continue to support regular reviews of HIV-related data, promoting the collection of good quality data, and the identification of areas to target for improved quality of services. Staff will continue to be assisted in generating reports needed for routine self-evaluation and for submission to higher military levels as required.</p>			
<p>In order to effectively further understand issues and respond to them, it is necessary to do special evaluations from time to time. With COP12 funds, I-TECH will continue to assist the MOD/NDF to evaluate different aspects of HIV prevention, care and treatment services, to analyze and interpret information collected and utilize information to improve services. Areas requiring special evaluation may include training needs assessments, program performance evaluations and others.</p>			
Strategic Area	Budget Code	Planned Amount	On Hold Amount



Governance and Systems	OHSS	100,000	0
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Narrative:

The overall objective of this continuing program is to support the MOD/NDF to further develop institutional capacity, strengthen systems and advocate for an enabling environment for implementation and scale-up of the MOD/NDF's HIV prevention, treatment and care services. These activities will greatly contribute to long term ownership and sustainability of these programs.

Utilizing COP12 funds, I-TECH will continue to support pre-service and in-service training and the attendance of MOD/NDF staff members to appropriate and relevant local, national, regional and international trainings, conferences, meetings, courses and study tours. Training topics may include leadership, management, information technology (advanced and basic), monitoring and evaluation, strategic planning, stigma and discrimination, mentoring skills, and others. I-TECH will support senior MOD/NDF members to attend International Military HIV-related conferences to enhance their sharing of experiences and lessons learned.

Answering to a dire need for more pharmacists within the military, I-TECH began supporting one NDF staff member to attend the University of Namibia's Pharmacy course in 2011. With COP12 funds, I-TECH will provide the student with a bursary for the 4th (final) year of pharmaceutical studies

Using COP12 funds, and with a view to long-term sustainability, I-TECH will continue to collaborate with the MOD's HIV coordination and training offices to strengthen MOD capacity to coordinate and deliver HIV-related training internally, especially focusing on integration of health services, quality service delivery, enhanced information systems and reporting, improved HIV financing and good governance and leadership .

Finally, noting the scarcity of military laboratory personnel, a high degree of staff "turn-over" and in anticipation of expanding and sustaining laboratory services, I-TECH provided 4 bursaries to military staff to attend the Polytechnic of Namibia's pre-service laboratory technologist 4-year degree program. Depending on funding, two students will complete their studies in 2013. With COP12 funds, I-TECH will continue to support the remaining two students for enrolment in their 3rd year of study.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	100,000	0

Narrative:



Male circumcision is recognized as an important part of a comprehensive HIV prevention package. The goal of this continuing activity is to decrease new HIV infections in the Ministry of Defence/Namibian Defence Force (MOD/NDF) through strengthening and expansion of Male circumcision (MC) services within the military.

Support MC service-delivery and demand creation: With COP12 support, free and confidential MC services will continue to be offered to MOD/NDF staff by military health care workers as part of a comprehensive HIV prevention program which also includes HCT with referrals as necessary, treatment for other STI, counseling on risk-reduction and safer-sex practices, and condom distribution. Following the fundamentals of MC care, military MC services will include informed and voluntary decision making, medically safe clinical procedures and quality assurance. With I-TECH support, the MOD/NDF established adult MC services at Grootfontein Military Hospital where MC services started in June 2010. By November 2011, 111 military men had been circumcised at Grootfontein Military Hospital following appropriate HIV testing and counseling. With COP12 funds, I-TECH will continue to provide TA and mentoring support to facilitate effective and high-quality MC services in all MC services sites, including outreach services. I-TECH will also assist MOD/NDF to enhance MC demand-creation through collaboration in the production of appropriate IEC materials.

Capacity building: With COP12 funds, I-TECH will continue to support expansion of MC services through training of doctors and nurses as required in safe and effective provision of MC. Training will include procurement of necessary equipment for training and implementation of service-provision. Counselors will be trained on MC-specific counseling to supplement existing counseling messages on risk-reduction programs. In support of long-term sustainability, I-TECH will also continue to train and coach military MC mentors to enable them to better support their own colleagues in the field and will train selected MC providers in how to train others in a training of trainers (TOT) course.

Quality assurance (QA): With COP12 funds, I-TECH will continue to support the MOD/NDF in quality assurance of MC service provision. With previous funding, I-TECH facilitated proficiency certification of military service providers and with COP12 funds will continue to facilitate this process. I-TECH will assist the MOD/NDF to operationalize national supportive supervision QA tools, and will train and coach selected MOD/NDF members to carry out such supervision with a view to long-term sustainability of a quality service.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	302,000	0

Narrative:

With COP12 funds, this continuing activity will support the Ministry of Defence and the Namibian Defence



Force (MOD/NDF) to strengthen and expand high-quality HIV testing and counseling (HTC) services including patient- and provider- initiated TC and routine HIV screening. The HTC program provides pre-test counseling services, rapid HIV testing, post-test counseling for both HIV-negative and HIV-positive clients, and referral to the care and treatment programs for those members who test positive.

Support to HTC services and demand creation: In 2011, I-TECH supported MOD/NDF to test and counsel 3004 military members. I-TECH will continue to provide TA in support of quality testing services, for individuals who voluntarily seek HIV testing and those who are offered testing when visiting health facilities for any other reason, at all static and outreach testing sites. I-TECH will also assist the MOD/NDF to enhance demand creation for HIV testing through collaboration in the production of appropriate IEC materials for use at testing events and for distribution to all health facilities and bases.

Support MOD to carry out HTC outreach services: Providing outreach HTC services has been shown to be a successful strategy for increasing the number of military staff accessing HIV testing in Namibia. As such, I-TECH will continue to support the MOD/NDF to carry-out outreach HTC services to all bases within the country.

Capacity building in support of HTC services: I-TECH will continue to provide TA in support of expansion of HTC services (voluntary TC and provider-initiated TC (PITC)) through training of health care workers in comprehensive HIV counseling and rapid HIV testing, including training on any new approaches to testing and counseling. Supervisors of health facilities, including sickbays, will continue to be trained and coached in the promotion of PITC and routine screening as appropriate. In support of long-term effective and efficient management of HTC services, I-TECH will continue to train and coach military HTC site supervisors and HIV coordinators in leadership and supervision and continue to train HTC experts in mentoring skills to better support their own colleagues in the field. With a view to long-term sustainability of the program, I-TECH will train more HTC experts in how to train others in an HTC training of trainers (TOT) course including training on procurement of necessary equipment for training and implementation of HTC service provision.

Quality assurance: I-TECH will continue to provide TA in support of quality assurance (QA) of MOD/NDF HTC service provision. HTC site supervisors will benefit from ongoing QA coaching in maintaining a quality HTC service, including evaluating the quality of counseling sessions, actual testing, stock maintenance and record-keeping. Further, I-TECH will continue to assist the MOD/NDF to strengthen the integration of other essential programs with HTC services, such as TB screening, referrals for other services including ART for HIV positive clients, discussion of gender-based violence and male norms, positive health dignity and prevention (PHDP) and alcohol-use screening. I-TECH will also facilitate quarterly HTC program review meetings to augment quality assurance activities through data analysis and timely identification of areas for improvement. In support of sustainability, I-TECH will train officials selected by MOD to monitor and evaluate quality of HTC services.



Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	322,000	0

Narrative:

The goal of this continuing program is to strengthen the capacity of the Ministry of Defence/Namibian Defence Force (MOD/NDF) to provide quality HIV treatment services for military and civilian employees working on military bases.

Support HIV treatment services: I-TECH supported the identification, renovation and opening of the HIV care and treatment center at Grootfontein Military Hospital (Fountain of Hope Clinic) in 2009. By the end of September 2011, 191 military members received ART at that facility. I-TECH will continue to provide TA for HIV treatment, appropriate initiation of ART, patient adherence to ARV, identification and management of treatment failure, pharmaceutical management, cervical cancer screening for HIV positive women, and other aspects of HIV treatment and to promote integration of other services, such as TB prevention and treatment, STI screening and prevention, family planning and others as appropriate. In addition, and in line with the Ministry of Health and Social Services strategy to decentralize HIV care and treatment to smaller health facilities which are closer to the patients, I-TECH will continue to provide TA to support integration of a package of HIV care and treatment into other services provided at sickbays and other smaller health facilities within the military.

I-TECH will continue to assist MOD/NDF to create more demand for military HIV treatment services through providing TA in the production and dissemination of appropriate IEC materials. Included in the materials will be updated practical information on how and where individuals can seek help. I-TECH will continue to support the military to enhance the capacity of military HCT sites and health facilities to effectively refer HIV-positive clients to military and other sites offering HIV treatment services.

Capacity building: I-TECH will continue assisting the MOD/NDF to build capacity of military doctors, nurses and pharmacists through in-service training and clinical mentoring, as well as through participation in national and international training. Timely training and mentoring will ensure military personnel are informed of new developments, such as changes to HIV treatment guidelines and protocols. I-TECH will continue to train more military nurses to provide ART services in line with the MOHSS strategy of decentralizing care to smaller health facilities. Training of health care workers will include procurement of necessary equipment for training and implementation of service provision. With a view to long-term sustainability of the program, I-TECH will continue to co-facilitate with selected military "HIV experts" in training of health care workers in ART-related courses. In further support of long-term



effective and quality management of HIV, I-TECH will continue to coach selected military HIV experts in implementation of their mentoring skills to enable them to better support colleagues in the field.

Quality assurance: I-TECH and MOD mentors will review the performance of military staff in correct HIV treatment according to MoHSS guidelines through chart reviews and case discussions with clinic staff. I-TECH will continue to assist the MOD/NDF to ensure good quality HIV treatment for patients through correct recording and reporting of patient and pharmaceutical data as a basis for generating accurate monthly and quarterly reports, and to monitor and evaluate their performance.

Implementing Mechanism Details

Mechanism ID: 10181	Mechanism Name: PEACE CORPS NAMIBIA
Funding Agency: U.S. Peace Corps	Procurement Type: Cooperative Agreement
Prime Partner Name: U.S. Peace Corps	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 50,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a continuing activity. Peace Corps (PC) continues to strengthen its approach to development which advances country ownership of PEPFAR program efforts through placement of PC Volunteers in requesting local governmental and non-governmental organizations for specific assignments that are time-limited and designed from the onset to build community capacity to sustain projects. Peace Corps uses PEPFAR funds to support the placement and training of Volunteers to work side-by-side with community partners to leverage all appropriate and locally-available resources and technology for development of sustainable, community-led responses to HIV. In the area of prevention, funds will be



used for the placement, training and support of volunteers to work with communities to design and implement context-appropriate and evidence-based prevention interventions addressing the keys drivers of the epidemic, including sexual and behavioral risk, vertical transmission from mother to child and harmful gender/cultural norms.

In support of care and treatment, funds will be used for the placement, training and support of volunteers to aid community members and organizations in designing and implementing care programs for PLHIV, OVCs and their caretakers to mitigate the effects of HIV, improve health outcomes for HIV positives, improve the developmental growth of OVCs, improve household nutritional status and optimize the quality of life of adults and children living with and affected by HIV. PC Volunteers placed in organizations to complement treatment efforts will support the enhancement of capacities of service providers to deliver and monitor treatment delivery.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	7,500
Education	12,500
Food and Nutrition: Policy, Tools, and Service Delivery	7,500
Gender: Reducing Violence and Coercion	5,000
Water	2,500

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors



Budget Code Information

Mechanism ID:	10181		
Mechanism Name:	PEACE CORPS NAMIBIA		
Prime Partner Name:	U.S. Peace Corps		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	10,000	0

Narrative:

This is a continuing activity from COP11. Funds will be used under the volunteer activities support and training (VAST) program. VAST grants support capacity-building projects among community based organizations (CBO), Local non-governmental organizations, and other community members working with, and providing services to local community responding to the HIV/AIDS pandemic.

With the support of the volunteer, local communities and organizations submit funding request for projects that centre on local-level issues related to HIV prevention that specifically address care and support activities.

For examples, VAST grant can be used to train local service providers in stigma reduction, establish home gardens projects for vulnerable families including child headed households, or fund support groups for PLWHA.

All VAST-funded projects include clear capacity-building components in order to increase the community's ability to sustain the work after the volunteers' departure.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	10,000	0

Narrative:

This is a continuing activity from FY11. Funds will be used under the volunteer activities support and training (VAST) program. VAST grants support capacity-building projects among community based organizations (CBO), Local non-governmental organizations, and other community members working with, and providing services to local community responding to the HIV/AIDS pandemic.

With the support of the volunteer, local communities and organizations submit funding requests for projects that centre on local-level issues related to HIV care and support that specifically address OVC activities. For example, VAST grants can be used to implement Girls Leading Our World (GLOW) camps and GLOW clubs etc.

All VAST funded projects include clear capacity-building components in order to increase the



community's ability to sustain the work after the volunteers' departure.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	10,000	0

Narrative:

This is a continuing activity from FY11. Funds will be used under the Volunteer Activities Support and Training (VAST) program. VAST grants support capacity-building projects among community-based organizations (CBO), local non-governmental organizations, and other community members working with, and providing services to local community responding to the HIV/AIDS pandemic. With the support of the volunteer, local communities and organizations submit funding request for projects that centre on local-level issues related to HIV prevention that specifically address abstinence and be faithful activities. All VAST-funded projects include clear capacity-building components in order to increase the community's ability to sustain the work after the volunteers' departure. Most education volunteers apply for VAST grant under AB as they work directly with school going children.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	20,000	0

Narrative:

This is a continuing activity from FY11. Funds will be used under the volunteer activities support and training (VAST) program. VAST grants support capacity-building projects among community-based organizations (CBO), local non-governmental organizations, and other community members working with, and providing services to local community responding to the HIV/AIDS pandemic. With the support of the volunteers, local communities and organizations submit funding request for projects that centre on local-level issues related to HIV prevention that specifically address 'other prevention' activities. For examples, VAST grants can be used to establish and train peer education groups that work with and teach community members in safer sex practices or referrals to clinics for STI/HCT. In addition, funds can be used to address potential harmful gender roles. All VAST-funded projects include clear capacity-building components in order to increase the community's ability to sustain the work after the volunteers' departure.

Implementing Mechanism Details

Mechanism ID: 10382	Mechanism Name: Communication for Change
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	(C-Change)
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A
Total Funding: 957,600	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	957,600

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Communication for Change (C-Change) supports domestic institutions, both governmental and local civil society organizations (CSO), to improve the quality of behavioral interventions, integrate HIV prevention into primary health care and sustain a combination HIV prevention response through strengthening of national and subnational HIV and AIDS coordination structures. The program provides technical assistance to local CSO and the Ministry of Health and Social Services and Ministry of Regional and Local Government throughout the country. Expected results include: Strengthen the quality of social and behavior change interventions of local CSO; strengthen the governmental national and subnational health program; and support the Directorate of Primary Health Care, regional entities and the National Health Training Center to design and implement the Health Extension Program (HEP)—a key task-shifting activity to improve effectiveness and efficiencies. It supports long-term improvements to access at primary health care through HEP. C-Change assistance provides long-term transition and sustainment of the HIV prevention response to country organizations, both governmental and CSO and is in line with the GHI strategic focus of transition. C-Change assists CSO to incorporate SBCC methodology, and implement quality improvement. On national and regional level, the program assists government offices to develop enabling structures, policies, strategies and standards, define essential service packages, and develop national SBCC materials and implement quality programs. C-Change will be evaluated in 2012. Monitoring efforts include a review of country organization progress against quality improvement benchmarks and implementation of HEP training.



No vehicle procurement

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

- Addressing male norms and behaviors
- Increasing gender equity in HIV/AIDS activities and services
- Malaria (PMI)
- Child Survival Activities
- Safe Motherhood
- Family Planning

Budget Code Information

Mechanism ID: 10382			
Mechanism Name: Communication for Change (C-Change)			
Prime Partner Name: FHI 360			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	957,600	0
Narrative:			



Communication for Change (C-Change) provides technical assistance to strengthen and focus social and behavior change (SBC) on comprehensive HIV prevention programming among local civil society organizations (CSO), national and regional Government of Namibia (GRN) programs and the GRN's Health Extension Program.

C-Change focuses on critical enablers such as social norms, national and regional implementation of strategies and response plans, strengthening coordination and the performance of technical committees and field workers in processes associated to SBC to support the enabling environment for SBC.

C-Change provides important technical leadership to the GRN and local CSO on diffusing best practices in SBC.

Activities to improve the quality of SBC interventions among selected local CSO include: Training in SBC Communication (SBCC) theories and methods; strategy development and planning; program strengthening to include SBC quality standards; field materials review and development; and quality improvement visits to strengthen HIV prevention quality improvement processes. Recipients include: 1) Selected USG-supported local CSO with direct recipient status including Catholic AIDS Action, LifeLine/ChildLine, Church Alliance for Orphans, and KAYEC Trust; and 2) Selected GFATM-supported CSO delivering SBCC at scale including those receiving sub-awards under the Namibia Network of AIDS Service Organizations.

Activities to strengthen the capacity of GRN national and regional programs to plan, monitor and evaluate SBC components of public health activities include: Engage the GRN to strengthen national and regional SBC strategies, policies, structures and efforts through technical assistance and training.

Recipients will include: 1) The Ministry of Health and Social Services/Directorate of Special Programs through the National Prevention Technical Advisory Committee and its Technical Working Groups; 2) The Ministry of Health and Social Services/Directorate of Primary Care; and 3) The Ministry of Regional and Local Government, Housing and Rural Development (MRLGHRD) and subnational coordination structures such as Regional AIDS Coordinating Committees (RACCOC) which fall under MRLGHRD mandate in the National Strategic Framework.

Activities to provide technical assistance to the MOHSS Primary Health Care Directorate on the design and implementation of the Health Extension Program include: Engage the GRN in a technical assistance model to ensure quality design and implementation of the MOHSS Health Extension Worker (HEW) program including integration of HIV, TB and malaria-related preventive and promotive services into community level primary health care implementation.

Implementing Mechanism Details

Mechanism ID: 10386	Mechanism Name: The Capacity Project
Funding Agency: U.S. Agency for International	Procurement Type: Cooperative Agreement



Development	
Prime Partner Name: IntraHealth International, Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 3,400,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	3,400,000

Sub Partner Name(s)

Anglican Medical Services	Catholic Health Services	Lutheran Medical Services
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Overview Narrative

The Capacity Project (CP) has been supporting the Government of the Republic of Namibia and civil society to reduce the spread and impact of HIV/AIDS by providing technical assistance to local organizations in governance and systems, prevention, treatment and care, which in turn builds organizational and institutional capacity. Specifically, CP strengthens financial and grant management, human resources, compliance and other health management systems so that these institutions are ready for transition to non-USG funding. The program operates in all regions in Namibia. IntraHealth and partners will contribute to the goals of the USG Partnership Framework and GHI by: 1) Positioning HIV/AIDS services within health systems, with an emphasis on service integration and maternal, neonatal and child health; 2) Transferring direct implementation, leadership and accountability of project deliverables/functions to Namibian partners to ensure ownership and sustainability; 3) Ensuring clinical excellence through evidence-based service delivery, performance improvement approaches, mentoring and supportive supervision; 4) Expanding access through technical assistance to increase community referrals and service integration; and 5) Promoting leadership and management through human resources strengthening and forming partnerships with the private sector and financial accountability. These efforts will help improve cost efficiencies over time. Furthermore, they are in line the GHI strategic focus of increased access and transition. A performance monitoring plan with measurable indicators, based on next generation indicators and custom indicators, has been developed to track results under this IM. A summative evaluation is expected at the end of the project. No vehicle purchases envisaged.



Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	66,000
Gender: Reducing Violence and Coercion	88,000
Human Resources for Health	1,360,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

- Addressing male norms and behaviors
- Increasing gender equity in HIV/AIDS activities and services
- Child Survival Activities
- Safe Motherhood
- TB
- Family Planning

Budget Code Information

Mechanism ID:	10386		
Mechanism Name:	The Capacity Project		
Prime Partner Name:	IntraHealth International, Inc		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	539,169	0
Narrative:			
Under this budget code in COP12, The Capacity Project, through IntraHealth International, Inc. (IH) will			



continue to support roll-out of the the Ministry of Health and Social Services (MOHSS) bi-directional referral network developed in COP10 and 11 to ensure a continuum of care to and from the community and health facilities for people living with HIV/AIDS (PLWHA). Support includes on-job training and mentorship and will be monitored through review of referral registers and slips.

IH will ensure that local FBO sub-partners provide all adult PLWHA with high quality care and treatment to reduce morbidity and mortality.

IH will support the implementation of a chronic disease model for HIV care encompassing enrollment into care and treatment, screening, treatment and prophylaxis for opportunistic infections (OIs), psychosocial and adherence support, routine bio and clinical monitoring and follow up to ensure early initiation of ART according to national guidelines, nutritional assessment counseling and support (NACS) and positive health dignity and prevention (PHDP). To complement clinical care, IH will continue to support the implementation of spiritual counseling. Healthcare workers were trained to identify and refer patients requiring spiritual counseling and care to clergy who were also trained on the basic facts of HIV/AIDS and on providing non-discriminative support to PLWHA. PLWHA will be able to express their feelings and their spirituality in order to alleviate the psychological burden and, ultimately, to improve coping capabilities.

IH will continue to collaborate with the MoHSS, USG partners and the HIV Clinicians Society in facilitating palliative care management training for staff by covering travel and per diem expenses. Palliative care training will be integrated in the training curriculum of the National Health Training Center (NHTC).

NACS will continue to be strengthened through training, clinical mentorship, supportive supervision and kitchen corner initiatives. Assessments include weights, heights and MUAC (for pregnant women). Onandjokwe and Oshikuku district hospitals are amongst the supported pilot sites for the NACS. The kitchen corner is implemented in three FBOs and IH will extend it to three remaining sites, including equipment and training.

IH will support the integration of all its programs into existing facilities, through training and support, capacity building of the MoHSS/Regional Medical Team (RMT) through joint quarterly support visits and also support the integration of programs into the NHTC and Regional Health Training Centers. Facilities across the country implement policies and guidelines differently. IH will support the operationalization of care through training and dissemination of standards of practice (SOP).

Sustainability of all services and quality of care will be supported through technical assistance and mentoring of supervisors at national, RMT, and FBO to provide supportive supervision and monitoring



and evaluation, ensuring national guidelines are followed and local SOPs are developed.

IH will collaborate with the MoHSS to ensure partners implement the mother-to-mother activities to ensure mothers living with HIV are effectively linked to HIV care and treatment services.

Activities will be implemented in Rundu, Omusati, Oshikoto and Ohangwena Regions and at the national level.

Activities are linked to activities funded in MTCT, HVCT, CIRC, HTXS, PDTX, PDCS, HVSI and OHSS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	55,945	0

Narrative:

Under this budget code in COP12, The Capacity Project, through IntraHealth International, Inc. (IH) will work with its sub-partners to ensure continuation of routine pediatric care for HIV infected and affected children. Areas of focus will be strengthening early infant diagnosis for HIV exposed infants by DNA-PCR testing available in all faith-based hospitals; registration of HIV positive children into care; strengthening the follow up of pre-ART children; strengthening nutritional assessments counseling and support (NACS) screening for opportunistic infections (OI); provision of OI prophylaxis for eligible patients; and provision of psychological and spiritual support to children and their caregivers.

The close follow up of pre-ART patients will ensure the children will be initiated on ART as soon as they are eligible for treatment. IH will continue to promote and monitor integration of services that will support prompt management of co-morbidities, management of diarrheal diseases, tuberculosis (TB) and malaria. Integration of the services will be strengthened including primary health care for under-fives, maternity wards, maternal and child health, and inpatient and outpatient services.

Spiritual support will be strengthened through faith-based hospital (FBH) clergy services. IH will work with its sub-partners to strengthen adolescent prevention messages for those who visit the hospital for different services, as well as for positive health dignity and prevention and support groups through the prevention officers available in the sites. IH sub-partners will continue regular evaluation of HIV positive children through TB, malaria, CD4 and other tests. Linkages to community activities through the bi-directional referral system will be strengthened after being piloted during COP11.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
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Governance and Systems	HVSI	75,000	0
Narrative:			
<p>Under this budget code, The Capacity Project, through IntraHealth International, Inc. (IH)) will continue to support the national research, monitoring and evaluation (RM&E) partners to improve and strengthen their monitoring and evaluation (M&E) systems. IH will ensure that processes promote national ownership and national capacity development.</p> <p>IH will support RM&E to improve the electronic patient management system (ePMS) in faith-based and non-faith-based facilities in the country. To expand the knowledge in ePMS, IH will assist the Ministry of Health and Social Services (MoHSS) to train all national RM&E staff, and senior data clerks at the regional level on the system as facilitators. The MoHSS will update user and training manuals.</p> <p>During COP12, the MoHSS, with support from an IH consultant, will continue developing the national ePMS system based on the new uptake forms. As ART guidelines change from time to time, the electronic system and paper tools will also be revised. In collaboration with the MoHSS and the USG CDC, IH will support the updating of monthly reporting tools and systems for prevention of mother to child transmission and ART programs.</p> <p>IH will continue to support the development of the national M&E system by: attending quarterly MOHSS M&E committee meetings; contributing to the effectiveness and efficiency of the national internal review board; training sub-partner organizations on data quality, use and dissemination, and specific M&E skills; and aligning and integrating sub-partners data reporting requirement with MOHSS reporting systems (tools, channels).</p> <p>IH will assist the MoHSS to integrate sub-partners reporting for the National System for Program Monitoring (SPM) and continue strengthening collaboration between sub-partner organizations, the Regional Councils and the National M&E Office.</p> <p>IH will conduct an end-of-project evaluation to identify lessons for each of the program areas/key results areas. The evaluation will include document review and selected interviews with key informants and a field mission to relevant regions.</p> <p>Activities will be implemented in Rundu, Omusati, Oshikoto and Ohangwena Regions and at the national level.</p> <p>Activities are linked to activities funded in MTCT, HVCT, CIRC, HTXS, PDCS, HBHC, PDTX and OHSS.</p>			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and	OHSS	100,000	0



Systems			
Narrative:			
<p>Under this budget code, The Capacity Project, through IntraHealth International, Inc. (IH) will continue to support faith-based sub-partners and the HIV Clinician’s Society to address identified capacity challenges and to conduct final Organizational Capacity Assessments (OCA) to assess progress and phase-out activities.</p> <p>During COP11, IH conducted OCAs to identify gaps and the priority capacity areas for the three sub-partner FBOs and the HIV Clinician’s Society. These organizations need to be strengthened to enable them to operate independent of USG support. The tool assessed the following organizational capacity areas: 1) Purpose and planning; 2) Programs and services; 3) Governance and program management; 4) Organizational sustainability and integration planning; 5) Financial and operational management; 6) Human resources; 7) Monitoring, evaluation and reporting; and 8) Advocacy and networking. A comprehensive institutional strengthening plan (CISP) was developed after the OCA for each institution.</p> <p>IH will continue to be an active participant in the Ministry of Health and Social Services (MOHSS) Human Resource for Health (HRH) Technical Working Group (TWG) to identify solutions to absorb donor supported staff into the GRN. This will involve estimating workloads and finding innovative solutions to integrate HIV services into primary health care activities to increase the efficiency of service delivery while ensuring quality of care without losing critical data. The transition will be monitored by setting benchmarks and advocating for integrated data collection tools. Beginning in COP11 and continuing in COP12, IH is collaborating with the MoHSS and faith-based organizations to ensure the availability of data for HRH planning and management at the central, regional and facility level, while ensuring data security. IH will support the MoHSS to ensure that the Human Resource Information Management System (HRIMS) data are cleaned before uploading into the Oracle-based system at the Office of the Prime Minister. IH will build the needed capacity for the MOHSS at the national regional levels to ensure they are receiving and using HR reports to improve HR management and planning. The National Health Training Center and Health Professional Council through will continue to receive IH support to have quality data available for tracking training (pre-service and in-service) of student health professionals and registration/licensing of health professionals after training completion. IH will support building capacity of faith-based organizations and national partners systems to function independent of IH.</p> <p>IH, together with the MoHSS, faith-based partners and other stakeholder will continue conducting several operational studies/evaluations during the financial year. These will assist the various faith-based facilities, regional management teams, and the MoHSS to use evidence based approaches to assess and test different ways to deliver patient care, manage their staff and their facilities and gain critical information about the actual or potential results using qualitative and quantitative data credibly.</p> <p>Activities will be implemented in Rundu, Omusati, Oshikoto and Ohangwena Regions and at the national</p>			

level.

Activities are linked to activities funded in MTCT, HVCT, CIRC, HTXS, PDCS, HBHC, HVSI and PDTX.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	189,576	0

Narrative:

Activities under this budget code, through IntraHealth International, Inc. (IH), will support the MOHSS to operationalize the MC strategy, including provision of MC through approved mixed service delivery models.

The National Strategic Framework (NSF) has set ambitious targets for MC by 2015/16 - to circumcise 450,000 men and 167,000 male newborns. To meet these goals IH supported the Ministry of Health and Social Services (MOHSS) to develop a five year MC strategy and implementation plan during COP10. IH will continue to support the MOHSS to operationalize the MC strategy through the following activities: 1) Training of healthcare workers; 2) Quality assurance and support and supervisory visits; 3) MC campaigns; and 4) support of in-country (through implementation of a roster of MC providers on clinical consultant basis) and international volunteer programs and task shifting activities. IH will advocate for more sustainable training approaches including incorporation of MC in the University of Namibia and the National Health Training Center's curricula.

