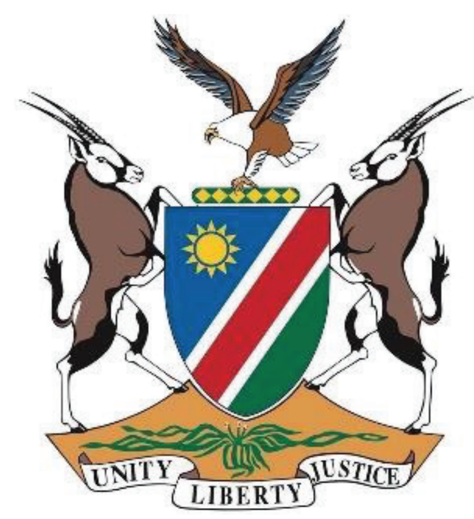


Republic of Namibia

Ministry of Health and Social Services,
Directorate of Special Programmes

National Strategic Framework for HIV and AIDS Response in Namibia 2023/24 to 2027/28

MARCH 1, 2023

FOREWORD

Namibia is on track to end AIDS as a public health threat by 2030 as demonstrated by the current data. This has been achieved through the implementation of the National Strategic Framework (NSF) for HIV and AIDS Response 2017/18 – 2021/22. Most of the targets set in the previous National Strategic Framework have been achieved and remarkable progress towards the 95-95-95 UNAIDS targets has been made.

The new National Strategic Framework 2023/24 – 2027/28 will pursue the same objective, with the aspiration to attain epidemic control by 2028 and move towards ending AIDS as a public health threat by 2030. Considering the current world economic situation, the National Strategic Framework places emphasis on financing the HIV/AIDS programmes, including the pooling and deployment of resources efficiently.

The stakeholder coalition that has worked diligently on the national HIV/AIDS response in the past delivered good results. However, it is recommended that coordination should be continuously strengthened to achieve total control of the epidemic and end AIDS. Stakeholders' involvement is crucial in complementing government efforts to address gaps in the response, such as access to HIV services, food security, non-adherence to treatment and access to accurate data.

Timely supply of adequate essential medicines and commodities is vital for an effective response. Therefore, the government continues to ensure that the procurement process meets the growing demands of the population.

The Ministry of Health and Social Services reiterates its commitment to the successful implementation of the National Strategic Framework to ensure access to safe, affordable and high-quality HIV care for all citizens. I therefore recommend that all the stakeholders use this National Strategic Framework to plan, implement, coordinate and monitor the HIV/AIDS response in Namibia.

Ministry of Health and Social Services
Office of the Minister

Hon. Dr. Kalumbi Shangula, MP

Minister

Preface

The National Strategic Framework for HIV and AIDS (NSF) 2023/2024 - 2027/2028 is designed to serve as the cornerstone of Namibia's response to the HIV and AIDS epidemic over the next five years. Just as the previous 2018 - 2022 framework played a pivotal role in guiding our HIV response, this new NSF continues to be a beacon of direction.

As we embark on this crucial journey, the NSF harmoniously aligns with the long-term vision set forth in the Namibian Development Plan for 2030. Drawing upon the invaluable lessons and insights garnered from a comprehensive End Term Review of the previous NSFs, the NSF 2023/2024 - 2027/2028 is carefully crafted through the involvement of diverse stakeholders, and is a testament to our ongoing dedication to refining and strengthening our HIV response.

The document outlines key programs and strategies that are more targeted, coherent and sustainable. In the current global economic climate characterized by financial constraints and reduced external support, we find ourselves at a juncture where we must navigate a path to self-sufficiency. To address this challenge head-on, we have adopted a sustainability-focused approach.

We are committed to achieving high-yield results, both in terms of impact and the efficient use of available resources and this NSF is a testament to our unwavering commitment to the ongoing battle against HIV and AIDS and to end AIDS as a public health threat by 2030.

Ben Nangombe
Executive Director

MINISTRY OF HEALTH AND SOCIAL SERVICES

ACKNOWLEDGEMENTS

The Ministry of Health and Social Services acknowledges all stakeholders that participated in the development of the NSF, including the following organisations:

- Civil society organisations
- City of Windhoek
- Global Fund
- Government ministries
- Key population communities
- MHSS
- Office of the President
- Office of the Prime Minister
- PEPFAR
- Private sector
- Regional councils
- United Nations Agencies

CONTENTS

FOREWORD II

ACKNOWLEDGEMENTS IV

CONTENTS V

List of Figures 10
List of Tables 11
List of Boxes 11
List of Annexures 11

LIST OF ACRONYMS 12

TERMINOLOGIES 14

EXECUTIVE SUMMARY XVI

CHAPTER 1 COUNTRY AND EPIDEMIOLOGICAL CONTEXT 1

1.1 Country Context 1
1.2 Epidemiological Context 1
1.2.1 HIV Incidence 2
1.2.2 HIV Prevalence 3
1.2.3 Mortality Trends 4
1.3 Progress towards Achievement of Fast-Track Targets 5
1.3.1 Progress towards HIV Epidemic Control, 1990 – 2022 5

CHAPTER 2 SUMMARY OF THE SITUATION ANALYSIS AND THE RESPONSE ANALYSIS 7

2.1 Overview of the Situation Analysis 7
2.1.1 Inequalities 8
2.2 Overview Response Analysis 8
2.2.1 Combination Prevention 8
2.3.3 Treatment and Testing Services 26
2.3.4 Mainstreaming, Multi-Sectoral Response and Pandemic Preparedness 26
2.3.5 Monitoring and Evaluation 27

CHAPTER 3 STATUS OF THE HEALTH SYSTEM AND ITS IMPACT ON THE HIV/AIDS RESPONSE 28

3.1 The Health System 28
3.1.1 Human Resources for Health (HRH) 29
3.1.2 Procurement and Supply Chain Management (PSM) 29
3.1.3 Health Management Information System (HMIS) 30
3.1.4 Laboratory and Diagnostic Services 30
3.2 Related Social Protection Schemes 37

CHAPTER 4 MULTI-SECTORAL RESPONSE SITUATION ANALYSIS 38

4.1 The Multi-Sector Response 38
HIV Specific Interventions being Implemented by Line Ministries 39
4.1.1 Ministry of Education, Arts and Culture (MoEAC) 39
4.1.2 Ministry of Agriculture, Water and Forestry 41

4.1.3 *Judiciary* 41
4.1.4 *Namibian Police Force* 41
4.1.5 *Immigration Services* 41
4.1.6 *Namibian Correctional Services* 41
4.1.7 *Ministry of Information, Communication and Technology (MICT)* 42
4.1.8 *Ministry of Environment and Tourism* 42
4.1.9 *Ministry of Works and Transport* 42
4.1.10 *Ministry of Sports, Youth and National Service* 42
4.1.11 *Ministry of Urban and Rural Development* 42
4.1.12 *National Planning Commission, Office of the President* 43
4.1.13 *Office of the Prime Minister (OPM)* 43
4.2 THE PRIVATE SECTOR 43
4.3 LOCAL GOVERNMENTS, ESPECIALLY LARGE/PRIORITY URBAN AREAS 44
4.3.1 *City of Windhoek* 44
4.3.2 *Other Cities* 45
4.4 PREPAREDNESS FOR FUTURE PANDEMICS 45
4.5 MONITORING AND EVALUATION 48
4.6 GOVERNANCE, COORDINATION, LEADERSHIP AND ACCOUNTABILITY 49

CHAPTER 5 STRATEGIC ORIENTATION OF THE NATIONAL RESPONSE 53

5.1.1 *Vision of the NSF 2023/24 – 2027/28* 53
5.1.2 *Mission of the NSF 2023/24 – 2027/28* 53
5.1.3 *Goal of the NSF 2023/24 – 2027/28* 53
5.1.4 *Strategic Objectives of the NSF 2023/24 – 2027/28* 53
5.1.5 *Orientation of the NSF 2023/24 – 2027/28 and its Relationship to Other Plans* 53
5.1.6 *Priorities of the NSF 2023/24 – 2027/28* 54
5.1.7 *Specific Objectives of the NSF 2023/24 – 2027/28* 55
5.1.8 *Sustainability* 58
5.1.9 *Programme Implementation and the National Coordination Framework* 58

CHAPTER 6 PROGRAMME OBJECTIVES, TARGET POPULATIONS, PRIORITY GEOGRAPHIC AREAS AND STRATEGIES 61

6.1 COMBINATION HIV PREVENTION 61
6.2 POPULATION-BASED INTERVENTIONS 61
6.2.1 *Adolescent Girls and Young Women (AGYW) and Vulnerable Children* 61
6.2.2 *Adolescent Boys and Young Men (ABYM) and Vulnerable Children* 65
6.2.3 *Key and Vulnerable Populations (KVP), Adolescents and Vulnerable Children* 66
6.3 SERVICE-BASED INTERVENTIONS 71
6.3.1 *Condom and Lubricants Programme* 71
6.3.2 *ARV-Based Prevention* 72
6.3.3 *Voluntary Medical Male Circumcision (VMMC)* 73
6.3.4 *Prevention of Mother-to-Child Transmission (PMTCT)* 73
6.3.5 *Sexual Reproductive Health Rights, Sexually Transmitted Infections and Demand Creation* 74
6.4 HIV TESTING AND TREATMENT 75
6.4.1 *HIV Testing Services* 75
6.4.2 *HIV Treatment Services* 76

6.4.3 Differentiated Service Delivery (DSD) for HIV Services ... *77*
6.4.4 Service Integration, Prevention and Management of Opportunistic Infections including TB/HIV Collaborative Activities ... *78*
6.4.5 Resilient and Sustainable Systems for Health and Related Social Protection Schemes Relevant for HIV/AIDS ... *78*
6.4.6 Health Systems Strengthening (HSS) ... *79*
6.4.7 Human Resources for Health (HRH) Relative to HIV Services ... *79*
6.4.8 Laboratory Services and Scale-Up ... *84*
6.4.9 Community Systems Strengthening for Health ... *85*
6.5 Related Social Protection Schemes ... 88
6.6 Integrating HIV/AIDS and TB Response in the Primary Healthcare System ... 89
6.6.1 Programme Objective ... *89*
6.6.2 Background ... *89*
6.6.3 Strategies for Developing the National Road Map for Integration ... *90*
6.7 Human Rights and Gender Equality ... 93
6.7.1 Programme Objective ... *93*
6.7.2 Target Populations ... *93*
6.7.3 Priority Geographical Regions ... *94*
6.8 HIV Mainstreaming in the Multi-Sectoral Response and Preparedness for Future Pandemics and Disasters ... 96
6.8.1 Programme Objective for HIV Mainstreaming in the Multi-Sectoral Response ... *97*
6.8.2 Target Populations ... *97*
6.8.3 Priority Geographic Regions ... *97*
6.8.4 Overall Strategies for HIV Mainstreaming in the Multi-Sectoral Response ... *97*
6.8.5 Specific HIV Interventions to be Implemented by Line Ministries ... *98*
6.8.6 Education ... *98*
6.8.7 Agriculture, Water and Forestry ... *98*
6.8.8 Judiciary ... *98*
6.8.9 Home Affairs, Immigration, Safety and Security ... *98*
6.8.11 Works ... *99*
6.8.12 Information, Communication and Technology ... *99*
6.8.13 Environment and Tourism ... *100*
6.8.14 Sports, Youth and National Service ... *100*
6.8.15 Urban and Rural Development ... *100*
6.8.16 National Planning Commission, Office of the President ... *100*
6.8.17 Office of the Prime Minister (OPM) ... *100*
6.8.18 Private Sector ... *101*
6.8.19 Local Governments ... *101*
Strategies for City of Windhoek and Other Large Urban Cities ... *101*
6.9 Analysis of the Impact of COVID-19 on HIV Response and Preparedness for Future Pandemics and Disasters 101
Programme Objectives ... 101
Target Populations ... 101
Priority Geographic Region ... 101
Strategies ... 102

CHAPTER 7 MONITORING AND EVALUATION, SURVEILLANCE AND KNOWLEDGE MANAGEMENT ... 103

7.1 Monitoring and Evaluation, Surveillance and Knowledge Management ... 103

7.1.1 *Programme Objective* ... *103*
7.1.2 *Strategic Objectives* ... *103*
7.1.3 *Target Population* ... *103*
7.1.4 *Strategies to Strengthen M&E, Surveillance and Knowledge Management* ... *103*
7.2 MONITORING AND RESPONDING TO INEQUALITIES ... 104

CHAPTER 8 COSTING, RESOURCE TRACKING AND EFFICIENCY ... 106

8.1 COSTING, RESOURCE TRACKING AND EFFICIENCY ... 106
8.1.1 *Costing of the NSF 2023/24 – 2027/28* ... *106*
8.1.2 *Efficiency Analysis* ... *111*

CHAPTER 9 FINANCING AND SUSTAINABILITY ... 113

9.1 RESOURCE GENERATION ... 113
9.2 POOLING AND FUND MANAGEMENT ... 114
9.2.1 *Integrating HIV Services into the Public Budget* ... *114*
9.2.2 *Integrating HIV Services into Universal Health Coverage (UHC) Schemes* ... *115*
9.3 STRATEGIC PURCHASING ... 115
9.3.1 *Efficiency and Effectiveness* ... *115*
9.3.2 *Financing Prevention Services including Community-led Interventions* ... *117*
9.4 GOVERNANCE ... 117
9.5 PROGRAMME OBJECTIVES OF THE NSF 2023/24 – 2027/28 ... 118
9.5.1 *Overall Objective* ... *118*
9.5.2 *Strategic Objectives and Interventions* ... *118*

CHAPTER 10 GOVERNANCE, LEADERSHIP, ACCOUNTABILITY, COORDINATION AND MANAGEMENT OF THE RESPONSE 132

10.1 PROGRAMME OBJECTIVE ... 132
10.2 TARGET POPULATION ... 132
10.3 PRIORITY GEOGRAPHIC REGIONS ... 132
10.4 STRATEGIES TO IMPROVE GOVERNANCE AND COORDINATION ... 132

CHAPTER 11 OPERATIONALISING THE NSF ... 134

INTRODUCTION ... 134
11.1 NATIONAL OPERATIONAL PLAN ... 134
11.2 PROGRAMME TECHNICAL WORKING GROUPS (TWGS) ... 134
11.3 REGULAR REVIEW OF NSF IMPLEMENTATION ... 134
11.4 ADVOCACY AND COMMUNICATION ... 135
11.5 FINANCING ... 135
11.6 REGULAR ANNUAL REVIEWS AND ANNUAL REVIEW REPORTS ... 135
11.7 NATIONAL LEVEL ... 135
11.7.1 *Immediate Actions at the National Level* ... *135*
11.7.2 *Medium-term Actions at National Level* ... *136*
11.7.3 *Long-term Actions at National Level* ... *136*
11.8 REGIONAL LEVEL ... 136
11.8.1 *Immediate Actions at the Regional Level* ... *136*
11.8.2 *Medium-term Actions at the Regional Level* ... *136*

11.8.3 Long-term Actions at the Regional Level *136*
11.9 MUNICIPALITY, DISTRICT AND CONSTITUENCY LEVELS 136

REFERENCES.. 138

ANNEX 1: COORDINATION FRAMEWORK – MANDATES, ROLES AND MEMBERSHIP OF THE NATIONAL COORDINATING STRUCTURES 145

ANNEX 2: NAMIBIA RISK CATEGORISATION ACCORDING TO GLOBAL GUIDANCE 154

ANNEX 3: NSF RESULTS FRAMEWORK... 155

National Level Impact and Outcome Indicators *155*
Additional Programme Level Indicators and Targets *170*

List of Figures

FIGURE 1: NAMIBIA POPULATION DENSITY (NSF, 2011) 1
FIGURE 2: NUMBER OF PEOPLE LIVING WITH HIV (PLHIV); SPECTRUM 2022 2
FIGURE 3: HIV INCIDENCE; SPECTRUM 2022........ 2
FIGURE 4: HIV INCIDENCE BY AGE AND SEX; SPECTRUM 2022........ 3
FIGURE 5: GEOGRAPHICAL HIV INCIDENCE 15 – 49 YEARS; SPECTRUM 2022 3
FIGURE 6: HIV PREVALENCE 15 – 49 YEARS; SPECTRUM 2022........ 4
FIGURE 7: HIV PREVALENCE 15 – 49 YEARS BY REGION; SPECTRUM 2022 4
FIGURE 8: AIDS DEATHS ADULTS 15+; SPECTRUM 2022........ 5
FIGURE 9: COMPARISONS OF NEW HIV INFECTIONS AND AIDS DEATHS, 1990 – 2021........ 6
FIGURE 10: TRENDS IN ART COVERAGE AMONG PLHIV IN NAMIBIA DISAGGREGATED BY AGE AND SEX, 2016 – 2021 .... **ERROR! BOOKMARK NOT DEFINED.**
FIGURE 11: RETENTION ON ART AT 12 MONTHS AND 24 MONTHS, NAMIBIA, 2009 – 2020........ **ERROR! BOOKMARK NOT DEFINED.**
FIGURE 12: PROGRESS TOWARDS THE 95/95/95 FAST-TRACK TARGETS BY AGE AND GENDER, 2021 .... **ERROR! BOOKMARK NOT DEFINED.**
FIGURE 13: TRENDS IN PROPORTION OF SELECTED TB/HIV INDICATORS 2008 – 2020........ **ERROR! BOOKMARK NOT DEFINED.**
FIGURE 14: PERFORMANCE OF LABS IN SLIPTA ASSESSMENT (QUARTERS 1 & 2, 2022) 31
FIGURE 15: TRENDS IN TOTAL EID TEST VS POSITIVITY RATES........ 31
FIGURE 16: PREGNANCIES AMONG AGYW 40
FIGURE 17: IMPACT OF COVID-19 PANDEMIC ON HIV CARE (GRN, 2021A) 48
FIGURE 18: CONCEPTUAL DIAGRAM FOR NSF........ 57
FIGURE 19: NATIONAL RESPONSE COORDINATION FRAMEWORK 59
FIGURE 20: GRN SPENDING: OVERALL AND ON MHSS, 2023 – 2025 90
FIGURE 21: NSF 2023/24 – 2027/28 TOTAL COST........ 107
FIGURE 22: NSF 2023/24 – 2027/28 RESOURCE NEEDS BY THEMATIC AREA 107
FIGURE 23: NSF 2023/24 – 2027/28 RESOURCE ESTIMATES BY INTERVENTION 108
FIGURE 24: NSF 2023/24 – 2027/28 RESOURCE NEEDS FOR PREVENTION PROGRAMME 108
FIGURE 25: NSF 2023/24 – 2027/28 RESOURCE NEEDS FOR TREATMENT, CARE AND SUPPORT........ 109
FIGURE 26: NSF 2023/24 – 2027/28 RESOURCE NEEDS FOR PROGRAMME SUPPORT, RSSH AND ENABLING ENVIRONMEN 109
FIGURE 27: CONCEPTUAL FRAMEWORK FOR HIV FINANCIAL SUSTAINABILITY 113
FIGURE 28: GRN'S ARV EXPENDITURE, APRIL 2017 – MARCH 2022 116
FIGURE 29: HIV RESPONSE PERSONNEL COST, DIRECTORATE SPECIAL PROGRAMMES 117
FIGURE 30: TREND OF GROSS NATIONAL INCOME PER CAPITA IN NAMIBIA 121
FIGURE 31: GOVERNMENT REVENUE AS PERCENTAGE OF GDP 122
FIGURE 32: NET DEBT TO GDP RATIO........ 122
FIGURE 33: THREE-YEAR CUMULATIVE GDP GROWTH RATE........ 123
FIGURE 34: TOTAL GRN HEALTH EXPENDITURE AS PERCENTAGE OF GDP 123
FIGURE 35: TOTAL GRN HEALTH EXPENDITURE AS PERCENTAGE OF GENERAL GRN EXPENDITURE 124
FIGURE 36: TOTAL HEALTH EXPENDITURE BY SOURCES 124
FIGURE 37: GRN SPENDING: OVERALL AND ON MHSS 125
FIGURE 38: HEALTH SPENDING DISPARITY BY BENEFICIARY POPULATION 125
FIGURE 39: HIV SPENDING AS PERCENTAGE OF CURRENT HEALTH EXPENDITURE AND GENERAL GOVERNMENT HEALTH EXPENDITURE........ 126
FIGURE 40: HIV EXPENDITURE (%) BY SOURCES 126
FIGURE 41: DOMESTIC SPENDING ON HIV AS % OF TOTAL POTENTIAL HIV SPENDING 130
FIGURE 42: RELATIONSHIP BETWEEN MURD, RACOCS AND CACOCS 133

List of Tables

TABLE 1: HIGH-LEVEL BODIES IN THE NATIONAL COORDINATION FRAMEWORK 51
TABLE 2: COMBINATION HIV PREVENTION PROGRAMME 61
TABLE 3: NATIONAL KP SIZE ESTIMATION 67
TABLE 4: CONDOM NEEDS QUANTIFICATION 2023 – 2028 671
TABLE 5: ROAD MAP FOR PILOT STUDY ON THE INTEGRATION OF HIV/AIDS AND TB INTO PHC 91
TABLE 6: NSF 2023/24 – 2027/28 RESOURCE NEEDS ESTIMATE FOR YEAR-ON-YEAR PROGRAMME INTERVENTIONS 111
TABLE 7: KEY STRATEGIES 111
TABLE 8: RESOURCE NEEDS ESTIMATE (US$ MILLION) 127
TABLE 9: POTENTIAL GOVERNMENT SPENDING ON HIV THROUGH THE MINISTRY OF HEALTH (US$ MILLION) 128
TABLE 10: OTHER PUBLIC SECTOR BUDGET (US$ MILLION) 128
TABLE 11: TOTAL GOVERNMENT SPENDING ON HIV (US$ MILLION) 128
TABLE 12: OTHER SOURCES OF FUNDING (US$ MILLION) 129
TABLE 13: POTENTIALLY AVAILABLE FUNDING FOR THE NSF 2023/24 – 2027/28 FROM ALL SOURCES 129
TABLE 14: FUNDING GAP IN THE NSF 2023/24 – 2027/28 (US$ MILLION) 130
TABLE 15: DOMESTIC SPENDING ON HIV (US$ MILLION) 130
TABLE 16: ALLOCATION OF MOBILIZED RESOURCES TO HIV INTERVENTIONS (US$ MILLION) 131

List of Boxes

BOX 1: THE IMPACT OF COVID 19 ON THE HIV CARE AND TREATMENT PROGRAMME 47

List of Annexures

ANNEX 1 : COORDINATION FRAMEWORK – MANDATES, ROLES AND MEMBERSHIP OF THE NATIONAL COORDINATING STRUCTURES 145
ANNEX 2: NAMIBIA RISK CATEGORISATION ACCORDING TO GLOBAL GUIDANCE 154
ANNEX 3: NSF RESULTS FRAMEWORK 155

LIST OF ACRONYMS

Acronym	Meaning
AAAQ	Available, Accessible, Acceptable, and of high Quality
ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
AHD	Advanced HIV Disease
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
AYFHS	Adolescent and Youth Friendly Health Services
CAB-LA	Long-acting Cabotegravir Injection
CAGs	Community Adherence Groups
CBOs	Community Based Organisations
CCBHS	Comprehensive Community-Based Health Services
CD4	Cluster of Differentiation 4
CLM&A	Community-Led Monitoring and Advocacy
COVID-19	Coronavirus Disease 2019
CQI	Continuous Quality Improvement
CSE	Comprehensive Sexuality Education
CSOs	Civil Society Organisations
CSS	Community Systems Strengthening
CXR	Chest X-ray
DBS	Dried Blood Spot
DHIS2	District Health Information System 2
DIC	Drop-in Centre
DQA	Data Quality Assurance
DSD	Differentiated Service Delivery
DTG	Dolutegravir
DV	Domestic Violence
DVR	Dapivirine Vaginal Ring
ECHO	Extension for Community Healthcare Outcomes
EDT	Electronic Dispensing Tool
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother to Child Transmission
ePMS	HIV electronic Patient Monitoring System
FBC	Full Blood Count
FBOs	Faith-Based Organisations
FSW	Female Sex Workers
GBV	Gender-Based Violence
GEWE	Gender Equality and Women's Empowerment
GF	Global Fund
iHRIS	Integrated Human Resources Information System
HRM	Human Resource Management
H-C19 NCESP	HIV COVID-19 National Community Engagement Strategy and Plan
HEI	HIV Exposed Infants
HEW	Health Extension Worker
HiAP	Health in All Policies
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HRC	United Nations Human Rights Council
HRG	Human Rights and Gender Equality
HTS	HIV Testing Services
IBBS	Integrated Bio-Behavioural Survey
ICT	Index Contact Testing
IEC	Information Education and Communication
IMC	Infant Male Circumcision
IPD	In-Patient Department
IPV	Intimate Partner Violence
KPs	Key Populations
LEA	Legal Environment Assessment on HIV and AIDS in Namibia
LGBTIQ+	Lesbian Gay Bisexual Transgender Intersex and Queer Persons
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MIMS	Multi-sectoral Information Management System
MMD	Multi-Month Dispensing
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NACDO	Namibia Anglican Community Development Organization
NAMPHIA	Namibia Population-based HIV Impact Assessment
NASA	National AIDS Spending Assessment
NCDs	Non-Communicable Diseases
NDHS	Namibia Demographic and Health Survey
NGOs	Non-Governmental Organisations
NIMART	Nurse Initiated Management of Antiretroviral Therapy
NPC	National Planning Commission
NQMP	National Quality Management Policy
NQMSP	National Quality Management Strategic Plan
NSF	National Strategic Framework for HIV/AIDS Response
NVP	Nevirapine
OMAs	Government Offices, Ministries and Agencies
OPD	Outpatient Department

OST	Opioid Substitution Therapy
OVC	Orphans and Vulnerable Children
PBFW	Pregnant and Breastfeeding Women
PEP	Post-Exposure Prophylaxis
PEPFAR	President Emergency Plan for AIDS Relief
PHQ	Patient Health Questionnaire
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PNC	Postnatal Care
POC	Point-of-care
PPPs	Public-Private Partnerships
PrEP	Pre-Exposure Prophylaxis
PWD	Persons with Disability
PWID	Persons Who Inject Drugs
QA	Quality Assurance
RBA	Rights-Based Approaches
RME	Response Monitoring and Evaluation
RNE	Resource Needs Estimate
SBCC	Social Behavioural Change Communication
SDC	Strengthening Development Committees
SDGs	Sustainable Development Goals
SEAH	Sexual Exploitation, Abuse and Harassment
Serum CrAG	Serum Cryptococcal Antigen
SGBV	Sexual and Gender-Based Violence
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
SVAC	Sexual Violence Against Children
TB-LAM	Lipoarabinomannan Antigen Assay for Diagnosing TB
TG	Transgender people
TGSW	Transgender Sex Workers
TPT	TB Preventive Therapy
TWG	Technical Working Group
U=U	Undetectable = Untransmittable
UHC	**U**niversal Health Coverage
VAC	Violence Against Children
VAW	Violence Against Women
VAWG	Violence Against Women and Girls
VIA	Visual Inspection with Acetic Acid
VIA TAT	Viral Load Turn-Around Time
VLS	Viral Load Suppressed
VMMC	Voluntary Medical Male Circumcision

TERMINOLOGIES

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

	social indicators such as household incomes, expenditure per capita, health status, life expectancy, access to basic social services, infant mortality rate, nutritional status and literacy.
Region	An administrative geographical area with clearly defined boundaries; Namibia has 14 administrative regions
Result	A measurable or describable change in the lives of people or organisations resulting from a cause-and-effect relationship or programme intervention
Results-based planning	A planning process that uses empirical evidence to inform planning and prioritising of interventions
Results chain	The causal sequence for an intervention to achieve impacts, moving from inputs and activities to outputs, outcomes, and impacts
Results framework	A diagrammatic illustration of the logical chain of results that will lead to strategic objectives being achieved
Rights holder	A person who has a human and/or legal right to claim for services from another person or institution with the mandate to provide such services
Risks	The probability that a person may be affected negatively by a condition or behaviour, i.e., acquiring an HIV infection
Sector	A section of society that has common characteristics or interests
Sex	A biological construct defining the physical differences that males and females are born with
Terminology	Definition
Three Ones principle	Principle where a country has one national coordinating authority, one national strategic framework and one national M&E framework
Vulnerability	Results from a range of external factors that are often beyond the ability of a person to control and that increase the possibilities of their exposure to HIV infection

EXECUTIVE SUMMARY

The National Strategic Framework for HIV and AIDS Response (NSF) in Namibia 2023/24 – 2027/28 is a five-year document guiding the planning, programming, resourcing and implementation of the national multi-sectoral and decentralised HIV and AIDS response in the country.

Vision: To achieve an AIDS-free Namibian nation.

Goal: To attain epidemic control by 2028 and move towards ending AIDS as a public health threat by 2030.

The NSF aims to achieve the following targets by 2028:

- Reduce the number of people newly infected with HIV per year to less than 1 out of 1,000 people (0.1% of the general population)
- Reduce the number of people dying of AIDS-related causes per year to less than 1 out of 1,000 people (0.1% of the general population)
- The number of people newly infected with HIV per year is less than the number of people dying of AIDS-related causes, i.e., incidence-mortality-ratio (IMR) less than 1

It is prioritised to achieve the following nine priority-specific objectives by 2027/28:

(i) Reduce HIV-related mortality rate from 1.06 % in 2023/24 to 0.66 % by 2027/28
(ii) Reduce TB/HIV-related deaths among PLHIV from 1,100 in 2023/24 to 300 by 2027/28
(iii) Reach 95% of the key and vulnerable populations, including AGYW and ABYM, in all regions with combination HIV prevention interventions
(iv) Reduce HIV vertical transmission rate among HIV-exposed infants from 4.1% in 2023/24 to less than 2% by 2027/28
(v) Increase treatment coverage within all sub-populations, age groups and geographic settings, including children living with HIV, from 95% in 2023/24 to 97% by 2027/28
(vi) Reduce to less than 10% the number of women, girls and people living with, at risk of and affected by HIV who experience gender-based inequalities and sexual and gender-based violence by 2027/28
(vii) Thirty percent (30%) of HIV testing and treatment services, 60% of programmes supporting social enablers, and 80% of HIV prevention services delivered by community-led organisations for populations by 2027/28
(viii) By 2025, initiate three (3) pilot projects towards converting the vertical HIV/AIDS programme into an integrated programme in the health system
(ix) By 2025 reduce inequalities on access to HIV testing, ART treatment and viral load suppression by 50% of the 2023 baseline levels

To achieve these results, this NSF further prioritised thirteen high-impact programmes, as explained below:

1) Adolescent Girls and Young Women (AGYW)
2) Adolescent Boys and Young Men (ABYM)

3) Key and Vulnerable Populations (KVP)
4) Condom and Lubricants Promotion and Distribution
5) ARV-based Prevention (PrEP)
6) Voluntary Medical Male Circumcision (VMMC)
7) Elimination of Mother-to-Child Transmission (eMTCT)
8) HIV Testing Services (HTS)
9) Treatment, Care and Support (Provision of ART)
10) Treatment of Opportunistic Infections
11) Resilient Health Systems that include Laboratory, Commodity Management and Preparedness for Pandemics
12) Addressing Human Rights, Gender Equality, Stigma and Discrimination
13) Community Systems Strengthening (CSS), including Community-led Service Delivery and Monitoring

The design of the NSF is premised on the Investment Framework, Results-Based Management (RBM), and Health-in-All-Policies (HiAP) approaches. The Namibian Government has adopted HiAP and has developed a draft HiAP strategic framework as part of its multi-sectoral and whole-of-society approaches to health governance. The NSF 2023/24 – 2027/28 is a catalytic document that will support the delivery of the innovations and best practices that are necessary to ensure the provision and sustainability of a quality and comprehensive national HIV response.

CHAPTER 1 Country and Epidemiological Context

1.1 Country Context

Namibia is a vast and sparsely populated country situated along the southwest of the Atlantic coast of Africa, with a total population of 2.6 million people (NSA, 2022) and a population density of 3 people per km^2 (Figure 1). It shares borders with Zambia and Angola to the north, Botswana to the east and South Africa to the south. Namibia is an upper-middle income country with a gross national income (GNI) per capita of US$4,729.3 (World Bank, 2021), but with unequal income distribution (UNDP, 2018). The country has a very high inequality rate, coupled with massive unemployment of about 33.4% (NSA, 2018), high levels of poverty and a lack of access to basic services for the majority of citizens (World Bank, 2022). In pursuit of alleviating poverty, the National Food and Nutrition Security Policy was revised in 2021 (GRN, 2021e) and led to the creation of the Nutrition and Food Security Alliance of Namibia (NAFSAN) (GRN, 2022m).

Figure 1: Namibia population density (NSF, 2011)

The distribution of wealth (assets/land) is highly skewed; e.g., commercial land is owned by minority elites, which exacerbates inequality among groups (World Bank, 2022). The country has inherited a miserable situation from the former apartheid regime of South Africa, with concentration of agricultural land ownership among the few. This legacy is regarded as one of the top sources of wealth inequalities in Namibia and South Africa (Moyo, 2022), and translates into weak property rights and titling. The majority of the population lives in communal areas, while a small segment of the population still holds most of the wealth and land in the country.

1.2 Epidemiological Context

Namibia has a generalised HIV epidemic, with an estimated prevalence of 11.43% of people living with HIV and incidence of 0.26% (GRN, 2022k). During the past two years, COVID-19 affected health conditions of communities, infecting about 7% of the population and reaching a 2.5% case fatality rate (GRN, 2021b).

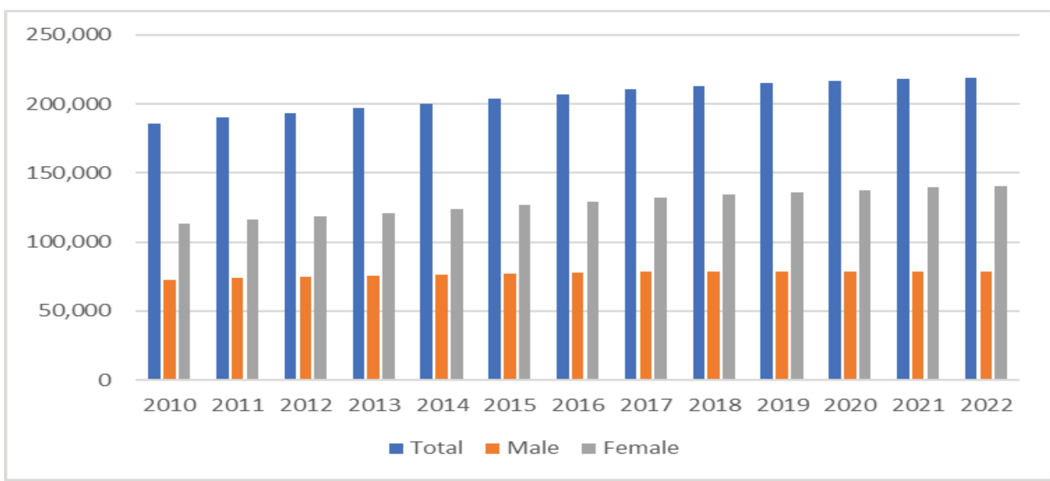


Figure 2: Number of people living with HIV (PLHIV); Spectrum 2022

A total of 218,829 people were estimated to be PLHIV, of which 78,312 were male and 140,517 were female.

1.2.1 HIV Incidence

The annual incidence of HIV in all age groups is 0.26%. It is lower among males than females (males: 0.18% and females: 0.33%).

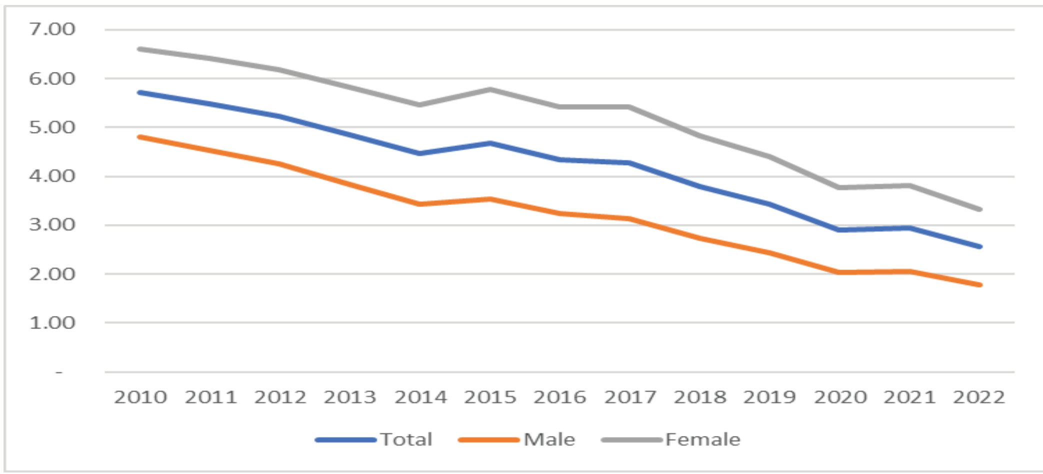
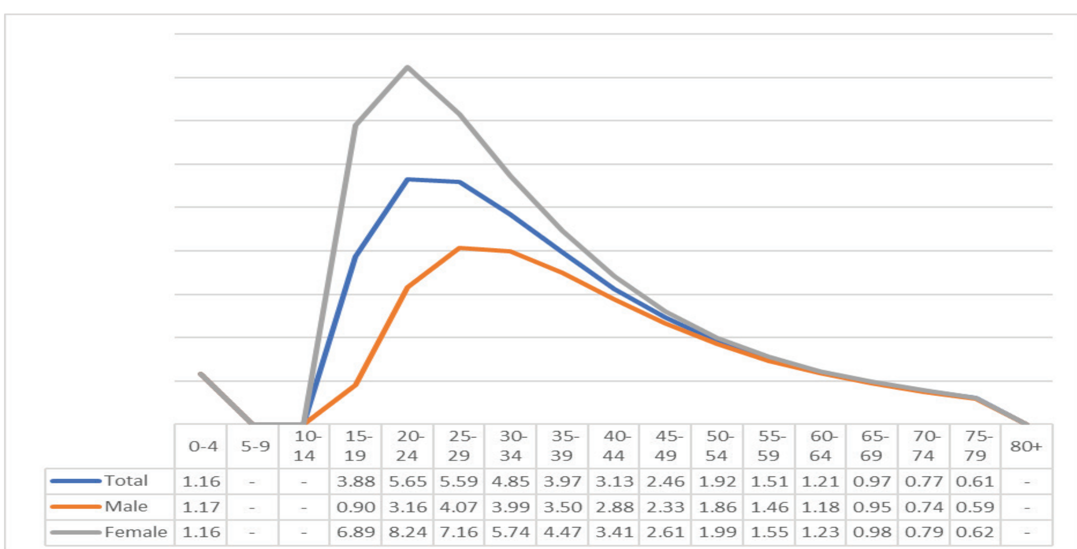


Figure 3: HIV incidence; Spectrum 2022

The annual incidence of HIV among adults aged 15 – 49 years in Namibia is 0.45% (0.62% among females and 0.29% among males). This corresponds to 3,547 new HIV infection cases annually among this age group.