IH will, in conjunction with MOHSS and other USG partners, continue to build the capacity of its partners to offer medical MC as an element of the national prevention strategy and ensure provision of a full package which includes sexually transmitted infection screening and management, behavioral counseling, provider-initiated counseling and testing and condom promotion and distribution.

Traditional circumcisers conduct a significant number of circumcisions particularly in communities known to circumcise their male children. To ensure safe MC by traditional circumcisers, IH, in collaboration with the MOHSS and stakeholders, will support advocacy, communication, information and training of traditional circumcisers in areas such as infection control, biohazard waste disposal, messaging and monitoring and evaluation of these activities.

IH will continue to support local partners to use counseling and testing services as an entry point for medical MC services (information and education), with counselors referring clients as appropriate. All counselors will be trained to provide medical MC counseling as well as ensure referrals of male clients

testing HIV negative for medical MC services. In addition, the clients seeking medical MC services who test HIV positive will be referred to care and treatment in the same facility. Partners will be supported to ensure availability of Information Education and Communication (IEC) materials in HCT centers which provide information on MC.

IH will support its partners to create MC demand in their localities through community mobilization activities, use of local radios, involvement of community leaders, councilors and church leaders, and campaigns to increase the number of men demanding medical MC services. The number of people reached with MC messaging will be monitored routinely.

IH will support revision and implementation of the MC M&E systems, including training for the users. During the COP11, IH supported the partner organizations to integrate reporting for MC into the overall MOHSS system. During COP12, IH will continue supporting the training of staff in the data collection tools and electronic system.

Activities will be implemented in Rundu, Omusati, Oshikoto and Ohangwena Regions and at the national level.

Activities are linked to activities funded in MTCT, HVCT, CIRC, HTXS, PDTX, HBHC, HVSI and OHSS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	569,544	0

Narrative:

In COP11, IntraHealth International Inc. (IH) transitioned HIV counseling and testing (HCT) Quality Assurance (QA) to local partners as well as to the Ministry of Health and Social Services (MOHSS). During COP12, IH will continue providing limited technical assistance (TA) for HCT. Partner organizations and MOHSS Regional Management Team (RMT) staff will continue providing support for monitoring and evaluation (M&E) and QA to all the sites.

The performance improvement approach will continue to be utilized to ensure that local teams develop strategies or interventions to close gaps identified during these support visits.

IH will support partners to increase access to testing and encourage uptake of HCT while advocating for integration of New Start stand-alone centers into government funding. This includes scaling up outreach and mobile testing services to hard-to-reach communities (with focus on men and couples). Emphasis will be on positive yield and linking clients testing HIV positive to care and treatment services using a



bi-directional referral system. This includes referral for sexually transmitted infections, tuberculosis, male circumcision and alcohol.

IH, in collaboration with the MOHSS, will continue to support its partners to roll-out provider-initiated HCT (PICT) activities. During FY2010, only 30% of HCT clients in faith-based organizations (FBO) sites were reported as PITC.

Since the average out-patient visits per person in FBO districts are 0.5 to 1.0 there is a huge opportunity to ensure cost-effectiveness of PICT. The following activities will be undertaken to ensure success: District Coordinating Committees to sensitize, advocate, promote and coordinate PICT activities in their facilities; community awareness and demand creation for communities and out- and in-patients; provision of in-room testing; support whole team approach training of staff on PICT; ensure proper inventory control systems for rapid test kits and timely ordering from central medical stores; and quality assurance by the partners and supported by RMTs.

IH will continue supporting partners to implement couples HCT. During FY2010, only 12% of individuals counseled and tested in New Start Centers were tested as couples with variation between 10-25%.

IH will continue to support partners to develop and utilize strategies to increase uptake of counseling and testing services (e.g. promotional activities, special opening times for couples). Partners will conduct "male only" testing days to try and increase the uptake of HCT services by men.

During COP11, IH collaborated with the MOHSS to integrate M&E into the MOHSS' existing system in order to standardize the information for reporting purposes. The standalone New Start centers will move away from anonymous HIV testing to shared HIV testing and clients seeking HCT services will be handled the same way as in public health facilities. In addition, New Start centers will use the MOHSS HCT registers and report directly to the MOHSS on a monthly basis.

IH will continue supporting the MoHSS to ensure that data quality is not compromised and that partners continue to report on the MOHSS HCT data collection tools. IH will also continue supporting the training of staff in HCT paper tools and electronic systems.

Activities will be implemented in Rundu, Omusati, Oshikoto and Ohangwena Regions and at the national level.

Activities are linked to activities funded in MTCT, PDCS, CIRC, HTXS, PDTX, HB.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
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Prevention	MTCT	915,676	0
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Narrative:

Activities under this budget code, through IntraHealth International, Inc. (IH), will support the virtual elimination of mother to child transmission (eMTCT) by working through the Ministry of Health and Social Services (MOHSS) PMTCT Technical Working Group (TWG) to ensure implementation of the National eMTCT action plan. The plan focuses on strengthening prevention of HIV among women of reproductive age (prong one) and prevention of unintended pregnancies in women living with HIV (prong two) in addition to keeping mothers and their children alive. IH will collaborate with the MOHSS to strengthen synergies with existing programs for HIV, maternal, newborn and child health (MNCH) and family planning FP). Using the performance improvement approach, IH will support its partners to identify existing gaps in the eMTCT, including poor partner testing, and develop interventions to close these gaps. IH will contribute to the revision and finalization of PMTCT guidelines, possibly adopting option B+.

IH will support community systems strengthening to achieve virtual eMTCT. This includes leveraging funding from other donors to increase geographic coverage of the mother-to-mother (M2M) project. IH will collaborate closely with the MOHSS Directorate of Primary Health Care for this activity. In addition to providing peer support, M2M will ensure HIV positive mothers are more informed about a number of pertinent issues including MTCT, infant feeding, and the importance of adhering to treatment/prophylaxis in order to eliminate MTCT.

Activities will support the national eMTCT plan by focusing on gaps identified in prong one and two. IH will support partners to make sure that all pregnant women who tested negative receive HIV prevention packages and strengthen the HIV retest in the last trimester including male involvement.

IH, in collaboration with the MOHSS and the University of Namibia will facilitate a short course on the training of midwives on emergency obstetric care (EMOC) and neonatal resuscitation. IH will build on the training of trainers conducted by the MOHSS and WHO in COP10 and make sure all midwives at the clinic and health center level are trained.

Integrating FP, PMTCT, HCT, ART and MNCH: The majority of clients accessing PMTCT, HCT and ART services in all the faith based hospitals are women. This creates a huge opportunity to reach these clients with FP messaging and commodities on site. FP messaging that is sensitive to the teachings of the Catholic Church will be developed and implemented.

IH will support partners to strengthen the tracking system for HIV exposed babies using a unique identifier. Tracking of these babies and testing them at six weeks or soon after would enable early



identification of HIV+ babies and early treatment to improve their survival.

PMTCT data is currently being collected through the health information system and reported through the district and regions. At the district level PMTCT data is entered into a computerized database and forwarded to the regional and national levels.

In COP11, IH supported the MOHSS to integrate data collection for EMOC into the overall MoHSS system. During COP12, IH will continue supporting the training of staff in the revised data collection tools and system.

Activities will be implemented in Rundu, Omusati, Oshikoto and Ohangwena Regions and at the national level.

Activities are linked to activities funded in HVCT, PDCS, CIRC, HTXS, PDTX, HBHC, HVSI and OHSS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	899,145	0

Narrative:

Under this budget code in COP12, The Capacity Project, through IntraHealth International, Inc. (IH) will improve quality of life for people living with HIV/AIDS by continuing support of integrated and comprehensive HIV care and treatment services for adults in hospitals, health centers and outreach services. The strategy will focus on capacity building of sub-partner organizations to implement and sustain quality HIV treatment services for adult patients. Through mentorship, in-service and on-the-job training, IH will ensure adherence to the national ART guidelines and maintain high quality of care for patients on ART. By the end of COP 12, IH expects the program will be under the leadership of the Ministry of Health and Social Services (MOHSS).

IH will support the expansion of outlets offering ARV services, through outreach and integrated management of adult & adolescent illnesses (IMAI). Under MOHSS support, faith-based hospitals (FBH) will continue expanding outreach services and support staff at these facilities. A total of 20-25 registered nurses (RN) will be trained in IMAI in COP12. Training for health professionals on IMAI is already integrated into the MOHSS system.

IH will work with sub-partners to ensure family-centered approaches for same-day-visits for all family members. This approach will reduce the cost and inconvenience of multiple trips as well as facilitate disclosure and family support.

IH will support training cadres in collaboration with the HIV Clinicians Society, MoHSS and I-TECH. The HIV Clinicians Society will be supported to train through both didactic courses as well as quarterly continuing professional development meetings. Training for doctors, nurses and other health staff on ART, which is already integrated into the MoHSS system, will continue under the leadership and support from the MOHSS.

IH will participate on technical advisory committees, contributing to the development and updates of national guidelines and support development of standards of practice to improve implementation consistency. IH will conduct joint mentoring and supportive supervisory visits with MOHSS staff.

IH will continue providing technical assistance to support the MOHSS and partners in the implementation of the electronic patient management system (ePMS) throughout the country. During COP11, IH focused on building the key competencies of the MOHSS Research, Monitoring and Evaluation (RM&E) sub-division to use, modify and manage the ePMS and support the training for the revised monitoring tools for ART. Support was also provided to developing the user manual and other program specification documents. IH will continue support to the MOHSS in ePMS implementation, especially monitoring the transition of monitoring and evaluation (M&E) staff and integration of sub-partners M&E into the MOHSS. Support will also be provided to train the RM&E staff, senior data clerks, data clerks, doctors and nurses on the updated ePMS version and ART tools and to ensure that the training material is available for future use. To ensure country ownership, IH will also continue to train IT staff from the RM&E division on ePMS program skills to enable the RM&E division to make any future system changes required by the program.

Activities will be implemented in Rundu, Omusati, Oshikoto and Ohangwena Regions and at the national level.

Activities are linked to MTCT, HVCT, CIRC, HTXS, PDTX, HBHC, HVSI and OHSS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	55,945	0

Narrative:

Under this budget code, The Capacity Project, through IntraHealth International, Inc. (IH) will continue to support the Ministry of Health and Social Services (MOHSS) through membership on the Technical Advisory Committee (TAC) for national pediatric care and treatment updates. IH participates in national



trainings offered by the National Health Training Center (NHTC) and serves as facilitators with I-TECH trainers. IH also provides in-service training for staff on updated guidelines during the supervisory and mentorship visits. Additionally, IH sits on the Maternal and Child Health Task Force in the Directorate of Primary Health care to ensure that pediatric HIV services are fully integrated into all child survival programming.

It is important to strengthen linkages of pediatric ART in-patient and out-patient services, primary health clinics and prevention of mother to child transmission (PMTCT) clinics and support efforts to integrate dried blood spot and maternal child health (MCH) services. Integration of these services will promote opportunities for pediatric treatment, minimize defaulting and decrease missed follow-up visits for infants.

IH will support and facilitate training of nurses, doctors and counselors in child and adolescent counseling skills for the faith-based hospitals, as many HIV positive children enrolled into care and treatment since the beginning of the ART program are now adolescents. Health workers need to be empowered to handle disclosure issues for children and adolescence as some of them will start asking questions about their status and may become sexually active, necessitating the importance to disclose their HIV status.

Facilities across the country implement policies and guidelines differently. IH will support the operationalization of treatment in partner faith-based facilities through training and dissemination of standards of practice. Analysis of cohort studies and electronic patient management system (ePMS) reports will enhance the quality of clinical services and in-time referral for laboratory investigation to detect treatment failure and its causes (adherence, drug resistance). IH will strengthen the sub-partners' staff at their facilities and community-based activities with the bi-directional referral system, piloted during COP11.

IH will continue to mentor and build the capacity of staff to independently conduct supportive supervision using a structured tool. This will improve the probability of sustainability while ensuring adherence to national guidelines. As the program is transitioned to the leadership of the MOHSS, IH will participate in support visit with the MOHSS (National and Regional Management Teams) and provide them with feed-back for smooth transition. Local management teams will conduct in-service training for the staff in these departments.

Activities will be implemented in Rundu, Omusati, Oshikoto and Ohangwena regions and at the national level.

Activities are linked to activities funded in MTCT, HVCT, CIRC, HTXS, PDCS, HBHC, HVSI and OHSS.



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Implementing Mechanism Details

Mechanism ID: 10389	Mechanism Name: Systems to Improve Access to Pharmaceuticals and Services
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,223,077	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	2,223,077

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Systems for Improved Access to Pharmaceuticals and Services (SIAPS) is a follow-on project to Strengthening Pharmaceutical Systems. The project is implemented by Management Sciences for Health (MSH) in Namibia. SIAPS builds the capacity of the Ministry of Health and Social Services (MOHSS) of the Government of Namibia (GRN) and other local institutions to manage pharmaceutical systems and service delivery of HIV/AIDS commodities in all regions of Namibia. The project contributes to three strategic areas of the Partnership Framework (PF) in all regions of the country: governance, systems strengthening and care and treatment, specifically addressing antimicrobial resistance, access to medicines, and the appropriate use of medicines.

SIAPS advocates for the absorption of technical staff seconded to MOHSS to reduce costs. In addition the project shares operational costs, leverages synergies of other mechanisms managed by MSH in Namibia and encourages MOHSS to co-fund selected interventions to be more cost-effective. SIAPS will focus on institutional leadership to strengthen local ownership and mentor relevant staff. These steps will be strategies for transition. In this regard, SIAPS is in line with USAID GHI strategic focus on transition as



well as improving access.

In order to strengthen monitoring and evaluation systems SIAPS has developed measurable indicators which have been used to track the progress of the project. SIAPS will monitor data quality assurance and outcomes and document case studies and success stories which will be disseminated. An end-of-project evaluation will also be conducted.

No vehicle purchases envisaged.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	555,800
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TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	10389		
Mechanism Name:	Systems to Improve Access to Pharmaceuticals and Services		
Prime Partner Name:	Management Sciences for Health		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and	HVSI	164,500	0



Systems			
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Narrative:

This is a continuing activity of the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) project, implemented by Management Sciences for Health (MSH) aimed at supporting program monitoring and data quality through improved an electronic dispensing tool (EDT), Pharmacy Management Information System (PMIS), and the data quality of the information from these systems. This intervention will strengthen pharmaceutical care services by supporting evidence-based decision making, and therefore cost effective and sustainable ART delivery.

With COP12 funding, SIAPS will also continue to promote operational research that will advance and sustain best practices and successful pharmaceutical management interventions deployed during the life of the predecessor project in Namibia, as well as support the dissemination of results and the adoption of best practices.

SIAPS will continue to support the integration and harmonization of the EDT data into the planned integrated health management system of the Ministry of Health and Social Services (MOHSS) as well as strengthen linkages between the EDT and ePMS data systems for ART monitoring. In addition, SIAPS will strengthen the capacity of the MoHSS to use and disseminate data and operational research activities to enhance evidence-based decision making and strategic planning in pharmaceutical management. SIAPS will support the Pharmacy Management Information System (PMIS) through review, upgrades, staff training, analysis and utilization of PMIS data for policy and management decisions.

The geographic coverage of this activity is national including all the 13 regions of Namibia.

This activity is linked to activities under HTXS, PDTX, and OHSS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	444,159	0

Narrative:

This continuing activity of the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) project, implemented by Management Sciences for Health (MSH) will continue providing technical assistance to the Namibia Medicines Regulatory Council (NMRC) and the Pharmacy Council to be effective as well as cost efficient in monitoring the quality, safety and effectiveness of medicines and ensure competent personnel to provide pharmaceutical services.



A strengthened NMRC and Pharmacy Council will contribute towards enhanced quality and availability of ART, tuberculosis and other essential medicines and services in Namibia. SIAPS will also support the Ministry of Health and Social Services (MOHSS) Division of Pharmaceutical services in monitoring and evaluating implementation of the National Pharmaceutical Master Plan (NPMP) in order to ensure sustainability of ART and other essential public health programs.

Support will be provided for the monitoring of the implementation of the NPMP through technical assistance, advocacy and supportive supervision visit. In addition, SIAPS will Support the NMRC and HIV and tuberculosis treatment programs to utilize evidence generated from the Therapeutic Information Pharmaco-Vigilance Center (TIPC) and post marketing surveillance in the implementation of quality assurance and risk management strategies that mitigate sub-optimal patient adherence and poor treatment outcomes through technical assistance and training.

SIAPS will strengthen governance through support to the Pharmacy Council of the Health Professions Councils of Namibia to develop and implement standards for professional licensure, pharmacy practice and accreditation of pharmaceutical service providers in Namibia.

The geographic coverage of this activity is national including all the 13 regions of Namibia.

This activity is linked to activities under HVSI, PDTX and OHSS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,267,554	0

Narrative:

This is a continuing activity of the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) project, implemented by Management Sciences for Health (MSH) to support initiatives for increasing ART coverage in both the public and private sectors and facilitate engagement of the private sector in ART service delivery.

Using COP12 funding, SIAPS will work with the Ministry of Health and Social Services (MOHSS) to build on previous achievements and consolidate and hand-over mature activities to the MOHSS.

SIAPS will support the revision and roll-out of adherence interventions (treatment literacy materials, routine adherence monitoring tools) and implementation and monitoring of the essential medicines list (NEMlist) that was fully transitioned over to the MOHSS in 2010, standard treatment guidelines that were handed over to MOHSS in 2011, and the guideline technical committees. The transition of these activities has been accomplished, and in COP12 SIAPS will focus on ensuring the long term sustainability of the transitioned activities and develop/strengthen sustainability indicators (metrics) to monitor performance of the pharmaceutical services (development, dissemination, implementation, compliance monitoring and systems for revisions).

Support will also be provided to the monitoring of Antimicrobial Resistance (AMR) and strengthening the



monitoring of interventions for HIV drug resistance (HIVDR) including analysis and use of early warning indicators (EWI). This includes strengthening the MOHSS Response, Monitoring and Evaluation Unit (RM&E) to improve the quality of data to ensure better monitoring of patient outcomes.

SIAPS will strengthen human resource capacity and systems for the delivery of sustainable pharmaceutical services that support ART service delivery (focusing on in-service and pre-service training of staff on new pharmaceutical management guidelines).

Activities will support public-private partnerships for better pharmaceutical service delivery by enhancing availability of Standard Treatment Guidelines and continuing professional development in the private sector through the Health Professions Council and The University of Namibia and by strengthening data collection of adverse events to medicines. The capacity of the University of Namibia, School of Medicine/Pharmacy Department and the MOHSS to conduct pharmaceutical related operational research through INRUD/Namibia Chapter will be strengthened. This activity will be transitioned to the University of Namibia and the Health Professions Council.

The geographic coverage of this activity is national including all the 13 regions of Namibia.

This activity is linked to activities under HVSI, PDTX and OHSS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	346,864	0

Narrative:

This continuing activity of the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) project, implemented by Management Sciences for Health (MSH) will focus on ensuring adherence to ART in pediatrics, which is often complicated by several factors. These include inadequate tools for monitoring pediatric adherence and the often low treatment literacy levels of caregivers who may make errors in the administration of medicines to children and who may not fully appreciate the need to adhere to prescribed treatment and dosing schedules.

With COP12 funding, SIAPS will continue to provide support for information, education and communication material to promote pediatric adherence. SIAPS will continue supporting the development of models of care that enable adequate management and follow-up of pediatric ART cases by improving data collection and analysis to inform interventions that will improve adherence and treatment outcomes among children. SIAPS will leverage the use of the electronic dispensing tool (EDT), to collect and analyze pediatric ART data that will inform improvement of treatment services for HIV infected children. Support will be provided to sites in reviewing gender disaggregated pediatric ART data to identify hard-to-reach pediatrics with increased focus on adolescents in need of and on ART in their catchment areas to ensure optimum health outcomes through technical assistance, training, equipment and EDT



support.

In addition, SIAPS will support implementation of adherence interventions in children and strengthen national capacity for delivery and monitoring of pediatric ART services through technical assistance, training and data analysis.

The geographic coverage of this activity is national including all the 13 regions of Namibia and will focus on the district hospitals which cover more than 90% of the pediatric clients on ART.

This activity is linked to activities under HVSI, PDTX and OHSS.

Implementing Mechanism Details

Mechanism ID: 10397	Mechanism Name: Tuberculosis Assistance Control Program (TB Care)
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: KNCV Tuberculosis Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,000,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	1,000,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Through the Royal Netherland Tuberculosis Association (KNCV), TB Care I provides technical support to the National TB and Leprosy Control Program (NTLP) to strengthen its capacity to address the TB/HIV burden in Namibia. The project goals are to accelerate early TB case detection and treatment success rates to achieve national targets of 70% and 87% respectively. The implementing mechanism (IM) supports the expansion of community TB care; prevention and treatment of drug-resistant TB; scale-up of TB/HIV collaborative activities and health system strengthening.



KNCV promotes sustainability and builds capacity of local staff in order to phase out external technical advisors. The IM improves cost-efficiency by using a TA model rather than service delivery. The IM co-locates project staff with the MOHSS; provides supervision and mentoring; and supports existing government structures for TB/HIV care.

KNCV collaborates closely with the Global Fund to ensure technical and financial assistance to NTLP is optimally organized. The IM is also engaged in the quarterly TB National Steering Committee meetings at which key stakeholders map national TA needs.

In addition to being in line with the NTLP strategic plan, the IM supports USAID Namibia's GHI strategy to: 1) Increase access to services; and 2) Help transition inherent government responsibilities, including funding for the community activities.

TB CARE I has an extensive monitoring and evaluation system to track the implementation of activities. KNCV does not operate separate M&E systems, but contributes towards strengthening the existing system. As a result, NTLP has been able to produce comprehensive annual reports for the past four years reflecting all its achievements.

No vehicle purchases are envisaged.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **No**

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000
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TBD Details

(No data provided.)

Motor Vehicles Details

N/A



Key Issues

Impact/End-of-Program Evaluation
 Child Survival Activities
 TB

Budget Code Information

Mechanism ID: 10397			
Mechanism Name: Tuberculosis Assistance Control Program (TB Care)			
Prime Partner Name: KNCV Tuberculosis Foundation			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	1,000,000	0

Narrative:

USG support will continue through KNCV TB Foundation using a TA model of knowledge and capacity transfer. KNCV support to the MOHSS and CSO is coordinated by the MOHSS National TB and Leprosy Program. Identifications of priority areas for support are aligned with the national strategic plans for TB and HIV. In line with the GHI strategy, KNCV does not support human resources for service-delivery to conduct TB activities. The NTLP is being prepared for gradual transition of current resident technical advisors.

TB/HIV care and treatment: In FY13, KNCV will continue to strengthen the implementation of TB/HIV collaborative activities with particular focus on the 3 I's. KNCV will support the MOHSS and its partners to improve early identification of TB in HIV infected individuals using the five question screening tool. TB screening will be expanded to ante-natal clinics (ANC) in addition to the pre-ART clinics to eliminate missed opportunities. The USG HIVQUAL program will be critical to this intervention. Intensified case-finding strategies will include the community to address gender inequalities for children and women in particular.

Provider-initiated counseling and testing (PICT) for HIV in TB patients remains a focus area and KNCV will increase HIV testing in TB patients currently at 76%. Given the low coverage of ART in TB patients early initiation of ART in line with the revised national guidelines will be key focus area under this component. KNCV will engage local care providers to develop the best modalities for the implementation



of IPT given the high Isoniazid resistance rate. KNCV will also provide support to operational research on aspects related to TB/HIV.

Programmatic management of drug resistant TB (PMDT): KNCV will continue to strengthen the implementation of the PMDT in the designated treatment centers. Early TB diagnosis using the standard diagnostic tools as well as rapid molecular diagnosis for drug resistant (DR) TB will be promoted and implemented in high burden areas for both HIV and Multi Drug resistant TB. KNCV will continue to support the MOHSS with its efforts to reduce Extreme Drug Resistant TB. KNCV will continue to support quarterly review meetings to strengthen surveillance of DR TB and to update the monitoring tools.

Health system strengthening: Health care workers will be trained on the revised TB guidelines. KNCV will also support the MOHSS to strengthen TB/HIV coordination in poor performing regions through tailor-made support. KNCV will continue its mentoring activities to MOHSS officials coordinating TB/HIV activities at the national and regional level to strengthen their capacity to support the implementation level. Limited support will be provided to national and regional level NTCP staff to enhance their program management capacity and skills.

TB Care and Treatment: KNCV will continue its support to community TB care in the Erongo and Karas regions respectively. Support will also contribute towards activities for the commemoration of the World TB day. Under this component USG support will contribute towards the lifestyle ambassadors' quarterly meetings for the TB Communication for Behavior Change Intervention (COMBI). Training of field promoters will also be supported under this activity. KNCV will support surveillance and monitoring activities related to TB care and treatment, including CSO.

Implementing Mechanism Details

Mechanism ID: 10780	Mechanism Name: Cooperative Agreement 1U58PS001452
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Washington	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	



G2G: N/A	Managing Agency: N/A
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Total Funding: 600,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	600,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism has four objectives: Strengthen professional development and support; strengthen content and delivery of the MPH program; improve research capacity and output of lecturers and students, and; strengthen sustainable institutional capacity and infrastructure for teaching public health. Strengthening UNAM’s capacity to train students in public health science, leadership and program management will contribute to GHI country ownership goals, and allow USG programs to increasingly hand-off program management and M&E responsibilities to local partners. UNAM trains students from all 13 regions. Most graduates serve in the public healthcare sector nationwide. I-TECH and UNAM have developed a transition plan and are establishing a Transition Technical Working Group to implement and monitor transition activities. Several staff positions previously funded through I-TECH have been absorbed by UNAM. Supporting public health education at UNAM will reduce the financial burden on MOHSS to fund bursaries for students to study abroad. Investment in the public education sector will also support the career ladder for faculty and staff, and contribute to the retention of Namibian instructors. This mechanism promotes cost-effective approaches including e-learning technologies, guest-lecturing, mentorship, and twinning with regional universities. The use of electronic journals has reduced costs for importing text books. ITECH submits an annual work plan aligned with national M&E indicators and targets.

Cross-Cutting Budget Attribution(s)

Education	500,000
Human Resources for Health	100,000

TBD Details

(No data provided.)



Motor Vehicles Details

N/A

Key Issues

- Malaria (PMI)
- Child Survival Activities
- Safe Motherhood
- TB
- Family Planning

Budget Code Information

Mechanism ID: 10780			
Mechanism Name: Cooperative Agreement 1U58PS001452			
Prime Partner Name: University of Washington			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	600,000	0
Narrative:			
<p>COP12 funds will support activities to strengthen five areas of graduate-level public health education in Namibia. These activities have been developed with the University of Namibia (UNAM) Faculty of Nursing and Public Health, and are guided by the UNAM Public Health Working Group (PHWG), consisting of the Dean, public health lecturers, and ITECH staff.</p> <p>Promote sustainability and transfer of knowledge and financial assets by the end of five years. The PHWG will continue to ensure grant deliverables are met and implement a multi-phase, multi-year strategic plan for MPH program expansion and specialization. A key component is ongoing planning for the transition process which involves the absorption of programming staff and the creation of an operational plan for implementing strategic plan priorities.</p> <p>Strengthen Professional Development and Support: COP12 activities will strengthen the professional</p>			



development and support for lecturers' teaching and student supervision capacity. The PHWG will establish a taskforce to identify, plan, and implement relevant activities, including financial absorption by UNAM of Faculty Development Workshops and twinning and exchange opportunities with other universities.

Strengthen content and delivery of the MPH program: Activities will strengthen and build content in nutrition, strategic information, health service planning and management, environmental health, primary health care and other key content needs identified during strategic planning. Additionally, the PHWG will lead efforts to begin a formal curriculum review process to review potential specialized tracks for the future. Technical assistance will be provided to assist lectures in adopting new teaching methodologies such as problem based teaching and distance learning.

Improve research capacity and output of lecturers and students: COP12 funds will support activities to promote a research culture within UNAM and to facilitate on-going research and publication activities. A TOT for lecturers on research and thesis development will increase lecturers' capacity to teach research skills and reinforce existing skills. A Thesis Workshop will be institutionalized and taught to incoming students. ITECH will also support UNAM to lead, plan, and evaluate students' thesis progress activities and develop supportive research materials as required. Lastly, ITECH will support the PHGW to establish an Ethics Review Committee and to plan for subscriptions to external medical libraries.

Strengthen institutional capacity and infrastructure for teaching public health: Activities will support improvement of structures, processes, policies, procedures and resources that are required to ensure the effective running of the MPH program. This includes planning for the development of a Quality Assurance Plan; relevant skills-building; and support for administrative functions for students and the procurement of training materials and equipment.