	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
Total	1.16	-	-	3.88	5.65	5.59	4.85	3.97	3.13	2.46	1.92	1.51	1.21	0.97	0.77	0.61	-
Male	1.17	-	-	0.90	3.16	4.07	3.99	3.50	2.88	2.33	1.86	1.46	1.18	0.95	0.74	0.59	-
Female	1.16	-	-	6.89	8.24	7.16	5.74	4.47	3.41	2.61	1.99	1.55	1.23	0.98	0.79	0.62	-

Figure 4: HIV incidence by age and sex; Spectrum 2022

HIV incidence is consistently higher among females than males across all age groups. It is highest for both groups in the age group 20 – 24 years (0.82%), followed by 25 – 29 years (0.72%) and then 15 – 19 years (0.69%).

Geographically, incidence is highest in the northern regions of Oshikoto (0.80%), Zambezi (0.78%), Kavango West (0.61%), Kavango East (0.58%) and Ohangwena (0.56%).

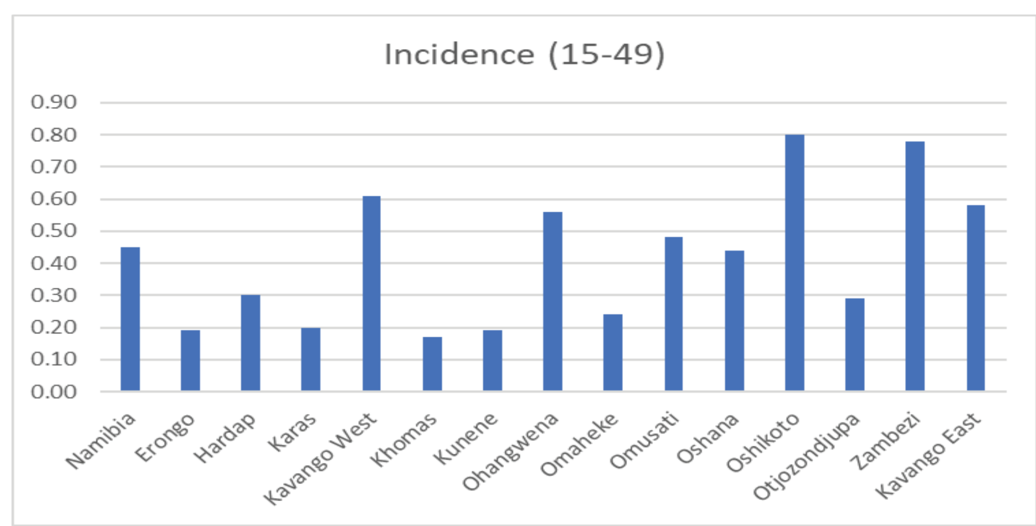


Figure 5: Geographical HIV incidence 15 – 49 years; Spectrum 2022

1.2.2 HIV Prevalence

HIV prevalence in Namibia is among the highest in the world, at 11.43% among adults aged 15 – 49 years (UNAIDS, 2022d). Prevalence by sex for this age group is shown in Figure 6.

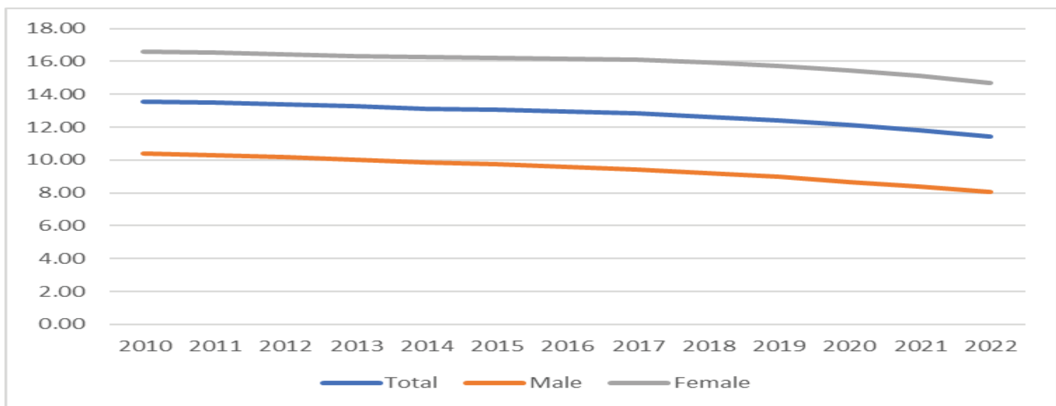


Figure 6: HIV Prevalence 15 – 49 years; Spectrum 2022

Among the 15 – 24 years age group, HIV prevalence rose until 2019 when it began a downward trend.

There are significant variations in HIV prevalence across regions, as shown in Figure 7.

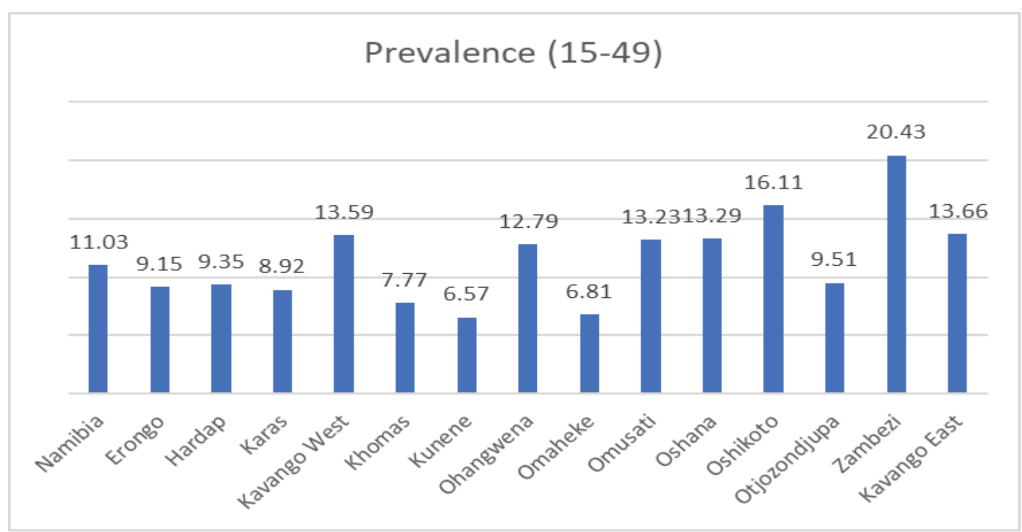


Figure 7: HIV prevalence 15 – 49 years by region; Spectrum 2022

Prevalence ranges from a high of 20.3% in Zambezi Region to a low of 6.57% in Kunene Region. Other high-prevalence regions include Oshikoto (16.1%), Kavango East (13.7%), Kavango West (13.6%), Oshana (13.3%), Omusati (13.2%) and Ohangwena (12.8%).

1.2.3 Mortality Trends

HIV and AIDS continues to be the leading cause of death in Namibia. Spectrum estimates that deaths from AIDS in adults aged 15 years and older has decreased from a peak of 8,791 in 2004 to 2,841 in 2022.

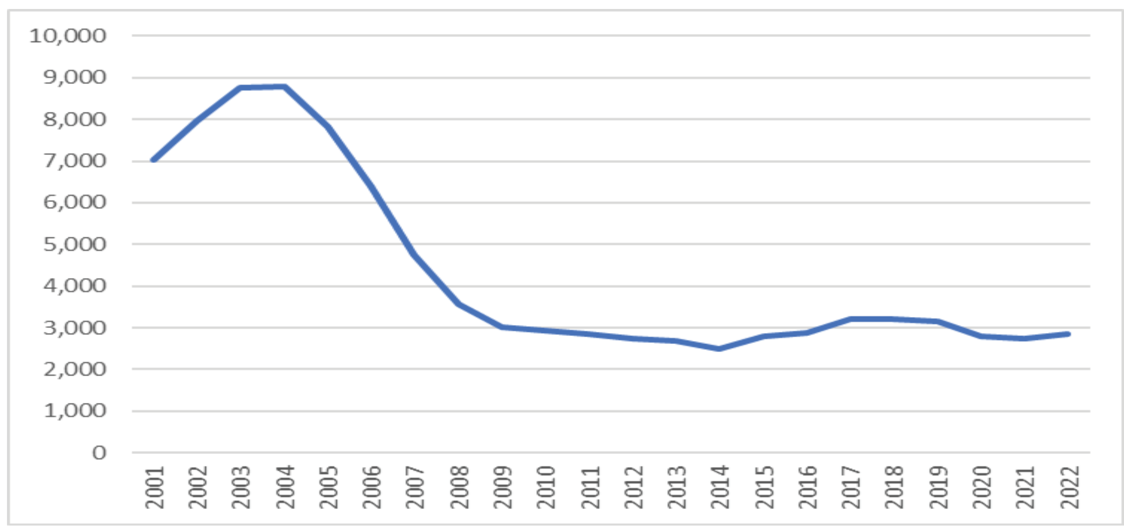


Figure 8: AIDS deaths adults 15+; Spectrum 2022

This decline is attributable to the success of the ART programme in the country.

1.3 Progress towards Achievement of Fast-Track Targets

The 2017 NAMPHIA results indicated that 86.4% of adult Namibians aged 15 – 64 years living with HIV knew their status; 96.4% of these were receiving ART; and 91.3% of those receiving ART had achieved viral load suppression. This shows that Namibia already achieved the UNAIDS Fast-Track AIDS targets of 90%-90%-90% before 2020. The 2021 HIV estimate confirmed the above achievement with a record of 90%-98%-91%. The country has surpassed the UNAIDS' global targets of 90-90-90 by intensifying interventions towards HIV diagnoses and treatment.

1.3.1 Progress towards HIV Epidemic Control, 1990 – 2022

Although the country is progressing towards epidemic control, new infections are still higher than deaths. The country needs to do more to reduce both new infections and HIV-related deaths, and at a faster rate for new infections if the country is to meet its set targets and achieve epidemic control.

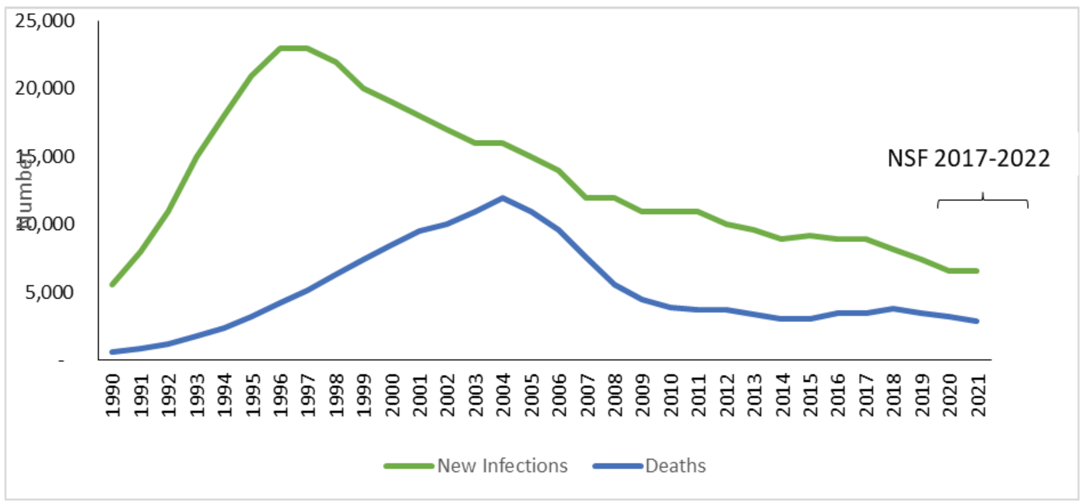


Figure 9: Comparisons of new HIV infections and AIDS deaths, 1990 – 2021 (Spectrum, 2022).

Programme implementation of the national HIV multi-sectoral approach is guided by the National Strategic Framework for HIV (NSF), which is aligned to the Ministry of Health and Social Services Strategic Plan and the National Development Plan. It has been primarily underpinned by the UNAIDS Fast-Track approach to ending AIDS by 2030 through the implementation of a combination prevention strategy, the life cycle approach, integration of HIV services into healthcare and a multi-sectoral approach.

CHAPTER 2 Summary of the Situation Analysis and the Response Analysis

2.1 Overview of the Situation Analysis

In Namibia, the HIV epidemic is driven mainly by unprotected heterosexual sex. Several reports have provided insights into the drivers of new HIV infections, which include multiple and concurrent partnerships (MCP), low and inconsistent condom use, low medical male circumcision rates, population migration and mobility, and marginalised populations. Furthermore, these key drivers are compounded by social factors that continue to increase risk, decrease resilience, and drive new HIV infections through high-risk sexual behaviours, such as:

- Intergenerational sex
- Alcohol abuse
- Low levels of HIV risk perception
- Transactional sex
- Stigma and discrimination
- Gender inequalities, including gender-based violence
- Poverty and unemployment

There are population groups at high risk of HIV infection, such as sex workers, gay men and other men who have sex with men, transgender people, people who inject drugs and inmates. AGYW, ABYM, mobile and migrant workers, people in uniformed services and people with disability are also among the populations vulnerable to HIV.

The HIV incidence rate is highest among adolescent girls and young women aged 15 – 24 years (0.9% versus 0.52% in the general population) and the adolescent reproductive rate is high, which could be due to the limited provision of comprehensive sexuality education in schools and limited access to family planning for adolescents.

The prevalence of HIV varies geographically across Namibia, ranging from 6.57% in Kunene to 20.3% in Zambezi. The northern regions of Oshikoto, Zambezi, Kavango West, Kavango East, Ohangwena, Oshana and Omusati have the highest HIV prevalence. Some of these regions receive a significant number of cross-border PLHIV from neighbouring countries accessing HIV care and treatment services in Namibia.

The Namibian Constitution provides and guarantees healthcare for all citizens. Healthcare services, including HIV prevention and treatment services, are provided for free to everyone in the country.

Stigmatisation and discriminatory attitudes towards people living with HIV is common. There is also self-stigma. Among government service providers, health workers, security services (police, immigration and correctional services personnel) and judicial officers, are mostly implicated in stigmatisation.

2.1.1 Inequalities

A study that examined socio-economic inequalities among adult PLHIV aged 15 years and older in 12 Sub–Saharan African countries in the attainment of the 90-90-90 targets[1] (Chipanta, 2022) showed that age, rural-urban residence, education and wealth status were essential determinants of PLHIV attaining the 90-90-90 targets. Plans to meet the 95-95-95 targets should include interventions to reduce socio-economic inequalities and indicators to measure equity.

The study found that in Namibia:

1) Awareness of HIV-positive status was pro-poor;
2) The rural-urban residence contribution to inequalities in awareness of HIV-positive status was −4.4%;
3) Inequalities in HIV viral load suppression was pro-poor; and
4) Insecurity compared to food security was associated with a probability decrease in access to ART (the same finding was made in Ethiopia and Uganda).

Based on these findings, available resources need to be used more efficiently to address socio-economic inequalities.

2.2 Overview Response Analysis

2.2.1 Combination Prevention

2.2.1.1 Service-Based Prevention

Service-based prevention aims to prevent the spread of HIV by providing comprehensive services to the public. These services include VCT, education on healthy behaviours, condoms and lubricants, VMMC, PrEP, PEP, early diagnosis and treatment.

Condom and lubricants promotion and distribution

Condom promotion and distribution remain important components of combination HIV prevention. Condom programming efforts are primarily focused on promoting condom use and distributing condoms across the country.

Namibia developed a national condom strategy in 2020 to improve the condom programme (GRN, 2020c); however, it has not been fully operationalised.

Namibia recognised the need for a total market approach to condoms; however, the approach has not been fully realised yet. The condom market largely depends on a free condoms approach and much less on a private market approach. The free condoms procured through the national medical store constituted 96% of the condoms distributed in 2020 (GRN, 2020a).

[1] Cameroun, Côte d'Ivoire, Tanzania, Uganda, Malawi, Zambia, Tanzania, Ethiopia, Uganda, Namibia, Eswatini, and Lesotho

The condom promotion and distribution were conducted largely through traditional condom outlets, such as public health facilities. There was limited condom distribution through non-traditional outlets, such as bars, nightclubs, hotels, pensions, workplaces and community settings. There was also limited support from and collaboration with partners, civil society and community-led organisations to take condoms to the last mile.

Intermittent condom supply has been the major challenge of the condom programme in Namibia. The intermittent condom supply is attributable to multiple factors, including lack of a standardised tool for the quantification of condoms, lack of an efficient system for procurement, and limited use of non-traditional outlets for condom distribution to the last mile.

2.2.1.2 ARV-Based Prevention

Namibia adopted the expanded role of PrEP, as a component of combination prevention strategies in 2016. The primary goal of this initiative is to reduce the incidence of new HIV infections. PrEP services are currently provided by healthcare professionals, encompassing both facility-based and community-based approaches. The PrEP programme is designed to specifically cater for priority populations, including pregnant and breastfeeding women (PBFW), adolescent girls and young women (AGYW), key populations (KP), sero-discordant couples, and HIV-negative people at substantial risk.

Namibia has made significant progress in increasing access to PrEP. By the end of 2021, a total of 18,340 clients were initiated on oral PrEP (PEPFAR, 2022b). While uptake of PrEP was high, retention was low.

The MHSS is currently reviewing the PrEP SOP to align it with the WHO's latest recommendations on PrEP, which will simplify PrEP implementation and acceptance.

Namibia has been implementing post-exposure prophylaxis (PEP) as per the WHO recommendation. Namibia has recently launched a communication strategy on undetectable HIV viral load with the message "Undetectable = Untransmittable" (U=U).

2.2.1.3 Male Circumcision

Namibia has made significant progress in the up-scaling of voluntary medical male circumcision (VMMC) towards the prevention of HIV since 2010 (GRN, 2022f). From the launch of the VMMC programme up until March 2023, a total of 270,000 VMMC were performed. By the end of 2022, VMMC coverage had reached 64% for the priority age group (15 – 29 years) and the circumcision rate for 15 – 49 years was 58% (PEPFAR, 2022a). According to MHSS programme data, 20,682 VMMCs were performed in the country during the 2022 financial year.

VMMC services are provided at public health facilities and at selected contracted private health facilities. Both public and private facilities provide VMMC services using an approach to service delivery, with a combination of static primary healthcare (PHC) and outreach (mobile and fixed)

sites. The outreach approach involves providing VMMC services at selected private healthcare facilities, lower-level health facilities or in communities at school premises, and other community structures or mobile clinics. The outreach fixed sites comprise government, private healthcare and NGO facilities. Strong demand was created through interpersonal communication (IPC) agents, community mobilisers, community health extension workers and major campaigns targeting youth, such as the back-to-school (BTS) campaign, and winter community campaigns. The campaigns used mass media, branding and champions to encourage youth to embrace VMMC.

However, the volume of VMMC services remained flat or decreased slightly at the end of the strategic period. The drop in the number of VMMC was associated with reduced funding, and in some regions, such as Zambezi and Kavango East, reaching saturation levels. In addition, the COVID-19 pandemic may have led to the scaling down of community programmes, including VMMC outreaches between March 2020 and June 2021 (GRN, 2022h).

2.2.1.4 eMTCT

The PMTCT programme was launched in Namibia in 2002 and the country has made remarkable progress in all PMTCT programme areas since then, achieving near universal coverage across the country. According to a 2017 NAMPHIA report and subsequent annual programme reports, 99% of all pregnant women attend at least one antenatal care (ANC) visit. HIV testing is routinely provided to pregnant women attending the first ANC visit and in 2021, 98% were tested for HIV, with a positivity rate of 13.5%. Of these, 87% knew their status before their first ANC visit and all HIV-positive pregnant and breastfeeding women were on ART in 2022 (GRN, 2022f). Mother-to-child transmission (MTCT) rates reduced from 13.4 % in 2012 to 4.14 % in 2022 (GRN, 2021k). The trend in rates contributed to the reduction of annual new HIV infections among children 0 – 14 years from 1,675 in 2012 to 408.

PMTCT services are available at almost all health facilities countrywide and integrated into MCH services for all pregnant and breastfeeding women and their children. All women attending their first ANC visit are offered HIV, syphilis and Hepatitis B testing. Point-of-care rapid HIV tests are commonly used, while blood samples are sent to the laboratory for syphilis and HBV testing and results are not available on the same day.

Lifelong ART is recommended for all HIV-positive pregnant and breastfeeding women. The current recommendation for VL monitoring among pregnant and breastfeeding women on ART is every three months until the cessation of breastfeeding. However, the VL monitoring among pregnant women was less than 83% in 2021, and 90% of those monitored had viral load suppression (<40 copies/ml). There is relatively low adherence to treatment during breastfeeding, and community adherence support to HIV-positive breastfeeding women is suboptimal. The difficulties of tracing patients through community health workers are partly due to patients moving across the country and supplying incorrect addresses.

Follow-up and scheduled early infant diagnosis (EID) is recommended for all HIV exposed infants (HEI). In 2021, 76% of HEIs had EID within two months and 95% by 12 months (PEPFAR,

2022b). Mother and baby follow-up, tracking and tracing through a bi-directional referral system between health facility and community level is not implemented adequately, resulting in less than 50% of HIV exposed infants having their final HIV status documented at the end of the breastfeeding period.

The recommended HIV retesting among HIV-negative pregnant and breastfeeding women is every three months until cessation of the breastfeeding period. While the HIV-positive test rate (yield) during the first ANC visit was 2% in 2021, the yield for HIV retesting after the first ANC visit was 2.8% (MoHSS Programme Data 2021, PEPFAR, 2022b). However, HIV retesting coverage for pregnant women was below 50%, partly due to the inadequate implementation of PMTCT retesting guidelines by healthcare providers.

Occasional stock-out of rapid test kits, reagents for VL and EID, as well as longer turn-around time for results sometimes affect the performance of the PMTCT programme.

Family planning (FP) services are widely available in the country. However, there is limited integration of FP in the HIV services delivery settings to encourage its use among PLHIV. PrEP services for PBFW are being rolled out in MCH settings, but uptake is still too limited to attain the goal of primary prevention of MTCT.

2.2.1.5 Sexual Reproductive Health Rights, Sexually Transmitted Infections and Demand Creation

In most public and private health facilities across Namibia, sexual and reproductive health services, including family planning, STI diagnosis and treatment, are delivered through an integrated approach. SRH and STI services are integrated with both facilities-based and community outreach services. The STI programme has been integrated into other health programmes, such as VMMC, condom distribution, PrEP, VIA, FP and MCNH.

STIs are recognised as the major cause of reproductive and psychological morbidities. The 2013 Namibian DHS showed that 9% of adults (10% of women and 6.3% of men) reported at least one STI symptom (discharge, blister or ulcer) and 64% of them sought medical care and treatment (GRN, 2013). Based on programme data for 2021, 102,988 STI cases were treated in all health facilities (GRN, 2021d).

Namibia is using the Syndromic Management Approach to diagnose, manage and report STIs. Syndromic STI case management requires periodic reviews of STI guidelines to update the treatment protocols and algorithms. The current STI guidelines are under review. Point-of-care testing for STIs can be utilised to diagnose STIs; however, it has not been implemented in Namibia yet.

Sexual reproductive health services are provided countrywide in all health facilities. The Namibian DHS 2013 reported that one in two Namibian women aged 15 – 49 (50%) use a particular method of contraception, while injectables are reported to be the most commonly used family planning method (21%). According to MHSS programme data, the delivery and uptake of contraceptives, particularly modern contraceptives, has increased in Namibia over the past decade. As a result, the

contraceptive prevalence rate (CPR) was estimated at 61% in 2020. However, the country still has a long way to go to meet its national CPR target of 80% by 2030.

Reproductive health and maternal health commodities are managed by the central medical store within the MHSS. The quantification of reproductive health and maternal health commodities has been done for the period 2022/23 – 2024/25 (GRN, 2022g). However, stock-out of SRH/FP commodities has been a major challenge. Currently, funding for pharmaceutical supplies, including FP commodities, is allocated based on historical allocation from previous years, which has resulted in inadequate funding leading to unmet needs and limited availability of these essential commodities and services.

A package of gender-based violence services has been provided in some health facilities. A package of health services, including HIV testing, pregnancy testing, emergency contraception, PEP, and STI treatment and prophylaxis, is provided to GBV survivors according to the national guidelines. However, linkage with mental, social and legal services has been limited.

The demand creation and SBCC have been implemented and integrated with different programme areas, such as PMTCT, condom distribution, ART etc. However, the section at the DSP responsible for designing, developing, producing and implementing the demand creation and SBCC communication materials has been underfunded, and skills underutilised.

2.3 HIV Testing and Treatment Services

2.3.1 HIV Testing Services

The HTS programme has evolved over time, shifting focus from testing volumes to targeting high-risk sub-populations to improve the likelihood of HIV case identification. Index Contact Testing (ICT), Optimised Provider Initiated Testing and Counselling (PITC) and HIV self-testing (HIVST) have proven to be effective testing modalities for a changing epidemic in Namibia. The successful implementation of these testing modalities has contributed to the realisation of the first 90 UN Fast-Track target, which stood at 92% by December 2021, compared to five years ago when the Namibia Population-based HIV Impact Assessment survey (NAMPHIA, 2017) reported that only 86% of PLHIV knew their status. Despite this outstanding recent performance, significant testing gaps still remain in some population sub-groups, such as men, and adolescent girls and young women (AGYW).

The age of consent for HTS was reduced from 16 years to 14 years or older in 2018 and has enabled access to HTS for younger adolescents.

The Government of Namibia has taken centre stage in funding its HTS programme by providing HIV test kits and laboratory consumables, while other partners, such as the Global Fund (GFATM) and PEPFAR, have supported the programme through procurement of HIV self-test kits, building human resource capacity through deployment of key staff and training support.

The MTR of the NSF noted that men had poor health seeking behaviour and this was mainly driven by gender norms that define masculinity and virility, coupled with intergenerational sex, among other factors. The need to implement more targeted testing approaches, such as ICT, with a strong community-based tracing component for men was highlighted.

There were missed opportunities for community-based test and treat approaches due to a limited number of testers to offer confirmatory HIV tests prior to initiating ART in the community.

HTS were disrupted during the COVID-19 pandemic due to travel restrictions, curfews and the suspension of community-based services. It was noted that an efficient system for managing logistics for HIV test kits exists through a “pull system” for the commodities that are stored and managed by the government’s central medical stores. A robust quality assurance system for rapid HIV testing, supported by the Namibia Institute of Pathology (NIP), provides certification and renewal of licences for testers at health facilities, while performance at most HFs has been satisfactory. The high linkage rates for ART initiation following an HIV-positive diagnosis were attributed to same-day ART start, escorting patients from testing sites to ART initiating sites and the use of bi-directional referral forms, existence of NIMART trained nurses, and decentralisation of HTS and ART services.

2.3.2 HIV Treatment Services

The Namibia ART programme has successfully reached the UN Fast-Track targets, with 92% of all PLHIV knowing their status, 99% of those knowing their status being on ART, and 93%

viral suppression among patients on ART (HIV Estimates, 2021). It is estimated that about 220,000 people are living with HIV in the country across all age groups. Decentralisation of ART services across all populations sub-groups was prioritised to improve treatment access to nearly 100% of all health facilities, given the vastness of the country geographically. Nurse-Initiated and Managed Antiretroviral Therapy (NIMART) roll-out was completed in 2019; however, the maintenance of NIMART sites remains a challenge due to staff attrition, especially in the Kunene, //Kharas and Hardap Regions where some clinics are located in remote and under-developed areas that are unattractive to health workers. By the end of December 2021, 98% of all public health facilities in Namibia were NIMART sites, with 98% of all registered nurses trained in the provision of ART services. A training gap was noted, with only 40% of enrolled nurses trained in NIMART, thereby limiting the capacity of facilities to provide ART services.

During the period of the strategy, ART coverage among PLHIV showed an increasing trend. Based on 2021 HIV estimates, Namibia has already achieved its target, among children and adults, of ensuring that at least 81% of all PLHIV in Namibia are on Antiretroviral Therapy (ART) by 2022.

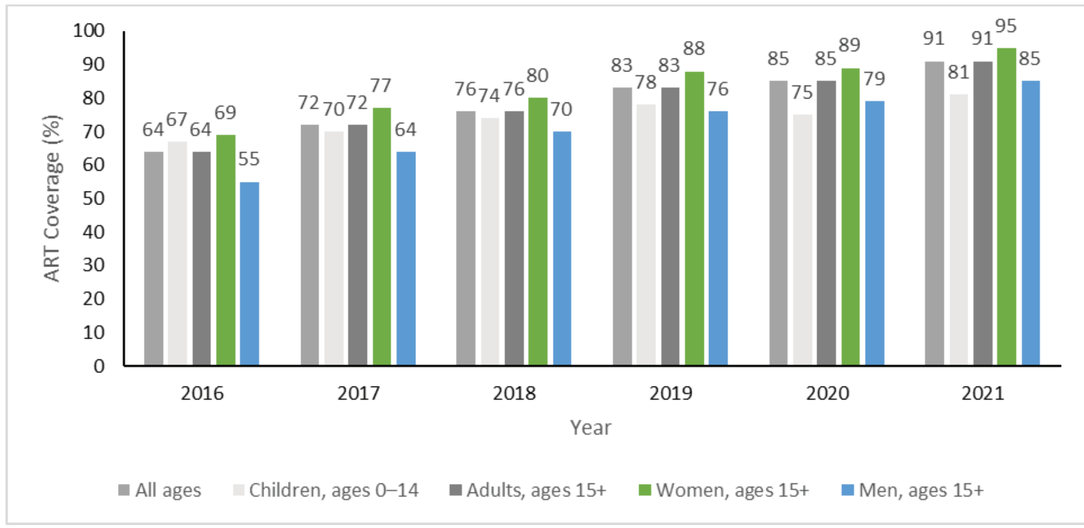


Figure 10: Trends in ART coverage among PLHIV in Namibia disaggregated by age and sex, 2016 – 2021

The programme aimed to retain 90% of adults and 98% of children at 12 months in 2021/2022 (NSF for HIV). However, retention in recent years has been below the set targets. Twelve-month retention is higher than 24-month retention. In both cases, retention was lower than targets set for children (90%, 94%, 95%, 07% and 98%) and adults (80%, 83%, 85%, 88%, 90%) for 2017 – 2022. The percentage risk of interruption in treatment was higher among patients <3 months on ART; however, in absolute numbers, the majority of patients who interrupted treatment had been on ART for periods of three months or more. It was also noted that the highest risk is among patients aged 20 – 29 years in both sexes (PEPFAR Programme Report, March 2022).

Adherence and retention challenges among ART clients were cited at facilities, with contributory factors including alcoholism, food insecurity associated with poverty and

unemployment, long travelling distances, stigma, high mobility, working commitments (in farming communities) and treatment fatigue. This was coupled with limited access to social services for clients experiencing socio-economic hardships. The need to strengthen collaboration across government offices, ministries and agencies (OMAs) is important and urgent. It should also be noted that M&E gaps exist, such as the lack of unique patient identifiers and the current state of stand-alone facility databases resulting in inaccurate retention data. Some clients move frequently between health facilities, leading to underestimation of continuity of treatment rates.

The MHSS recently developed SOPs for Tracing and Post Tracing Services to standardise tracing of patients who interrupt treatment, re-engage them in treatment and address the unique underlying causes of treatment interruption for each individual client.

Based on the 2021 HIV estimates, all sub-populations (all ages, children aged 0 – 14 years, adults aged 15+ years, women aged 15+ and men aged 15+ years) progressively showed significant improvements in terms of knowledge of HIV status among PLHIV, enrolments on ART among PLHIV who know their HIV status, and viral load suppression among PLHIV on ART over the lifespan of the strategy (2017 – 2021). The country is on track towards achieving the UNAIDS Fast-Track targets, having already achieved the second 95. This is more evident among adults 15+ years (92-98-93), especially females (95-98-94), where both the first and second 95s have been achieved and the third 95 is within reach. However, children (81-98-93) and adult males (88-96-91) continue to remain behind, especially on the first 95. Notably, viral load testing coverage improved during the strategy period and was consistently at 100% during the 2020 and 2021 reporting periods.

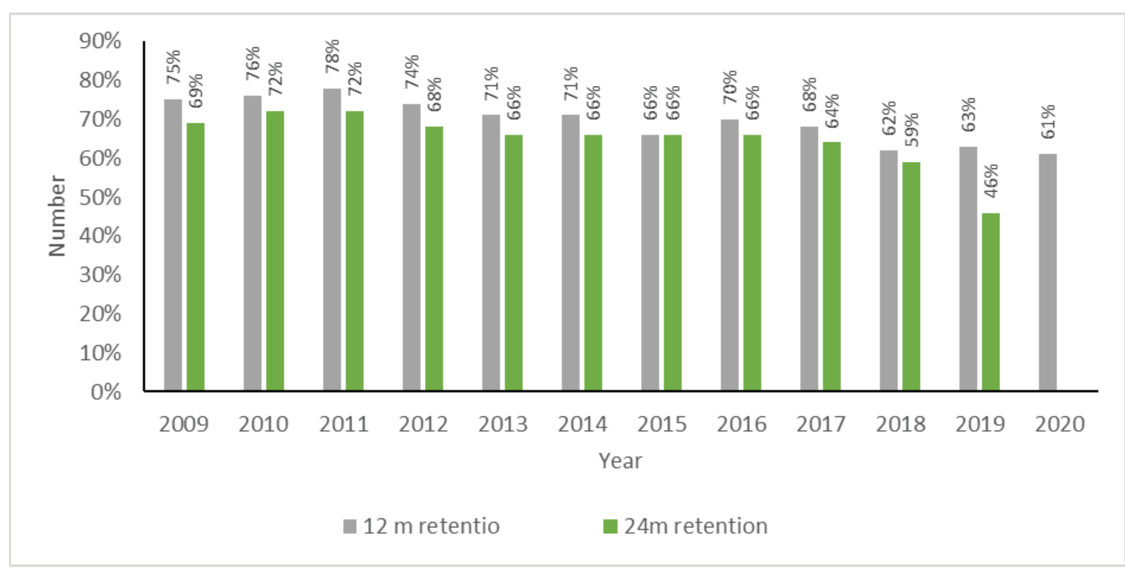


Figure 11: Retention on ART at 12 months and 24 months, Namibia, 2009 – 2020

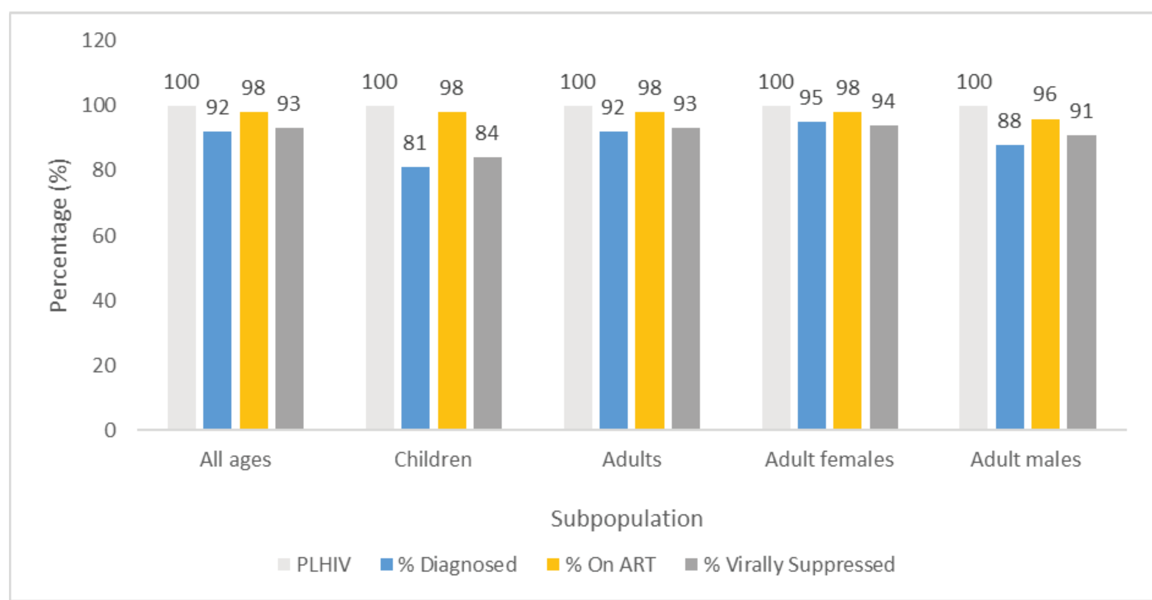


Figure 12: Progress towards the 95/95/95 Fast-Track targets by age and gender, 2021

In the 12-month period from April 2021 to March 2022, patients were able to access the following tests at health facilities: Hb, Serum CrAG, and serum creatinine.