Implementing Mechanism Details

Mechanism ID: 11572	Mechanism Name: US Centers for Disease Control and Prevention
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention (HHS/CDC)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	



G2G: N/A	Managing Agency: N/A
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Total Funding: 896,253	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	896,253

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism supports technical assistance projects implemented by CDC technical and administrative staff based in Namibia and in Atlanta. CDC’s Global AIDS Program office in Namibia provides direct technical assistance and capacity building to technical and administrative partners within the MOHSS, the Namibia Institute of Pathology, local training institutions, and local NGOs. This direct TA contributes to the continuum of care, access to services and transition objectives described in the PF and GHI Strategy for Namibia. CDC Namibia has offices in Windhoek and Oshakati, Namibia. From these two sites, CDC technical and administrative staff may provide technical assistance to all 13 regions. CDC is committed to a technical assistance model that focuses on direct support to the Ministry of Health and Social Services and other partners directly involved in human capacity development, biomedical prevention, and community-based activities that provide HIV counseling and testing and link HIV-infected patients to ART services, or contribute to TB case finding and drug adherence. CDC is heavily engaged in the USG-GRN HRH technical working group and has successfully shifted away from direct salary support for medical officers. CDC technical advisors will remain involved in transition planning for HRH, commodities and other programmatic activities. Providing direct financial and technical assistance to the MOHSS is less costly than providing similar support via US-based implementing partners. CDC technical assistance contributions are linked to MOHSS and other partner work plans, which are monitored and evaluated by PEPFAR, the GRN, and often, other donors (e.g., Global Fund, WHO).

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)



Motor Vehicles Details

N/A

Key Issues

- Addressing male norms and behaviors
- Impact/End-of-Program Evaluation
- Increasing gender equity in HIV/AIDS activities and services
- Child Survival Activities
- Mobile Population
- Safe Motherhood
- TB
- Family Planning

Budget Code Information

Mechanism ID:	11572		
Mechanism Name:	US Centers for Disease Control and Prevention		
Prime Partner Name:	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention (HHS/CDC)		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	589,798	0
Narrative:			
<p>In her November 8, 2011 address to NIH, Secretary Clinton laid out a strategy for a combination prevention of HIV based on preventing mother to child transmission (PMTCT), expanding voluntary male circumcision (VMC), and scaling up antiretroviral (ARV) programs. The secretary noted that this strategy will rely on strong health systems and country ownership. When national and sub-national health departments take ownership of health strategies and participate in their design and management success is more likely.</p>			



Secretary Clinton signaled a broad global interest in strengthening health systems. Yet there is still a lack of consensus of how best to measure the impact of such efforts. Several of the largest multilateral health donors and technical agencies (World Bank, GFATM, GAVI, and WHO) have recently committed to developing a common funding platform for HSS, associated with a common approach to measuring the impacts of HSS. USG and PEPFAR have not been partners in the actual common HSS funding platform per se, but in recent months have committed to participate in the development and use of a global set of metrics for HSS that would be adopted by those organizations and by PEPFAR. Discussions with those partners in the summer 2010 led to the concept that an especially useful role for PEPFAR in this process would be in assisting countries with the implementation of emerging HSS indicators and related processes. This project will help CDC Namibia monitor and evaluate the impact of its investments in health systems strengthening, which currently account for more than 40% of the annual COP budget.

Funds in this area will support technical assistance (TA) for data collection, a quality audit, analysis, and validation of priority health systems strengthening indicators. Deliverables from this TA will include: Reports, scientific manuscripts, and revised or adapted protocols, which will be produced in collaboration with technical staff from the CDC Namibia office. This collaboration will build local capacity to conduct future health systems evaluations, and to use health systems metrics for ongoing monitoring and evaluation. This technical assistance (from CDC Atlanta and an expert partner to be selected by Atlanta) will contribute evidence to inform a mutual understanding by the USG and GRN of emerging concepts such as “country ownership” and sustainability.

CDC will also support technical assistance for the MoHSS to conduct analyses for epidemic and lab systems strengthening, including;

Epidemic modeling to estimate the relative impact of prevention interventions on incidence: Given the new information on the prevention impact of treatment from HPTN 052, Namibia may have better insight into the impact of its programs where treatment has reached coverage of 80% and has also seen a decline in incidence. This activity would collect retrospective data and work closely with the government of Namibia to build capacity to conduct epidemic modeling to better understand the dynamics of the epidemic.

Measuring the impact of lab system strengthening : Focus to include assessment of impact of MEDITECH (LIS), HRH, Equipment and other commodities on LSS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	150,000	0

Narrative:



To support the MOHSS strategy of identifying new HIV infections and rapidly referring infected patients to ART services, the MOHSS is shifting focus to increase efforts to identify sero-discordant couples. CDC will facilitate the identification of a specialist partner from the southern African region (either Zambia (ZEHRP) or Rwanda (PSF)) to provide south-to-south technical assistance to the MOHSS on couples HCT. This TA will consist of training of HCT service providers and promoters, follow up support visits, extended TDY support from the TA providers to establish implementing sites, ensuring quality and M&E. An exchange visit for Namibian staff to visit Zambia or Rwanda to learn from their programs is envisaged.

Support for south-to-south Technical Assistance will play an increasingly important role in CDC Namibia's sustainability strategy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	156,455	0

Narrative:

PMTCT is one of PEPFAR Namibia's most important points of engagement with the Primary Healthcare Directorate. As such, PMTCT will play an increasingly important role in PEPFAR Namibia's work to expand the impact of PEPFAR investments to primary healthcare objectives described in the Namibia GHI Strategy. For instance, PEPFAR investments in PMTCT continue to have positive ripple effects on the integration of and access to non-HIV services offered in antenatal clinics and on task-shifting for nurses who are implementing the government's IMA/IMCI strategy.

Therefore these funds contribute to the expansion of support and technical assistance for PMTCT services within the regions. In addition, efforts will be made to enhance integration with primary health care to strengthen maternal-child health care. Support will include technical assistance, supervisory visits, equipment, supplies and office running costs, especially for CDC's field-based work in northern Namibia.

Implementing Mechanism Details

Mechanism ID: 12705	Mechanism Name: Cooperative Agreement 1U2GPS001094
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health and Social Services, Namibia	



Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 19,377,769	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	19,377,769

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism supports USG and GRN contributions in the PF and GHI strategy. The MOHSS has a mandate to manage and coordinate the national HIV/AIDS response in accordance with the strategies outlined in the 2010 NSF. Direct funding to this partner, a government institution, emphasizes strengthening GRN capacity and ownership of the HIV response. This mechanism is designed to support activities with a national scope. Support to the MOHSS is designed to contribute to systems strengthening and human capacity development throughout the public health care sector. This support in turn benefits Namibians who access care nationwide. Direct support strengthens MOHSS’s ability to plan, implement, monitor and evaluate strategies within and beyond the national HIV/AIDS response. Over time, MOHSS will identify activities that may be absorbed completely by the GRN, that require continuing technical assistance from the USG, or that could be terminated, e.g., in COP12 the USG will cease funding for ARV drugs. The transition of other commodities is also under discussion. Within the public healthcare system, services are increasingly coordinated and integrated at the facility level. This mechanism contributes to efforts to improve the capacity of MOHSS to recruit and retain Namibian staff. USG support for training supports a sustainable pool of healthcare workers; point-of-care testing and other new lab technologies will reduce per-test costs and reduce the Ministry’s dependence on NIP for bio-clinical monitoring. The MOHSS’s work plan is based on PEPFAR indicators and targets in the NSF and PF. National M&E systems are used to generate data for PEPFAR, GF and national reporting requirements.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**



- 2. Is this partner also a Global Fund principal or sub-recipient? **Principal Recipient**
- 3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
CIRC	MOHSS	200000	Salary support for key technical staff (e.g., MC and National Prevention Coordinators) helps improve communication between MOHSS departments that receive funding from USG and GF.
HVSI	Response M&E Unit	100000	Revision and updating the National Strategic Framework for HIV/AIDS will improve coordinated planning between USG and GF by providing harmonized indicators and targets.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	150,000
Food and Nutrition: Policy, Tools, and Service Delivery	650,000
Human Resources for Health	4,500,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors



Impact/End-of-Program Evaluation
 Increasing gender equity in HIV/AIDS activities and services
 Malaria (PMI)
 Child Survival Activities
 Mobile Population
 Safe Motherhood
 TB
 Family Planning

Budget Code Information

Mechanism ID: 12705			
Mechanism Name: Cooperative Agreement 1U2GPS001094			
Prime Partner Name: Ministry of Health and Social Services, Namibia			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	358,750	0

Narrative:

Funding under this activity supports the procurement of equipment for HIV-related clinical care, including tools to improve clinical monitoring. To address barriers to proper care of HIV-infected women, equipment has, and will continue to be, procured to improve gynecological screening and care of HIV-positive women to more adequately address HIV-related conditions such as cervical dysplasia and reproductive tract infections.

Funds will be used to replace outdated equipment (e.g, scales, and exam tables) in existing Integrated Management of Adolescent and Adult Illnesses (IMAI) sites and procure new equipment for new sites in the IMAI network. Funding will also support printing of IMAI patient cards and files.

The procurement of new equipment will also support the national task-shifting initiative, which is central to the success of the IMAI strategy. Taking on tasks previously provided by physicians, nurses will increasingly provide palliative care, including screening and treatment for minor OI, Nutrition assessments and management. Nurses will also manage pre-ART and stable ART clients who have completed their first six months of ART without incident. They will provide appropriate referrals and linkages with community-based Health Care (CBHC) organizations.



The 2010 HIV treatment guidelines recommend baseline and routine annual cervical cancer screening for all HIV infected adult women. With the scale up of this activity facilities will need to be equipped with the tools such as speculums, slides, lamps, cervico-brushes, and other equipment necessary for pap smears. Onsite training will train providers in pap smear specimen collection, preservation and logistics for transport to the laboratory for analysis. The referral system for management of patients found to have abnormal results will also be refined. An implementation plan for the national roll out of this initiative will be supported. The capacity to deal with abnormal pap smear results will also be strengthened. In COP12, PEPFAR support to the MOHSS for cervical cancer prevention and treatment within HIV programs will include support for an assessment of the country's needs and readiness for a broader cervical cancer prevention program and treatment program. The activities will also focus on refinement of policies and protocols, IEC materials, printing and distribution of these tools for the scale up of cervical cancer prevention activities among HIV infected women.

Continued support to MOHSS for cervical cancer screening is another example of PEPFAR Namibia's support for the integration of HIV/AIDS services with the primary healthcare system. This funding will contribute to the access objectives described in the Namibia GHI strategy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	2,067,326	0

Narrative:

Community Counselors: Funding for the Community Counselor (CC) program is distributed among six activity areas: Other Prevention (20%), Counseling and Testing (45%), Preventing Mother to Child Transmission (15%), and Adult Treatment (10%). Facility-based CC provide HIV counseling and testing (HCT); adherence, prevention, and male circumcision counseling; and provide referral services.

Procurement of HIV Test Kits and Supplies for TB patients and suspects: The Ministry of Health and Social Services (MOHSS) will continue to purchase Determine and Unigold HIV test kits (using a parallel testing algorithm) for approximately 50,000 TB patients and suspects at 250 MOHSS facilities; ELISA or a MOHSS-approved rapid test device for tie-breaker re-testing in cases of discordance; HIV rapid test starter packs to launch new testing sites, and rapid HIV test supplies for training CC. These kits and supplies will be procured and distributed by the MOHSS Central Medical Stores.

Support TBHIV program contribution to bio-clinical monitoring costs.

Support for the programmatic management of Drug Resistance TB: including intensified DR TB case findings, contact tracing, strengthening specimens collection and referral systems, There are over 372 cases of drug resistant TB cases in Namibia, including 23 Extensively Drug Resistant (XDR) TB.

Namibia Institute of Pathology (NIP) will continue to provide diagnostic support to MOHSS for aggressive DR TB case finding through C/DST and rapid molecular test of all at risk patients including (HIV positive



patients, previously treated patients and DR contacts).
 Support the Electronic TB Register (ETR) and TB Surveillance Systems: MOHSS will expand TB surveillance system with technical assistance from CDC .
 Support to the TB program midterm review as well as support infection control and support to the Community TB care and community TB promoters is integrated into COP12.
 Development and implementation for integrated service delivery model for TB HIV: USG will support development, implementation and evaluation of a service integration model for TB HIV services. Funding will cover TA, baseline assessment, tools development, training of HCW.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	1,143,116	0

Narrative:

The estimated ART coverage among the pediatric population is close to 100%. As the PMTCT program effectiveness increases, more pediatric infections will be averted and fewer children will be born HIV infected. The program budget for care and support is shared with HBHC, with approximately 85% supporting adult services and 15% supporting pediatrics through PDCS. Activities supported in this budget code include;

Clinical Equipment and Supplies: Funding under this activity supports procurement of equipment necessary to provide essential HIV-related clinical care, including tools to improve clinical monitoring and care for children. Emphasis will focus on tools to monitor growth and nutritional status in pre-ART sites and maternal and child clinics. Job aides and patient education materials will be produced, printed and disseminated. PEPFAR has supported basic essential clinical equipment since 2004. In line with the PEPFAR Namibia transition strategy; this budget line item will continue to decline over the next few years as the GRN takes on this responsibility.

HIV DNA PCR testing for early infant diagnosis. PEPFAR funds will continue to support a portion of DNA PCR testing for the Early Infant Diagnosis (EID) program. Support is reduced from COP11 levels as the MOHSS assumes increased responsibility for EID costs.

Assessment of the EID program: PEPFAR funds will support a comprehensive assessment of the EID program with a specific focus on HCW compliance with guidelines and timeliness of processing and return of lab as part of an effort to improve the program for early identification of HIV+ infants.

Improving mother baby follow up: MOHSS, in collaboration with partners, has been piloting follow up of



HIV exposed infants. PEPFAR funds will support rolling out mother-baby follow up nationwide, including support for revision, printing and distribution of tools and registers for mother-baby follow up including child health passports, postnatal registers and patient clinic booking cards and job aids. Patient unique numbers will facilitate linking of mothers and their HIV exposed infants during postnatal period and to address double counting concerns. Funds will also be used for training health workers and data clerks, supervision (national, regional, district), phones for facilities and airtime for SMS/calls to remind patients of follow-up clinic visits, M&E, and review meetings.

CDC will continue to work with the MOHSS sustainability task force to ensure that the essential services that are currently supported by PEPFAR will be included in coming years' budget motivations. CDC will also work closely with MOHSS and other USG agency partners to support costing exercises for essential services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	890,800	0

Narrative:

The MOHSS is responsible for HIV surveillance, M&E, and HMIS activities related to the national HIV/AIDS response. In COP12, strengthening the capacity of the RM&E unit will continue while new activities for drug resistance monitoring, ANC sentinel surveillance /PMTCT data comparison, and more comprehensive M&E activities will be priorities. In line with transition of activities, funds for logistical support such as printing and purchasing of computer equipment will now be supported by MOHSS. Capacity building through training and mentorship activities will promote autonomy within the MOHSS and reduce the need for future external assistance. In line with GHI principles, operational research activities will be a focus and capacity building activities will include several Directorates across the MOHSS, including Primary Health Care. All activities will support the Multi-Sectoral M&E Plan, the indicators included in the National Strategic Framework (NSF) and the National HIV Research Agenda.

Building research and monitoring capacity will allow the MOHSS to do more with fewer resources. Documenting and understanding process, outcome and impact indicators will promote evidence-based programming and the identification of non-performing or low-impact activities.

Key activities include: 1) Support for the MOHSS Response Monitoring & Evaluation (RM&E) unit and the Health Research Unit for essential responsibilities and functions including supportive supervisory visits and trainings for current M&E, surveillance and research methods including ethical review standards; 2)

Strengthen TB/HIV surveillance. Currently, M&E systems do not effectively capture TB/HIV information; data from TB systems and HIV systems are currently interpreted together to gain an understanding of the TB burden with HIV infected persons, however better linkages among systems and TB and HIV programs is urgently needed; 3) Implementation of a TB MDR survey. The last TB MDR survey was conducted in 2008 and a new survey is needed to understand the current situation of drug resistant TB; 4) Support for an ANC sentinel surveillance /PMTCT data comparison exercise. This exercise will determine if PMTCT data can be utilized for HIV surveillance and potentially replace the need for conducting bi-annual ANC sentinel surveys; 5) Implement HIV drug resistance monitoring. Drug resistance monitoring is one component of the Namibia HIV drug resistance strategy which includes the use of early warning indicators and a drug resistance threshold survey. In conjunction with WHO, MOHSS is piloting new methods for monitoring drug resistance and these funds will be used for a national survey; and 6) Implement an M&E system for male circumcision scale-up. An M&E system needs to be developed with the roll out of the male circumcision program. Efforts will include aligning needed indicators into existing M&E systems for routine data and also conducting process evaluations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	1,133,284	0

Narrative:

Inadequate human resource capacity is among the leading obstacles to the development and sustainability of HIV/AIDS-related health services in Namibia. The USG has recognized pre-service training as instrumental in scaling up and sustaining the national HIV/AIDS response, and to strengthening the overall healthcare system.

Critical human resource gaps exist at all levels of the healthcare system, from the national administration to local facilities. The lack of pre-service training institutions for doctors and pharmacists in Namibia, coupled with limited local training opportunities for other allied health professionals, has contributed to a chronic shortage of health professionals.

COP12 will support bursaries for Namibian students with demonstrated financial needs and educational qualifications to train as doctors, pharmacists, pharmacy assistants, nurses, enrolled nurses, laboratory technologists, social workers, public health administrators, epidemiologists, and nutritionists in Namibia, South Africa, Kenya, and elsewhere. Students awarded bursaries through this program will be bonded to serve the MOHSS upon completion of their studies. To assess whether bursary recipients are remaining within the Namibian health workforce, the USG will work with the MoHSS to track the employment status



of previous, current and future bursary recipients. USG technical advisors will also facilitate the flow of information about the bursary program between MOHSS program managers and MOHSS leadership. In COP12 USG will also raise the issue of linking individuals who benefit from other USG-funded capacity building projects (e.g, those that help vulnerable students) to the bursary program. This kind of direct linkage between USG projects and the bursary program has not been attempted in the past. Historically (and continuing in COP12), busary opportunities are widely publicized; and applicants are selected base on merit and need. This facilitation will include, where relevant, support for the collection, analysis and dissemination of information captured in human resource information systems.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	429,703	0

Narrative:

As the demand for male circumcision (MC) increases in Namibia, PEPFAR will support the Ministry of Health and Social Services (MOHSS) to ensure that appropriate supplies, equipment, and commodities are available. These supplies and commodities may include, but will not be limited to, surgical equipment, sterile equipment, local anesthetic, patient education materials, training curricula, and circumcision devices. In addition, supplies such as surgical beds, lights, privacy screens, tents, and other materials needed to roll out MC are included. Where possible, existing GRN procurement services will be used, specifically the MOHSS Central Medical Stores to order, stock, and distribute the appropriate supplies, commodities, and equipment. A distribution plan will be aligned with the National MC Implementation Plan. Travel to and from targeted regions is an essential to the success of this program; funds allocated for this purpose may be used by MOHSS national and regional staff, as well as MC service providers. In COP12, while continuing to provide MC services through the current integrated service model in all the regions, the MOHSS also intends to specifically target 3 to 4 regions to ramp up the scale of MC services through sustained intense MC campaign models in those few regions. The regions will be selected by the MOHSS through the MC TWG guided by the MC implementation plan (which is currently in draft form), once it is finalized and adopted. This will require extensive travel for coordination and management of the campaigns through the national and regional health managers.

Support for equipment, materials and logistics will support MOHSS efforts to increase access to MC services in high-need areas of Namibia. A successful rapid roll-out of MC services will also accelerate the transition of the MC program from a time-limited program focused on adult males to an MOHSS-led routine program focused on neonatal MC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
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Prevention	HVCT	2,327,964	0
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Narrative:

Community Counselors (CC): Namibia introduced the CC program in 2004 as part of the national task-shifting initiative. Facility-based lay CC provide a range of counseling services. Under HVCT, focus will be on couples counseling, provider-initiated counseling and testing (PICT), and outreach HCT services (e.g., mobile). Continued support with funding for approximately 45% of the facility-based lay-Community Counselors program is distributed among five activity areas: Other Prevention (20%), Prevention of Mother to Child Transmission (15%), Adult Treatment (10%), and HIV/TB (10%). This includes salaries for 650 CC who are deployed in public health sites to work on activities such as HCT, ARV, TB, PMTCT, as well as correctional facilities; training implemented by MOHSS with support from ITECH; supervisory support visits by MOHSS staff persons who provide supervision and support to the CC, and support for planning meetings and an annual retreat for CCs.

CDC will continue to work with the USG-GRN HRH TWG to develop and implement a rational transition plan for Community Counselors and other lay facility- or community-based health care workers.

CDC continues to transition responsibility for the procurement of HIV Test Kits and Supplies to MOHSS, which will procure a greater number of test kits with its own funds in COP12. The COP12 budget for this line item represents a nearly 50% reduction compared to COP11. Kits will be procured and distributed by the MOHSS Central Medical Stores. MOHSS will also continue a feasibility assessment for implementing oral fluid rapid HIV testing in specific settings, including outreach and correctional settings as well as related quality assurance support.

Promotion of HCT through an Annual National HIV Testing Event: Funding will support promotional activities in all 13 regions, including drama presentations, radio announcements, other educational events, and production and distribution of print materials. Outreach-based HIV counseling and testing services will be provided during the National Testing Day event.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	914,246	0

Narrative:

Continued support for approximately 20% of the facility-based lay-Community Counselors (CC) program = \$656,212. Procurement of approximately 4.5 million male and female condoms = \$0. Supporting the Ministry of Health and Social Services' (MOHSS), Department of Social Welfare Services for alcohol/HIV prevention activities = \$120,000. Support for MOHSS Prevention staff to conduct e program support visits and to attend capacity building trainings and conferences = \$50,335. Support for Condom Logistics



Officers at district hospitals to facilitate local supply and distribution of condoms to health facilities and PEPFAR-funded nongovernmental organizations (NGO) and faith-based organizations (FBO) who distribute condoms to high-risk people = \$87,699.

Community Counselors (CC): Continued support for approximately 20% of the facility-based lay-Community Counselors (CC) program will be given in COP12, which is distributed among five activity areas: Other Prevention (20%), counseling and Testing (45%), Prevention of Mother to Child Transmission (15%), Adult Treatment (10%), and HIV/TB (10%). This includes salaries for 650 CC who are deployed in public health sites to work on activities such as HCT, ARV, TB, PMTCT, as well as correctional facilities; training implemented by MOHSS through ITECH, supervisory support visits, and support for planning meetings and an annual retreat for CCs.

Under HVOP, facility-based lay CC work will focus on condom distribution, HIV prevention counseling, and outreach to people living with HIV and AIDS (PLWHA) to reduce high-risk behaviors through faithfulness to one partner. CC address cultural norms that factor into HIV transmission, including lack of health care seeking behavior by men, multiple sex partners, transactional and trans-generational sex, power inequities between men and women, and alcohol abuse. Funding is also used to support refresher training workshops on HCT related topics such as male circumcision, prevention for PLWHA, and alcohol abuse.

Condom Procurement: The budget for this activity was zeroed and moved to a USAID central mechanism. In COP12 support for Condom Logistics Officers at district hospitals is given, to facilitate local supply and distribution of condoms to health facilities and PEPFAR-funded nongovernmental organizations (NGO) and faith-based organizations (FBO) who distribute condoms to high-risk people.

Alcohol/HIS Prevention: USG funds will continue to support the MOHSS' Coalition on Responsible Drinking (CORD). CORD incorporates media messaging and works with community, business, and health partners, as well as shebeens and breweries to reduce alcohol abuse, a major driver of the HIV epidemic in Namibia. CORD exists in all 13 regions of Namibia. Funds will educate business owners and the general public about the association between alcohol consumption, high-risk sexual behavior, and HIV transmission.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,540,304	0

Narrative:

Community Counselors (CC): MTCT support will focus on HIV counseling and testing (HCT); adherence,



prevention, and referral services in PMTCT and ANC settings. Funds will also support refresher training workshops. In COP12, CDC will continue to work through the USG-GRN HRH TWG to develop a transition plan for this cadre of lay healthcare workers.

Procurement of supplies and equipment, including hemoglobin meters for monitoring anemia, weighing scales, furniture, lockable cabinets and equipment.

Training for Traditional Birth Attendants (TBA): TBA will be trained on PMTCT, HIV prevention, reproductive health, and referrals. In addition funds will be used for TBA kits and supervisory visits. Support for an IEC campaign promoting PMTCT. Activities will include development, production, and dissemination of PMTCT IEC materials for use in clinical and community settings.

Funds will support revision, printing and distribution of tools and registers for improved mother-baby follow-up.

Implementation of the new PMTCT guidelines: Funds will support the roll-out of revised PMTCT guidelines including printing and distribution, curriculum review, and review of user tools for PMTCT (registers summary reporting forms, job aids and IEC materials).

Capacity building of health workers to implement new guidelines: MOHSS will roll out training at regional level to complement limited numbers of health workers trained by ITECH and NHTC.

Development and implementation of service integration model for PMTCT, ART, TB/HIV and pediatric ART. Funds will support the development and implementation of a service integration model for PMTCT, ART, FP and ANC services, technical assistance, baseline assessment, tools development, training of providers, supervision, monitoring, evaluation and roll out of service integration model.

eMTCT coordination. Funds will support MOHSS coordination efforts between the Directorate of Special Programs and Primary Health Care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	6,973,044	0

Narrative:

Routine bio-clinical monitoring tests: Funding will support bio-clinical monitoring of ART patients.
 Support for CD4 Point of Care (POC): In COP12, this technology will be rolled out to remote health facilities to increase access to testing, decrease lab costs and increase quality of care.
 Community Counselors (CC): CC provide HCT, ART adherence, prevention, and MC counseling; and make use of referral services.
 Nutrition support for PLWHA: Implementation of the nutrition assessment, counseling and support (NACS) program as it expands to every district over the next two years. See PDTX for additional details.
 Basic clinical equipment: Reduced support for commodities procurement for ART services in primary



care clinics.

Mobile HIV Services: Ongoing implementation of mobile service units to deliver prevention counseling, HCT, MC, ART and other PHC services to remote areas.

HR administration: Funds will support operational costs, internet access, IT support within the HR unit.

Renovations: Funds will supplement MOHSS and Global Fund resources to renovate existing public health facilities for expanded HIV, PMTCT, and TB services.

HIV quality improvement (HIVQUAL) program: In COP12, partial funding for this activity will be directly funded through the MOHSS to support QI mentoring, conference participation and training.

Regional ART trainings: In COP12 the USG will increase direct support to the MOHSS to conduct localized trainings through the regional health training network to address the individual training needs of the regions.

Adherence promotion: MOHSS will pilot evidence-based ART adherence support interventions such as SMS technologies (baseline and follow assessments).

Service integration: USG will support development, implementation and evaluation of a service integration model for PMTCT, ART, FP and ANC services (TA, baseline assessment, tools development, training of HCW).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	1,599,232	0

Narrative:

Routine bio-clinical monitoring tests: Funding will support routine bio-clinical monitoring tests for pediatric patients at MOHSS facilities. These tests will be performed by the Namibia Institute of Pathology (NIP). Funding will also support CD4 monitoring of non-ART patients enrolled in pre-ART care. The MOHSS will also link clinical and laboratory data systems to reduce turn-around time and improve data quality.

Point of care testing: The NIP's system for specimen referral ensures countrywide coverage for laboratory services. However, the referral system faces the challenges of specimen collection, transportation from health facilities to the laboratories, and long turn-around times for test results. The cost of laboratory testing has also increased and seems not to be sustainable. To address these challenges, MOHSS and USG piloted a CD4 POC in 2011. In COP12, this technology will be rolled out to remote health facilities. This will increase access to testing, decrease cost of laboratory testing and increase quality of care and support services.

Nutrition support for PLWHA on ART, including children: PEPFAR will support MOHSS to strengthen the nutrition assessment, counseling and support (NACS) program as it expands from 15 to 34 districts over



the next two years. This activity is linked to the USAID FANTA III project and ITECH's support for building capacity of health care workers in ART, MCH and PHC clinics. Funds will procure and deliver reduced quantities of food supplements as USG transitions out of food procurement and logistics. This activity will include support for regional and national supportive supervision, oversight and program monitoring in coordination with other USG partners.

Implementing Mechanism Details

Mechanism ID: 12721	Mechanism Name: Strengthening HIV/AIDS Responses in Prevention and Protection (SHARPP)
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Lifeline/Childline Namibia	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,826,389	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	2,826,389

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Through quality programs and services LifeLine/ChildLine (LLCL) seeks to improve the safety, health and resilience of children, youth, families and communities in Namibia. LLCL focuses on HIV counseling and testing (HCT) programs; and trainings which address behavior change, efficacy and gender equity related to HIV prevention, care and support. It more broadly addresses child health, safety, rights and resilience. LLCL advocates for zero tolerance of abuse against children and gender-based violence. The program is aligned with the GHI Strategy and Partnership Framework's focus on social behavior change in HIV prevention, legal rights and protection for vulnerable persons, specifically children and women. LLCL targets communities in Kavango, Khomas, Hardap, Oshana and Ohangwena Regions. For HCT, LLCL



targets vulnerable youth (16-30) and most at risk populations in Windhoek, Rundu and Oshikango. The latter will be reached through partnership with the SFH MARPs project. Sustainability efforts will target the diversification of donor funding, development of partnerships with private sector, designing public fundraising plans and responding to GRN and other tenders. Also, LLCL will pursue integration with GRN, where possible, for programs and staff to be absorbed into GRN structures. This strengthens program sustainability, and contributes to the achievement of USG GHI strategy goal of transition. LLCL will rationalize its own premises, human resources and programs as well as building consortia with civil society organizations for the sharing of premises, human resources and programs, increasing cost-efficiency gains.

Outcome and output indicators are used to monitor the program. A baseline and endline assessment will be conducted.