The burden of patients with advanced HIV disease (AHD) has not been well-tracked. There is need for the programme to pay special attention to screening and management of patients with AHD.

The government successfully introduced Dolutegravir-based regimens for both adult and paediatric populations. Transitioning of adult patients started in October 2019 and was completed by the end of 2021, with >95% of adult ART patients on the new DTG-based regimens. Nevirapine-based regimens have successfully been phased out to pave the way for newer robust optimised therapy. In the past two years, most health facilities in Namibia have not experienced stock-outs of first-line ART for both adults and children. However, supply interruptions were observed for third-line ART medicine (Darunavir). The government has demonstrated political commitment in supporting the ART programme by covering most of the ARV budgetary requirements of the programme, including HIV rapid test kits, viral load testing services and other related laboratory tests for monitoring HIV treatment. Other partners, such as PEPFAR and Global Fund, cover costs for some laboratory reagents, infrastructure, equipment, medicines and human resources. The ART programme introduced some Point-of-Care (POC) laboratory tests for Early Infant Diagnosis (EID) and POC viral load to address access challenges and reduce the turnaround times for diagnostics.

Capacity building in paediatric ART has helped to reduce referrals of paediatric HIV patients to higher levels, supported by the decentralisation of paediatric ART services to lower facilities and paediatric ART optimisation. The paediatric ART programme is implementing the Namibia Adolescence Treatment Supporters (NATS), a peer-support model adopted from Zvandiri in January 2022, starting off in two regions, namely Khomas and Oshana, with the aim of expanding to additional regions. This intervention was aimed at addressing the challenges that adolescents and youth experience in adherence and retention to treatment that are mainly associated with delayed disclosure of HIV status, lack of adequate psychosocial

support, lack of support from caregivers/parents and some negative experiences at boarding schools. The implementation of the Continuous Quality Improvement (CQI) collaboratives targeted at improving several high-priority indicators, including linkage to ART, retention, TB screening, TB preventive therapy, VL monitoring and VL suppression, helped the programme to achieve such a high performance.

2.3.2.1 Differentiated Service Delivery for HIV Services

In 2016, the country implemented Differentiated Service Delivery (DSD) models for less-intensive HIV care following WHO guidelines. A pilot for Community Adherence Groups (CAGs) started in 2017, expanding to 2,467 CAGs by March 2022 across all 14 regions, with 20,945 clients enrolled. The ART programme established a DSD training curriculum and SOP manual in 2019.

The diversified HIV treatment models, including CAGs and outreach, allow recipients of care (ROCs) to access tailored services within communities, thereby easing facility congestion. The HIV programme, in collaboration with primary healthcare, expanded the community ART outreach to a comprehensive community-based health services model for remote areas. Civil society organisations help to deliver ART and trace patients, but limited funding hampers the involvement of local CBOs, with few international NGOs stepping in.

The COVID-19 era saw a surge in Multi-Month Dispensing (MMD) models to reduce facility visits and minimise transmission risk. The 2017 – 2022 NSF report highlighted significant MMD progress, with 53% receiving medicines for three months or more. However, the June 2022 programme report noted only 31% of ART patients received monthly ART, reflecting a shift in dispensing practices.

2.3.2.2 Service Integration, Prevention and Management of Opportunistic Infections including TB/HIV Collaborative Activities

As Namibia moves from the emergency response posture of the past 30 years into sustaining the epidemic control status, there will be need to integrate vertical HIV/AIDS programming more efficiently and effectively into the general health service delivery infrastructure of the country. Where possible, Namibia will appropriately and carefully integrate HIV programming into strengthened public health systems to manage tuberculosis and high-burden non-communicable diseases, sexual reproductive health, rights and services, as well as other health priorities that impact PLHIV, to protect HIV/AIDS gains and strengthen health and economic outcomes.

There was evidence of service integration across the following programmes:

- Over 90% of visited HFs offered condoms, oral contraceptive pills and injectables (Depo Provera) within ART clinics as a one-stop shop service. Oral contraceptive pills were out of stock at some facilities visited.
- Nutrition screening and management was being offered routinely in 86% of facilities visited during clinical consultations. Severe cases were referred to medical doctors for further management.

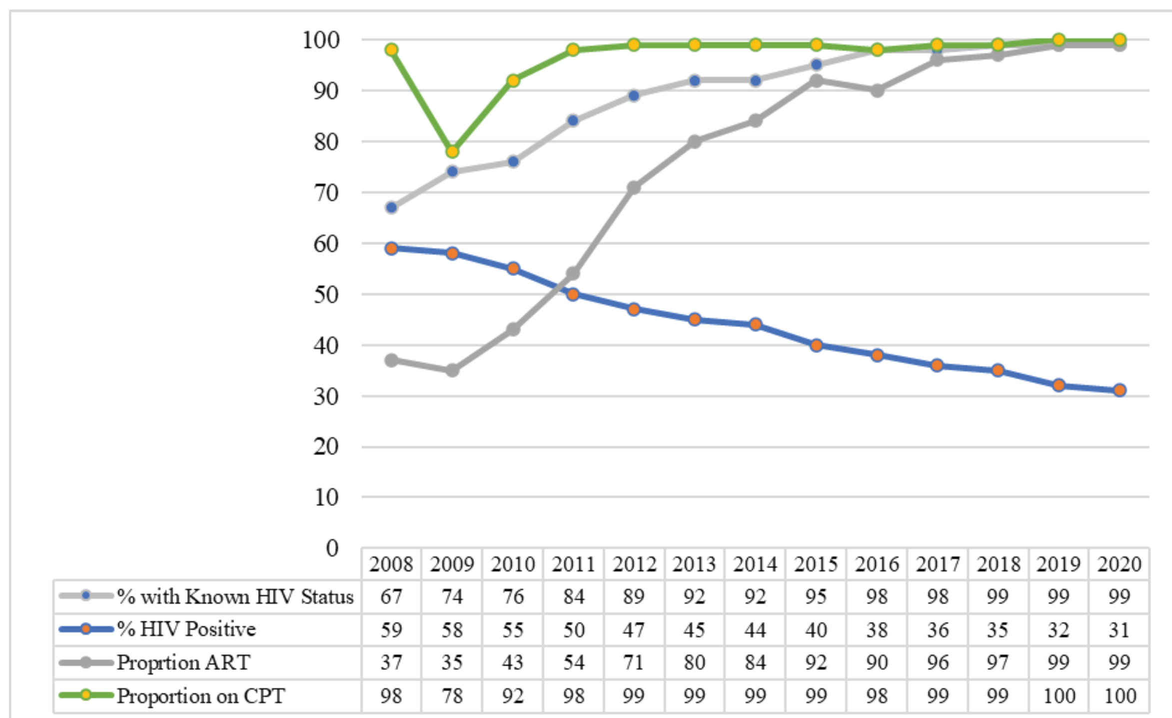
- STI screening and management was integrated in all the facilities.
- ART patients had BP checks at each clinical consultation visit.
- Cervical cancer screening and treatment of precancerous lesions for WLHIV was offered at 82% and 57% of the facilities visited, respectively.

2.3.2.2.1 TB/HIV

In 2021, Namibia ranked among the top 30 high-TB-burden countries globally and as the ninth highest in relation to its incidence rate. TB is the most common life-threatening opportunistic infection that affects PLHIV in Namibia. Other, but less common, opportunistic infections include Cryptococcal Meningitis and Kaposi Sarcoma. The risk factors attributed to TB in Namibia are HIV, undernutrition, alcohol use disorders and smoking. Both the TB and HIV programmes fall under the same directorate and there are coordinating structures in place to support joint activities, strategic and technical planning, and proposal development; joint policy and guidelines review and development; and monitoring and evaluation.

At health facility level, there are attempts to implement a one-stop shop model for TB/HIV services with varying levels of success. The TB/HIV co-infection rate declined from 34% in 2018 to 30% in 2021 (Global TB Report). However, it was noted that some clinicians were not capacitated to manage both TB and HIV patients, and hence limiting the implementation of the one-stop shop model. Among the visited facilities, 18 (82%) offered a one-stop shop service model for TB/HIV services.

Namibia's TB/HIV programme has made significant progress in joint collaborative activities, registering high performance for HIV testing and ART coverage among TB patients at 99% for both indicators in 2020. Initiation of Cotrimozaxole preventive therapy remained high at 100% among TB/HIV co-infected patients. TB screening among PLHIV is performed at all health facilities at each visit using a four-symptom check list, although the sensitivity of the screening tool is questionable as Namibia is reported to miss about 42% of all TB cases (Global TB Report, 2022). The programme has introduced routine annual CXR for PLHIV at selected pilot ART facilities to help determine the burden of TB among PLHIV.



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
% with Known HIV Status	67	74	76	84	89	92	92	95	98	98	99	99	99
% HIV Positive	59	58	55	50	47	45	44	40	38	36	35	32	31
Proprtion ART	37	35	43	54	71	80	84	92	90	96	97	99	99
Proportion on CPT	98	78	92	98	99	99	99	99	98	99	99	100	100

Figure 13: Trends in proportion of selected TB/HIV indicators 2008 – 2020

The scale-up of TB Preventive Therapy (TPT) has been phenomenal, with current reports showing TPT coverage at 92% and a completion rate of 91% among PLHIV by end of December 2021. Measuring TPT completion was noted as a challenge five years ago. However, aided by the mentorship programme and the quality improvement collaboratives, a rapid capacity building strategy for health workers to assess eligibility for TPT, initiation of TPT and monitoring of treatment completion was possible. Quality improvement collaboratives are implemented in most high-volume facilities.

TPT medicine stock-outs in the past 12 months were reported in 50% of health facilities visited. However, in most cases where the preferred TPT regimen was not available, the alternate regimen was available. Some stock-outs of Pyridoxine were reported during the period under review and it was noted that there was no clear policy on how to manage patients eligible for TPT in the absence of Pyridoxine medications.

In 2019, the national TB treatment guidelines provided for the use of the Lateral Flow Tuberculosis Lipoarabinomannan (LF TB LAM) for TB screening among adults, adolescents and children living with HIV and with advanced disease. The mentorship programme and the quality improvement collaboratives have facilitated a rapid capacity building strategy for health workers to provide TB/HIV services.

2.3.2.2.2 Cervical Cancer Screening and Treatment of Precancerous Lesions

Cervical cancer is the second most prevalent cancer after breast cancer in Namibia, and the second most frequent cancer among women between the ages of 15 and 44. Namibia's cervical cancer programme is relatively new and, as a result, the majority of screenings are first-time screenings, making up 63% of all screenings in 2021.

Cervical cancer screening and treatment of precancerous lesions have been successfully integrated into the national ART programme. The National Guidelines for Cervical Cancer Prevention were developed, followed by training of nurses and doctors in visual inspection using acetic acid (VIA), thermocoagulation and surgical excision of large lesions. Women living with HIV in the age range of 20 – 49 years are screened once every three years, while HIV-negative women in the age range of 25 – 49 years are screened every five years. Programme reports indicated that only 33% of the targeted group was screened, with 18% positivity rate for VIA. However, the programme achieved 95% treatment rate among the VIA-positive women.

In November 2022, the government approved the procurement and introduction of the Human Papillomavirus (HPV) vaccine for the prevention of cervical cancer in the expanded programme on immunisation. This is a huge progressive step towards elimination of cervical cancer as a public health problem in Namibia.

The country is in the process of transitioning from screening using the VIA method to HPV DNA testing in accordance with WHO guidelines.

2.3.2.2.3 Mental Health for PLHIV

Research shows that people living with HIV are more likely to experience anxiety, depression and other mental health conditions compared to the general population.

As the Namibia HIV treatment programme increasingly focuses attention on ensuring the retention of the more than 200,000 PLHIV on lifelong treatment, there is need to establish, strengthen and integrate low-cost, scalable, standardised mental health screening and treatment interventions as part of a routine HIV care and treatment package accessible in settings throughout the country.

2.3.2.3 Human Rights and Gender Equality

Namibia's commitments to human rights and gender equality are enshrined in the Namibian Constitution under Chapter 3 (Bill of Rights) and Chapter 11 (Principles of State Policy), especially Articles 5, 6, 7, 8, 10, 14, 15, 19, 20, 23 and 95 (GRN, 1990). The Government of the Republic of Namibia (GRN) has also ratified a number of regional and international treaties that guarantee fundamental human rights and freedoms and, as a member of the African Union and SADC, Namibia is committed to the AU Heads of State Solemn Declaration on Gender Equality (July 2004) and the SADC Protocol on Gender and Development. As a state party to these various regional and international standards, GRN is legally bound and takes responsibility for promulgating domestic measures, legislation and policies, defining institutional frameworks compatible with the various treaty obligations and duties, as well as designing and resourcing appropriate programmes to actualise human rights and gender equality.

Namibia is a Member State of the United Nations that is committed to the United Nations Agenda 2030 on Sustainable Development (2015) and detailed in the 17 SDGs and 169 targets aimed at ensuring that **"No One Is Left Behind"**. Namibia is committed to achieving the SDG

targets critical to the HIV response, especially SDGs 1, 2, 3, 4, 5, 8, 10, 11, 16 and 17[2]. Furthermore, Namibia's commitment to reducing human rights barriers, enabling gender equality and equity, addressing inequalities and the elimination of stigma and discrimination as prioritised in the NSF 2023/24 – 2027/28 feeds into: The UNAIDS Global AIDS Strategy 2022 – 2026 *Ending Inequalities, Ending AIDS*; the 2018 United Nations Political Declaration on the Fight against Tuberculosis (to weave intersection of Namibia's HIV/TB programming on stigma and discrimination); African Union Agenda 2063: The Africa We Want; the Global Fund Strategy 2023 – 2028 (The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), 2022); the WHO Global Health Sector Strategy on HIV, Hepatitis and STIs (GHHS 2022-2030) (WHO, 2022); PEPFAR Namibia Country Operating Plans (COPs); the Political Declaration on HIV and AIDS June 2021 (United Nations, 2021) and the United Nations Political Declaration on Universal Health Coverage 2019 (United Nations, 2019). In addition, Namibia is committed to peer review mechanisms, such as the African Peer Review Mechanism (APRM) and the UN Human Rights Council's Universal Peer Review (UPR).

In order to address stigma, discrimination and violence, Namibia has put in place conducive legal and policy frameworks that include the National Policy on HIV/AIDS (2007), the National Policy on HIV/AIDS for the Education Sector (2003), the Public and Environmental Health Act (2015), the Labour Act (2007), the Social Security Policy (1994), the Combating of Rape Act (2000), the Combating of Rape Amendment Bill 2022, the Domestic Violence Act (2003), the Married Persons Equality Act (2007), the Prevention of Organised Crime Act (2004), the Child Care and Protection Act (2015), the National Policy on Orphans and Vulnerable Children (2004), the Combating of Trafficking in Persons Act (2018), the Social Protection Policy (2021 – 2030), the National Gender Policy (2010 – 2020), the Social Security Act (1994), and the National Policy on Disability (1997), as well as key sector plans, strategies and frameworks, such as the Ministry of Health and Social Services Strategic Plan 2017/18 – 2021/22, Ministry of Justice Strategic Plan 2017 – 2022, National Gender Plan of Action (NGPA) and National Plan of Action on Gender-Based Violence (NPAGBV).

Additionally, the country has an established institutional framework to support the realisation of human rights, gender equality and the elimination of stigma, discrimination and violence. Key among these are the Office of the Ombudsman, which is mandated to investigate human rights violations; the Law Reform Commission (LRC), which is mandated to repeal outdated laws and propose the enactment of laws that actualise human rights; the Office of the Prime Minister (OPM), which is mandated to coordinate the executive function of Parliament, and the work of cabinet and public service for a result-driven service delivery to citizens; the National Planning Commission (NPC), which is mandated to plan and spearhead the course of national development; the Ministry of Health and Social Services (MHSS), which is mandated to provide integrated, affordable, accessible and quality health and social welfare services that meet the needs of people in Namibia; the Ministry of Gender Equality, Poverty Eradication and Social Welfare (MGEPESW), which is mandated to ensure gender equality, eradicate

[2] Achievement of the Human Rights and Gender Equality Programme feeds into the following SDGs: Goal 1 (targets 1.1, 1.3 and 1.4), Goal 3 (targets 3.3, 3.4, 3.5 and 3.7), Goal 5 (targets 5.1, 5.2, 5.3, 5.4, 5.5, 56, 5a. and 5c.), Goal 8 (targets 8.2, 8.5 and 8.6), Goal 10 (targets 10.2 and 10.7), Goal 11 and Goal 16 (targets 16.1, 16.3, 16.6, 16.9, 16b.) and Goal 17.

poverty, and ensure socio-economic development; the Ministry of Education, Arts and Culture (MoEAC), which is mandated to educate learners, as well as improve life skills education among young people in Namibia and; the Ministry of Justice (MOJ), whose mandate is to provide legal services and ensure access to justice. Namibia also has a number of civil society organisations, networks and citizen groups that are actively engaged in the HIV response, human rights awareness and advocacy, strategic interest litigation, legal aid service provision, care and support for PLHIV, community mobilisation and the provision of HIV services. Robust programming to address gender-based violence (GBV) was rolled out in response to evidence that suggested that GBV is rampant in Namibia. Government has also established GBV Protection Units and shelters as part of its services to victims and survivors.

Major milestones have been registered in the previous NSF for the period 2017 – 2022, including legal and policy reforms; prevention programmes targeting specific sub-populations at risk of HIV infection, death and human rights violations; and the integration of SRHR and HIV programming, especially family planning, cervical cancer screening, contraceptives and comprehensive sexuality education. Namibia has also generated data and evidence. In 2018, Namibia undertook an HIV and AIDS Stigma and Discrimination Survey (the Stigma Index) (GRN, 2018a). The Legal Environment Assessment for HIV and AIDS (LEA) was conducted in 2016 (UNDP, 2016), and updated by UNAIDS in 2022 to include GBV-related laws. The PLACE study and the LEA for KVPs were also undertaken, thereby complementing previous surveys, such as the Integrated Bio-behavioural Surveillance Studies (IBBS) among MSM (GRN, September 2014) and the July 2015 IBBS among female sex workers (GRN, 2015b). There are also wellness programmes that have integrated HIV in the workplace, though these need to be better coordinated and need to mainstream gender. There was an 18% reduction in HIV incidence rate among young women 15 – 24 years from 1.1% in 2015 to 0.9% in 2022, although this reduction in incidence rate falls far behind the 75% target set in the NSF 2017/18 – 2021/22 (MHSS, 2021). In the education sector, life skills education was introduced to impart sexuality education, and human rights subjects have been mainstreamed in primary, secondary and tertiary institutions of learning. In addition, human rights awareness sessions were undertaken by the Office of the Ombudsman.

However, although Namibia has made significant progress in legal, policy, institutional and programme arrangements for the realisation of human rights and gender equality in HIV and AIDS, key barriers still prevent access to and utilisation of HIV services, care and support. These include, among others, internal and external HIV related stigma and discrimination that impedes PLHIV from accessing services and selective application of laws and policies, especially where they contradict social norms, culture, religion and practices. Health passports affect the right to privacy and confidentiality and promote stigma and discrimination. High rates of inequality hamper the consolidation and sustainability of achievements so far registered in Namibia's HIV and AIDS response. With a Gross National Income (GNI) per capita of US$9,190 and a Gini coefficient of 59.1 in 2015, Namibia was second only to South Africa in terms of inequality (UNDP , 2022). There are workplace programmes for the public sector (for the various OMAs) which are coordinated by the Office of the Prime Minister (OPM), but the overall national coordination for non-public actors requires strengthening.

In addition, the fact that the right to health is not provided for under the Bill of Rights in the Namibian Constitution affects the equitable provision of health to all people irrespective of their diversities, life choices and location. There are inadequate safeguards to protect citizens from rights violations perpetuated by duty bearers (like law enforcement, judicial officers, correctional officers and healthcare providers) and non-state norm shift actors (like faith-based institutions and traditional leaders).

While Namibia's dual legal system enables the enjoyment of social and cultural rights, at the same time it hampers the achievement of human rights, gender equity and substantive equality (USAID, 2012). The country has weak interventions targeting social norm-shift change and inadequate engagement and coordination of non-state actors (e.g. private sector, traditional leadership, faith-based institutions). As such, there is inadequate engagement of norm-shift actors at community level in anti-stigma and anti-discrimination interventions (e.g. faith-based institutions, traditional authorities, traditional healers and other community structures). Men and boys continue to be under-represented in HIV programmes due to negative masculinity and gender norms that influence their health-seeking motivations.

Stigma, discrimination and violence targeting PLHIV, key populations, women and AGYW hampers access to services (health, SRHR, education, justice, etc.), and the strong socio-cultural and religious values limit the reach and effectiveness of HIV interventions for those who are most at risk of HIV infection and mortality, yet least able to access HIV services. There is lack of up-to-date data to track indicators on gender, human rights, equity and other social enablers. The lack of population size estimates for some population sub-groups affects the development of appropriate programmes and response mechanisms, a case in point being the inadequate data on KVPs to inform national programming as existing data is outdated and only speaks to FSWs and MSM and leaves out other KVP sub-populations. This is coupled with the lack of evidence on HIV prevalence and services for some sub-populations, such as mobile populations, people in congregate settings and people who inject drugs (PWID). The invisibility of some of these sub-populations and inadequate links between them, the general population and KPs increases their vulnerability and falling out of care. Monitoring, evaluation and reporting tools to capture human rights, gender equality, stigma and discrimination are inadequate. More often, human rights and gender issues are addressed as stand-alone issues, yet they are critical in enabling the achievement of key outcomes in HIV and AIDS.

Lastly, while Namibia as a country undertook a multi-sectoral approach to its HIV response, in reality most sectors look at HIV as a health outcome under the sole responsibility of the MHSS, which affects the multi-sectoral responses and the active engagement of other sectors and OMAs.

2.3.2.4 Population-Based Programmes

The AGYW were still underserved, recording high rates of infection, compared to their male peers. Consequently, there is a need to work with a broad array of stakeholders to successfully and sustainably programme adolescent HIV and reproductive health. Programmes that target ABYM at health facility and community levels were limited. Some health facilities were, to some extent, not friendly to AGYW and ABYM.

2.3.2.5 Combination Prevention for AGYW and Vulnerable Children

Young women 15 – 24 years old make up a disproportionate share of new HIV infections. A third of new HIV infections occurs among adolescent girls and young women (AGYW) (GRN, 2021i). Several factors contribute to the high rate of HIV infection among AGYW, including low comprehensive knowledge about HIV transmission and prevention, substance abuse, multiple sexual partnerships, sex with older men (intergenerational sex), transactional sex, gender-based violence, limited condom use, limited access to HIV prevention services, and poverty, among many others (GRN, 2017b).

Combination HIV prevention interventions were implemented using community-based approaches that include mentor and peer-led services and outreach. Health facilities are providing combination HIV prevention services. Comprehensive sexuality education is integrated into life skills education at schools. Health workers conduct school health programmes on a regular basis. However, the scale and quality of the AGYW programme were not adequate. There is low condom use and suboptimal uptake of HIV testing among AGYW. PrEP access is good, but retention in PrEP is suboptimal. The rate of GBV, unwanted pregnancies and school dropouts is high among AGYW (GRN, 2022a).

AGYW programmes are affected by a range of challenges, including limited programme coordination and limited quality and availability of data, stock-out of commodities, and low access to testing, treatment and viral suppression. There is a need to strengthen access to and uptake of SRH services, including STI screening and treatment, as well as access to the HPV vaccine.

2.3.2.6 Combination Prevention for ABYM and Vulnerable Children

Namibia has an epidemic where more women (16.9%) are living with HIV and AIDS than men (10.9%). The HIV incidence among ABYM is less than 0.03%, making it a low-risk category as per the global AIDS strategy risk category (UNAIDS, 2021b). However, programme data indicate that there is a category of ABYM that is increasingly at risk and vulnerable to HIV and AIDS. Early sexual debut, multiple sexual partners, and sex with a non-regular partner were some of the risk behaviours of ABYM in Namibia (GRN, 2017c).

Men had less access to HIV testing and treatment than women (GRN, 2017d). Only a quarter (24%) of ABYM had been tested in the past 12 months. Only 71% of HIV-positive ABYM know their HIV status (GRN, 2017a). Young men have limited access to HIV services due to a lack of community and peer-based HIV programmes targeting ABYM, and the low healthcare-seeking behaviour of men.

Integration of HIV prevention programmes into STIs/SRH/TB/other medical services of health facilities, the workplace and programmes that offer peer education have the potential to yield better health outcomes by engaging adolescents and young men in prevention, HIV testing, care and treatment. However, such programmes were very limited in scale and quality. Community and school-based peer-led HIV prevention programmes largely targeted AGYW, with ABYM left behind, unable to benefit from these programmrs on their doorsteps.

There is a need to scale facility, school, workplace and community-based combination HIV prevention, HIV testing, care and treatment programmes targeting high-risk ABYM. The HIV

programme needs to develop and implement a national risk screening tool to identify and target high-risk ABYM.

2.3.2.7 Combination Prevention for Key Populations

Key populations, especially FSWs, are disproportionately affected by the HIV/AIDS epidemic in Namibia. According to IBBS 2019, the HIV prevalence among FSWs was three times higher than in the general population (GRN, 2019b). Alcohol abuse, violence and high multiple sexual partnerships are prevalent among KPs. There is transactional sex among MSM and TG people. There are sexual network connections between the KPs of MSM, TGW and FSW, as well as to the general population of women. Condom use at last sexual intercourse with a sexual partner was 50% – 69% among FSWs and 68% among MSM in 2019 (GRN, 2019b). Similarly, both access to and use of lubricants were very low among the KPs (USAID & Intrahealth Namibia, 2022a).

Namibia's HIV programme has been implementing key population programmes targeting FSWs, MSM and TG people, with PEPFAR and GF support in priority regions. FSWs and MSM were mainly provided a combination of prevention, care and treatment interventions. The combination prevention interventions include peer-based and outreach demand creation, condom and lubricants promotion and distribution, HIV testing including self-test, oral PrEP including event-based PrEP, PEP, FP, STI treatment, and VMMC treatment and care, among other interventions. The peer-based and moonlight outreach services, including combination prevention, care and treatment services, were provided at hotspot areas such as bars, hotels and nightclubs, and other community settings.

The key populations' access to PrEP was good in Namibia. A study in 2021 showed that more than 39% of KPs (FSWs, MSM and TG people) have ever received PrEP (USAID & Intrahealth Namibia, 2022b). However, a study in 2021 among KPs (FSWs, MSM and TG people) revealed that only two-thirds (63%) of KPs received free condoms at least once in the preceding 12 months and less than half (41%) received lubricants for free in the preceding 12 months (USAID & Intrahealth Namibia, 2022b).

The KP programme performance on the Fast-Track 90-90-90 treatment targets was lagging behind compared to the performance of the treatment programme of the general population. For example, the 2019 IBBS indicated that only about half of HIV-positive FSWs know their status. A quarter of those who know their status were not on treatment. Moreover, a significant proportion of those initiated on ART did not attain viral suppression (GRN, 2019b).

There has been limited use of drop-in centres or virtual safe spaces. The public health facilities are major service delivery platforms for HIV prevention, care and treatment services for KPs in Namibia.

The MHSS has been closely working with the MHAISS, Department of Correctional Facilities, on various health programmes. In 2021, there were 14 correctional facilities and an average of 4,500 inmates. The Department of Correctional Facilities was implementing HIV and TB services for inmates, including SBCC, PrEP, VMMC, HIV testing, TB diagnosis and treatment, PMTCT and ART through referral at public facilities. Inmates were provided condoms upon release from prison to the community, but are not provided access to condoms and lubricants

while in prison. There has been no integrated bio-behavioural survey conducted on inmates to determine behavioural risks and HIV burden among prisoners.

2.3.2.8 Combination Prevention for Vulnerable Populations

The MHSS, in collaboration with multi-sector ministries, has been implementing combination HIV prevention interventions targeting vulnerable populations, including long-distance truck drivers, mobile and migrant workers, people with disability, and people in uniformed services. PEPFAR, GF and other partners, including civil society, have supported combination HIV prevention programmes targeting these population groups.

The MHSS has been providing people with disability a combination of HIV prevention services through routine health facilities and community services, like any other community member. The transport sector harbours mobile workers (long-distance truck drivers and workers at construction sites). Several initiatives, including mobile clinics, workplace condom distribution and wellness clinics, provided HIV/AIDS services to mobile workers, such as long-distance truck drivers, migrant sex workers, seafarers, construction workers, and communities within proximity of cross-border areas.

The Namibian Defence Force and Namibian Police Force, in collaboration with the MHSS, have been implementing HIV prevention interventions targeting people in uniformed services. A range of HIV prevention, care and treatment services, including the distribution of condoms, VMMC, HIV testing, HIV self-test, and treatment have been implemented and integrated in routine health services.

However, the scale and quality of combination HIV prevention services targeting vulnerable populations have been limited.

2.3.3 Treatment and Testing Services

Besides the interruptions caused by COVID-19, poverty, hunger and long distances to health facilities were the main reasons for poor adherence to ART therapy. Overall, males, AGYW and ABYM showed the lowest adherence to ART. Consequently, there is a need for various types of peer and community support, including stronger linkages between the MHSS and the Ministry of Gender Equality, Poverty Eradication and Social Welfare, which administers welfare grants.

2.3.4 Mainstreaming, Multi-Sectoral Response and Pandemic Preparedness

The multi-sectoral response waned as the AIDS epidemic was controlled, but recent events like the COVID-19 pandemic, the war in Ukraine and the attendant increase in global food prices, which have exacerbated poverty and food insecurity in Namibia, have made it imperative to improve coordination and targeting of efforts to reduce the impact of social enablers, such as poverty alleviation, food security, social welfare, etc. for PLHIV.

Resource Mobilisation

The implementation of the NSF 2023/24 – 2027/28 is estimated to cost approximately US$1.4 billion (or N$23.75 billion) (refer to Figure 21). The main resource driver is ART under the Treatment and Care component, accounting for 34.9% of required resources. However, substantial resources are required for other programme areas, if the ambitious targets of this NSF are to be met.

Health Finance

The NSF adopts the WHO's framework for health financing and universal health coverage. Sustainably financing the HIV/AIDS response requires resource generation, pooling and fund management, strategic purchasing, governance arrangements, and supportive governance arrangements.

The NSF has adopted strategies of financing the HIV and AIDS response in the short to long term through resource mobilisation, pooling, fund management and strategic purchasing to ensure the sustainability of the provision of HIV/AIDS services that would achieve HIV-related national and global health goals.

The NSF highlights the importance of increased domestic funding for the needs of the national multi-sectoral HIV and AIDS response to 80%; integrating HIV services costing into the public budget of all offices, ministries, agencies and regional councils; integrating HIV services into all existing healthcare services and new universal health coverage initiatives; strengthening efficiency, optimisation and value for money in the HIV and AIDS response; earmarking at least 30% of domestic financial resources for HIV prevention and sustainability of community-led interventions; and strengthening the institutional arrangements that support the financing of the HIV and AIDS response.

There are significant challenges with mobilising additional domestic resources, as donor funding is declining, while the fiscal space of the GRN is constrained, partly due to the global economic downturn.

2.3.5 Monitoring and Evaluation

The M&E system is fragmented, and siloed data systems need to be migrated and integrated into the national Ministry of Health and Social Services M&E system.

CHAPTER 3 Status of the Health System and its Impact on the HIV/AIDS Response

3.1 The Health System

Government has made tremendous investments in developing clinics and health centres, as well as maintaining general and district hospitals, including upgrading existing public health infrastructure into teaching hospitals. It has employed multi-disciplinary health cadres, and procured vehicles and other health commodities, including HIV medicine and health products.

The primary healthcare system is robust. It is comprised of clinics and health centres, with cases referred from clinics to health centres. HIV services in the PHC system are currently run as a vertical service, with dedicated ART clinics. The viable way to improve/scale up HIV services is to gradually integrate these services fully into PHC. The PHC system tests for multi-diseases (HIV/AIDS, TB and malaria), but currently as vertical programmes. Screening for cervical cancer is offered to all women and there is a dedicated cervical cancer screening programme for PLHIV. Furthermore, government galvanised funding and cultivated harmonious engagement with development partners, CSOs, faith-based organisations and the private sector.

The Ministry of Health and Social Services has a Finance Division to improve financial efficiency, and among several other functions, the division enables the MHSS to better track funding flows from domestic and external sources and improve its interface with the finance and national planning ministries in defending its budget requests. Additional information, including the graphs covering health financing, are included in Chapter 9 on health financing.

In addition, government continues to provide and improve a broad range of HIV services, such as improved and expanded HIV combination prevention packages, differentiated ARV treatment, and catalytic innovations, such as DSD, aimed at sustaining and ensuring the continuation of improved HIV service offerings, particularly during the COVID-19 pandemic when HIV services continued unhindered.

Among significant achievements is the "Test and Treat" initiative commenced at all healthcare facilities to initiate all individuals, who tested HIV-positive and are eligible, on ART. Other achievements included introducing cervical cancer screening at various health facilities, during which communities were sensitised on HIV and AIDS services, and counselling and testing were done. PrEP, PEP and females who experienced GBV were referred to social services.

Collaboration between the MHSS and the MoEAC on school health is very strong. The MHSS provides personnel and implements the school health programme, and provides the report on school health programmes to the MoEAC, while the MoEAC disseminates the report to parents during annual parent meetings organised by the MoEAC. During the annual meetings with parents, the school health team is invited to present the report on school health to the parents. The report contains data on teenage pregnancy incidence among learners, VMMC, immunisation, eye tests, referrals, etc.

Overall, the health sector, which is responsible for coordinating the national response for HIV/AIDS, has made strides, which led to achievements in both the health and non-health

response. In the non-health response, the health sector has worked well and collaborated with other line ministries, CSOs, faith-based groups, the private sector, etc. The introduction of the community-led monitoring and social contracting policies by the MHSS is also a significant achievement, as these two initiatives are likely to improve the delivery of HIV/AIDS services implemented by CBOs and CSOs with funding from the government.

3.1.1 Human Resources for Health (HRH)

The vision and mission of the current NSF are aimed at contributing to the attainment of the objective of the fifth National Development Plan (NDP5) that consists of building capable and healthy human resources. An adequate and appropriately trained and competent health workforce is critical for controlling the HIV epidemic and achieving broader health outcomes. Namibia has made significant progress in establishing the prerequisite structures and creating a conducive policy environment to support strengthening of the health workforce for the delivery of health and HIV services. There is a strong political will across the broader government to support the health workforce, a National HRH Strategic Plan is in place to guide HRH interventions in the sector, and a human resource information system has been established to simplify the human resource function and ensure easy availability of up-to-date HRH data for decision making. The capacity for training professional health cadres has been expanded through pre- and in-service training and the establishment of training institutions, both private and public, to ensure an adequate pool of appropriately trained health professionals in the country.

The MHSS has been implementing the community health workers programme since 2013. The first phase of the restructuring process, in which 4,652 positions were approved, was completed in 2019.

Despite the progress made in strengthening the HRH system, the sector continues to experience several HRH challenges that could undermine attainment and sustainability of HIV programmes. Priority issues include limited access to data to inform decisions, such as data on the number and type of HCWs needed to attain the broader health outcomes, including HIV epidemic control, which would inform review of staff establishment.

3.1.2 Procurement and Supply Chain Management (PSM)

Commodities: Condoms and Test Kits

There were periods of stock-out of essential items, as procurement is a key gap. The procurement challenges affected availability of consumables like testing kits, ARVs, condoms and TB prophylaxis. Lubricants are procured using donor funds, especially from the GFATM.

Forecasting and Quantification

The CMS faces challenges regarding forecasting and quantifying commodities to be procured in the absence of actual patient consumption and morbidity data for most essential medicines, and there is a need to strengthen forecasting, quantification and procurement of all items, but particularly of condoms and rapid test kits. Health workers are trained and sensitised on stock management at service delivery points, and convene regular supply chain management

meetings with various stakeholders, including relevant programme staff to inform programme needs and to monitor stock status. However, stock levels at health facilities are not always accurate, yet this issue can be improved with continuous training and tracking tools. End-to-end supply chain visibility with accurate and near real-time data is required to make informed decisions on the procurement and distribution of essential medicines and to allow for efficient supply chain planning that will coordinate operational activities. Supply chain planning activities are currently limited and not well coordinated.