No vehicle purchases are envisaged.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	125,000
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TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

- Addressing male norms and behaviors
- Increasing gender equity in HIV/AIDS activities and services
- Increasing women's legal rights and protection

Budget Code Information



Mechanism ID:	12721		
Mechanism Name:	Strengthening HIV/AIDS Responses in Prevention and Protection		
Prime Partner Name:	(SHARPP)		
	Lifeline/Childline Namibia		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	752,719	0

Narrative:

The goal of the HKID work under the Strengthening HIV/AIDS Responses in Prevention and Protection (SHARPP) IM through Lifeline/ChildLine (LLCL) is to complement government child protection efforts to prevent/mitigate violence against children and build sustainable and cohesive systems that uphold the right to a safe and secure childhood. This targets children under the age of 18 with national coverage through the 116 HelpLine and Uitani Radio activities. In addition, community activities will take place in Kavango, Hardap and Khomas Regions. LLCL will continue to build on the Child Protection Program with the Ministry of Gender Equality and Child Welfare (MGECW).

Community Parenting Training will be conducted for duty bearers and other stakeholders to promote better family relationships, children’s rights, reporting and referral. Government and civil society officials will be identified and trained to promote ownership and sustainability.

SHARPP will implement an evidence-based child protection program in schools complementing the Ministry of Education’s (MOE) life-skills curricula and LLCL combination prevention offered under the HVAB budget code which targets vulnerable/at risk children as well as learners with leadership potential to act as agents of change. The intervention comprises small group sessions to build self-efficacy and coping skills as well as dealing with gender, protection and HIV prevention. Sessions will be co-facilitated with teachers in order to enhance their skills and build sustainability. Drop-in counseling and referrals into the safety net system will be offered to children in need/at risk. SHARPP will also offer structured interventions at schools to respond to abuse incidents and build capacity of teachers to use intervention tools.

The 116 ChildLine is a national number to report/prevent child abuse, free from all networks and offers crisis debriefing and lay counseling by phone and face-to-face as part of the national safety net. Referrals and case tracking from 116 calls is done with service providers. Online counseling and SMS counseling will continue, together with a generic counseling line for adults. Provision of counseling services to children and adolescents living with HIV will be pursued and LLCL will provide counseling services to Women and Child Protection Units (WACPU) and other organizations to reduce burnout.



Discussions with MGE CW and/or telecoms providers to fund the radio programs will take place, in line with the National Agenda for Children. A memorandum of understanding to recruit University of Namibia (UNAM) social work and psychology student interns to provide services for sustainability and to reduce counselor salary burden will be sought and group/family counseling will promote systemic approaches and increase efficient use of human resources.

Children's Radio programs (Uitani) covering protection topics (as well as topics covered under HVAB), will continue to be produced and presented by children 8-14 years of age, including by children in the regions who participate in school programs. Uitani is broadcast weekly on four national radio stations and local/community radio stations.

Advocacy and government collaboration: LLCL will continue to participate in and support GRN agencies and national/regional fora to implement a national safety net and referral flow chart that incorporates service agreements and standard operating procedures.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	282,281	0

Narrative:

The activities under this budget code are all aimed at sustainability and are part of a broader sustainability plan for Lifeline/Childline (LLCL).
 Aligning with the transition and sustainability objectives of the GHI, organizational systems strengthening will be conducted to enable LLCL to be a sustainable indigenous civil society organization (CSO). Utilizing cost-share principles resources will be provided to strengthen the viability of the corporate wing of LLCL. This will support the GHI and Partnership Framework goal of building local capacity to sustain the HIV/AIDS response.
 LLCL will offer training, technical assistance (TA) and other marketable services to CSO, government and the private sector at market prices. LLCL will also respond to the Government of Namibia (GRN) and private sector tenders, working on a consultancy basis within their scope of expertise.
 Self-enhancement of LLCL in terms of capacity to strengthen its response to the market will be supported. Ongoing market research and marketing will be carried out to inform this process. LLCL will continue to provide capacity development opportunities to LLCL staff to enable them to fulfill their program activities at the highest quality.
 The Training Team of LLCL follows a system to ensure continued quality. In addition to annual

performance appraisals for the trainers, trainers are regularly monitored and supervised by the Training Manager and the Curriculum Specialist to ensure that training is of a consistently high quality. Planned and unplanned visits to workshops take place for this purpose. Written feedback is captured on a LLCL training standards sheet and a narrative report is also given to each trainer. One- on-one supervision is also provided. Regular monthly meetings conducted by the Training Manager and Curriculum Specialist encourage discussion of challenges faced in training each course and regarding necessary curriculum changes.

Monitoring and evaluation will be implemented based on the approved performance-monitoring plan that captures critical training indicators such as ability of trainers to transfer skills as well as transferability of developed training materials. Other training outcomes will be assessed using pre-post assessments as well as trainee evaluations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	300,000	0

Narrative:

The Strengthening HIV/AIDS Responses in Prevention and Protection (SHARPP) through Lifeline/Childline (LLCL) will carry out integrated and multi-level interventions under this budget code to:

- 1) Build skills and knowledge for young adolescents on age appropriate comprehensive/combination HIV/AIDS prevention;
- 2) Lay foundations for HIV risk perception, self-efficacy for HIV prevention and optimal uptake of biomedical prevention including medical male circumcision (MMC); and
- 3) Provide age-appropriate dosage of information relating to national campaigns on drivers of the HIV epidemic.

Complementary activities will be carried out with school children selected together with the Ministry of Education (MOE). Emphasis is on reaching vulnerable children and on obtaining a critical mass for behavior change for HIV prevention and gender-based violence (GBV).

Skilled counselors will offer small group interventions using drama, games, discussions and interpersonal communication tools. The program is evidence-based and complements MOE life skills curriculum. Sessions cover:

- 1) Building self-esteem and self-efficacy;
- 2) Reasons for and ways to delay sexual debut;
- 3) Gender inequality, GBV and child protection;
- 4) Exploring social and family norms; and
- 5) MMC and HIV testing and counseling awareness (with children, parents and teachers).

Immediate one-on-one counseling will be offered to children from the small groups who are experiencing difficulties. Such children may also be referred for Government of Namibia (GRN) and LLCL protection services described under HKID.

SHARPP will mobilize in-school youth to recognize and respond to GBV. This will be integrated in to HIV prevention social and behavior change communication (SBCC) activities.

The combination nature of the program is provided through access to national services offered under



HKID and HVOP, including 116 helpline, HER (sexual and reproductive health information SMS service) and Uitani Radio.

SHARPP will work closely with MOE to build teacher capacity on combination prevention approaches to complement the life skills programs for sustainability. SHARPP will employ a catchment area approach, working in schools and in the surrounding community with parents, teachers and opinion leaders for effective saturation of messaging.

Through strong working relationships with HAART clinics, SHARPP will pilot specifically-tailored SBCC and adherence counseling packages to child and adolescent patients as well as their parents.

SHARPP will work through regional and constituency level coordinating groups to promote coordination in community based activities.

In order to ensure quality, small group sessions will be in line with minimum standards and curriculum developed by the C-Change IM. Regular supervisory support will be offered to facilitators using a supervisory checklist and through observation and spot checks of sessions. Debriefing sessions will be scheduled using activity, counseling and supervisory reports to inform coaching, mentoring and capacity building.

To reduce costs, improve integration and sustainability, youth groups and teachers will be identified and trained to gradually take over the program.

In order to strengthen evidence and inform programming SHARPP will conduct baseline and end-line assessments. Monitoring of activities using agreed-upon performance indicators will be carried out.

Target regions: Hardap, Kavango, Khomas, Oshana, and Ohangwena.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	900,000	0

Narrative:

Under this budget code, HIV Counseling and Testing (HCT) services are provided through the Strengthening HIV/AIDS Responses in Prevention and Protection (SHARPP) from stand-alone sites in Rundu, Oshikango and Windhoek as part of the mixed model. The sites are non-clinical settings and use a client-initiated approach through voluntary counseling and testing, mobile and outreach services. Targets are geographically hard-to-reach populations, adolescents and youth 16 -30 years of age, men, couples and key populations in collaboration with the Strengthening HIV Prevention for MARP.

Targeted HCT community mobilization and promotion activities will continue to increase awareness on availability and benefits of HCT and linkages to other services. SHARPP will partner with the Strengthening HIV Prevention for MARP IM to complement their activities. Partnerships with Ministry of



Education (MOE) and other specific non-governmental organizations (NGO) will also be formed to reach youth and adolescents in the education system. Collaboration will be sought with Ministry of Youth and several NGO to reach out-of-school youth in different settings. For couples and men, campaigns and testing days will be used, including making sites more male friendly. Outreach and mobile testing services will be provided to geographically hard-to-reach populations in line with MOHSS guidelines.

HCT is a critical gateway to combination prevention, treatment, care and support. Screening and referrals of HCT clients for STI, TB, alcohol abuse, voluntary medical male circumcision will continue. For HCT positive clients, bi-directional referrals to treatment and care services, existing post-test support clubs, family counseling to facilitate disclosure to children and partners will continue. The new MOHSS bi-directional referral strategy will be implemented to provide individual and group adherence counseling for clients referred from MOHSS and others. Partnerships will be formed with the African Palliative Care Association and Positive Vibes to complement the Positive Health Dignity and Prevention intervention for HIV positive clients and individuals in sero-discordant partnerships. For clients with negative results, risk reduction plans will be developed together with them. Generic counseling and support around barriers to prevention will be offered especially to repeat testers and GBV survivors. In line with combination prevention, HCT clients will be referred to SHARPP social behavior change communication (SBCC) sessions, where appropriate, while SBCC participants will be offered HCT services. Female and male condoms will be offered as part of HCT services. All referrals at the sites will be monitored, tracked and reported periodically.

Routine monitoring comprises a site-level client/patient register to record client information and a laboratory log to record test kit information and HIV test results for every test performed. Sites have standardized data collection and collation tools, reporting formats and electronic data bases. Retesting of 5% samples is done by the National Institute of Pathology. For counseling quality assurance, weekly sit-in supervision and debriefing sessions are done, a counseling of counselor safety net program is supported and client satisfaction questionnaires are used.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	591,389	0

Narrative:

In line with the GHI strategy to increase access to evidence-based combination prevention intervention the Strengthening HIV/AIDS Responses in Prevention and Protection (SHARPP) will carry out integrated social behavior change communication (SBCC) interventions to: 1) Address HIV risk perception and social/behavioural barriers to HIV prevention; 2) Promote uptake and adherence to biomedical prevention especially voluntary medical male circumcision (VMMC); 3) Provide Positive Health Dignity and



Prevention (PHDP) links and information for people living with HIV (PLHIV); and Provide dosage relating to national campaigns on epidemic drivers

Beneficiaries will be segregated in to two groups: 1) The 15-24 year old; and 2) Adults 25-49 years old. The 15-24 year old group will target vulnerable youth, including PLHIV, identified through schools, Ministry of Health and Social Service (MOHSS), youth programs, Ministry of Gender Equality and Child Welfare (MGECW) and Ministry of Youth. Beneficiaries are specifically vulnerable to alcohol/drug abuse, multiple concurrent partnerships, domestic violence and poor adherence in case of PLHIV. The program will provide information and skills to engage in safer and healthier sexual activity where appropriate. SHARPP will work with civil society organizations offering economic empowerment programmes (e.g. Junior Achievers, KAYEC, Project HOPE) and refer beneficiaries between programs. As a member of the Task Force on Teenage Pregnancy in the Kavango Region, Lifeline/ChildLine (LLCL) will design activities to address study recommendations.

The adults 25-49 years old group will comprise two sub-groups: 1) Those referred from LLCL HIV counseling and testing (HCT) programs, MOHSS, MGECW, where high HIV risk is identified and behavior change/counseling is advised; and 2) Those referred by parents, teachers and community members that interact with the learners reached through the HVAB budget code program. Working with the latter group reinforces messages given to the children in the AB program. SHARPP will offer a program for parents and teachers, based on sessions from our positive parenting and social behavior change communication curricula to address discipline, child abuse, gender norms and rights and effective communication for HIV and sexual and reproductive health.

SHARPP will use small group sessions in line with minimum standards developed by MOHSS with C-Change support. Participants will be given access to accurate sexual and reproductive health information through SMS services and calls to 116 ChildLine to prevent and report abuse.

Community sensitization and mobilization to recognize and respond to GBV and its relationship to HIV infection will underscore the SBCC work implemented under SHARPP in Hardap and Kavango Regions. Adequate and effective supervision for facilitators will be conducted via observations and spot checks of sessions and applying a supervisory checklist. Debriefing sessions will use activity, counseling and supervisory reports to inform coaching and capacity building.

To reduce costs, improve integration and sustainability, teachers, youth and community leaders will be identified and trained to gradually take over the program with continued support from LLCL.

Implementing Mechanism Details

Mechanism ID: 12752	Mechanism Name: Cooperative Agreement 1U2GPS003014
Funding Agency: U.S. Department of Health and	Procurement Type: Cooperative Agreement



Human Services/Centers for Disease Control and Prevention	
Prime Partner Name: Ministry of Health and Social Services, Namibia	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A
Total Funding: 1,494,230	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	1,494,230

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism supports MOHSS's ability to implement cross-cutting programs that leverage investments in HIV/AIDS and other areas across the entire healthcare system. PEPFAR continues to support GRN activities associated with improving access to sustainable quality healthcare services, and transitioning donor-funded programs to GRN and national partners. The MOHSS staffs, operates and maintains hospitals, health centers and clinics nationwide. The MOHSS is actively working with the Ministry of Finance to increase the annual budget for health. In FY12, the MOHSS will seek up to N\$900 million in additional funding for HRH, commodities and other line items identified by PEPFAR and other donors for transition over the next five years. This mechanism will provide TA to MOHSS to implement transitioned programs as domestic funds become available, and to support cross-cutting programs in primary healthcare, maternal and child health, and nutrition. This mechanism will strengthen MOHSS ability to plan, implement, monitor and evaluate programs, and to identify and implement efficiencies. This mechanism will also expand the MOHSS's capacity to identify, choose and, increasingly, finance technical assistance. MOHSS submits an annual work plan aligned with national M&E indicators and targets. CDC technical advisors monitor technical progress on a routine (often daily) basis. The CDC cooperative agreement management team, including technical advisors, the CDC project officer and the financial manager hold monthly meetings with the grantee for financial and programmatic updates.

Cross-Cutting Budget Attribution(s)



(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Child Survival Activities

Safe Motherhood

Family Planning

Budget Code Information

Mechanism ID: 12752			
Mechanism Name: Cooperative Agreement 1U2GPS003014			
Prime Partner Name: Ministry of Health and Social Services, Namibia			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	460,190	0

Narrative:

The MOHSS and NIP will refine its annual work plans in conjunction with CDC technical advisors and other members of the USG combined technical team to coordinate with technical assistance provided through the IBLC mechanism.

In COP12, MOHSS will work on the following issues:

- 1) Implementation of National Strategic Plan for Laboratory Services and strengthening the National

Public Health Laboratory network. Strengthening the policy environment for health care services is a priority for the government of Namibia. Because most laboratory services are delivered by a parastatal entity (NIP), the ministry of health's ability to oversee the laboratory network is weak. Projects like this will strengthen the MOHSS's oversight role and contribute to the development of a public health network that will include human diagnostic and research laboratories, agricultural laboratories, veterinary laboratories, and laboratories specializing in environmental analyses. The MOHSS plans to develop the network using the hub-and-spoke model with MOHSS as the hub for the network of participating laboratories.

2) Support a national quality assurance system for Point of Care (POC) testing

NIP was established by GRN to provide laboratory services to the public sector. It operates a two-tier laboratory system through a network of 37 laboratories in most but not all health districts. NIP provides clinical pathology, bioclinical monitoring, and other laboratory services to the MOHSS, however, the specimen referral system faces several challenges, including the quality specimen collection and transportation from health facilities to laboratories. These challenges frequently result in long turn-around times for test results. The cost of laboratory testing has also increased to unsustainable levels. To address these challenges, and in light of the availability of newer, cheaper and POC technologies, MOHSS and USG piloted a CD4 POC in 2011. In COP12, this technology will be rolled out to remote health facilities. This will increase access to testing, decrease cost of laboratory testing and increase quality of care and support services. Newer POC technologies (e.g., for early infant diagnosis) will be explored as they become available.

3) Strengthening the lab based surveillance system within the PHLN

To develop a functional, national, laboratory-based surveillance system within the PHLN, an assessment of current surveillance systems and practices is required. This assessment will help members of the PHLN to identify existing strengths and weaknesses, and to develop a common strategic plan for the future. This assessment will also look at data systems and produce recommendations on strategies for the development of a common, or integrated, data system for public health surveillance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	650,000	0

Narrative:

HIS and Epidemiology Unit Capacity Building: Capacity will be built for conducting public health surveillance and research beyond routine reporting. Activities will include technical assistance and training for maintaining and using the national DHIS system along with other disease reporting systems.

In addition, funding will support a workshop for developing the HIS annual report.

IRB Capacity Building: Capacity-building for M&E, surveillance and research includes building capacity for ethical review and oversight of activities involving human subjects in Namibia. Although review boards are in place within GRN and academic institutions, standardization of review and overview practices need to be developed.

Prevalence and determinants of NCD Survey: There is a dearth of data in Namibia on prevalence and determinants of NCDs. Planning for this survey will include reviewing methods such as the WHO STEPwise approach to chronic disease risk factor surveillance. Results will be used for future resource prioritization and allocation by GRN as donor resources are reduced.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	100,000	0

Narrative:

In COP12 the USG will support the MOHSS to conduct a mid-term review of the National Strategic Framework to assess progress towards expected results and impacts of the multi-sectoral HIV and AIDS response in Namibia.

Understanding the progress made toward NSF objectives since the document was launched in 2010 is a critical step toward revising the strategy and objectives where needed (e.g, to reflect the new evidence within prevention, and sustainable financing goals).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	284,040	0

Narrative:

Training will take place for MOHSS clinical staff in key elements of Emergency Obstetric Care (EMOC). Training courses will focus on the six key elements of EMOC, plus blood transfusion and caesarian section. Decisions on specific courses for COP12 will be made in conjunction with MOHSS-based on the national work plan developed for the Campaign for the Reduction of Maternal Mortality in Africa (CARMMA). CDC and the MOHSS will ensure coordination with other USG-supported investments in this area.

This activity reflects the USG team's strategy to leverage PMTCT as a rational entry point for investments



that impact the broader primary healthcare system. By supporting the government's CARMMA-associated initiatives, USG Namibia intends to contribute to the access and transition objectives described in the 2012 Namibia GHI Strategy.

Implementing Mechanism Details

Mechanism ID: 12860	Mechanism Name: Ministry of Regional, Local Governments, Housing and Rural Development (MRLGHRD)
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Ministry of Regional, Local Governments, Housing and Rural Development (MRLGHRD)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 100,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Ministry of Regional, Local Government, Housing and Rural Development (MRLGHRD) plays an important role in Namibia's HIV response and in the financing and oversight of Regional Councils. While Namibia has outlined a decentralization agenda that supports regional level planning, coordinated budgeting, implementation and problem solving by regional stakeholders, support is still needed for implementation. Under the National Strategic Framework (NSF) the MRLGHRD serves as a co-chair of the National AIDS Executive Council and must operationalize all subnational structures of the HIV response. This has been largely completed through the structuring of Regional AIDS Coordinating Committees and Constituency AIDS Coordinating Committees to assist local authorities address HIV. The USG aims to utilize the country's procurement systems to supplement existing domestic resources



available for Regional Councils to allocate to the multi-sectoral response. In Namibia the USG government intends to transition to a role of technical assistance and limited direct service delivery, supporting its GHI strategy of transition. Current assistance to the GRN remains project-oriented processed under USG financial systems. USAID will conduct a standard Public Financial Management Risk Assessment Framework to assess fiduciary risk from use of partner country systems. This will ensure that assistance will be managed appropriately using host country procurement systems and treasury provisions. The USG will provide technical assistance to the MRLGHRD and to Regional Councils as required to establish high impact investments by Regional Councils into the multi-sectoral response. An appropriate monitoring and evaluation plan will be developed with the MRLGHRD. No vehicle procurement is envisaged.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12860		
Mechanism Name:	Ministry of Regional, Local Governments, Housing and Rural Development (MRLGHRD)		
Prime Partner Name:	Ministry of Regional, Local Governments, Housing and Rural Development (MRLGHRD)		
Strategic Area	Budget Code	Planned Amount	On Hold Amount



Prevention	HVOP	100,000	0
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Narrative:

This is a continuing activity and will provide direct financial support to the Namibian Ministry of Regional, Local Government, Housing and Rural Development (MRLGHRD) to fulfill their mandate of regional operationalization and coordination of the national multi-sectoral HIV and AIDS response. Namibia's HIV and AIDS response will continue decentralizing under the auspices of the National Strategic Framework on HIV and AIDS, 2010 – 2016 (NSF). This requires functional Regional AIDS Coordination Committees (RACOC) to prioritize domestic resources, plan and review regional responses across sectors.

Under the NSF there will be a greater emphasis on decentralization of the response to RACOC who will continue to coordinate the regional multi-sectoral HIV and AIDS response, including ensuring meaningful involvement and participation of all stakeholders in the implementation of the Regional Operational Plans. They are also tasked with coordination of non-health sector responses which primarily consist of HIV prevention stakeholders.

This activity, coupled with direct technical assistance of the USG, will continue to improve the efficiency and effectiveness of regional planning and review structures and prioritization of community-based HIV prevention efforts among Government of Namibia (GRN) and civil society stakeholders. As an initial step in supporting GRN to build a comprehensive regional response, support is focused on strengthening the planning and coordination of community-based HIV prevention activities. Current funding will permit initial activities for RACOC planning and review of HIV prevention efforts by stakeholders in regions to be selected by the MRLGHRD. Assistance will finance limited regional efforts to convene stakeholders to operationalize NSF regional plans and support planning and review of HIV control efforts.

Implementing Mechanism Details

Mechanism ID: 12997	Mechanism Name: Scaling up Palliative care for People Living with HIV/AIDS
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: African Palliative Care Association	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A



Total Funding: 1,104,831	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	1,104,831

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The African Palliative Care Association (APCA) provides technical assistance and works with providers of palliative and other health care services to expand palliative care (PC). APCA builds capacity, strengthens health systems and supports PC integration at all levels, creating linkages and retention in care and improving the quality of life of PLWHA. APCA Namibia is scaling up PC provision through a public health approach, balancing quality with coverage.

APCA will address the Partnership Framework objective of strengthening PC services and is aligned to USG Namibia’s GHI strategy to strengthen health systems to ensure transition and sustainability and improve access to women, children and vulnerable populations.

APCA has a national coverage and works cost-effectively by integrating PC into the Government of Namibia’s care and support program and existing community home-based care organizations. APCA works with the National PC Task Force which consists of in-country stakeholders who guide the strategic direction of PC development. APCA is committed to moving forward PC policy, standards and guidelines.

APCA will work to transition its activities to a strengthened National PC task Force. APCA is working with various educational institutions to integrate PC into pre-service and in-service trainings to ensure that more healthcare workers gain exposure to PC. At the community level, APCA works closely with Catholic AIDS Action and other community based organizations to implement a community-based palliative care program.

APCA has measurable indicators to monitor its activities and a performance monitoring plan. APCA will work with its partners to collect quality data and implement the monitoring and evaluation plan.

No vehicle purchases are envisaged.



Cross-Cutting Budget Attribution(s)

Human Resources for Health	161,000
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TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID: 12997			
Mechanism Name: Scaling up Palliative care for People Living with HIV/AIDS			
Prime Partner Name: African Palliative Care Association			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	888,831	0

Narrative:

Scaling up Palliative Care for People Living with HIV/AIDS (PLWHA), implemented by the African Palliative Care Association (APCA) will continue to support the Ministry of Health and Social Services (MOHSS) to integrate palliative care (PC) into the health system by building capacity of health professionals and providing on-going support and mentorship to health facilities and community home-based care (CHBC) organizations.

APCA will work with four learning institutions to ensure continuous pre- and in-service training of professionals. In COP 11 APCA commenced negotiations with Polytechnic of Namibia to establish a PC course. Efforts to formalize this will be supported in COP 12 with actual course delivery projected to start in 2013. APCA will support curriculum development and twinning of the institution with others in the



Southern African region. APCA will also support the MOHSS to integrate PC into the curricula of the University of Namibia Medical School. Sensitization has already commenced with COP 11 resources.

APCA will support COHENA, Hope Hospice, TKMOAMS and Aids Care Trust by training their coordinators and providing re-fresher trainings for their staff and volunteers in PC.

APCA will strengthen Tonata's capacity as a network for PLWHA through supporting annual general meetings, reinforcing networking opportunities with regional and constituency AIDS coordinating committees as well as increasing linkages between constituent PLWHA support groups and service providers.

APCA will provide technical assistance to MOHSS and CHBC organizations to implement the bi-directional referral system established by the GRN to improve linkages between communities and health services.

In COP11, APCA supported the MOHSS' directorate of Primary Health Care to integrate PC into the CHBC Standards. In COP 12, APCA will continue to facilitate the roll-out the standards for providing quality palliative care and support the MOHSS to monitor the implementation of these standards within CHBC organizations. An audit of the CHBC Standards will be conducted with the six main CHBC organizations providing integrated HBC.

APCA will continue to support Positive Vibes to implement PHDP messages through monitoring and supervision. In COP12, APCA will work with the group to integrate specific PC messages around identification and assessment of pain for community based providers into the existing PHDP tool kit.

APCA will support Catholic AIDS Action (CAA) to become a center of excellence (CEE) for PC. In COP11, APCA worked with the MOHSS's Oncology units in Windhoek and Oshakati to become centers of excellence. These centers support students studying towards qualifications in PC. Staff will participate in exchange visits in the region and will be supported through relevant courses and to attend the APCA conference in Uganda.

APCA will continue to support the establishment of a national association for sustainability of PC work in Namibia that was started in COP11.

Specific target populations include HIV/AIDS care providers at all levels in government, pre- and in-service training institutions, FBOs, CBOs and policy makers throughout the entire country.



Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	216,000	0

Narrative:

Under this budget code, the Scaling up Palliative Care for People Living with HIV/AIDS (PLWHA) project, through APCA, will continue to work with MOHSS to integrate specific issues relevant to children in the trainings for health care professionals and staff and volunteers of the community home based care (CHBC) organizations that they support. The trainings will ensure that service providers are equipped to work with children. APCA will continue to provide on-going support and mentorship to health facilities and CHBC organizations. Additionally, special attention will also be paid during mentorship activities to check how children clients are handled by providers.

Meeting the care and support needs of adolescents and children living with HIV requires a comprehensive and integrative approach from a skilled multi-disciplinary team at the different levels of care provision. Integrating palliative care (PC) into care and support provides comprehensive and quality care including appropriate pain management, psycho-social, spiritual and end-of-life care for beneficiaries.

APCA will build capacity and mentor CHBC organizations such as COHENA, Hope Hospice, TKMOAMS and Aids Care Trust, in integrated community home-based palliative care including addressing specific child and adolescent issues such as sexual and reproductive health. Four coordinators from the above CHBC organizations will undertake specialised training in PC which includes pediatric care.

APCA will strengthen Tonata's capacity as a network for PLWHA by supporting the organization's information sharing program on topical issues for PLWHA, especially awareness on addressing the needs of children and adolescents living with HIV (ALHIV). Through support provided to Positive Vibes for updating and disseminating the community PHDP toolkit, APCA will facilitate scale-up of the work Positive Vibes is piloting in Katutura Hospital focusing on psycho-social support for ALHIV.

APCA will continue to provide technical assistance to the MOHSS for integration of pediatric care needs into existing HBC programs implementing a family-centred approach in line with the GHI strategy. Findings from an assessment conducted with COP 11 resources will guide the implementation of integrated home-based palliative care for children and adolescents living with HIV. APCA will continue to monitor its activities based on a performance plan to ensure it meets its targets for human resources for health. A mid-term evaluation is planned in FY 2012.

Strong referral networks are needed between health facilities and community services at all levels of care



to ensure comprehensiveness of services across the continuum of care, from diagnosis through to death and bereavement. APCA will continue to work with MOHSS and CHBC organizations to create important linkages between communities and health services thereby improving access to services.

In line with the transition objective of GHI APCA's work will build local capacity in the public sector and civil society to continue to provide quality and comprehensive services for vulnerable and affected populations. This will be achieved through the strengthening of a National Palliative Care Association birthed with COP 11 resources. Specific target populations include HIV/AIDS care providers at all levels in government, pre- and in-service training institutions, FBOs, CBOs and policy makers throughout the entire country.

Implementing Mechanism Details

Mechanism ID: 13042	Mechanism Name: Central Bureau of Statistics, National Planning Commission, Office of the President
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Central Bureau of Statistics	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 150,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	150,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Quality population survey data is the foundation for evidence-based program design, policy-making, monitoring and evaluation. Historically, however, development decisions in the region have not been sufficiently guided by this data.



Under the draft Statistics Bill of 2009, the Central Statistics Bureau (CSB), under the National Planning Commission (NPC)/Office of the President of Namibia, must collect, compile, manage, analyze, publish, and disseminate official statistics for Namibia. While the CBS is gaining more experience, a recent assessment identified its need for technical assistance and training.

Under this mechanism CBS/NPC/Office of the President have two main goals: 1) To provide direct technical support to CBS to manage and administer USG-funded surveys; and 2) Build local research capacity so CBS can coordinate major research in Namibia.