Fleet Management

Whereas the HIV response has been supported by PEPFAR and the GFATM to procure vehicles for key programmes, there is still a need to procure additional vehicles in order to reach all regions with HIV services. Some challenges, such as the maintenance of vehicles, remain an issue due to related costs. This has negatively affected outreach services to underserved populations.

Reforms of the Procurement Process

Through the study on Strengthening of Health Procurement for Impact, which was led by the Ministry of Finance (MoF), in collaboration with the Ministry of Health and Social Services (MHSS) and other partners, priority reforms were identified, which were subsequently incorporated in the Procurement Act 2015 (Act No. 15 of 2015). These include provision for pooled procurement and use of framework agreements for health procurement. Upon implementation, these reforms will help to ensure efficient procurement of vaccines and essential medicines for improved availability and outcomes for children. As part of the study recommendations, a high-level reference group was made operational, comprised of key organisations, ministries and agencies in the health sector, for continuous discussion of Public Financial Management (PFM)/procurement challenges and monitoring the implementation of recommendations from the study. The reference group is chaired by the Executive Director for Finance.

3.1.3 Health Management Information System (HMIS)

There is a major issue with regards to the use of health passports and the associated stigma, as health passports contain some medical records and laboratory reports, and partners and employers have accessed these with or without consent, fuelling stigma, discrimination and GBV. Some women resort to removing information from their health passports to hide their HIV-positive status from their partners and to protect themselves from abusive partners.

The MHSS should support a rapid roll-out of the electronic database system to improve the quality of reported data (informed by the pilot project for the ICT and HIVST in DHIS2) and to strengthen the mentorship and quality improvement initiatives to support the implementation of ICT. This will also support improvement in terms of the quantification for medicines.

3.1.4 Laboratory and Diagnostic Services

The Namibia Institute of Pathology (NIP) is mandated to provide laboratory diagnostic services to the MHSS. Medical laboratory services fall under the Directorate of Tertiary Healthcare and Clinical Support Services. The directorate is responsible for assessing labs for licensing and compliance to ISO 15189 standards for clinical laboratories, including private labs. These

operations are currently managed by three staff at the directorate. A committee within the MHSS with representatives from NIP deals with issues of laboratory service delivery and costs.

The MHSS does not have a national laboratory policy or laboratory strategic plan. The government provides funding for laboratory services through monthly payments to NIP for services rendered. Partners make contributions towards NIP funding by providing equipment and reagents, which offsets the cost of tests on the invoices to the MHSS by 20%. Support towards lab reagents from partners has been decreasing over the years, with government stepping up its funding for laboratory services. The current trend indicates that the government is meeting 75% of funding, with a gap of 25%. It is important for the MHSS to engage NIP on managing test-related costs and to forge a way forward to work within an agreeable budget.

The NIP laboratory network begins at the national level with the National Reference Laboratory, six regional laboratories, and 32 district laboratories. Health centres and clinics do not have laboratory services, but refer samples to the nearest district or regional laboratories.

The NIP implements a rigorous quality management system in the network, which is managed by the Quality Management Unit at NIP. The unit is responsible for updating SOPs across all facilities, monitoring quality indicators, enrolling labs in external quality assurance programmes/proficiency testing schemes, and providing corrective actions. New staff are taken through the quality management system before deployment. Out of 39 laboratories, 11 are accredited for HIV tests, STIs, HBsAg and other tests. The remaining laboratories are enrolled in the Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) programme and are audited quarterly.

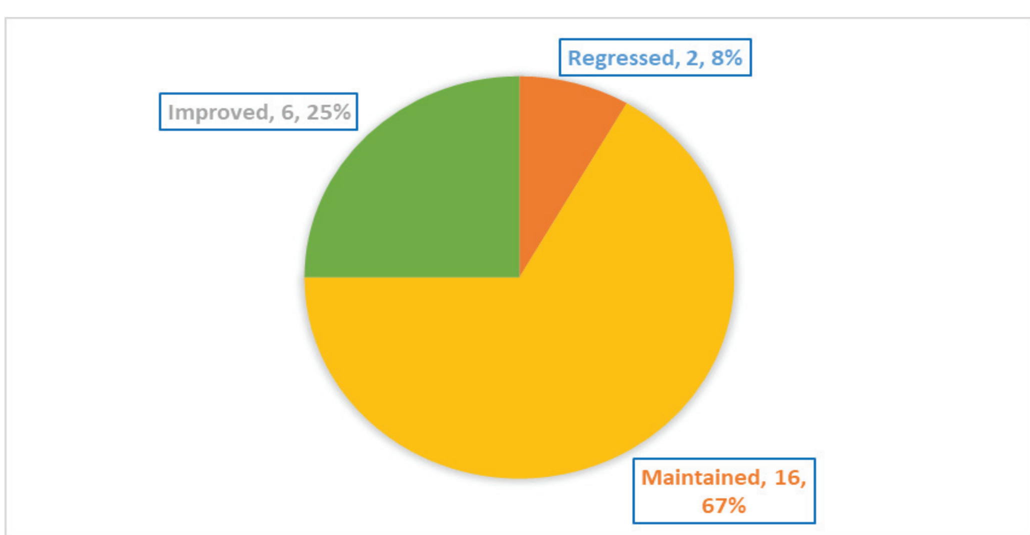


Figure 14: Performance of labs in SLIPTA assessment (Quarters 1 & 2, 2022)

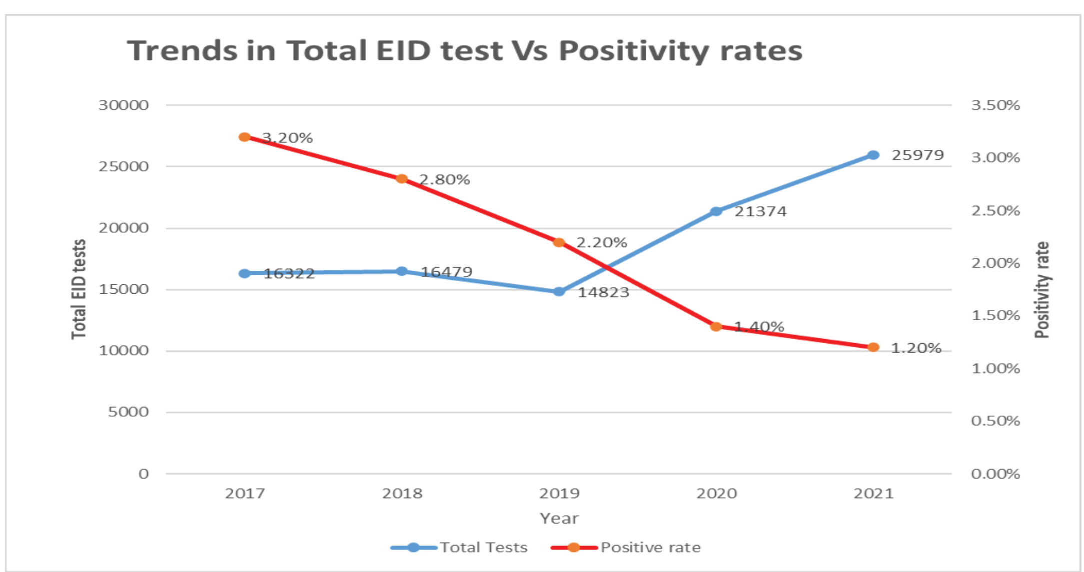


Figure 15: Trends in total EID test VS positivity rates

Figure 15 indicates a reducing trend in the positivity rate for EID from 2017 to 2021. This trend is using total number of tests performed in the lab.

Out of the NIP laboratories visited, 64% had impressive infrastructure with adequate working space, storage and safety measures, and the remaining 36% had limited space, which poses a risk in terms of biosafety and limits the capacity to use some equipment. Laboratory biosafety and all safety issues are incorporated within biosafety manuals. Biosafety officers oversee biosafety measures and conduct annual biosafety audits.

Service and maintenance of all equipment at the NIP is outsourced, as there is no capacity for equipment service and maintenance in terms of qualified biomedical engineers and service tool kits. It is important for the NIP to consider building capacity for equipment service and maintenance to minimise equipment downtime and costs related to equipment service.

The NIP is responsible for procurement, storage and distribution of supplies to the network. There is an efficient distribution system using the existing transport network among the laboratories. In addition to manual stock cards, the Meditech system is used to monitor stock status. Stock-out of reagents and consumables for VL, EID, CD4, HB, CREAT, RPR and HBsAg was reported, with possible reasons being disruption of the supply chain due to the COVID-19 pandemic, NIP procurement processes, demand forecasting, and supplier issues, such as delayed delivery and funding.

The country has adopted the use of point-of-care testing (POCT), and the Directorate of Tertiary Healthcare and Clinical Support is developing a POC policy to streamline the use and management of POC. The POC equipment currently in use includes the TB LAM and GeneXpert machines, which enable testing for TB in hard-to-reach areas, and EID and VL for priority patients, such as pregnant women and breastfeeding mothers. POC testing is supported by partners, to complement the NIP lab network, and operated by trained nurses and health assistants. The key challenges noted are task shifting, issues with the supply of reagents, and issues related to supervision and training. The maintenance and service records are available.

The NIP provides internships for Work Integrated Learning Simulation (WILSIM) for medical laboratory students and has recently opened a research department to build research capacity among lab staff. This is intended to support operational research, the development of document and share best practices, and the publication of scientific papers.

New staff are trained in the quality management system and biosafety. The NIP should consider expanding the scope of training to laboratory staff in other areas, such as:

- Laboratory Field Epidemiology Programme
- Surveillance
- Global Laboratory Leadership Programme
- Biosafety and biosecurity

3.1.4.1 COVID-19 Impacts

The COVID-19 pandemic impacted negatively on healthcare delivery and uptake in general, and HIV services in particular, creating unprecedented treatment interruptions. The potential devastating impacts of the pandemic were cushioned by quick action and innovative interventions by government, civil society and communities. Much of the ripple effect, however, was unavoidable and many infections, illnesses and deaths resulted. In terms of the consequences of COVID-19 for the national response to HIV and AIDS and other disease epidemics, the H-C19 NCESP[3] characterised the pandemic as a two-pronged (i.e., TYPE I and TYPE II) challenge or "problem" as follows:

- TYPE I – Impairment of health services delivery by service providers, and diminution of uptake by users due to anxiety and fear of infection by both health workers and health service seekers alike.
- TYPE II – Exacerbation of social and psychosocial pressures on individuals and communities resulting in increased instances of issues, such as intimate partner violence (IPV), gender-based violence (GBV), child abuse, sexual abuse, etc. (NANASO, 2022a).

In addition to its biomedical and psychosocial impacts, the pandemic steeply worsened the decline in funding for community actors who mostly rely on international donors, who have, in any event, been downscaling funding for Namibian civil society for over a decade.

HIV-COVID-19 National Community Engagement Strategy and Plan (H-C19 NCESP) 2022 – 2026

In addition to guiding the overall approach to community engagement for pandemic and epidemic preparedness, control and containment in Namibia, the intention of the HIV-COVID-19 National Community Engagement Strategy and Plan (H-C19 NCESP) was to provide a strong basis for research and proposal writing in support of the community engagement aspirations contained in it (NANASO, 2022a, p. 3). The purpose of the H-C19 NCESP 2022 – 2026, therefore, was and remains to mobilise, link, coordinate, capacitate and deploy civil society and communities to better align with and complement public and private sector health systems towards increased resiliency against HIV and other epidemics and underlying

[3] HIV COVID-19 National Community Engagement Strategy and Plan (H-C19 NCESP) 2022-2026

conditions in the context of the COVID-19 pandemic and other emergencies (NANASO, 2022a, p. 15).

Community-Led Monitoring and Advocacy (CLM&A) Strategy 2021 – 2023

Namibia recently launched a CLM strategy which attempts to standardise some of the many good community monitoring practices undertaken by civil society and communities to date, and to expand the inventory of methods and practices associated with it (Perez, 2021). Community-led monitoring and advocacy (CLM&A) positions communities as key players within the health system infrastructure, capable of assessing the quality of health services and advocating for corrective action. In the context of CLM&A, "community" refers to the beneficiaries of health services and civil society entities promoting access to care for PLHIV, and other marginalised groups. The CLM strategy proposes a number of indicators for monitoring the capacity of implementing partners in the areas of evidence, education, engagement and advocacy, some drawn from the NSF 2017/18 – 2021/22. The roll-out of the CLM&A strategy was limited in scale and scope and consensus was not achieved on its objectives and implementation. The strategy's expiry in 2023 calls for the development of a successor CLM strategy as a front-end intervention for the implementation period of the NSF 2023/24 – 2027/28.

Advocacy

Advocacy is a vital input into policy development and review, in addition to its potential contributions to the research base for strategy development. Advocacy is an important pillar for human rights and gender and ending the inequalities that hamper access to health services.

Advocacy is the common denominator in advancing the rights of diverse groups, including people with disability (PWDs), people living with HIV (PLHIV), adolescent girls and young women (AGYW), as well as boys, pensioners, men and people displaced by natural disasters, such as floods, droughts and economic push factors.

Creating a well-informed advocacy agenda for Namibia will require inclusion of all stakeholders, adept stakeholder coordination, and enhanced ownership of community-led evidence. Currently, the MHSS coordinates and regulates health-related research activities, including those proposed by civil society organisations, to ensure ethical probity and compliance to set standards. Community-led interventions generate important research material which can be optimised to increase the granularity of strategic information. The H-C19 NCESP 2022 – 2026 details a number of candidate issues to include in the HIV and AIDS advocacy agenda of national civil society and communities.

3.1.4.2 Mitigating Threats to the Three Ones Principle -- International NGOs in the Local Civil Society Space

The presence of international NGOs in the local civil society space results in gaps and overlaps in programming and coverage, accompanied by inequalities in the allocation of financial and technical resources that crowd out many local actors. As part of the drive to build community resilience, international NGOs should be re-directed to play a more enabling and capacitating role, which should include some level of mentoring for local communities as part of their scorecard and sustainability justification.

3.1.4.3 Mitigating Threats to the Sustainability of Civil Society Involvement

Ending the Fiscal Burden on CSOs and Optimising the Revenue Environment

In addition to the need to eliminate the tax burden on CSOs and community-led organisations, there is a great need for the government to introduce fiscal reforms to create a well-balanced incentive structure, based on an appropriate mix of "sticks" and "carrots", to incentivise increased private sector involvement and investment in communities and the national response space. The "carrots" could include tax allowances and deductions for the private sector for investments in communities and in the national response to HIV and AIDS. Similar recognition and fiscal rewards should also accrue to the private sector for their support for, and data submissions into MIMS, for the community-led evidence base for the country's M&E system.

Contracting Practices of the Private Sector

Public-private partnerships (PPPs) are an effective strategy to address gaps in the provision of healthcare services. This is supported by the results achieved in PPPs, including the Walvis Bay Corridor Group (WBCG).

The WBCG model presents an important best practice to replicate and upscale for private sector engagement, service delivery to the country's relatively hard-to-reach male demographic, and multi-sectoral and whole-of-society collaboration.

3.1.4.4 Community Systems Strengthening (CSS)

Community systems are the processes, structures and mechanisms that civil society and affected people and communities use to organise and coordinate themselves to respond to the health-related and broader social needs of their peers. The goal of CSS is to leverage the unique comparative advantages and communities in fast-tracking the HIV response by ensuring that services are designed, delivered (and monitored) to be people-centred, accessible, equitable, cost-effective and accountable. CSS also addresses social and structural barriers to healthcare access. Community-based and community-led organisations and networks interact with and reach affected communities, react quickly to community needs and issues, and influence decision makers to ensure that they implement and resource policies and programmes to address the health needs of communities effectively and timeously. It is imperative that civil society and community organisations and actors have effective and sustainable systems and structures, whose operational activities, services, networking, partnership and coordination activities are adequately resourced to ensure their effectiveness and sustainability.

3.1.4.5 Community Systems for Health

Namibian civil society and communities are determined to achieve fully recognised, empowered, resourced and integrated community-led HIV responses for a transformative and sustainable HIV response that is all-inclusive through universal healthcare (UHC) that delivers services that are available, accessible, acceptable and of high quality (AAAQ). In line with the Global AIDS Strategy's call to "End Inequalities, End AIDS," Namibian civil society and communities are resolute in their quest for health equity through the active and meaningful engagement of communities affected by HIV in the delivery of health and other services.

The agreed local definition for quality healthcare in Namibia emphasises safety, timeliness, effectiveness, affordability, people-centredness and friendliness, in accordance with the National Quality Management Policy (NQMP) and the National Quality Management Strategic Plan (NQMSP). The achievement of the aspirations of the NQMP and NQMSP will be dependent on the timely commitment of appropriate and adequate investments in community systems strengthening (CSS) which, in turn, will ensure that services are designed and delivered in a more people-centred, accessible, equitable, cost-effective and accountable manner through meaningful civil society involvement and community engagement (GRN, 2021f).

The notable progress and gains in Namibia's national response to HIV and AIDS were marked by its achievement of the UNAIDS 90-90-90 Fast-Track targets in 2020. The NSF target to reduce new infections by 75%, however, was not met. This is an important symptom of the gaps and blind spots in the national response, which will only be mitigated and uncovered through the meaningful involvement of civil society and communities in the planning, design, delivery and monitoring of services. With seven short years left before the 2030 deadline to end AIDS as a public health threat, glaring gaps remain across the response. Therefore, civil society coordination and involvement, and overall meaningful community engagement are imperatives for the national response and are essential for epidemic control.

The national response continues to enjoy top-down political support from the President and First Lady to the Office of the Prime Minister (OPM) – which hosts an HIV desk – as well as the lower echelons of government. Technical Working Groups (TWGs) at the national level provide the necessary guidance to the response. At the regional and constituency levels, the RACOCs and CACOCs, under the Ministry of Urban and Rural Development (MURD), coordinate the response in their geographical settings. Within the Ministry of Health and Social Services (MHSS), the Directorate of Special Programmes (DSP) coordinates the national HIV response. The MHSS is the principal recipient of the Global Fund grant and has the primary custodial responsibility for the nation's HIV, TB and malaria programmes. The Directorate of Primary Healthcare (PHC) is on the frontlines of the Ministry of Health and Social Services' holistic, multi-sectoral and whole-of-society approach to healthcare provision. The core functions of the PHC Directorate are organised around four pillars; namely, health promotion, disease prevention, curative services, and rehabilitation services. The directorate oversees programmatic and financial appropriation for sexual and reproductive health and rights (SRHR), maternal and child health (MCH), and nutrition services, among others.

The health system, according to Article 95 of Namibia's Constitution, guarantees every citizen fair and reasonable access to public facilities and services. Around 82% of the population accesses healthcare at public facilities funded mainly by the government, with some resources from donors.