This mechanism will increase country ownership of research activities and surveys in Namibia. It equips local decision-makers with data better quality data to support the development of better services and programs and the transition to locally-driven development decision-making. It is therefore in line with the goals for the Partnership Framework and Global Health Initiative Strategy. In 2011, USG strengthened the capacity of CBS to coordinate, plan and implement the 2011-12 Census. In 2012, the capacity-building to support the Demographic and Health Survey will be initiated.

This award will have national-level impact. The target population is the staff of the CBS and research collaborators from other ministries, such as the Ministry of Health and Social Services.

The effectiveness of all the trainings will be evaluated.

No vehicles purchases are envisaged.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A



Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	13042		
Mechanism Name:	Central Bureau of Statistics, National Planning Commission, Office of the President		
Prime Partner Name:	Central Bureau of Statistics		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	150,000	0

Narrative:

This continuing activity with the Central Bureau of Statistics (CBS) has two main goals: 1) to provide direct technical support to CBS so that they can manage and administer USG-funded surveys; and 2) build local research capacity so that CBS can be the coordinating body for major research in Namibia. Under the draft Statistics Bill of 2009, CBS is the agency within the National Statistics System that is responsible for the collection, compilation, custody, analysis, publication and dissemination of official statistics for Namibia. The functions of CBS include conducting statistical studies, either alone or in collaboration with government bodies or private sector entities; publishing and disseminating official statistical data throughout the country; ensuring compliance with statistical standards; keeping an inventory of official statistics of Namibia; providing statistical services and assistance to government bodies or the private sector; formulate a national plan for official statistics; and liaising with national and international organizations on statistical matters.

In 2011, CBS received support by the U.S. Bureau of Statistics to train staff in the analysis of the 2011 Namibian Census. The analysis is intended to assist the government to make appropriate funding decisions, including decisions in health allocations. Efforts will continue to build local research capacity and increase country ownership of research activities and surveys in Namibia, and, as such, is in line with the transition principles of the Partnership Framework and the GHI. The long-term goal of these activities is that the CBS will be able to coordinate, plan and implement, on its own, major studies such as the Demographic Health Survey (DHS+), the National Health Facility Census (also referred to as a Service Provision Assessment (SPA)), and the AIDS Indicator Survey.

Although targeted at the main CBS office in Windhoek, this award will have national-level impact, since all regions will benefit from increased research capacity at CBS. The target population of the award is the staff of the CBS and research collaborators from other ministries, such as the Ministry of Health and



Social Services.

This award strengthens Namibia’s health system by strengthening local research capacity among the main governmental research body in Namibia, the Central Bureau of Statistics. Since health programs and policies depend upon accurate data on the health of the population, increasing Namibian research capacity will improve the quality of the health data produced by surveys and over time it will reduce the costs of collecting such data.

This award will strengthen health information systems (broadly defined to include surveys and other studies) in Namibia and thus improve Namibia’s ability to plan and monitor its HIV/AIDS response and to coordinate, plan and prioritize future surveys. Long-term benefits will enable the public sector to budget and target its resources more efficiently.

Effective implementation of this award will decrease the costs of conducting surveys and other studies in that the CBS will be less reliant on external technical assistance, which can be the most expensive component of large-scale studies like the DHS.

Implementing Mechanism Details

Mechanism ID: 13090	Mechanism Name: OVC and Tuberculosis Services in Namibia
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Project HOPE	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 900,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	900,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This IM will be implemented by Project Hope. It focuses on mitigating the impact of HIV/AIDS on OVC and OVC caregivers, addressing economic needs and health aspects of HIV and tuberculosis (TB). It has



three strategic results: 1) improved economic status of communities and households caring for OVC and TB patients; 2) Strengthened community and household capacity to provide health services including TB services and psycho-social services for OVC and TB patients; and 3) Strengthened linkages and referrals of communities and households to services. The mechanism is in line with USG commitments of the Partnership Framework. It supports the GHI strategic area of transition and access in that it addresses structural barriers and builds capacity to ensure program sustainability and improves access by strengthening linkages and referrals.

The geographic coverage includes six political regions: Oshana, Omusati, Ohangwena, Oshikoto, Kavango, and Caprivi. The target populations are: a) caregivers of OVC b) OVC in their care and c) TB patients and patients co-infected by TB and HIV.

The IM will become more efficient over time by delivering services in partnerships with the private sector. The IM trains local CBO to promote technical sustainability of program objectives. The monitoring and evaluation (M&E) plan will measure outcomes at the household and child levels. M&E for the community-based directly observed therapy activities uses the government's reporting system and reports to the health system.

This project has not purchased any vehicles. In COP12 the purchase of one vehicle is planned. It will replace two older vehicles due to cost of repairs and time lost to maintenance. It is the only vehicle purchase planned for the life of the mechanism.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	400,000
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TBD Details

(No data provided.)

Motor Vehicles Details

N/A



Key Issues

Increasing gender equity in HIV/AIDS activities and services
 Increasing women's access to income and productive resources
 Child Survival Activities
 TB

Budget Code Information

Mechanism ID: 13090			
Mechanism Name: OVC and Tuberculosis Services in Namibia			
Prime Partner Name: Project HOPE			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	700,000	0

Narrative:

This is a continuing activity implemented by Project HOPE. The OVC and TB Services in Namibia project goal is to strengthen the capacity of families to care for orphans and vulnerable children (OVC). It targets guardians and parents of OVC in six regions (Omusati, Ohangwena, Oshana, Oshikoto, Kavango, and Caprivi), providing them with community based comprehensive health education combined with economic strengthening interventions. Given that the majority of OVC caregivers are female, the project will target women with the aim of increasing access to income and productive resources.

Activities include establishment of village savings and loans groups amongst OVC caregivers combined with health education focusing on young child health, hygiene, nutrition and psycho-social aspects of parental care.

Program strategies were adjusted based on findings from an external evaluation completed in 2010 and program data collected from 2007-2010. Key changes include: 1) implementing economic strengthening through partnership with a local micro-lender; and 2) increased focus on caregiver savings. Outcomes are measured through baseline and recollection of data using tools that measure changes in the economic status of a household and changes in the status of children in the home. Caregivers are supported to access the health and social welfare systems, including child welfare grants, through referrals. Further, vulnerable youth are assisted to complete applications to vocational training institutions. Project HOPE collaborates with the relevant government providers of bursaries to support inclusion of vulnerability criteria as part of selection procedures.

Project HOPE's work in economic strengthening and OVC is a recognized strength, therefore the partner



trains community based organizations to deliver care using their combination approach.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	200,000	0

Narrative:

Project HOPE works through the National TB and Leprosy Program (NTLP) to support the NTLP's community-based directly observed therapy strategy (CB-DOTS) in three regions: Oshana, Oshikoto and Kavango. Project HOPE is a member of the Ministry of Health and Social Services' (MOHSS) TB National Steering Committee. The CB-DOTS under this IM engages field promoters, in line with the national approach, who form the link between communities and patients and health facilities. Project HOPE's contribution is evident in the high TB treatment success rates of 84% in Oshana and Oshikoto as well as 74% in Kavango Region. Effective coordination exists with USG partner Development AID for People from People (DAPP). Project HOPE has a statement on collaboration with DAPP which defines priorities for collaboration in areas of geographic overlap.

HR capacity and sustainability: The program trains community based health care workers on a continuous basis and through refresher trainings with technical support from the Ministry of Health and Social Services (MOHSS). Funding through the Global Fund for the program will support sustainability of USG investments.

The primary source of TB data used is the MOHSS's Electronic TB Register (ETR) fed by the paper-based registers which capture information about all confirmed TB patients supported by the NTLP. Project HOPE's data contributes to results and reporting by the NTLP. Revised TB/HIV indicators are reported through the NTLP. Additionally, field promoters conduct household visits and outreach sessions to verify data collection and improve recording and reporting of TB and TB/HIV collaborative activities captured in the ETR.

Low coverage for Isoniazid Preventive Therapy (IPT) is an identified weakness. Project HOPE has responded by promoting demand-driven service delivery, and TB patients and their contacts are educated on IPT and when it is appropriate for use, during household visits. Additionally, TB services have been integrated into OVC activities to improve case detection.

Implementing Mechanism Details

Mechanism ID: 13110	TBD: Yes
REDACTED	



Implementing Mechanism Details

Mechanism ID: 13120	Mechanism Name: Self-Development and Skills for Vulnerable Youth
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Kayec Trust	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 761,014	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	761,014

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The implementing mechanism (IM) is a three year cooperative agreement with KAYEC Trust, a local NGO. Goals of this IM are economic strengthening of vulnerable out-of-school youth and OVC caregivers through vocational training, as well as psycho-social and educational support to in-school OVC. HIV prevention forms an integral part for the program. The IM is in line with the Partnership Framework and National Strategic Framework by employing evidence-based approaches to improve livelihoods for vulnerable populations.

The vocational training is conducted in two regions: Khomas and Oshana. The in-school component, for 12–18 year olds, is carried out in seven regions.

Cost efficiency strategies include utilization of volunteers for the in-school component and close relationship with industry for job placements.

The transition and sustainability plans include leveraging resources under the National Training Authority which regulates vocational training. An outsourcing agreement to KAYEC for specific courses is in place for FY12 and is expected to continue. The implementing partner also expects to become eligible for a national training fund to be established by government. In addition, the implementer receives funds from the private sector.



These various strategies complement the objectives of the GHI in Namibia in that they focus on transition. The monitoring and evaluation plan for this IM includes a tracker study for graduates of vocational training, as well as a mid-term evaluation.

No vehicle purchases are envisaged under this agreement.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	500,000
Education	150,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

- Addressing male norms and behaviors
- Increasing gender equity in HIV/AIDS activities and services
- Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID:	13120		
Mechanism Name:	Self-Development and Skills for Vulnerable Youth		
Prime Partner Name:	Kayec Trust		
Strategic Area	Budget Code	Planned Amount	On Hold Amount



Care	HKID	511,014	0
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Narrative:

The project focuses on two goals: 1) to improve livelihoods of older OVC and junior heads of households by providing appropriate market-driven vocational education and training; and 2) to provide vulnerable 12-18 year olds with self-esteem and leadership skills to ensure they complete their schooling and exercise their rights.

For economic strengthening, KAYEC has developed its Artisan Training for Self Employment (ATSE) program, under which it provides market-driven competency-based skills training in construction related trades through short courses (six to twelve weeks) to vulnerable youth who have dropped out of school and do not meet the academic requirements of the government vocational training centers. The training in vocational skills is complemented by basic business training tailored to small enterprises, as well as by facilitating job placements with formal industry. A tracer study has shown that 73% of graduates earn an income derived from their new skills (average US\$ 138 monthly), often through small enterprises, and with which they support children in their households. A key contributor to success has been shown to be the toolkits tailored to the different trades which the best students receive upon graduation from their training.

The KAYEC Youth Development Program (KYDP) is conducted as an after-school activity for over 1,000 children and adolescents aged 12 –18 and addresses the educational, psycho-social and HIV prevention need of vulnerable youth. Evaluation has shown that KYDP participants had higher school pass rates and lower drop-out rates. The KYDP model was used to develop minimum quality standards for after-school care programs in the MGECW Service Standards for OVC.

Key partner successes include the securing of outsourcing agreements with government (Ministry of Education) and the National Training Authority, as well its close collaboration with industry in designing market related vocational training. A best practice is also the integration of behavior change /HIV communication with OVC programming for both components of this program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	50,000	0

Narrative:

New Budget Code for activities that will be implemented by the Monitoring and Evaluation (M&E) Officer and for a final evaluation.

Activities include: 1) plan to assess KAYEC's current M&E system against donor compliance criteria and recommend amendments and changes; 2) implementation of KAYEC's M&E systems and



requirements, including M&E training programs for program staff and supervisory visits to program staff to periodically assess their M&E systems (verify data and identify areas for continued strengthening); 3) collection of quality data from the KAYEC Youth Development (KYD) and Artisan Training for Self-Employment (ATSE) programs including managing the client service database and analysis and aggregate monitoring of evaluation data; and 4) conducting tracer studies and other strategic information analysis.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	200,000	0

Narrative:

Prevention interventions will target all beneficiaries of both of KAYEC's programs, namely 1,300 vulnerable out-of-school youth and OVC caregivers in Khomas and Oshana Regions and 1,090 in-school OVC in Khomas, Otjjozondjupa, Kunene, Oshana, Ohangwena and Hardap regions.

The in-school OVC intervention will integrate age-appropriate HIV awareness and behavior formation with educational and psycho-social support, aiming to build resilience and life skills covering value education and gender norms for healthy low-risk relationships.

For the out-of-school program, which provides market-related vocational skills in construction trades to school drop-outs, a Social and Behavior Change Communication (SBCC) strategy will be developed focusing on HIV prevention and gender norms including drivers of the epidemic such as alcohol abuse, and include evidence-based promotion of voluntary counseling and testing and voluntary medical male circumcision. Referrals for counseling in alcohol abuse cases will be made.

For both, the in- and out-of-school programs, technical assistance is being provided by C-Change to review current SBCC practices and models and develop targeted sessions for KAYEC's beneficiaries. KAYEC will collaborate with other USG partners for referrals to services for medical male circumcision, male engagement interaction and counseling for alcohol abuse, as well as MOHSS for STI referrals and HIV related peer education.

Implementing Mechanism Details

Mechanism ID: 13166	Mechanism Name: Strengthening Health Outcomes through the Private Sector (SHOPS)
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Abt Associates	



Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,000,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	1,000,000

Sub Partner Name(s)

Banyan Global	JHPIEGO	Marie Stopes International
O'Hanlon Health Consulting	The Monitor Group	

Overview Narrative

SHOPS/Namibia aims to catalyze private sector investment to increase sustainability for the HIV/AIDS response and health care system. This addresses the GHI principles of systems strengthening, transition and improving access. The project will work nationally to strengthen the capacity of the Government of Namibia and civil society to develop public private partnerships (PPP), to motivate private employers to provide health benefits for the formal sector and to support private health providers to deliver quality services to help achieve national health goals. SHOPS will work on: 1) Health Financing: Work with the Ministry of Health and Social Services (MOHSS) and medical aids to expand access to low-cost insurance for the formally employed; 2) NGO sustainability: Strengthen the ability of local NGO to market their competencies and other assets to private firms and providers; 3) Quality improvement: Work with local institutions and other USG partners to provide training opportunities, incentives and modalities tailored for private health providers; and 4) Enabling policy environment and innovative partnerships: Support the MOHSS to partner with the private sector through a new MOHSS PPP unit. Additionally, SHOPS will assess and complete a pilot to develop a sustainable PPP mechanism for primary health care mobile clinics and continue to identify and facilitate new PPP. SHOPS will add to the evidence-base to show how private sector involvement can lead to greater cost-efficiencies, cost-saving and accessibility of health care. The project will work with a number of local partners, including the MOHSS, PharmAccess and the Namibian Medical Aid Fund. Monitoring and evaluation will entail data collection from the private sector, NGO and MOHSS. No vehicle purchase envisaged.



Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Workplace Programs

Budget Code Information

Mechanism ID: 13166			
Mechanism Name: Strengthening Health Outcomes through the Private Sector (SHOPS)			
Prime Partner Name: Abt Associates			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	643,820	0
Narrative:			
<p>This continuing activity, implemented by the Strengthening Health Outcomes through the Private Sector (SHOPS) project will continue activities to 1) Promote non-governmental organization (NGO) sustainability; 2) Facilitate public-private partnerships (PPP) and help support an enabling policy environment for the provision of private health services; 3) Expand access to low-cost health insurance and promote the financing of ART through the private sector; 4) Expand access to training opportunities and promote quality improvement for private providers; and 5) Strengthen private sector reporting to the Ministry of Health and Social Services (MoHSS) on health information, including that related to HIV/AIDS services.</p> <p>In COP11, SHOPS developed a sustainability strategy for NGO providing HIV/AIDS services after</p>			

conducting market research about possible demand and willingness to pay for NGO services by corporations and public institutions. In COP12, SHOPS will focus on training a selected number of NGO in developing and implementing individualized sustainability strategies, and will help to establish a network of potentially sustainable NGO that can help train other NGO reliant on donor funding on how to improve prospects for financial sustainability. Additionally, SHOPS will conduct a cost benefit analysis of potential private sector support to the Social Security Development Fund (SS DF) to support both civil society organizations and bursaries for human resources for health.

SHOPS will continue to identify and facilitate promising public-private partnerships (PPP) and will provide technical assistance to the MoHSS in contracting and partnering with the private sector. SHOPS will help guide private sector involvement in the upcoming National Health Insurance effort to promote universal health coverage. As the new PPP unit comes on board in the MOHSS, SHOPS will support the unit (jointly with GIZ) with developing needed justifications, legal landscape analyses, and the development of a private sector policy.

Increasing private contributions to fund HIV treatment will reduce the public burden to pay for ART. SHOPS will build on the analytical work conducted in COP11 for a basic package for low cost insurance as well as lessons learnt from primary health care mobile clinics to work with the medical aid industry to develop and market low cost insurance products to employers and employees.

SHOPS will continue to provide technical assistance (TA) to local training institutions on adapting curricula for private providers to expand access and will work to link Continuing Professional Development credits for private providers with the uptake of these training courses. This includes demand creation for preventive services among insurance and private provider stakeholders.

In COP12, SHOPS will work to support the MOHSS to routinely link in private sector information. They will work closely with both the public and private sector to determine the parameters of data needs, raise private sector awareness, allay fears, promote understanding of why the data submission is needed and how it will be used and the scheduling and format of data submissions to the MOHSS. SHOPS will work with Namibian Medical Aid Fund and medical aid schemes to develop a health sector database and provide TA to support private sector. SHOPS will also continue to provide to support reporting to MoHSS on workplace HIV programs.

This activity is linked to HVCT, CIRC and HTXS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	100,000	0

Narrative:

Using COP12 funding, this continuing activity, implemented by the Strengthening Health Outcomes through the Private Sector (SHOPS) project will focus on three medical male circumcision (MMC) activities as they relate to the private sector. Firstly, funds will be used for the Mister Sister initiative

(described in the HVCT budget code narrative) to provide technical assistance to public-private primary health care (PHC) mobile clinics to promote the understanding of and access to MMC services in the communities serviced by the mobile clinics. This will include communities in remote rural areas. While the clinics themselves will not conduct MMC, they will create demand and link males requiring MMC to facilities and support follow-up of referrals.

Additionally, SHOPS Namibia will continue to work with the Workplace Wellness Network to facilitate MMC demand creation through the workplaces.

Finally, SHOPS will continue to work with medical insurance schemes to make sure that MMC as an explicit benefit is sustained and work with schemes that did not include it in COP11 to include it in COP12. Moreover, SHOPS will work with Namibian Medical Aid Fund (NAMAF) to collect information on MMC performed in the private sector; such that this information becomes routinely shared with the Ministry of Health and Social Services.

This activity is linked to HTXS and OHSS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	150,000	0

Narrative:

Using COP12 funding, this continuing activity will complete the 'proof of concept' stage of a mobile primary health care (PHC) clinic to remote and farm areas of two more regions in Namibia. Mobile clinic initiatives in Namibia have traditionally offered singular interventions such as for immunization or HIV/AIDS counseling and testing (HCT). Preliminary results are showing that doing so reduces stigma and reluctance to receive services associated with mobile clinics that offer only HCT. Part of the services provided by the mobile clinic is HCT. However, through a new public-private 'Mister Sister' initiative, a broader package of primary health care services will be offered in a mobile clinic setting. This activity aims to increase access to PHC to underserved populations. The premise of the public-private partnership is as follows: 1) A private corporate entity procures the mobile clinic vehicle; 2) Employers in remote locations (such as farms) pay for the clinic to offer health care services to their employees and dependents (these payments pay for the transport and operational costs); and 3) On route to these locations, the mobile clinic offers services to communities based on an agreement with the Government of Namibia, in which all commodities are provided by the Ministry of Health and Social Services and the National Institute of Pathology covers related services. The mobile clinic visits each point along its route once a month and provides basic PHC services through a registered nurse, including follow-up, referrals, and even picking up chronic medication for patients who would have to otherwise travel long distances to the clinic.

In this COP, Strengthening Health Outcomes through the Private Sector (SHOPS) will continue to support the Mister Sister initiative to promote awareness for HCT through education as well as providing



HCT services in the farms and neighboring rural communities. Through support from SHOPS, Mister Sister will also continue to improve linkages and referrals between testing and treatment.

This activity is linked to work under OHSS, CIRC and PDTX.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	106,180	0

Narrative:

Using COP12 funding, this continuing activity, implemented by the Strengthening Health Outcomes through the Private Sector (SHOPS) project, will continue to work with private distributors as well as the MOHSS to establish mechanisms to improve efficiencies and lower ARV prices for all ART patients in the private sector in order to realize sustainable ARV funding.

Findings from a SHOPS study have shown that the private sector pays twice as much for ARV as the public sector; this is largely due to the private sector providers ordering small volumes from a number of distributors. Interestingly enough, the principle payer of these higher-priced ARV is the GRN which runs the heavily subsidized civil servants insurance scheme (PSEMAS) that entitles beneficiaries to receive out-patient care (including ARV) in the private sector. Depending on the direction chosen by stakeholders in COP11, SHOPS support may include support to the GRN to procure ARV for the private sector, establishing mechanisms to charge the private sector for these ARV, supporting the procurement mechanism to meet private sector client volume requests, and conducting additional analyses on possible cost savings of procuring other public health related medicines through cheaper mechanisms. SHOPS/Namibia will also continue to work with Workplace Wellness Network, to work on standards for workplace programs (WPP) that will ensure quality of care and services provided through the WPP. This activity is linked to CIRC and OHSS.

Implementing Mechanism Details

Mechanism ID: 13207	Mechanism Name: Cooperative Agreement 1U2GPS002902
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Polytechnic of Namibia	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A



Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A
Total Funding: 350,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	350,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism supports curriculum development and instruction in the laboratory technologist training program at PON; renovation and equipping PON academic laboratories and classrooms, and; practical internships for students and continuing education for faculty. This mechanism strengthens institutional capacity to train laboratory scientists in Namibia. Direct support to Namibian universities contributes to country ownership and increased research capacity; PON graduates will contribute to expanding access to laboratory services. The PON educates students from all 13 regions of Namibia. Most graduates will work in the public sector nationwide. Support to PON is based on a cost-sharing model to extend existing PON investments to scale-up the medical laboratory degree program. Examples include: PEPFAR support to equip a new six-floor lab building constructed with PON funds; CDC staff TA to the PON curriculum advisory board; PON faculty must secure partial PON funding for professional development before accessing PEPFAR funds. As the program matures, funding will transition to support PON's involvement in the FELTP program managed by MOHSS. Supporting PON will reduce MOHSS costs for expensive bursaries to students attending schools abroad. Investments in PON also support the career ladder for faculty and staff, and contribute to the retention of Namibian instructors. This mechanism promotes cost-effective approaches including e-learning technologies, guest-lecturing, mentorship, and twinning with regional universities. Electronic journals and texts reduce shipping costs for hardcopy textbooks. PON submits an annual work plan aligned with national M&E indicators and targets.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	50,000
Education	150,000
Human Resources for Health	100,000



TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

- Malaria (PMI)
- Child Survival Activities
- TB

Budget Code Information

Mechanism ID: 13207			
Mechanism Name: Cooperative Agreement 1U2GPS002902			
Prime Partner Name: Polytechnic of Namibia			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	350,000	0

Narrative:

Technical support from University of Arkansas (UAMS) and other international partners will enable research linkages to be made to enhance the development of post-graduate training (Masters) and develop extended exchanges for meritorious students to receive specialized training at UAMS as well as complete honors research projects. Through CDC and UAMS assistance, outreach will be made to other key Namibian stakeholders seeking to upgrade local service laboratories to 'training' status thus improving placement options for biomedical science students. Through the assistance of the CDC Laboratory Advisor, the priority of further training for faculty will be assisted through short-term contracts for experts to teach courses during the upgrading period.

The CDC Laboratory Advisor supports the linkage with the CDC Field Epidemiology and Laboratory



Training Program (FELTP) by monitoring and assisting in the renovation of laboratory training facilities and equipping the labs for training exercises.

The other core activity will be to expand diagnostic and service provision capacity of the Polytechnic in specialty public health areas such as mycology, cytology, and specific zoonotic diseases. Through the guidance of the CDC technical team, the aim of this activity is to assist Polytechnic to meet current needs to monitor and report on specific infectious diseases in Namibia, thereby becoming an active participant in the planned public health laboratory network.

Implementing Mechanism Details

Mechanism ID: 13209	Mechanism Name: Community Action for OVC
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Church Alliance for Orphans	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,131,638	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	1,131,638

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This implementing mechanism (IM) is a cooperative agreement with the Church Alliance for Orphans (CAFO) in its third year of implementation. The award’s objective is to mobilize and sustain community-based responses to the needs of OVC, in line with envisaged impact mitigation results under the Partnership Framework. The IM targets OVC and their caregivers in 12 regions in Namibia. CAFO is an indigenous CSO, formed as an interdenominational umbrella organizations devoted to promote local action by church congregations and communities to mitigate the impact of HIV on children. CAFO has over 500 member congregations across the country.



To be cost-efficient, the IM works through existing community and church projects organized under ecumenical committees. CAFO provides capacity building for these projects to ensure quality service delivery, and technical assistance for leveraging of local level resources.

In line with the GHI strategic focus area of transition and increasing access to services, the IM is facilitating access to government child welfare grants for eligible children as well as to education and health services. All projects will develop graduation plans.

Routine monitoring activities will take place at project and regional levels via regional committees and regional support officers, and will feed into the IM national data base. The national monitoring and evaluation team will be responsible for data quality assessments. Implementation will be guided by the IM mid-term evaluation scheduled for the end of FY12.

No vehicles are scheduled to be purchased under this IM.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	50,000
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TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities



Budget Code Information

Mechanism ID: 13209			
Mechanism Name: Community Action for OVC			
Prime Partner Name: Church Alliance for Orphans			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	931,638	0

Narrative:

The partner Church Alliance for Orphans (CAFO) is an indigenous faith-based organization (FBO) constituted as an umbrella body to advocate for rights and services for OVC. CAFO has over 500 member congregations across the country, and technical and financial support is channeled through member congregations.

The project combines capacity building for service delivery through community grants and training with advocacy and referrals to service providers. Service delivery at community level focuses on psychosocial support, nutrition and behavior change communication for HIV prevention for OVC. Training for community projects also focuses on engaging OVC caregivers. Capacity building targets community projects as well as regional committees and focuses on basic organizational development to ensure projects have transparent structures, as well as strategies and skills to become sustainable. The project will reach approximately 10,000 OVC in nine regions.

CAFO provides small grants to community projects which are selected based on proposals evaluated against technical criteria. Sub-granting for service delivery is supplemented with facilitation of linkages of community projects with key government officials (schools, social workers), NGO and business entities, and with technical assistance for measures promoting service sustainability including economic strengthening/income generating activities and leveraging private and public sector resources. An additional component is the development of tools for church congregations (sermon sketches) to galvanize church communities into action to support OVC. The implementing mechanism's (IM) approach has been shaped by an evaluation of the IM preceding the current cooperative agreement with CAFO.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	200,000	0

Narrative:

The partner Church Alliance for Orphans (CAFO) is an indigenous faith-based organization (FBO) constituted as an umbrella body to advocate for rights and services for OVC. CAFO has over 500



member congregations across the country, and technical and financial support is channeled through member congregations.

Prevention interventions target vulnerable and orphaned adolescents aged 10 to 18, who are at risk of early sexual debut and unsafe sex due to transient or instable family situation and resultant lack of parental and adult support, as well as due to poverty. Sexual prevention for female and male adolescents (OVC) will be implemented with evidence-based social and behavior change communication (SBCC) methodology through 12-18 interactive group sessions focusing on delay of sexual activity and for caregivers of OVC to improve parental communication with children on drivers of early sexual initiation and related social norms.

HIV prevention activities will be integrated with OVC support interventions, especially psychosocial and educational support, and referrals to protection and health services, including HCT. Intervention sites will be select community projects run under the auspices of church congregations in four regions.

Quality assurance will be promoted through the use of standardized materials developed by C-Change, and through supportive supervision by CAFO's Regional Support Officers and by local ecumenical committees.

Monitoring tools will be developed to be administered in conjunction with mechanisms to monitor other OVC services.

Implementing Mechanism Details

Mechanism ID: 13227	Mechanism Name: I-TECH: Support to MOHSS National Health Training Center (NHTC)
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: ITECH	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 4,823,781	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	4,823,781



Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism supports the NHTC to train health care workers in the public and private sectors. Current training courses focus on PMTCT, Early Infant Diagnosis, HIV prevention, male circumcision, nutrition, HIV treatment, TB diagnosis and care, HIV counseling and testing, and nursing. Strengthening NHTC’s capacity to provide in-service training and continuing medical education to healthcare workers in the public and private sectors contributes to GHI country ownership and access to quality health services goals. The NHTC trains healthcare workers nationwide. In-service trainings are provided through the NHTC headquarters and four regional training centers, as well as via Digital Video Conferences. Training schedules have been adapted to attract more private providers nationwide. I-TECH has successfully transitioned several project staff to the NHTC payroll, and has formed a joint Transition Technical Working Group with MOHSS (NHTC) and UNAM. In COP11, PEPFAR shifted a portion of funds from I-TECH to directly support the NHTC. Activities supported under this mechanism are integrated with CDC’s direct technical assistance to the MOHSS. Supporting training activities through NHTC avoids duplicative training efforts and reduces costs associated with training abroad. Hiring of trainers, tutors, and other key staff is coordinated with MOHSS and CDC through Potentia. I-TECH maintains a robust M&E system to measure progress towards national targets. A detailed work plan and M&E plan is developed each year and is reported to CDC and HRSA on a quarterly basis. I-TECH is committed to transferring operational control over these systems to its Namibian counterparts.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	2,400,000
Human Resources for Health	2,423,781

TBD Details

(No data provided.)

Motor Vehicles Details



N/A

Key Issues

- Addressing male norms and behaviors
- Impact/End-of-Program Evaluation
- Increasing gender equity in HIV/AIDS activities and services
- Child Survival Activities
- Mobile Population
- Safe Motherhood
- TB
- Family Planning

Budget Code Information

Mechanism ID: 13227			
Mechanism Name: I-TECH: Support to MOHSS National Health Training Center (NHTC)			
Prime Partner Name: ITECH			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	540,000	0

Narrative:

Activities supported through I-Tech in this budget code include;

Training of HCWs in HIV/AIDS related Nutrition, OIs and STIs: Support for revision of the curriculum on HIV/Nutrition Management and will conduct two regional trainings, of 25 participants each. I-TECH will conduct regional trainings on Nutrition Assessment and Counseling and Support (NACS), STI surveillance and management of opportunistic infections. I-TECH will also support the procurement of supplies and equipment for training.

Capacity Building of MOHSS/Nutrition unit: Capacity development for staff in the MOHSS nutrition unit with the aim of transitioning the work of the I-TECH Nutrition Advisor to MOHSS staff. To transition these functions to MOHSS staff, I-TECH will support capacity building activities including but not limited to short courses of 3-4 weeks for nurses in the nutrition unit. The courses will include topics such as: Infant/breast feeding, nutrition and HIV, HIV and non-communicable diseases, growth monitoring, nutrition



surveillance, M&E and basic nutrition.

Printing of Materials: I-TECH will print copies of guidelines and the strategic plan developed in 2011. I-TECH will also print IEC materials in an effort to address the information gap identified in a 2011 landscape analysis among clients accessing nutrition services.

Clinical Mentoring for Nurses: Tutors from the Regional Health Training Centers will conduct quarterly clinical support visits to facilities providing nutrition services in the regions to ensure transfer of learning and to provide on-site mentorship. During these visits, 2-3 tutors will assess the facility, supplies, and quality of service provision in nutrition. The Nutrition Advisor will also join the tutors from NHTC during these visits.

Distance Learning Training: To complement the training and mentoring, I-TECH will provide distance learning opportunities for health care workers to enhance their knowledge about all aspects of treatment of patients with HIV including cervical cancer screening and provision of ARV services. This will include digital video conferences as well as internet-based distance learning opportunities.

I-TECH continues to work with NHTC to implement an HR and programmatic transition plan. Support for human capacity development in Namibia will contribute to the integration of support activities, such as nutrition, into HIV/AIDS and primary healthcare services. The expansion of access to integrated services is a primary objective of the Namibia GHI Strategy. CDC and I-TECH will continue to coordinate with USAID-funded nutrition programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	290,000	0

Narrative:

Curriculum review/development: In response to Namibia's growing number of patients with MDR and XDR TB, the National TB and Leprosy Program (NTLP) developed Drug Resistant TB management guidelines in COP11. ITECH, with its partners, will develop a Programmatic Management of DR-TB training curriculum. In addition, ITECH will revise a basic TB curriculum for public sector nurses.

Pilot testing and training in Programmatic Management of DR-TB: The MDR-TB curriculum will be piloted tested in COP12 with 25 participants; one course will be conducted.

Training of public and private sector nurses in TB: In collaboration with the Global Fund, ITECH will continue to train public and private nurses in TB/HIV and will conduct one training for 20 private nurses. This training will focus on the new TB guidelines. ITECH will support four trainings for 100 public sector

nurses.

TB training materials: ITECH will continue to provide training materials for HIV/TB training courses offered to public sector nurses. This includes trainer and participant manuals, and relevant handouts and teaching aides. Training for public sector nurses is funded by the Global Fund; ITECH will continue to collaborate with Global Fund to provide training materials for 250 nurses.

Training of doctors, and pharmacists on TB/HIV co-infection: ITECH will strengthen the abilities of public and private sector clinicians to prevent, diagnose, and manage TB, including DRTB. In COP12, ITECH will conduct four basic TB courses using the updated curriculum, with 30 participants each. A course called "Updates in TB management" will be provided to 50 public sector doctors and pharmacists in two trainings.

Training in Clinical HIV Care and OIs: ITECH will enhance doctors' and pharmacists' capacity to appropriately diagnose and manage OIs, assess and manage pain and provide other appropriate care. ITECH, with MOHSS, revised the curriculum for "Clinical Care of HIV, AIDS and Opportunistic Infections" to correspond to guidance given in the Namibia Standard Treatment Guidelines launched in 2011. ITECH will conduct two training courses with 25 government doctors and pharmacists each.

Clinical Mentoring: Clinical mentors provide daily in-service training for healthcare staff and will provide mentoring support to clinicians following the training in TB/HIV and OI management. Tutors from the Training Networks will conduct quarterly visits to the facilities for skills transfer, on-site mentorship and to identify gaps and make recommendations for improvement.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	210,813	0

Narrative:

Activities supported in this budget code include;

Training of HCWs in pediatric HIV treatment: ITECH will train HCWs in comprehensive pediatric HIV care using a curriculum that includes clinical pre-ART and ART care, management of common clinical conditions, opportunistic infections, nutrition and growth monitoring, psychosocial challenges, and other palliative care issues. In COP12, part of the curriculum will be updated to align with the new "Essential Services for Adolescents Living with HIV (ALHIV)" Strategy.

ITECH will conduct two training courses on comprehensive pediatric HIV care, each with 25 people, for public sector doctors and pharmacists.

An advanced ART curriculum addressing the use of ARVs in adults and children, as well as the



management of TB/HIV co-infection will be regularly revised and updated, and used to conduct training for doctors and pharmacists already trained in the basic courses (See HTXS).

HIV Clinical Mentoring: Four HIV physician clinical mentors will provide mentoring support on the management of pediatric HIV care and treatment primarily to doctors in 8 of the 13 regions of Namibia, reaching 94 clinicians in 36 sites (NB: see links to HTXS and PDTX). Clinical mentors provide on-site support to health workers in health facilities in managing OIs, malnutrition and providing ART, and work with the sites to assess quality of HIV care provided (link to HIVQUAL).

Clinical mentors will also assess training needs and routinely provide didactic and hands-on training as well as regular DVC case discussions co-hosted with mentees from the field, thus promoting sustainability. They will also promote a multi-disciplinary approach to HIV care, and strengthen mechanisms to address site specific patient retention and referral issues including the use of outreach, bi-directional referral systems and defaulter tracing.

Support of Community Based Child Growth Monitoring and Promotion: ITECH will support the initiation of Community Based Growth Monitoring and Promotion (CBGMP), which will assist in early identification of children with poor growth as a result of HIV infection and related illness. This will coincide with support and promotion of exclusive breastfeeding with appropriate complimentary feeding for up to two years and beyond. Five courses on Nutrition assessment counseling and Support will be conducted with 25 participants each, for a total of 125 people trained

Distance Learning Training: To complement training and mentoring, ITECH will provide digital video conferences and internet-based distance learning.

Investments in human capacity development through ITECH and, increasingly, through its local partners, the NHTC and the University of Namibia, contribute to the USG Namibia team's transition objectives. Increasing the availability of trained healthcare workers in the field also contributes to the access objectives described in the Namibia GHI strategy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	920,000	0

Narrative:

Funding in this budget code includes the following activities:
 Training workshops in various health sector tools: Continuing capacity building for the MOHSS Response

Monitoring and Evaluation (RM&E) unit to implement monitoring, data collection, and analysis, and reporting of health sector data. The RM&E unit will train its regional staff, including data clerks, to improve data collection, entry, data cleaning, analysis, and use.

System for Program Monitoring training: Support for the System for Program Monitoring (SPM), the system through which all non-health sector HIV/AIDS related activities are reported by the Ministry of Regional and Local Government to the National AIDS Commission. This activity will support one M&E training for the 13 Regional M&E officers; two SPM trainings for regional implementers; one report-writing training and TOT for regional M&E officers and community liaison officers.

Support for Health Information Systems capacity building and training support: Support to the MOHSS HIS through capacity building for regional HIS officers in data entry, analysis, use, and quality. One training on DHIS for new recruits will be held, along with two Data Review and Analysis workshops.

Evaluation of HIV Disclosure to Children Program: ITECH will conduct an evaluation to 1) assess the implementation fidelity of the MOHSS child disclosure intervention at nine high patient volume sites; 2) determine benefits of the program to HCWs in increasing their knowledge, confidence and stress reduction with disclosure; 3) determine the benefits of the program to caregivers in improving their ability to care for children living with HIV; and 4) compare patient outcomes for children in the disclosure program with those who are not in the program.

Evaluation of MOHSS/ITECH Distance Learning Program: MOHSS and ITECH implement the Distance Learning (DL) and Digital Video Conferencing program. In COP12, ITECH will conduct an evaluation of the program to simultaneously assess the impact that the program has made to HCWs throughout the country and to inform the transition plan to the MOHSS moving forward.

M&E of transition to the National Health Training Center (NHTC): ITECH collaborates with NHTC and has been transitioning activities and staff to this MOHSS unit. As part of the transitioning activities, ITECH will promote and monitor processes and outcomes associated with this transition.

Conducting a national research dissemination workshop: ITECH and the MOHSS will organize a national research dissemination conference in 2013 focusing on program data, surveillance data, and operational research across multiple program areas. No such dissemination activity exists in Namibia; this workshop responds to a mandate in the National HIV Research Agenda.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	56,025	0

Narrative:

Assist MOHSS to develop its capacity to assume management and use of the Digital Video Conferencing (DVC) system: An assessment was conducted with COP11 funds to evaluate MOHSS's capacity to take

on responsibility of DVC. In COP12, comprehensive plans will be developed to transition operation of DVC to MOHSS. In COP12 ITECH will continue to work with MOHSS, UNAM, and partners to expand the use of DVC. ITECH will intensify training of MOHSS and UNAM staff to operate and maintain equipment, and to organize and manage DVC sessions and programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	412,703	0

Narrative:

Curricula review/development of community counselor training in MC: Community counselors (CC) play a key role in recruitment, health education and providing HIV counseling services to men enrolled in Namibia's national MC program. I-TECH will continue to ensure that training curricula and other materials are updated regularly to ensure standardization and continuity in the CC cadre.

Training of regional and district managers on the Namibian MC policy and its implementation: In this activity, regional and district managers will be oriented on the Namibian Policy for MC and its implementation. In COP12, I-TECH, in collaboration with the MOHSS, will conduct two training courses for 40 regional and district managers.

Training of Trainers: Roll-out of MC requires provision of services by clinicians who are highly trained on the theory and practice of the MC procedure. Skilled clinical trainers will form a crucial part of the MOHSS MC Strategy and Implementation plan. I-TECH will identify clinicians who have demonstrated competence in performing MC and who show potential as future MC training facilitators. In COP12, I-TECH will revise its TOT program and conduct two MC TOT training courses.

Training of Service Providers: Training of doctors, nurses, and community counselors will continue to support the national MC program's efforts to scale-up to meet the National Strategic Framework (NSF) goal of circumcising 450,000 men by March 2016. The MC training curriculum covers technical skills and infection control. Non-consumable surgical equipment and consumable commodities will be procured to support these training courses. Five training courses will be conducted for doctors, nurses and CC, targeting 150 staff.

MC Quality Assurance and Certification: Several months following the training for MC providers, I-TECH MC trainers (a physician and a nurse) will track the progress made by clinical trainees and will conduct 1-2 day visits to the sites where clinicians, who have received MC training, are operating. The WHO Quality Assessment toolkit will be used to evaluate each clinical provider's proficiency in the MC operative procedure and to assist in additional skills transfer where necessary. A "certificate of MC



proficiency” will be issued to individual providers meeting all the set requirements. It is anticipated that 60 providers in 30 sites will be assessed for proficiency.

Neonatal Circumcision: The NSF sets a goal of circumcising 167,900 newborn males by March 2016. In COP12, I-TECH will collaborate with the MOHSS to: 1) Develop a neonatal MC providers’ curriculum; 2) Support one neonatal MC TOT training for 16 people; 3) Conduct one pilot training for 16 participants; and 4) Conduct one “roll-out” training for 16 participants.

Distance Learning Training: To complement the didactic and practical training, as well as the mentoring support described above, I-TECH will continue to provide distance learning opportunities for HCW to enhance their knowledge about MC. DVC will be used for continuing education and refresher courses on the Namibian MC Policy, neonatal MC and other relevant topics.

Support for training and expert supervision will support expanded access to MC services in high-need areas of Namibia. A successful rapid roll-out of MC services will also accelerate the transition of the MC program from a time-limited program focused on adult males to an MOHSS-led routine program focused on neonatal MC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	105,000	0

Narrative:

Training in HIV Counseling and Testing: HCT is the entry point for Prevention and for PLHIV to access care and treatment. Accordingly, there is a great need to train nurses and community counselors (CC) throughout the country in order to increase service coverage through different service delivery methods. Health Care Workers (HCW) will be trained in HCT. The counseling component involves training in HIV individual counseling, couples HIV counseling and testing (CHCT) using either the client-initiated or provider-initiated testing and counseling (PICT) approaches. In 2009 MOHSS integrated PICT into the HCT course in an effort to increase PICT coverage. With COP11 funds ITECH reviewed the HCT curriculum in line with the revised HCT guidelines. In COP12, a total of 120 HCW will be trained in HCT (VCT and PICT). In addition, ITECH will conduct PICT courses via the digital video conferencing (DVC) for nurses in out- and various in-patient departments. This is in line with the MOHSS’s goal of increasing the number of persons receiving HCT, and to rapidly refer a greater number of infected persons to ART services for treatment. Five additional trainings in CHCT will be conducted to train a total of 120 health workers. Overall, a total of 240 HCW will be trained in HCT.

Distance Learning (DL) Training: To complement the didactic training, ITECH will continue to provide



distance learning opportunities for health care workers to enhance their knowledge about management to provide effective and quality HCT. This will include digital video conferences as well as internet-based distance learning opportunities. In addition, in line with the ITECH transition plan, with FY12 funds, ITECH will begin training NTN resource persons to operate, manage and operationalize the DL component of the training including DVC equipment.

ITECH continues to implement a transition plan with the NHTC. ITECH activities to build human capacity in the healthcare field will contribute to MOHSS efforts to expand access to HIV and primary healthcare services throughout the public health care network. The increased focus on PICT is designed to improve uptake of services by populations (e.g., men) who have historically not accessed HCT or benefitted from rapid referral to treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	140,000	0

Narrative:

ITECH will support the national roll out of the training of Prevention for PLHIV curriculum. The core framework of this course is based on CDC's Prevention with PLHIV evaluation intervention and includes: Prevention messaging (e.g., disclosure, partner testing, condom use, and an intervention on alcohol use); syndromic screening for STIs as well as the provision of family planning counseling. The prevention course will also include a brief overview of TB and nutrition screening. Four trainings will be conducted, with 40 participants each, for a total of 160 health workers trained.

To complement the didactic training and information dissemination support, ITECH will continue to provide distance learning opportunities for health care workers to enhance their knowledge about management of PMTCT patients. This will include digital video conferences as well as internet-based distance learning opportunities. In addition, in line with the ITECH transition plan, ITECH will begin training GRN staff to operate and manage the distance learning component, including the DVC system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	379,240	0

Narrative:

Curriculum review/development and training of nurses in the provision of PMTCT and EID services: In 2010, the Ministry of Health and Social Services (MOHSS) revised the Prevention of Mother to Child Transmission (PMTCT) regimen to align with the World Health Organization (WHO) recommendations. In 2009, the Early Infant Diagnosis (EID) course was integrated into the PMTCT course in order to



harmonize training, reduce vertical training, and to ensure that Health Care Workers (HCW) were trained in all components of PMTCT. In addition, in COP12 the MOHSS plans to embark on a strategy to eliminate MTCT. In FY 2012, ITECH, in partnership with technical experts from the MOHSS, will revise the training curriculum in accordance with the new guidelines. In line with ITECH's transition plan with COP12 funds, ITECH will begin supporting and providing technical assistance for National Training Network to establish the Curricula Unit within the National Training Center. ITECH will use the funds to train a total of 225 HCW. Funds will also be used to procure training materials and supplies.

Clinical mentoring for doctors and nurses: To support the national efforts to eliminate MTCT through effective and quality PMTCT services, ITECH will use the current structured clinical support visit assessment tools and tutors from the Regional Health Training Centers to conduct quarterly clinical support visits to facilities providing PMTCT/EID services in the regions in order to ensure transfer of learning and to provide on-site mentorship. During these visits, two to three tutors will work as a team to assess the facility, supplies, and quality of service provision in PMTCT/EID. In COP12, through this support, the National Training Network (NTN) tutors will visit 50 sites mentoring a total of 200 HCW. To ensure sustainability and transfer of activities, ITECH will train regional tutors as Nurse Mentors. In addition, four HIV expert physician clinical mentors will continue to provide mentoring support primarily to doctors in 8 of 13 regions of Namibia in their management of pregnancy and delivery of HIV-infected pregnant women and their HIV-exposed infants. Clinical mentors will also assess training needs and routinely provide didactic and hands-on training and mentorship as needed in the PMTCT.

Distance Learning Training: To complement the didactic training and information dissemination support, ITECH will continue to provide distance learning (DL) opportunities for health care workers to enhance their knowledge about management of PMTCT patients. This will include digital video conferences as well as internet-based distance learning opportunities. In addition, in line with ITECH transition plan, it will begin training NTN resource persons to operate, manage and operationalize the DL component of the training including Digital Video Conferencing equipment.

Investments in human capacity development through ITECH and, increasingly, through its local partners, the NHTC and the University of Namibia, contribute to the USG Namibia team's transition objectives. Increasing the availability of trained healthcare workers in the field also contributes to the access objectives described in the Namibia GHI strategy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,440,000	0

Narrative:



Doctors ART Training: ITECH will conduct three basic ART courses and advanced ART and TB management trainings for the public and private sector for doctors and pharmacists.

Clinical Mentoring for Doctors: Clinical mentors will provide on-site support to Health Care Workers (HCW) in ART facilities, using MOHSS and HIVQUAL tools and work with the sites every 6 months to assess the quality of HIV care provided by mentees.

In COP12, ITECH task-shifting courses for nurses and doctors will support MOHSS' plans to implement findings of the task-shifting study.

Training of Trainers will provide training skills to clinicians already proficient in delivering ART care. This will encourage sustainable training for HCW.

ITECH will support the Integrated Management of Adult Illnesses (IMAI) training program targeting 60 nurses and community counselors. 10 ART trainings for nurses will be conducted.

Curriculum review/development: Revise three curricula: 1) Task Shifting; 2) IMAI; and 3) Training of Trainers. ITECH will support and provide technical assistance for National Training Network to establish a Curricula Unit.

Clinical mentoring and training of 34 nurses in ART clinics will be focused on in COP12. Nurses will provide mentoring and will work closely with IMAI facilities.

Training of Nurses in Medicine Adherence Counseling (MAC): Train nurses in MAC, print training materials, and procure training supplies and equipment. In COP12, ITECH will conduct 5 regional trainings targeting 125 HCW.

Distance Learning Training: Provide HIV-related distance learning (DL) to HCWs through digital video conferences (DVC) as well as internet-based DL. ITECH will train NTN resource persons to manage the DVC equipment.

Strengthen National Health Training Network (TN): Trainings in Leadership and Management, Curriculum Development, Training Delivery, Distance Learning, and M&E and Research. ITECH will support the revision of nursing curricula, skill and competency development, and integration of the Leaders in Health (LIH) course.

UNAM's School of Nursing (SoN): Support professional development for UNAM SoN faculty and initiate "twinning" relationships of UNAM with nursing schools in South Africa. The curricula and Lecturer's Resource Guide will also be revised.

School of Medicine (SoM): Support to the SoM to review curricula to address the content gaps relating to HIV within the medical student curriculum.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	330,000	0

Narrative:

Training of Health Care Workers (HCW) in pediatric HIV treatment: ITECH will train HCW in comprehensive pediatric HIV care using a curriculum that includes clinical pre-ART and ART care, management of common clinical conditions, opportunistic infections, nutrition and growth monitoring, psychosocial challenges, and other palliative care issues. In COP12, parts of the curriculum will be updated to reflect the new “Essential Services for Adolescents Living with HIV (ALHIV)” strategy. ITECH will conduct two training courses on pediatric HIV care, each with 25 people, for public sector doctors and pharmacists.

Training in HIV Disclosure to Children: ITECH and the MOHSS developed a course focusing on psychosocial and practical aspects of HIV disclosure to children in COP11. Practical tools were also developed and provided as “starter packs” to sites trained for implementation. This interactive and practical course was piloted and conducted in COP11. In COP12, ITECH will conduct six training courses with 27 participants (at least 3 participants from each ART site). The “Why I take my medicines” book will be translated into three additional local languages.

Supporting the dissemination of Essential Services for Adolescents Living with HIV (ALHIV) Strategy: A new MOHSS strategy for ALHIV is expected in 2012. To facilitate timely dissemination and implementation of the new strategy, ITECH will incorporate information from the strategy into module-relevant curricula such as: Comprehensive Pediatric HIV Care, ART guidelines courses for doctors, pharmacists and nurses, IMAI, HCT and PMTCT.

Clinical Mentoring for Doctors: Clinical Mentors will continue to assist facilities to focus on increasing access to early infant diagnosis and enrolment of HIV-infected patients into HIV care and treatment. Clinical mentors will also assist facilities to address psychosocial issues such as HIV disclosure for children, and addressing the needs of adolescents living with HIV.

Supportive Supervision and quality improvement: Using structured clinical support visit assessment tools, tutors will conduct quarterly clinical support visits to facilities providing pediatric care and treatment. During these visits, two to three tutors will assess the facility, supplies, and quality of service provision. To promote sustainability, ITECH will also train regional tutors as Nurse Mentors.

Investments in human capacity development through ITECH and, increasingly, through the University of Namibia, contribute to the USG Namibia team’s transition objectives. Increasing the availability of trained healthcare workers in the field also contributes to the access objectives described in the Namibia GHI strategy.



Implementing Mechanism Details

Mechanism ID: 13253	Mechanism Name: Global Development Alliance
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: New Partner	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A
Total Funding: 340,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	340,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Synergos Global Development Alliance (GDA) is a USG/Ministry of Health and Social Services (MOHSS)-private sector partnership that aims to strengthen leadership and performance within the MOHSS to achieve its maternal and child health and nutrition targets. This partnership, envisioned over three years, entails a total USG contribution of \$1,000,000 and a private sector contribution of at least \$1,215,000 from various entities. This GDA works towards the national policy of decentralization as well as the GHI principles of systems strengthening, resource mobilization and transition.

In COP12, the Synergos GDA will focus on: 1) National level: capacity building to support most senior leaders of the MOHSS to performance-manage progress on Ministry's plans and goals; and 2) Regional level: Expand regional delivery units (RDU) to the remaining ten regions over three years. RDU are high-performance units that drive policy implementation and coordinate service delivery. In the past, these units have led to reduced waiting times in ANC clinics and decreased congestion at referral hospitals.

Cost-efficiencies will be realized through the use of MOHSS structures and in-kind contributions of direct costs (such as staff time, workshops and data). Sustainability and transition is rooted in the project's use of RDU, conceived as permanent structures institutionalized within the Ministry, and efforts to engage senior leadership to create the enabling environment for more rapid progress on health indicators. A joint



MOHSS monitoring and evaluation plan will be developed that focuses on developing and refining systems for utilizing data effectively and efficiently to enable informed data-driven decisions.

No vehicle purchases envisaged.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	100,000
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TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Child Survival Activities
Safe Motherhood

Budget Code Information

Mechanism ID: 13253			
Mechanism Name: Global Development Alliance			
Prime Partner Name: New Partner			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	200,000	0
Narrative:			



This is a continuing activity that leverages domestic and international resources to the amount of \$1,343,499 over three years. USAID funding is expected to reach \$1,000,000 over three years, pending the availability of funds. This initiative brings new contributory partners to the health sector in Namibia; it includes the Synergos Institute, Ministry of Health and Social Services (MOHSS), Containers to Clinics (C2C), the Global Alliance for Improved Nutrition (GAIN) and the First National Bank (FNB) Foundation.

Activities will focus on both the national and regional level as described below. They will also facilitate better targeting of health services to pediatric health needs and nutrition related goals. The activities will also link to and support the Namibian Alliance for Improved Nutrition (NAFIN), Regional Councils, and Regional AIDS Coordination Committees of which Synergos is a founding member and serves as the secretariat for NAFIN.

Support will be provided to MOHSS senior leaders to implement strategy and establish a clear direction for the Namibian public health system to more effectively achieve national maternal and child health and nutrition goals. This will be achieved by working with, and building the capacity of, senior MOHSS officials, national political leaders, coordinating bodies, and others, to provide the leadership 'push', management support, policy and budget adjustments, and political will required for improved maternal and child health outcomes.

Activities will also work to strengthen Regional Delivery Units (RDU) within the public health system that will coordinate actions and performance management toward achieving national maternal and child health and nutrition goals. At present, regional health departments are not organized effectively to deliver results on key performance targets. This activity involves establishing high-performance units at the regional level, RDU, to drive policy implementation and coordinate effective service delivery. RDU would centralize regional accountability for improving maternal child health into a single, authorized entity within the MOHSS. A prototype of this structure has already been tested with success in the Khomas Region and known to have reduced waiting times for ANC visits and alleviated the patient flow at hospitals through better streamlining and referral processes. The RDU will help to lay the foundation for replicable systems change, on issues such as malnutrition in teen pregnancies, low birth weight babies, the role of traditional birth attendants and redeploying existing health facilities for maternal and child health service delivery.

To build regional capacity to design and implement innovative, frontline projects for addressing maternal and child health and nutrition, the Alliance will address key drivers and critical blockages of maternal and child health and nutrition. Current innovations include a research initiative managed by the Mother, Infant and Young Child Nutrition (MIYCN) working group in the MoHSS to test the application of micro-nutrients (sprinkles) to improve the nutritional value of supplementary feeding practices for mothers and infants.



This activity is linked to MTCT.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	140,000	0

Narrative:

This is a continuing activity that leverages domestic and international resources to the amount of \$1,343,499 over three years. USAID funding is expected to reach \$1,000,000 over three years pending the availability of funds. This initiative brings new contributory partners to the health sector in Namibia; it includes the Synergos Institute, Ministry of Health and Social Services (MoHSS), Containers to Clinics (C2C), the Global Alliance for Improved Nutrition (GAIN) and the First National Bank (FNB) Foundation. Activities under this budget code will focus on both the national and regional level; in doing so, they will build the capacity of health managers to deliver and sustain effective and efficient maternal health care, inclusive of PMTCT and post-natal care services, in the public sector.

Support will be provided to strengthen the ability of Ministry of Health and Social Services (MOHSS) senior leaders to implement strategy and establish a clear direction for the Namibian public health system to more effectively achieve national maternal and child health and nutrition goals, including PMTCT. This will be achieved by working with, and building the capacity of, senior MoHSS officials, national political leaders, coordinating bodies, and others, to provide the leadership 'push', management support, policy and budget adjustments, and political will required for improved maternal and child health outcomes. Activities will also work to strengthen Regional Delivery Units (RDU) within the public health system that will coordinate actions and performance management toward achieving national maternal and child health and nutrition goals. At present, regional health departments are not organized effectively to deliver results on key performance targets. This activity involves establishing high-performance units at the regional level, RDU, to drive policy implementation and coordinate effective service delivery. RDU will centralize regional accountability for improving maternal child health into a single, authorized entity within the MOHSS. A prototype of this structure has already been tested with success in the Khomas Region and is known to have reduced waiting times for ANC visits and alleviated the patient flow at hospitals through better streamlining and referral processes. The RDU will help to lay the foundation for replicable systems change, on issues such as malnutrition in teen pregnancies, low birth weight babies, PMTCT, the role of traditional birth attendants and redeploying existing health facilities for maternal and child health service delivery.

To build regional capacity, to design and implement innovative, frontline projects for addressing maternal and child health and nutrition, the Alliance will address key drivers and critical blockages of maternal and child health and nutrition. With respect to maternal health, a number of regions are designing innovations



around improved access to services in un/under-served areas. For example the Ohangwena and Oshana RDU are busy translating key health messages in Oshiwambo to be broadcast on Ohangwena Radio. The messages vary, but amongst these are messages to educate expectant mothers about the benefits of early and regular ANC visits that will greatly benefit the mothers with regard to PMTCT. The past deployment of a container clinic in Erongo Region deals with a similar issue of improved access to services, inclusive of PMTCT and nutrition.
 This activity is linked to PDC

Implementing Mechanism Details

Mechanism ID: 13289	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 13420	Mechanism Name: Ministry of Gender Equality and Child Welfare
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Ministry of Gender Equality and Child Welfare	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 180,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	180,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism provides direct funding to the Ministry of Gender Equality and Child Welfare (MGE CW) for activities and technical assistance (TA) to improve systems for service delivery to children and to



strengthen the ministry to coordinate the National Agenda for Children (NAC). Activities will take place at the national and regional levels. The beneficiaries will be Orphans and Vulnerable Children (OVC). The project activities will improve protection measures under the Child Care and Protection Act, a new legislation in Namibia, and put administrative frameworks and training plans in place for its roll-out. These activities include an integrated approach to alternative care and support services for survivors of violence and abuse. Under this mechanism, the MGECW will also be able to access TA to ensure the Early Childhood Development Program has adequate support and administration systems. The MGECW will also establish procedures and an operating mechanism for the national Children’s Council, a high-level committee that ensures all sectors report on the results for children. The main collaborating partners will be UNICEF and the Global Fund for AIDS, Tuberculosis and Malaria as well as local OVC NGO service providers.

These activities are part of the Government of Namibia’s (GRN) strategy on OVC and will form part of the MGECW Annual Work Plans. The activities will be monitored as part of the MGECW quarterly and annual work plan, using existing monitoring and evaluation systems. This program is in line with the USAID GHI strategy in that it increases access to services for OVC. The mechanism will provide TA to the GRN to build its capacity to support OVC, to prepare for transition and be more cost-efficient over time. Vehicle purchases or leases are not envisaged.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HKID	Local Child Protection Committees; Social Workers; OVC Caregivers	75000	Training of subnational child protection committees on tool and guidelines; training of social workers on psychosocial support, psychosocial support interventions with OVC caregivers

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	75,000
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TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
 Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	13420		
Mechanism Name:	Ministry of Gender Equality and Child Welfare		
Prime Partner Name:	Ministry of Gender Equality and Child Welfare		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	180,000	0

Narrative:

The Ministry of Gender Equality and Child Welfare (MGECW) is the host government entity which spearheads the national response to mitigate the impact of HIV on children. COP 12 resources will support the MGECW to coordinate line ministries and CSOs and to develop an effective accountability framework to ensure that different sectors work towards achieving the results set out in the National Agenda for Children 2012 - 2016. This will include the establishment of a high-level Children's Council, as provided for in a new child protection law which is expected to be promulgated in FY12. Specific TA needs to implement other components required to roll out child protection under the Child Care and Protection Act will be defined, with particular regard to capacity for monitoring and evaluation. USG resources will also be used to strengthen the social welfare workforce, based on the Human Resource Strategic plan developed by the MGECW with USG support. In particular, targeted measures will be taken to fill social worker vacancies and implement training standards for educators in early



childhood development centers.

Implementing Mechanism Details

Mechanism ID: 13448	Mechanism Name: Prevention Alliance Namibia
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Nawa Life Trust	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,000,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	1,000,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This is a cooperative agreement with local partner NawaLife Trust and is in its second year of implementation. Annual funding was reduced in COP12 due to delay in award and subsequent pipeline. Future annual COP allocations are estimated to be \$2.5M. The award's objective is to strengthen social mobilization for the general population including HIV sero-positive individuals to increase adoption of safer sexual behaviors and demand for biomedical interventions through multi-channel health communications. This includes stigma reduction; utilization of HIV counseling and testing (HCT) and medical male circumcision; hazardous drinking; and multiple concurrent partnerships. Past investments of a successful predecessor mechanism of the same design. Community-based efforts will complement existing PEPFAR investments.

The monitoring and evaluation plan will measure: Improved coverage of social and behavioral change interventions focused on drivers of the HIV epidemic and access to core biomedical HIV prevention interventions; improved demand by and retention of Namibians engaged in evidence-based public health interventions; Improved quality of evidence-based public health interventions and improved enabling environment for evidence-based public health interventions



Each media campaign will be conducted over three and a half years. A legacy plan will be incorporated into design to ensure sustainability and transition to the Government of Namibia. This is in line with the GHI strategic focus on transition. Media organizations will contribute substantial non-federal cost share. Implementation will focus on selected regions to saturate community-level coverage.

Motor vehicles remain the title of USG and were transferred from the predecessor project.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

- Addressing male norms and behaviors
- Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID: 13448			
Mechanism Name: Prevention Alliance Namibia			
Prime Partner Name: Nawa Life Trust			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and	HVSI	75,000	0



Systems			
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Narrative:

The Prevention Alliance Namibia project will continue activities under this budget code to work extensively with local organizations, people living with HIV, and the Government of Namibia (GRN) to employ a results-based “mixed-model approach” to target populations in seven diverse Namibian regions with an evidence-based focus on the drivers of the epidemic to achieve the following results: 1) Improved coverage and dosage of high quality and evidenced based social and behavioral change interventions focused on drivers of the HIV epidemic and access to core biomedical HIV prevention interventions; 2) Improve the demand by and retention of Namibians engaged in evidence-based public health interventions; 3) Improved quality of evidence-based public health interventions; and 4) Improved enabling environment for evidence-based public health interventions.

The program will implement multi-level programming that supports national level health communications used by USG and non-USG funded civil society partners. In addition the activity will implement sustained community-level activities in the seven regions.

This activity represents a minimal HVSI funding allocation for project M&E supporting the implementation of combination HIV prevention program. This activity allocates funds for an M&E Advisor to support operations and provide limited technical assistance support to local organizations and GRN. Any additional technical assistance will support community and regional-level M&E implementation including planning, operationalizing standard M&E systems (with emphasis on HIV prevention) and increase the use of data analysis for HIV prevention program performance improvement and decision making in regions of operation and by the program.

M&E activities will build upon existing GRN and international standards and systems.

Sustainability components will include capacity building of local civil society and regional administrations to better coordinate and implement evidence-based HIV prevention strategies.

This activity is linked to activities funded in CIRC and HVOP.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	300,000	0

Narrative:

The Prevention Alliance Namibia project will continue activities under this budget code to working extensively with local organizations, people living with HIV, and the Government of Namibia (GRN) to



employ a results-based “mixed-model approach” to target populations in seven diverse Namibian regions with an evidence-based focus on the drivers of the epidemic to achieve the following results: 1) Improved coverage and dosage of high quality and evidenced-based social and behavioral change interventions focused on drivers of the HIV epidemic and access to core biomedical HIV prevention interventions; 2) Improve the demand by and retention of Namibians engaged in evidence-based public health interventions; 3) Improved quality of evidence-based public health interventions; and 4) Improved enabling environment for evidence-based public health interventions.

The program will implement multi-level programming that supports national level health communications used by USG and non-USG funded civil society partners. In addition the activity will implement sustained community-level activities in seven regions.

Demand creation for MC and implementation of National MC Communication Strategy: This activity will build upon an existing MC communication strategy, which includes demand creation strategies, informational campaigns for males and females to better understand the procedure, as well as positioning MC within the larger context of HIV prevention strategies to discourage inhibition.

Expanding on existing materials supported by PEPFAR/Namibia, the recipient will partner with other national and regional stakeholders to implement campaigns utilizing mass media. Local partners conducting media and community outreach activities supported under CIRC will participate in the National Male Circumcision Task Force. The task force ensures a coordinated effort to develop and adapt non-clinical training, message development, and outreach models related to the promotion and demand creation of adult male circumcision.

Sustainability components will include capacity building of local civil society and regional administrations to better coordinate and implement evidence-based HIV prevention strategies.

This activity is linked to activities funded in HVCT.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	150,000	0

Narrative:

The Prevention Alliance Namibia project will continue activities under this budget code to working extensively with local organizations, people living with HIV, and the Government of Namibia (GRN) to employ a results-based “mixed-model approach” to target populations in seven diverse Namibian regions with an evidence-based focus on the drivers of the epidemic to achieve the following results: 1) Improved coverage and dosage of high quality and evidenced-based social and behavioral change interventions



focused on drivers of the HIV epidemic; and access to core biomedical HIV prevention interventions; 2) Improve the demand by and retention of Namibians engaged in evidence-based public health interventions; 3) Improved quality of evidence-based public health interventions; and 4) Improved enabling environment for evidence-based public health interventions.

The program will implement multi-level programming that supports national-level health communications used by USG and non-USG funded civil society partners. In addition the activity will implement sustained community-level activities in seven regions.

The activity will 1) mainstream health communication messages on the utilization of HIV counseling and testing, either voluntary or provider-initiated, with the intent of promoting greater acceptability among males and couples in addition to the adoption of safer sexual behaviors; and 2) provide technical assistance to the Ministry of Health and Social Services, Regional AIDS Coordination Committees and District Health Teams to plan, implement and review communication activities.

Media efforts will leverage domestic and GFATM resources used by the Ministry of Health and Social Services and the Ministry of Information and Communication Technology for multi-level communications to support implementation of partners. Efforts will focus on refining existing interpersonal materials, supporting events and promotions and additional language adaptations, and focusing on intensifying depth, breadth and dosage of HIV prevention activities and strengthening linkages to biomedical interventions.

Sustainability components will include capacity building of local civil society and regional administrations to better coordinate and implement evidence-based HIV prevention strategies.

This activity is linked to activities funded in CIRC and HVOP.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	475,000	0

Narrative:

The Prevention Alliance Namibia project will continue activities under this budget code to working extensively with local organizations, people living with HIV, and the Government of Namibia (GRN) to employ a results-based “mixed-model approach” to target populations in seven diverse Namibian regions with an evidence-based focus on the drivers of the epidemic to achieve the following results: 1) Improved coverage and dosage of high quality and evidenced based social and behavioral change interventions focused on drivers of the HIV epidemic and access to core biomedical HIV prevention interventions; 2)



Improve the demand by and retention of Namibians engaged in evidence-based public health interventions; 3) Improved quality of evidence-based public health interventions; and 4) Improved enabling environment for evidence-based public health interventions.

The program will implement multi-level programming that supports national-level health communications used by USG and non-USG funded civil society partners. In addition, the activity will implement sustained community-level activities in the seven regions.

Media and community outreach activities: Media activities will be on a national scale and will build capacity of the GRN to plan and manage an effective media program, while also providing implementation support for specific media campaigns and activities. Community outreach will be implemented within regional and local-level GRN structures for program coordination and monitoring, while providing implementation support for a comprehensive, robust program of social and behavior change. Local partners conducting community outreach activities will utilize outreach materials and training guidelines previously developed under PEPFAR, strengthen community groups' implementation of structured prevention activities and implement a strengthened M&E system to support program management.

The behavioral change objectives include building skills for safe behaviors, increasing perceptions of risk regarding multiple concurrent partnerships, increasing correct and consistent condom use, increasing risk perceptions of hazardous drinking, cross generational and transactional sex, and increasing positive attitudes for gender empowerment and male engagement. An integration of Positive Health, Dignity and Prevention (PHDP), formerly the PWP initiative, will offer comprehensive HIV prevention programming to sero-positive individuals.

Support to local organizations and GRN community health initiatives: Regular supportive supervision, distribution of standardized materials and monitoring visits will be undertaken by prime recipients to ensure that media and community outreach activities are being conducted to standards established by the GRN and USG, that linkages are strengthened to biomedical interventions available and that data reporting is accurately reflecting progress against PEPFAR indicators. Activities shall support GRN community health initiatives.

Sustainability components will include capacity building of local civil society and regional administrations to better coordinate and implement evidence-based HIV prevention strategies.

This activity is linked to activities funded in CIRC and HVCT.



Implementing Mechanism Details

Mechanism ID: 13479	Mechanism Name: Building Local Capacity
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A
Total Funding: 800,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	800,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Building Local Capacity (BLC) aims to strengthen leadership, governance, coordination and management in the public and civil society sectors. BLC will target activities to senior and mid-level managers at national, regional and facility levels in select line ministries and civil society organizations (CSO). BLC will:

- 1) Build the Namibian Institute of Public Administration and Management's capacity to institutionalize leadership trainings to support career progression to higher management levels;
- 2) Strengthen leadership at select ministries by strengthening communication and management practices within the Ministry of Gender Equality and Child Welfare and the Ministry of Regional and Local Government and Rural Housing. It will support the Ministry of Health and Social Services to strengthen hospital management practices; and
- 3) Strengthen the Network of AIDS Service Organizations to fulfill its GFATM principal recipient responsibilities while meeting its mandate to represent and advocate for member CSO. In addition, BLC is supporting the centrally funded USG-GFATM collaboration and coordination initiative to support Namibian recipients of both donor mechanisms to maximize resources as funding levels decrease. In addition, BLC will build local capacity and institutionalize activities. For example, rather than conducting leadership and management trainings itself, BLC will support the Government of Namibia entity responsible for public service management to incorporate such trainings as requirements for civil servant promotions to management positions. These activities support the GHI principles of systems strengthening, transition and country ownership. BLC has developed clear, measurable indicators to track



the progress of its activities. No vehicle purchase envisaged

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
OHSS	Network of AIDS Service Organizations	200000	Strengthen the Network of AIDS Service Organizations to fulfill its Global Fund principal recipient responsibilities while meeting its mandate to represent and advocate for member CSO.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	500,000
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TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Workplace Programs



Budget Code Information

Mechanism ID:	13479		
Mechanism Name:	Building Local Capacity		
Prime Partner Name:	Management Sciences for Health		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	800,000	0

Narrative:

This is a continuing activity through which Building Local Capacity (BLC), through Management Sciences for Health, will continue its leadership and management activities to address the governance and service delivery building blocks of systems strengthening. Specifically, activities will target systems barriers identified in a number of Ministerial and civil society organization (CSO) assessments with respect to organizational weaknesses, leadership and planning, along with constraints in the provision of effective and efficient facility-based health care services. This will yield gains across functional areas, as ‘intentional spillover’ and ‘targeted leveraging’ activities.

BLC will provide organizational strengthening of the Namibia Network of Aids Service Organizations (NANASO) to fulfill its GFATM and networking responsibilities. BLC will provide targeted technical assistance, coaching and mentoring to NANASO to ensure that they operate efficiently and effectively as a GFATM principle recipient. This entails trainings for NANASO and its sub-recipients in grant implementation, management, finance, monitoring and evaluation. This activity leverages GFATM support for CSO and dovetails the USG-GFATM coordination initiative in Namibia. Based on a mapping exercise of NANASO’s members done in COP11, BLC will also work with NANASO to realign its strategic focus to address members’ needs and to develop an approach for ensuring financially sustainable of the organization.

BLC will support institutionalizing leadership and management training within the Government of Namibia (GRN). BLC will continue to work with the Namibian Institute of Public Administration and Management, which is the legal body for training civil servants, to develop and institutionalize a leadership and management training program that will be required for all GRN officials, including those from HIV/AIDS response line ministries considering promotions to management level functions.

BLC will also select health facilities to achieve accreditation status along with continued improvement in quality and leadership management. As requested by the GRN, the MOHSS would like to roll-out an accreditation program for facilities, such that their weaknesses are clearly defined and addressed to achieve international accreditation status. BLC, with support from the Council on Health Standards



Accreditation of South Africa will launch a quality improvement and leadership (QIL) accreditation process in select public facilities that include at a minimum Katutura Hospital and may be extended to include Windhoek Central Hospital and Katutura Health Center depending on the programmatic focus area of the QIL effort. This process will enable healthcare professionals to measure themselves against internationally acceptable standards of patient safety and quality of care (including for HIV/AIDS services) and monitor improvements to reach international standards. The process will also incorporate basic practices of facility management and leadership so that managers are capable of leading their workgroups to face the challenges of achieving the requisite accreditation scores on all facility service elements. Initiated with COP11 funding, COP12 funds will be focused on completing the accreditation process and also institutionalizing continued quality improvement processes and practices.

Implementing Mechanism Details

Mechanism ID: 13601	Mechanism Name: Strengthening HIV Prevention for MARPS
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Society for Family Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,035,754	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	2,035,754

Sub Partner Name(s)

Institute for Capacity Development	King's Daughters	Legal Assistance Center, Namibia
LGBTI Namibia	Namibian Planned Parenthood Association	Outright Namibia
Population Services International	The Red Umbrella	Walvis Bay Corridor Group



Walvis Bay Multi Purpose Center, Namibia		
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Overview Narrative

Implemented by a consortium of local organizations led by the Society for Family Health (SFH) with three key results: to deliver a set of interventions to reduce HIV transmission; to strengthen MARP-led organizations to advocate and implement public health interventions; and to support an enabling environment for MARP-led advocacy, networking and partnership with the Government of Namibia. The program targets sex workers (SW), clients of SW and men who have sex with men (MSM). The program is implemented in ten urban areas across the country with a high density of MARP and high HIV prevalence rates. Under-served populations are linked with MARP-led community systems. MARP face barriers to care including punitive laws, stigma and discrimination. Namibia's five-year National Strategic Framework includes priorities for MARP.

A core set of interventions for SW, clients of SW and MSM will be delivered. Capacity-building of MARP-led civil society organizations to plan, implement and monitor the delivery of a core set of interventions will occur. Strengthening the enabling environment for MARP programming, through collaboration with the Ministry of Health and Social Services, Members of Parliament, and local CSO, will facilitate domestic scale-up and sustain of HIV prevention, care and treatment services and other legal and social services. Interventions are costed annually and serve as a benchmark.

The program supports the GHI by promoting access to services by under-served populations; supporting domestic institutions to advocate and recognize health needs of MARP communities; and establishing networks to transition and sustain investments. Core costs for MARP-led advocacy and service delivery will not be supported by GRN.

No procurement of motor vehicles is expected.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HVOP	Society for Family	1200000	Activities related to HIV prevention and



	Health who disburses funds to multiple community based organizations who represent most at risk populations		care for persons at higher risk of HIV infection
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Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
 Mobile Population

Budget Code Information

Mechanism ID: 13601 Mechanism Name: Strengthening HIV Prevention for MARPS Prime Partner Name: Society for Family Health			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVS1	80,000	0
Narrative: Under this budget code support to the M&E Advisor will continue to provide technical assistance for the capacity development of M&E of MARP-led organizations and networks to operationalize standard M&E			



systems (with emphasis on HIV prevention) and increase the use of data analysis for HIV prevention program in ten geographic areas of operation by the program.

Core components include:

Increased organizational capacity of local stakeholders to develop, implement and evaluate effective HIV prevention and health interventions. The transfer of knowledge and skills required to operate efficient, cost-effective, accountable and transparent organizations managing the implementation of the integrated interventions for MSM, SW and their clients is a core component of the program.

Strengthening the enabling environment for the provision of health services to MARP: This will be accomplished by developing, strengthening, and supporting MSM and SW advocates and networks to assume leadership in the policy process; working with stakeholders, including uniformed services and the government; and collecting data for evidence-based decision-making and advocacy.

M&E activities are aligned with GRN and international standards and systems. Costs represent an M&E Advisor based at SFH and associated operational costs to provide routine project support and engagement with the relevant GRN offices.

This activity links with activities funded under HVOP and HVCT.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	150,756	0

Narrative:

Strengthening HIV Prevention for MARP will continue activities under this budget code to establish and strengthen innovative and tailored models for delivering HIV counseling and testing (HCT) in “MARF-friendly” settings to sex workers (SW), their clients and men who have sex with men (MSM). The program prioritizes mobile and outreach HCT approaches to ensure that MARP overcome stigma and discrimination. Referral approaches for MARP, including STI suspects in selected high-volume facilities, to both voluntary and provider-initiated HCT sites is underway and will continue to be strengthened. The project is providing enhanced risk reduction counseling for MARP groups with linkages for referrals for medical male circumcision, substance abuse treatment, PMTCT (including family planning), and post-exposure prophylaxis, tailored to the needs of each target group.

The bulk of current HCT programming represents general population approaches through integrated service delivery sites in health facilities and outreach based on primary health care service packages. This activity will work with national, regional and district stakeholders to utilize alternative models which



have been demonstrated to access clandestine and hard-to-reach populations with HIV testing. This may include extended hour HCT services in specific NGO clinics, mobile, moonlight and targeted testing for focus populations in areas of operation. Activities will be coordinated with stakeholders to leverage their expertise and utilization of available HCT personnel and commodities where available.

Sensitization of health care providers to provide MARP-friendly services will continue to be part of the intervention package. The program will continue to explore opportunities to bring mobile HIV testing services to locations that are convenient to MARP.

The program will continue to scale-up delivery of the intervention package to MARP in the ten priority program areas through collaboration with local organizations, including MARP-led organizations and the commercial sector. The program will continue to use information derived from program monitoring to strengthen service delivery and will propose additional innovative approaches to reaching MARP with prevention services.

The Strengthening HIV Prevention for MARP IM has established M&E systems to track referrals to HCT from interpersonal communication activities. Qualitative and quantitative reviews of where MARP access HCT services will continue to be conducted to better focus technical assistance.

This narrative links to other activities in HVOP and HVSI.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,804,998	0

Narrative:

Strengthening HIV Prevention for MARP will continue activities under this budget code to support linkages to “MARP-friendly” health services, especially a package of HIV prevention services and referrals to HIV care and treatment, given high HIV prevalence among these populations.

A core set of interventions will be delivered, either directly or through referrals, including risk reduction counseling, peer education and outreach/referral and condom/lubricant promotion and distribution. Linkages to services include referrals to male circumcision, substance abuse treatment, HIV care and treatment such as PMTCT (including family planning), and post-exposure prophylaxis tailored to the needs of different MARP. Routine STI assessment, treatment (by partner country health services), and referral to risk reduction remains an integral part of the package of services. Sensitization of health care providers will remain a key component of the program. Activities will train current health care workers



interacting with MARP and STI suspects and, in parallel, provide a basis for national level training to be transitioned to the Ministry of Health and Social Services to promote long term capacity. The program will continue to work through collaboration with local organizations, including MARP-led organizations and use information derived from program monitoring to strengthen service delivery and propose additional innovative approaches to reaching MARP with prevention services.

Increased attention to enrolling STI suspects appearing in high volume public health facilities in risk reduction counseling will occur with the intent of receiving HCT and post-test services for both sero-negative and sero-positive individuals.

This narrative links to other narratives in HVCT and HVSI.

Organizational Capacity Building: Given the variable capacity among MSM and SW-led organizations, the program will continue focusing on meeting the particular organizational development needs of specific target organizations. Capacity-building covers a broad range of substantive areas, ranging from advocacy to administration and finance, governance, leadership, management, networking and strategic planning. Particular attention will continue to be given to M&E, supportive supervision and quality assurance, given the importance of the quality of interventions to achieving successful behavior change.

Policy and Advocacy: Mobilization of key stakeholders, including government, civil society, and members of targeted populations is critical to creating a legal, political and social environment where MARP can be reached with effective prevention programming. In the Namibian context, where sex between men and commercial sex remain illegal, HIV prevention and treatment programs must enlist the explicit cooperation of law enforcement, health authorities and the political and religious communities to reduce fear of arrest and stigmatization that cause MARP to avoid health seeking behaviors.

The program will continue to partner with MSM and SW-led organizations such as the Legal Assistance Centre and MARP-led networks in spearheading advocacy for policies to reduce barriers to delivery of services. A range of local, national and regional stakeholders such as traditional leaders, Regional Governors and Members of Parliament will continue to be capacitated to assume leadership of advocacy efforts, to sustain policy work beyond the life of the project.

Implementing Mechanism Details

Mechanism ID: 13605	Mechanism Name: Livelihoods and Food Security Technical Assistance Project (LIFT)
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Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A
Total Funding: 200,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Livelihoods and Food Security Technical Assistance Project (LIFT) is managed by FHI 360 with support from Save the Children and Care International. LIFT will provide technical assistance (TA) to PEPFAR and its partners; the Government of Namibia (GRN); and civil society to improve access for nutrition assessment counselling and support (NACS) beneficiaries to livelihoods and economic strengthening (ES) programs that promote positive health outcomes and program sustainability. This supports the GHI, National Strategic Framework and Partnership Framework’s efforts of access to comprehensive care and support to improve the quality of life of people living with HIV/AIDS (PLWHA). LIFT works in a cost- efficient manner by strengthening networks and referrals and facilitating integration. LIFT will engage stakeholders to identify ES and community-based services for PLWHA and vulnerable groups by providing TA for the design and standardization of the referral system piloted by Ministry of Health and Social Services. LIFT will provide program design and implementation TA to partners with the highest potential to improve the health and nutrition of NACS patients, OVC and caregivers, and build their capacity to address their immediate economic needs, identify viable livelihoods and develop appropriate skills. Over time, LIFT efforts will be transitioned to the GRN and civil society organizations to ensure sustained foods security for NACS beneficiaries. This is in line with the GHI strategy of transition. LIFT will work with MOHSS to track bi-directional referrals from NACS and ART sites and implement an M&E plan. LIFT will work in: Khomas, Caprivi, Oshana, Oshikoto, Hardap, Ohangwena, Omusati, Kavango, Otjozondupa, Hardap and Karas Regions. No vehicle purchases are envisaged



Cross-Cutting Budget Attribution(s)

Economic Strengthening	100,000
Food and Nutrition: Policy, Tools, and Service Delivery	100,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services
 Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID:	13605		
Mechanism Name:	Livelihoods and Food Security Technical Assistance Project (LIFT)		
Prime Partner Name:	FHI 360		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	100,000	0

Narrative:

Under this budget code in COP12, Livelihoods and Food security Technical Assistance (LIFT), through FHI 360 will provide TA to PEPFAR, its partners, the Government of Namibia (GRN) and commercial and civil society entities to improve access for nutrition assessment counseling and support (NACS) patients and graduates to livelihoods and economic strengthening (ES) programs that promote positive health and nutrition outcomes and enhance the long-term sustainability of PEPFAR's investments in Namibia.



In 2012, LIFT and Namibian Alliance for Improved Nutrition (NAFIN) will develop an action plan building on objectives developed during the 2011 Livelihoods, Nutrition and Health Conference. These objectives are to: 1) determine how to promote an enabling environment for improved health and nutrition; 2) identify opportunities to address the social, economic and environmental causes of under nutrition; and 3) identify and link appropriate stakeholders to implement recommended actions and manage specific functions within a clinic to community ES service delivery network. LIFT working closely with NAFIN responds to both the Partnership Framework and GHI principle and objectives of country ownership and sustainability.

LIFT will strengthen networks and referral systems through which NACS patients and graduates are linked with livelihoods and ES programs by providing technical input into the design and standardization of the referral system piloted by Ministry of Health and Social Services (MOHSS). In each of the nine regions where NACS is implemented, LIFT will engage stakeholders to identify livelihoods options and map ES and community-based services for PLHIV and vulnerable groups. LIFT will provide program design and implementation TA to partners with the highest potential to improve the health and nutrition of NACS patients, OVC and caregivers, and build their capacity to address their immediate economic needs, identify viable livelihoods and develop appropriate skills.

LIFT will collaborate with Namibia's directorate of Disaster Risk Management in the Office of the Prime Minister to strengthen links with ES and livelihoods program staff to improve access to and use of livelihoods and early warning information.

LIFT activities are also supported from central funds, as Namibia is a one of two LIFT priority countries. LIFT will work with MOHSS, NAFIN and other stakeholders to establish and implement an effective mentoring and supervisory system for referral linkages for NACS beneficiaries.

Activities will be conducted at the national level and in Khomas, Hardap, Otjozondjupa, Oshana, Oshikoto, Caprivi, Rundu, Omusati and Ohangwena Regions.

Activities are linked to activities funded in HKID.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	100,000	0

Narrative:

Under this budget code in COP12, Livelihoods and Food security Technical Assistance (LIFT), through FHI 360 will provide the USG OVC partners with technical assistance in strengthening their livelihoods and food security interventions as sustainable options for graduates of Nutrition Assessment Counseling and Support (NACS) and other vulnerable households, particularly child headed and OVC households. Many OVC and their households in Namibia experience food insecurity caused or exacerbated by the impacts of HIV. Improved access to food is a critical need for many OVC and is often cited as the highest



priority among groups served by PEPFAR programs. As the USG is supporting the NACS program, which integrates nutrition interventions into clinical care and treatment services, it will be critical to establish sustainable strategies to help clients obtain adequate nutrition after graduating from NACS. HIV contributes to food insecurity by reducing food production, income and availability of labor, eroding savings, and increasing health care expenses. In many households supporting OVC much of the additional income earned is used to buy alcohol or pay for other leisure activities rather than to purchase nutritious food or pay for health services for vulnerable household members. For most households, agriculture is a supplementary but essential source of income.

In 2011, LIFT worked to develop strong linkages between NACS sites and livelihood and economic strengthening opportunities in the surrounding communities. Building on work done in FY 11, LIFT will facilitate the targeting of HIV-affected households with OVC (especially child-headed households), bearing in mind HIV-related stigma at the community level. LIFT will consider the gender issues that adversely affect OVC around nutrition, food security and economic strengthening and ensure that these are comprehensively addressed. LIFT will also contribute to the development of monitoring and evaluation tools for tracking the bi-directional referrals between OVC partners NACS sites and other community-based interventions

This activity is related to LIFT's activity in HBHC and will specifically support implementation of a livelihood strategy developed with COP11 resources and strengthen existing livelihood interventions implemented by supported HKID partners.

Cost efficiency is a critical consideration in this activity, as these resources will leverage more than three times the resources from central sources. Namibia is one of two priority countries for the LIFT project. Activities will be conducted at the national level and in Khomas, Hardap, Otjozondjupa, Oshana, Oshikoto, Caprivi, Rundu, Omusati and Ohangwena Regions.

Implementing Mechanism Details

Mechanism ID: 13676	Mechanism Name: Food and Nutrition Technical Assistance III (FANTA)
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A



Total Funding: 339,675	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	339,675

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This IM is implemented by FHI 360 and will contribute to the GHI and Partnership Framework goals and objectives through cross-cutting programs on food and nutrition policy; tools and service delivery; integrating nutrition assessment counseling and support (NACS) into the HIV and TB programs; and human resources for health.

Through the predecessor project, FANTA II, the MOHSS and I-TECH/Namibia have trained health managers and providers in NACS in 62 ART sites and antenatal, postnatal, and primary health care clinics. FANTA II also trained community health care providers in NACS to strengthen home-based care and link clinic and community HIV services. FANTA III will build on this work to: achieve cost efficiencies by improving client outcomes through capacity building of health care workers and the Health and Nutrition Working Group of the OVC Permanent Task Force; build upon UNICEF support for the Integrated Management of Acute Malnutrition program; and support World Food Program efforts to improve food security of people living with HIV/AIDS (PLWHA).

Activities will enhance the sustainability of NACS services in Namibia and improve the quality and access of USG-supported services. Activities will be transitioned to GRN training institutions and program staff, contributing to GHI strategies of increased access.

Target populations are malnourished PLWHA, pregnant and post-partum women and OVC throughout Namibia. The project will support integration of nutrition indicators into the patient care booklet and child health passports. Activities will be monitored and reported in collaboration with MOHSS.

No vehicle purchases envisaged.

Cross-Cutting Budget Attribution(s)



Food and Nutrition: Policy, Tools, and Service Delivery	339,675
Human Resources for Health	75,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Child Survival Activities

Safe Motherhood

Budget Code Information

Mechanism ID: 13676			
Mechanism Name: Food and Nutrition Technical Assistance III (FANTA)			
Prime Partner Name: FHI 360			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	267,675	0

Narrative:

The Food and Nutrition Technical Assistance III (FANTA III) project will continue to work with the Ministry of Health and Social Services (MOHSS) under this budget code to implement nutrition assessment counseling and support (NACS) in five additional health districts. Focus will be on building technical capacity within public sector health facilities to integrate nutrition into HIV/ AIDS care. This includes assessing human resource and logistical capacity, the need for anthropometric equipments and NACS training. Based on assessment results, FANTA III will provide technical assistance to improve the sites' capacity to implement NACS, co-facilitate NACS training of at least two health care providers from each



site and provide job aids and client materials.

FANTA III will support the MOHSS to conduct supportive supervisory visits to NACS sites to monitor the quality of services, identify challenges and provide technical assistance. The IM will support regular meetings between facility staff and community-based health care providers (CBHCP) to strengthen clinic-community linkages to ensure access to services within the continuum of care. FANTA III will continue to train CBHCP to follow-up NACS clients, screen for malnutrition and provide mid-upper arm circumference tapes and job aids to enhance community screening and referral of PLHIV and TB clients for treatment of malnutrition. The IM will work with MOHSS to ensure that nutrition and HIV is integrated into the training of the new cadre of health extension workers.

FANTA III will collaborate with the Livelihood and Food Security Technical Assistance (LIFT) IM to ensure that NACS beneficiaries are linked to community-based livelihood strengthening programs to improve household income and prevent relapse.

With established NACS policy guidance and consolidation of procurement, storage and distribution of specialized food products, and supply of anthropometric equipment to the initial NACS sites, support is needed in COP12 to scale up and improve the quality of services and health care provider monitoring and supervision. FANTA III will work with the MOHSS and I-TECH/Namibia to institutionalize systems for continuous quality improvement (QI) of NACS services to allow the MOHSS to better define health care provider roles and responsibilities, task shift effectively, improve time allocation and create performance standards. TA will include dissemination of job aids to improve, client management, record keeping, reporting, mentoring and supervision.

FANTA III will disseminate the results of a COP 11 review of NACS processes, efficiencies, challenges, participant perceptions, acceptability of food products and initial outcomes. Quantitative and qualitative information on utilization, efficiency and impact of NACS services including sustainability and system performance will inform refinement and improvement of NACS in Namibia.

The predecessor IM, FANTA II, supported the MOHSS to integrate nutrition and HIV indicators into the national HIV patient management booklet. FANTA III will work with the MOHSS and other UGS IM to refine reporting mechanisms and provide support for data collection and analysis. The IM will continue to work with the MOHSS to strengthen M&E.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	72,000	0



Narrative:

The Food and Technical Assistance III (FANTA III) IM will work under this budget code with the Ministry of Health and Social Services (MOHSS) to train health care providers in antenatal care (ANC) and maternal and child health (MCH) clinics in nutrition assessment and counseling and support (NACS), including infant and young child feeding (IYCF) counseling in the context of HIV. FANTA III and the MOHSS will provide supportive supervision at these sites to monitor the quality of services and provide technical support as needed, including nutrition and HIV data collection on HIV-exposed children.

Approximately 285 ANC and MCH clinics offer counseling on PMTCT and infant feeding during antenatal visits, but post-natal follow-up of PMTCT clients and their infants is limited and arbitrary.

The MOHSS has adopted the policy of promoting exclusive breastfeeding for all infants for the first six months with anti-retroviral coverage for eligible infants or HIV positive mothers during breastfeeding. With support from UNICEF/Namibia, the MOHSS has developed infant and young child feeding (IYCF) counseling cards to address inconsistent counseling messages particularly on replacement feeding and complementary foods.

FANTA III will continue to build the capacity of community-based health care providers (CBHCP) in nutrition management and support for HIV-affected families, especially infants and young children. The CBHCP will be trained to strengthen screening referral and follow-up of child and adolescent clients in the community. The IM will provide mid-upper arm circumference tapes and job aids to enhance community screening and referral of malnourished children, adolescents and pregnant and post-partum women for treatment of malnutrition. FANTA III will also support the MOHSS to disseminate take-home client materials on IYCF in the context of HIV.

FANTA III will continue to support the MOHSS and other USG partners working with home-based care and other community services for PLHIV and orphans and vulnerable children (OVC) in strengthening referral links between clinical nutrition services for pediatric HIV clients and community -based nutrition, food security and livelihood services for caregivers. This IM will leverage the activities of the Livelihood and Food Security Technical assistance IM. The linkages will also include systems for sharing client information between facility and community services adapted from existing management information systems.

Technical support at the community level will include developing materials and training care workers in early childhood development centers supporting OVC. This capacity building effort will be coordinated through the Health and Nutrition Working Group of the Ministry of Gender Equality and Child Welfare lead by the Permanent Task Force for OVC



FANTA III will work with the MOHSS and other USG IM to refine reporting mechanisms and provide support for data collection and analysis. The IM will continue to work with the MOHSS to strengthen monitoring and evaluation (M&E) to ensure it meets PEPFAR reporting requirements and feeds into the national M&E system.

Target populations are pregnant and post partum women, HIV exposed infants and OVC (particularly those enrolled in ECD centers).

Implementing Mechanism Details

Mechanism ID: 13752	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14285	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14296	Mechanism Name: Capacity Plus
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: IntraHealth International, Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 400,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	400,000



Sub Partner Name(s)

Abt Associates	IMA World Health	Liverpool Associates in Tropical Health
Training Resources Group		

Overview Narrative

This new IM Capacity Plus, led by IntraHealth International Inc., is a global flagship project uniquely focused on the health workforce needed to achieve the Millennium Development Goals. In Namibia, the project will work with the Government of the Republic of Namibia (GRN) to: 1) Enhance human resources for health (HRH) policy and planning, including human resource management and information; 2) Generate and disseminate knowledge and analyses to promote use of evidence-based HRH approaches; 3) Support the donor HRH transition process; and 4) Support the GRN to improve health worker recruitment and retention. This support is critical to achieving the GHI intermediate results and principles of transition, sustainability, country ownership and strengthened HRH. By supporting the GRN to strengthen its capacity to better plan, budget and make informed decisions about its staffing complement needs and projections, this activity will help the GRN sustain and improve upon the gains made to deliver needed HIV/AIDS services to Namibians. The project targets the national and regional levels. The monitoring and evaluation plan will entail joint-developed indicators and targets with the Ministry of Health and Social Services; regular joint assessments will be conducted to measure progress towards benchmarks and targets.

No vehicle purchases envisaged.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	400,000
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TBD Details

(No data provided.)

Motor Vehicles Details



N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	14296		
Mechanism Name:	Capacity Plus		
Prime Partner Name:	IntraHealth International, Inc		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	400,000	0

Narrative:

Through the new Capacity Plus implementing mechanism, IntraHealth International, Inc. will draw upon its international expertise and experience as one of the leading HRH TA providers to focus on strengthening the underlying human resources for health (HRH) building block of systems strengthening for the Government of Namibia (GRN) so it is better able to budget, plan, and deploy needed health care workers to meet the needs of the epidemic. This work is particularly important as the USG transitions to a stronger TA model, whereas in the past, one of the major efforts of the USG to support treatment scale-up was to finance the salaries of health care workers to deliver needed treatment.

As defined in the Ministry of Health and Social Services (MOHSS) systems review, there are major systems barriers associated with HRH, notably, the Ministry experiences high vacancy rates, high levels of attrition, and outdated staffing norms that do not accommodate the current and emerging health system needs. Also, in the HIV/AIDS program (including those in the public and faith-based facilities), health care worker salaries are heavily dependent on financing from donors, namely the USG and the GF. Given the impending declines in external resources, donor supported health workers, who are deemed critical beyond donor-related projects, will need to be transitioned to the GRN payroll (including those in the faith-based facilities which are otherwise largely financed by the public sector). This process began in COP 10 and COP 11 with the establishment of a joint GRN/donor HRH transition technical working group and taskforce. In line with the GHI strategy's transition objective and to support the GRN to make informed decisions about who should be transitioned and how they will fit into a new MOHSS structure that is being defined, a number of data estimates, analyses, and staffing projection numbers are needed.



Capacity Plus will support the following “targeted leveraging” activities – some of which are complemented by HRH activities supported by WHO: 1) Determining the regional staffing complement: Support regions to conduct workload estimates and develop staffing projections to inform and justify their proposed staffing complement request as part of the MOHSS restructuring process; 2) HRH implications of strategic integration: Support the MOHSS with scenario modeling to describe the workload burden on cadres if different elements of the HIV/AIDS program were integrated within other health system services, such as primary health care. This modeling can inform the development of staffing norms to meet the needs of the newly revised minimum district service package. This activity will work closely in collaboration with the Health System Strengthening IM to develop cost estimates for various scenarios of integration; and 3) Developing better retention approaches: Through an analysis of the market and other tools such as ‘discrete choice experiments’, this mechanism will support the MOHSS to implement better recruitment and retention practices to reduce HRH turnover in the public sector.

Implementing Mechanism Details

Mechanism ID: 14304	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14305	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14306	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14307	TBD: Yes
REDACTED	



Implementing Mechanism Details

Mechanism ID: 14312	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14317	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14334	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14340	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14341	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14371	Mechanism Name: Maternal and Child Health Integrated Program (MCHIP)
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: JHPIEGO	
Agreement Start Date: Redacted	Agreement End Date: Redacted



TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A
Total Funding: 450,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	450,000

Sub Partner Name(s)

Broad Branch Associates	ICF Macro	John Snow, Inc.
Population Services International	Program for Appropriate Technology in Health	

Overview Narrative

The Maternal and Child Health Integrated Program (MCHIP) IM aims to provide technical assistance on the institutionalization of the new health extension worker cadre and the strategic integration of HIV/AIDS into the broader health care system. These goals directly link to the GHI intermediate results and principles of transition, sustainability, and access.

The IM will address the governance, operational, and capacity issues associated with formalizing the health extension worker cadre and HIV/AIDS integration into primary health care and other relevant fields as appropriate. This IM will build upon other COP12 activities relating to task shifting and integration. MCHIP activities will support the National Health Extension Worker (HEW) Steering Committee to develop needed policies, protocols, budget estimates and plans for approval of a new cadre by the Government of Namibia (GRN) (including the Public Service Commission and the Ministry of Finance). MCHIP will also support the Ministry of Health and Social Services to operationalize its new structure for service delivery, including HIV/AIDS, in accordance with its revised minimum district service package, integration goals and GRN decentralization principles.

This approach will strengthen the GRN capacity to access underserved populations and sustain service delivery, including those relating to HIV/AIDS. A monitoring and evaluation plan will be developed jointly with the GRN in alignment with its own performance management system targets for the health sector.

No vehicle purchases envisaged.



Cross-Cutting Budget Attribution(s)

Human Resources for Health	250,000
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TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

- Malaria (PMI)
- Child Survival Activities
- Safe Motherhood
- TB
- Family Planning

Budget Code Information

Mechanism ID: 14371			
Mechanism Name: Maternal and Child Health Integrated Program (MCHIP)			
Prime Partner Name: JHPIEGO			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	450,000	0

Narrative:

This is a new activity, implemented by the Maternal Child Health Integrated Program (MCHIP), that will provide technical assistance on the institutionalization of the new health extension worker (HEW) cadre and the strategic integration of HIV/AIDS into the broader health care system.



As defined in the Ministry of Health and Social Services (MOHSS) systems review, there are major systems barriers associated with providing needed health care services in the community; the public health care system is largely facility based with no existing government health care cadre based in the community. To address this issue, the MOHSS plans to introduce a new cadre of HEW, which in addition to increasing access, will support task shifting and increased efficiencies in the delivery of care. In addition to this service delivery issue, the Minister of Health has stated that HIV/AIDS services need to be integrated within the broader health care system. This is in keeping with the Health Systems Review recommendation to streamline fragmented and parallel systems. Strategic integration of this magnitude has not been done before so it is important that this process be informed to minimize disruption during transition.

This mechanism will draw upon its international expertise as one of the leading technical assistance providers on integrated maternal child health care, to support the following “targeted leveraging” activities—some of which are complemented by human resources for health activities supported by UNICEF.

Support the institutionalization of the HEW Cadre: MCHIP will support the development of needed policies and plans for approval of the new cadre by the Government of Namibia (GRN), such as a HEW policy, capacity building strategies for HEW (both to become a HEW and to be promoted within HEW cadre), management plans, employment plans and health professional licensing. In addition, the mechanism will support the development of viable recruitment and retention strategies, including an appropriate benefit package. Finally, support will be provided to define and formalize the relationship of HEWs with non-governmental organizations’ (NGO) volunteers (particularly, in face of declining NGO resources). MCHIP’s activities will complement other COP12 activities relating to HEWs that are focused on defining the scope of practice for the cadre (e.g. developing the training curriculum).

Support the MOHSS with its strategic integration of HIV/AIDS into primary health care and other related fields as appropriate: MCHIP will support the MOHSS to determine how the new minimum district package will be delivered. In addition, MCHIP will support the MOHSS to operationalize its new organizational structure, including its goal of strategic HIV/AIDS integration, at the facility and community level (e.g. the health care facility patient flow and arrangement of rooms may need to be altered). Strategic integration of an HIV/AIDS program has not been done before to this extent and it will be important to determine what services should and perhaps should not be integrated; this decision process should be well-informed to minimize disruption during transition. The MCHIP activity will build upon other COP12 activities that will support implementation relating to integration and some human resource and costing analyses to inform the path chosen for integration.

Implementing Mechanism Details



Mechanism ID: 14385	Mechanism Name: Cooperative Agreement 5U2GPS001285
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention (HHS/CDC)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 996,672	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	996,672

Sub Partner Name(s)

American Society for Microbiology	American Society of Clinical Pathology	Association of Public Health Laboratories
Clinical and Laboratory Standards Institute	TBD	

Overview Narrative

The International Laboratory Branch Consortium (ILBC) is a centrally-managed cooperative agreement with multiple sub-recipients (Association of Public Health Laboratories (APHL), the American Society for Microbiology (ASM), the American Society for Clinical Pathology (ASCP), the Clinical Laboratory Standards Institute (CLSI), and a TBD regional partner for south-to-south assistance). In Namibia, TA is focused on the national public health lab system, lab quality systems, TB diagnostics, and training for bio-clinical monitoring testing, lab workforce strategies, research capacity, and mentoring. Strengthening lab capacity contributes to accessible, equitable, effective, affordable, and quality services for all. Lab strategic planning has been identified as a priority for the MOHSS in the NSF, which informs the PF and GHI Strategy. This mechanism’s coverage is national. The training of trainers as instructors and mentors will, over time, reduce ILBC’s role in Namibia. This mechanism provides short-term technical trainings or consultancy services. MOHSS and NIP manage the logistics of the trainings and consultancies, and,



increasingly, provides trainers from its own staff to conduct follow-up mentoring and monitoring. MOHSS and NIP are also responsible for procuring equipment and reagents for the trainings. The grantee must submit a detailed work plan with its annual continuation application, as well as bi-annual status reports to CDC. Routine monthly meetings are also held with the CDC Namibia project management team.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	14385		
Mechanism Name:	Cooperative Agreement 5U2GPS001285		
Prime Partner Name:	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention (HHS/CDC)		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	149,000	0
Narrative:			
Technical assistance from the American Society of Microbiologists (ASM) is a sub-grantee under a cooperative agreement managed by the CDC Global AIDS Program International Laboratory Branch.			

Technical assistance from ASM: ASM has provided short- and long-term technical advisors to work with the CDC Namibia laboratory technical advisor, alongside NIP staff at the main laboratory in Windhoek, to improve their proficiency with TB diagnostic testing. This assistance has included on-the-job training on TB-related laboratory equipment and infection control practices. ASM will focus support on peripheral NIP laboratories. Areas of technical focus for this training and TA will include establishing a blinded quality assurance process for rechecking slides; strengthening the management of existing external quality assurance systems, and; training for NIP laboratory technicians on fluorescence microscopy, TB culture, and drug susceptibility testing (DST) strengthening in Windhoek, Walvis Bay and Oshakati.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	847,672	0

Narrative:

These partners are all sub-grantees under a cooperative agreement managed by the CDC Global AIDS Program International Laboratory Branch (ILB) in Atlanta.

1) American Society for Clinical Pathology (ASCP) support to Namibia Institute of Pathology (NIP) will include training on basic lab operations for district level labs and phlebotomy training for Ministry of Health and Social Social Services (MOHSS) and NIP staffs. After COP12, local and regional lab partners will be able to provide the TA currently being provided by ASCP.

2) Clinical Laboratory Standards Institute (CLSI) technical assistance to NIP will include support for quality management systems as NIP prepares for laboratory accreditation through Regional accreditation bodies (SADCAS & SANAS). CLSI will support a thorough assessment of NIP's quality management system and practices; conduct an active gap analysis; asses overall program effectiveness, and; provide mentorship. Based on these assessments and reviews, CLSI will help NIP develop improved standard operating procedures and other policy level and training improvements.

3) Association of Public Health Laboratories (APHL) will support:

- Finalization of National Lab Policy (NLP) and strategic plan, technical assistance for leadership management and strategic planning
- Develop a master plan for the phased implementation of the NLP and strategic plan
- Establish a governance structure and organizational plan for the National Public Health Lab
- Provide institutional capacity building through coaching, mentoring and training to strengthen the capacity of NIP and MOHSS leadership to develop and implement sustainable management and



financing structures for the NPHL.

- Assist MOHSS and NIP to cost lab services.

4) PEPFAR Namibia will support a regional partner through a cooperative agreement managed by the CDC Global AIDS Program International Laboratory Branch (ILB) in Atlanta. This partner will be drawn from eligible applicants within sub-Saharan Africa (i.e., not an international partner).

Additional supervision and mentoring will be provided by lab advisors from CDC Namibia. NIP managers and supervisors provide day-to-day management oversight and supervision.

All ILB consortium partners provide short-term technical trainings. NIP manages the logistics of the trainings, and increasingly provides trainers from its own staff for follow-up mentoring and monitoring. NIP is also responsible for procurement for the trainings. Procurements, stock management and delivery are done through NIP's ordering system. Training of trainer (TOT) methods will reduce ILBC's role in Namibia. USG seeks to develop NIP's administrative capacity to allow NIP to contract and fund its own TA

Implementing Mechanism Details

Mechanism ID: 14389	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14390	TBD: Yes
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14391	Mechanism Name: University of California-San Francisco
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement



Prime Partner Name: University of California at San Francisco	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 350,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	350,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This partner's main goal is to provide technical assistance to strengthen the information base for public health planning and decision-making, with focused efforts on epidemiology, surveillance, monitoring and evaluation of high-burden infectious disease.

This partner directly builds capacity for epidemiology, surveillance, and monitoring and evaluation. Under GHI principles, this partner contributes to the areas of M&E and research and innovation. The MOHSS, NHTC and UNAM activities supported by this partner are national in scope. This partner's focus on capacity development will emphasize the transfer of specific skills (e.g., research and scientific writing) to national counterparts. Following each training, UCSF and will play an advisory role to encourage utilization and institutionalization of these skills. This mechanism will work with national counterparts to institutionalize epidemiology, surveillance and M&E activities and reduce Namibia's need for external technical assistance. This partner will submit a work plan and annual progress reports in addition to contributing to national reports on the outcomes of activities.

Cross-Cutting Budget Attribution(s)

Education	350,000
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TBD Details

(No data provided.)



Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
 Impact/End-of-Program Evaluation

Budget Code Information

Mechanism ID: 14391			
Mechanism Name: University of California-San Francisco			
Prime Partner Name: University of California at San Francisco			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	350,000	0

Narrative:

This centrally-managed mechanism will support the following activities:

Surveillance, M&E, Epidemiology Technical Assistance: In COP12, UCSF will provide support to conclude the behavioral survey with MSM and FSW by conducting analysis and scientific writing workshops. Work with data triangulation will continue through 2012 with a final stakeholder workshop. M&E support activities will continue including training regional M&E staff to work with ART cohort data; supporting TCE to conduct an evaluation and upgrade the current M&E reporting methods; and finalizing the second volume of the national M&E plan with indicator definitions and annual plan.

Short- and Long-Courses in epidemiology, M&E and surveillance: Courses will be conducted to complement existing academic programs and may include: 1) Targeted short courses, ideally with a training-of-the-trainer model and with a goal of incorporating material from the short courses into the education curriculum of the institution(s). The courses offered fall under the categories of research



methods, ethics in research, scientific writing, surveillance, monitoring and evaluation, biostatistics, data management and analysis, and geographic information systems; 2)UCSF-based longer-term training programs in research methods and scientific writing, with hands-on mentoring and technical assistance by UCSF faculty. The research methods course results in a pilot research protocol that the scholar will implement in their home country; and the scientific writing course results in a manuscript to be submitted to a peer-reviewed journal; and 3) A tailored course or series of courses using a combination of in-country workshops and distance-learning modules.

Implementing Mechanism Details

Mechanism ID: 14746	Mechanism Name: Central Contraceptive Procurement
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: USAID Central Commodity Fund	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 350,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	350,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Central Contraceptive Procurement (CCP) IM implements the USG policy of centralized contraceptive and condom procurement by providing a simplified mechanism for the transfer, obligation and disbursement of all USG funds designed for contraceptive and condom procurement. CCP takes orders based on forecasts from individual missions and consolidates these needs into large multi-program procurements. CCP implements the procurement of contraceptives, condoms, pharmaceuticals, diagnostics and medical equipment supplies. CCP also provides a mechanism for independent testing of products purchased by USAID to monitor the quality of products donated to USAID programs. The quality



assurance component of CCP includes pre-acceptance surveillance and testing of products purchased by USAID and testing of these products already in the field. The quality assurance testing is implemented by Family Health International (FHI). The freight forward and warehousing services are provided by a contract with Agility Logistics.

The program supports the GHI by promoting sustained access to contraceptive (male and female condoms) security including stop-gap condom donations to the Government of Namibia and technical assistance to support domestic institutions to implement sustainable contraceptive security when USG assistance is phased out.

No procurement of motor vehicles is expected.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	14746		
Mechanism Name:	Central Contraceptive Procurement		
Prime Partner Name:	USAID Central Commodity Fund		
Strategic Area	Budget Code	Planned Amount	On Hold Amount



Prevention	HVOP	350,000	0
Narrative:			
<p>This activity will collaborate with the Ministry of Health and Social Services (MOHSS) to provide stop-gap male/female condom commodity donation to the MOHSS using the USG Central Contraceptive Procurement mechanism. Through this mechanism, generic condoms can be requested or condoms can be repackaged using country specific brands.</p> <p>Namibia's National Strategic Framework for HIV and AIDS 2010/11 to 2015/16 (NSF) includes a program component area for condom social marketing and distribution. The NSF outlines an ambitious target of 237.7 million condoms to be distributed by 2015/16. This translates to a plateau of 52 million condoms per year by 2015/16. Namibia distributed 18 – 22 million condoms annually preceding the NSF. Between April 2010 and March 2011 Namibia distributed 18,251 million condoms. Namibia's condom program is dominated by public sector procurement and free distribution. Since the introduction of fully subsidized condoms the Ministry of Health and Social Services distribution has grown from an approximate market share of 64 percent in 2005 to 91.5 percent in 2009 against partially subsidized condoms. The USG has not estimated market share of commercial condom products.</p> <p>Technical assistance and commodity donation under this activity are a component of the GHI transition strategy and prioritize supporting sustainable activities and working with Namibia to prepare for the day when USG assistance for commodity donation is phased-out during COP13.</p>			



USG Management and Operations

1.
Redacted
2.
Redacted
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Redacted

Agency Information - Costs of Doing Business U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Computers/IT Services		288,369			288,369
ICASS		585,190			585,190
Management Meetings/Professional Development		351,743			351,743
Non-ICASS Administrative Costs		1,030,942			1,030,942
Staff Program Travel		833,090			833,090
USG Renovation		97,365			97,365
USG Staff Salaries and Benefits		152,470			152,470
Total	0	3,339,169	0	0	3,339,169

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT		GHP-State		288,369



Services				
ICASS		GHP-State		585,190
Management Meetings/Professional Development		GHP-State		351,743
Non-ICASS Administrative Costs		GHP-State	<p>\$21,706 = freight; \$127,638 = other rental payments; \$65,156 = communication, utilities and miscellaneous; \$5,537 = printing/reproduction; \$529,273 = advisory/assistance services; \$84,732 = other services such as guards, vehicle insurance and commercial advertising; \$15,366 = operation/maintenance of equipment and storage; \$16,143 = supplies and materials; \$165,391 = equipment, include purchase of two vehicles (4x4 \$70,303 and sedan \$35,577) which exceed minimum USG standards for age and mileage</p>	1,030,942



USG Renovation		GHP-State		97,365
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U.S. Department of Defense

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Capital Security Cost Sharing		2,000			2,000
Computers/IT Services		2,000			2,000
ICASS		10,000			10,000
Management Meetings/Professional Development		10,000			10,000
Non-ICASS Administrative Costs		20,000			20,000
Staff Program Travel		35,000			35,000
USG Renovation		2,000			2,000
USG Staff Salaries and Benefits		184,143			184,143
Total	0	265,143	0	0	265,143

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GHP-State		2,000
Computers/IT Services		GHP-State		2,000
ICASS		GHP-State		10,000
Management Meetings/Professional Development		GHP-State		10,000



Non-ICASS Administrative Costs		GHP-State	\$10,000 for office rental; \$5,500 for fuel, maintenance and insurance of the U.S. DoD PEPFAR vehicle; \$1,500 for telecommunication; and \$3,000 for office supplies	20,000
USG Renovation		GHP-State		2,000

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Capital Security Cost Sharing		67,000			67,000
Computers/IT Services		400,000			400,000
ICASS	387,266	87,734			475,000
Institutional Contractors		2,347,120			2,347,120
Management Meetings/Professional Development		80,000			80,000
Non-ICASS Administrative Costs		1,145,001			1,145,001
Staff Program Travel		442,000			442,000
USG Staff Salaries and Benefits	1,112,734	213,967			1,326,701
Total	1,500,000	4,782,822	0	0	6,282,822



U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GHP-State		67,000
Computers/IT Services		GHP-State		400,000
ICASS		GAP		387,266
ICASS		GHP-State		87,734
Management Meetings/Professional Development		GHP-State		80,000
Non-ICASS Administrative Costs		GHP-State	\$420,001 for Relocation and R&R; \$350,000 for Office & Administration costs; \$100,000 for Office Furnitures & Equipment; and \$275,000 for Staff residence and maintenance, utilities	1,145,001

U.S. Department of State

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Computers/IT Services		15,000			15,000
ICASS		170,794			170,794
Management Meetings/Professional		60,000			60,000



nal Development					
Non-ICASS Administrative Costs		34,706			34,706
Staff Program Travel		50,000			50,000
USG Staff Salaries and Benefits		181,400			181,400
Total	0	511,900	0	0	511,900

U.S. Department of State Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		15,000
ICASS		GHP-State		170,794
Management Meetings/Profession al Development		GHP-State		60,000
Non-ICASS Administrative Costs		GHP-State	\$5,000 = Misc Equipment and Supplies; \$1,500 = Cellular Phone Contracts and other Communication Expenses; \$25,000 = Lease for Sanlam Building; and \$10,000 = Utilities and Securities	34,706

U.S. Peace Corps

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total



Management Meetings/Professional Development		16,000			16,000
Non-ICASS Administrative Costs		83,000			83,000
Peace Corps Volunteer Costs		893,300			893,300
Staff Program Travel		7,000			7,000
USG Staff Salaries and Benefits		480,700			480,700
Total	0	1,480,000	0	0	1,480,000

U.S. Peace Corps Other Costs Details

Category	Item	Funding Source	Description	Amount
Management Meetings/Professional Development		GHP-State		16,000
Non-ICASS Administrative Costs		GHP-State	\$3,000 = Postage and Courier; \$800 = Printing and Reproduction; \$9,200 = Other Services; \$30,000 = Supplies (including vehicle fuel); and \$40,000 = Replacement vehicle (The amount is based on our Headquarters cost factor for a 4 wheel drive SUV.)	83,000