3.1.4.6 Structural Dimensions of the Community Response in the NSF

In the implementation of the NSF 2023/24 – 2027/28, CSS will be driven along two structural dimensions; namely, horizontal and vertical. The horizontal dimension will address synergy optimisation at the civil society and community levels through enhanced coordination, collaboration, networking and information-sharing between and among organisations. The

vertical dimension will address vertical information sharing, collaboration and partnership from the grassroots community level upwards into the civil society space and across the civic interface into collaboration and partnership with government, the private sector and development partners.

3.2 Related Social Protection Schemes

In Namibia, social protection programmes are implemented by the Ministry of Gender Equality, Poverty Eradication and Social Welfare.

Situation Analysis

The consequences of poverty among PLHIV are dire, as poverty affects food security, which in turn affects the ability of PLHIV to take ARVs, and to travel to health clinics for appointments.

A major milestone is the enactment of the Social Protection Policy 2021 – 2030, which aims to harmonise and improve all social grants, including the development of a more robust monitoring system. The policy recognises HIV/AIDS as an issue and “aims to extend coverage and impact of HIV-sensitive social protection services for the most vulnerable, including children and people living with disabilities” (GRN, 2021d).

The establishment of soup kitchens and backyard gardens, including the proposed establishment of gardens in urban areas, is a welcome development. Public-private partnerships and coalitions between CSOs and faith-based organisations must develop a synergised response to hunger. One way of achieving this could be a scheme, under which companies that have outlets where cooked food is sold, donate the food to designated CSO, CBO or FBO representatives (introduced to the companies by the MHSS). At the end of each day when these stores close, the food would be available for collection and distributed to PLHIV that same night. Third-party insurance could be taken out to mitigate the risk of any fall-out resulting from the scheme, e.g., food poisoning. As an incentive, private companies could compile the cost of donated food and use it to secure tax rebates, or mark it as a donation under their CSR initiatives. These schemes would work best with decentralised implementation at the regional, district and village levels overseen by RACOCs and CACOCs, and policy set at national level to cover guidelines for collection of food and distribution of food. Another possible approach would be to give food vouchers to PLHIV to enable them to purchase food. The advantage of this approach would be that it would not introduce stigma.

While health workers should improve adherence through better counselling and addressing stigma, workers delivering the non-health response (agriculture, poverty alleviation and social welfare, etc.) must also be capacitated to enable them to deliver interventions in a non-stigmatising manner.

CHAPTER 4 Multi-Sectoral Response Situation Analysis

4.1 The Multi-Sector Response

Namibia is at a crucial turning point as the country embarks on a path to accelerate the HIV/AIDS response to reach epidemic control. With Namibia having achieved the 95-95-95 Fast-Track targets, a final acceleration of targeted interventions is required to fully realise these targets and achieve epidemic control.

Globally, the fight against HIV and AIDS continues to be critical. The involvement of non-health sectors in national HIV and AIDS strategies is appropriate to address the causes, drivers and effects of HIV. However, HIV and AIDS sector responses with the full participation of stakeholders have remained a challenge in Namibia. Most sectors are largely unclear about the context of sector responses and their institutional and coordination structures.

In response to this, the Directorate of Special Programmes (DSP) of the Ministry of Health and Social Services (MHSS) has highlighted the need to support sectors in developing their HIV and AIDS programmes. As a result, guidelines have been developed to facilitate the sectoral response. These guidelines are broad to allow sectors to adapt them to their specific context, situations and needs.

HIV Mainstreaming and Using the Current Economic Crisis to Advocate for Increased Political Support to Achieve High-level Targets

The term “HIV mainstreaming” refers to how well a sector responds to HIV/AIDS, both internally and externally. Internal mainstreaming refers to how well the sector looks after the health of its employees in its entire value chain, and focuses on preventing HIV infections and supporting employees who do become infected, and mitigating the impact of an infection. External mainstreaming refers to how the sector ensures that it responds to HIV/AIDS as it delivers on its mandate, for example how the educational sector reduces HIV infection rates among learners, or how the agricultural sector reduces food insecurity, etc.

Mainstreaming remains key in the HIV response as it harmonises biomedical and non-health responses.

The Public Sector

In this chapter, the government sector is reviewed in the order listed below, ending with the two coordinating entities that are mandated to oversee the activities of the other sectors, namely the Office of the Prime Minister and the National Planning Commission. Reviewing their roles after the others demonstrates the vital importance of their coordinating role.

- Education
- Agriculture
- Judiciary
- Home Affairs, Immigration, Safety and Security
- Works
- Communications
- Finance

- Environment and Tourism
- Sports, Youth and National Service
- Urban and Rural Development
- National Planning Commission, President's Office
- Prime Minister's Office
- Local governments, especially of large/priority urban areas

Significant progress has been made in the multi-sector response to HIV/AIDS, and it should be noted that most interventions, while not labelled as HIV/AIDS interventions, play a significant role in the response to HIV/AIDS. A good example is the Food and Nutrition Policy revised in 2021, which justifies the school feeding programme as follows: *"Potentially, it increases dietary intake of children and provides an opportunity for food diversification, valorization of locally produced crops, and capacity building for the private sector and women that provide services to schools. It also offers a platform for delivering cost effective nutrition-specific interventions such as nutrition education, micronutrient supplementation, deworming, HIV and AIDS, psychosocial support and school gardening"* (GRN, 2021c). The policy impacts HIV response as it provides food for vulnerable school-age children, some of whom are HIV-positive.

The coordination framework, which comprises the Committee of Senior Civil Servants, NAEC, Technical Advisory Committees (TACs) and Technical Working Groups (TWGs), is in place, and has delivered success (epidemic control, ART, screening for cervical cancer, etc.). This framework is further described in section 5.1.9 of this report. There are functional RACOCs and CACOCs, with adequate involvement of CSOs, CBOs and traditional authorities in the response. However, the involvement of faith-based institutions and the private sector has been suboptimal, with their HIV/AIDS coordinating entities being non-functional. The vacancy of the officer responsible for HIV mainstreaming in the DSP is set to be filled shortly. Namibia has shown great political will in combating HIV/AIDS; however, increased political will and commitment is needed in the new NSF, particularly to sustain or increase the resources allocated to HIV/AIDS in light of financial challenges being faced by the government due to the effects of COVID-19 and the war in Ukraine. The health sector has provided excellent leadership and coordination for the national HIV/AIDS response.

HIV Specific Interventions being Implemented by Line Ministries

4.1.1 Ministry of Education, Arts and Culture (MoEAC)

The education sector delivers HIV response models and services, some of which it delivers itself, such as the CSE/life skills strategy and education for HIV, COVID-19, the nutrition policy and emergency preparedness and response plans, and others which it delivers in collaboration with other ministries like the MHSS, e.g., school health, VMMC, etc.

A highly robust school programme, headed by the HIV/AIDS Management Unit (HAMU) at the MoEAC headquarters in Windhoek, is in place. Each region has a Regional AIDS Coordinator of Education (RACE). Life skills teachers are posted to schools. The National Institute for Educational Development (NIED) conducts research at schools to gather data on learner mothers and learner fathers. As stated earlier, strong collaboration exists between the

MoEAC and MHSS to implement school health. In the PHC Directorate at the MHSS headquarters in Windhoek, there is a School Health Unit, which falls under the Family Health Division.

Teen Clubs are run by the MHSS for youth living with HIV. The MHSS provides reports on school health programmes to the MoEAC, which the MoEAC then disseminates to parents through school health teams at annual parent meetings. The reports contain data on VMMC, immunisation, eye testing, referrals, etc.

Learner Pregnancies

The UN expedited the start of an impact assessment of the Prevention and Management of Learner Pregnancy Policy and of COVID-19 on girls in education, to be completed towards the end of 2022 (2021 UN Country Annual Results Report Namibia, March 2022).

Teenage pregnancies have a tremendous impact on the lives of affected young women, not only disrupting their education, but also negatively affecting their health from birth-related injuries and STIs.

National level data from the Education Management Information System (EMIS) showed that there were 1,542 learner pregnancies in 2019 and 2,681 learner pregnancies in 2021. The increase could be a side effect of the shutdown of schools during the COVID-19 pandemic. Nationally, teenage pregnancies stood at 14.54% and 14.95% for 2020/2021 and 2021/2022, respectively. The regions with the highest learner pregnancy ratios are Kavango West (23.9%), Kunene (22.9%) and Kavango East (21.1%), while the ratios are lowest in Khomas (7.4%), Erongo (8.9%) and //Kharas (9.8%).

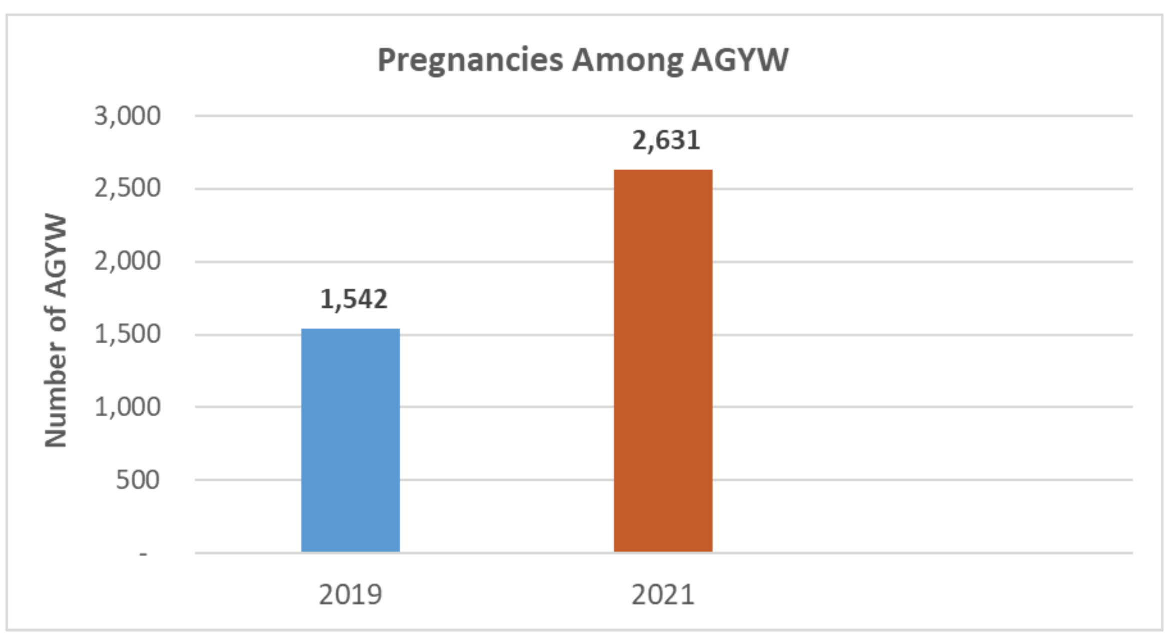


Figure 16: Pregnancies among AGYW[4]

[4] MoEAC EMIS Statistics 2019 and 2021

HIV Awareness Creation

The MHSS provides school health as an outreach programme under the PHC Department. Secondary schools provide comprehensive health education on HIV prevention. The team that oversees school health is composed of a school health nurse, dentist and social workers provided by the MHSS, as well as an occupational therapist and life skills teachers. Based on guidelines in a teachers' manual, teachers know when to ask for TA from the school health nurse, who is from the MHSS through the PHC Directorate. Upon request, MHSS staff are called in. In the //Kharas region, PHC staff include one registered nurse, one enrolled nurse and two to three community health extension workers, who are deployed for two to three months to provide school health services, after which they return to their regular jobs at the PHC clinic.

4.1.2 Ministry of Agriculture, Water and Forestry

The Ministry of Agriculture, Water and Forestry and the Ministry of Gender Equality, Poverty Eradication and Social Welfare must form a strong partnership to reduce poverty, food insecurity and hunger, as these factors prevent PLHIV from adhering to treatment, as ART cannot be taken on empty an stomach.

The Ministry of Agriculture, Water and Forestry provided support to the MHSS through the establishment of communal vegetable gardens for PLHIV, and the supply of Plumpy'Nut to fight malnutrition in children. The World Food Programme (WFP) supported the establishment of vegetable gardens in communities. In addition, the WFP partnered with Correctional Services to establish farms. Produce from these farms is shared with vulnerable populations, e.g. PLHIV, TB clinics and school feeding programmes.

4.1.3 Judiciary

The judiciary supported GBV interventions through ensuring charged offenders are reprimanded. There is a need to sensitise all employees of the justice sector, including judicial and non-judicial personnel, on human rights and the right to non-discrimination.

4.1.4 Namibian Police Force

There are GBV Units in the Namibian Police Force. The units are responsible for implementing the SADC programme that obliges all national police forces to ensure the reduction of GBV. To this end, the units implement annual advocacy programmes to reduce GBV. In addition, GBV support networks have been established and survivors can seek redress at police stations.

4.1.5 Immigration Services

HIV services are offered to all Namibians, Refugees, Detained persons, Students, Permanent and temporally permit holders as well as any visitors who are in need. Additionally, cross border patients are offered HIV services on daily basis especially along the northeast and northwest borders of Namibia.

4.1.6 Namibian Correctional Services

There is a minimum package of HIV and TB services for correctional services and police cells (GRN, 2022j), HTS and ART are available, and PEP is offered. Health services are provided

to inmates, including HIV/AIDS prevention packs, which are supplied to inmates upon discharge. The MHSS donated pre-fabricated structures to clinics.

Through a partnership with the World Food Programme (WFP), the Namibian Correctional Services (NCS) have established farms on land at correctional facilities and the food grown on these farms is used to support rations for inmates and donated to school feeding programmes and vulnerable people in the community, such as PLHIV. As part of a re-integration programme, the Community Advisory Committee (CAC) acts as a liaison between the NCS and communities.

4.1.7 Ministry of Information, Communication and Technology (MICT)

The MICT has facilitated dissemination of information, especially through social media, but ICT potential has not been fully exploited yet in the provision of HIV/AIDS services.

4.1.8 Ministry of Environment and Tourism

The Ministry of Environment and Tourism mainstreams HIV/AIDS, food and nutrition security into mitigation and adaptation strategies for managing the threat of desertification, drought, climate change and other disasters. The existence of HIV workplace policies for most of the big companies in the sector is a good practice.

4.1.9 Ministry of Works and Transport

Most construction companies have wellness programmes that provide health information to employees. Most construction workers are encamped at construction sites, and the status of HIV services in the sector needs to be ascertained through further studies. Poor road infrastructure and remoteness of some areas in the vast regions make it difficult for the community to access health and other services.

4.1.10 Ministry of Sports, Youth and National Service

The Ministry of Sports, Youth and National Service (MSYNS) supports behaviour change communication and healthy lifestyles, including nutrition and physical activity, and incorporates nutrition, food security, food safety and health issues, including HIV/AIDS prevention, into existing youth development programmes. The Ministry's youth centres are used to provide free office space for youth-focused CSOs. Sports are used to teach life skills, leadership, discipline and HIV prevention to AGYW and ABYM. UNICEF supported these initiatives.

4.1.11 Ministry of Urban and Rural Development

The Regional AIDS Coordinating Committees are overseen by the Ministry of Urban and Rural Development (MURD) and the regional councils. The RACOC is headed by a chairperson of the council, who is an elected regional councillor. He/she and two other regional councillors form the Management Committee. Together with the heads of the various sectors in the region, they form the Regional Development Coordinating Committee (RDCC). The chairperson for the council oversees the Chief Regional Officer (CRO), who is the head of the civil service at regional level. The RACOC is chaired by the regional chairperson, and its secretariat is manned by the DSP focal point in the region and the Chief Liaison Officer (CLO), who is appointed to

the RACOC by the region. The CLO implements the activities of the RACOC, with oversight from the CRO.

Some regional councils, such as the Khomas Regional Council, provide funds to support the feeding of indigent PLHIV and for the economic empowerment of their constituents. In addition, the Khomas Regional Council engaged the University of Namibia to assist with the evaluation of the impact of the nutrition support it had been giving to PLHIV.

Where they worked well, the RACOCs and CACOCs galvanised the non-health sector response. The MURD mandated all regions to create an HIV/AIDS Unit at the regional headquarters level. These units oversee the RACOCs and act as the RACOC secretariats. The region votes money to these units for HIV/AIDS activities. The HIV Unit funds the RACOCs and CACOCs. Each unit has three personnel:

- One Senior Liaison Officer
- Two Liaison Officers, of whom one is the M&E Officer

At the Constituency Offices in the Hardap Region, staff, such as the Senior Administrative Officers, are responsible for CACOC, among other things, such as rural electrification.

4.1.12 National Planning Commission, Office of the President

The National Planning Commission (NPC) is responsible for development planning and the sectoral coordination that this entails. The development planning process is working well, with five National Development Plans (NDPs) having been formulated and implemented to date.

The NPC ensured that line ministries and agencies involved in the multi-sectoral response to HIV/AIDS included activities as described in the National HIV/AIDS Strategic Plan in their sectors' input into the NDP. The NPC also monitors the implementation of NDPs.

4.1.13 Office of the Prime Minister (OPM)

The OPM supports the President in managing the entire public service. The Division for Wellness and HIV in the OPM has galvanised the public service to provide a robust HIV/AIDS prevention programme, to which COVID-19 should be added, and to respond to HIV/AIDS and look after its workforce.

The coordination of the non-health sector response, particularly coordination structures, is weak.

The Ministry of Education, Arts and Culture has not adequately prioritised the teaching of life skills, with principals diverting life skills teachers to teach other subjects, and life skills classes not included on time-tables, etc. This situation could be rectified by oversight from the OPM.

4.2 The Private Sector

The private sector has played various roles in the national and regional response under the NSF, for example by contributing to the refurbishment of government health facilities. There is scope for expanding the private sector's involvement and reach, and for innovative partnerships with local private entities that might be assessed and replicated in the NSF. A good practice from the private sector is the Walvis Bay Corridor Group, which was initially established to drive HIV initiatives, but rose to the challenge of addressing COVID-19. The private sector needs to

be engaged in a systematic and strategic manner, which can be achieved by inviting private sector stakeholders to be part of the coordination framework.

4.3 Local Governments, especially Large/Priority Urban Areas

4.3.1 City of Windhoek

Situation Analysis for City of Windhoek

The City of Windhoek (CoW) developed a strategic plan for 2017 – 2022, which was aligned with the revised NSF and the Fast-Track Cities Initiative (FTCI), and was geared towards accelerating the implementation of the 90-90-90 Fast-Track targets.

The CoW strategic plan places emphasis on greater male involvement, adolescent girls and young women, informal settlement communities, elimination of mother-to-child transmission, condom distribution, VMMC and HTS. The aim of the plan is to contribute towards the attainment of the national goals set for these areas. The Health and Wellness Committee of the City is tasked with overseeing the implementation of the plan and may delegate the implementation of certain strategic themes to departments within the CoW. The strategic themes and objectives in the plan are operationalised in performance agreements, which enable effective monitoring and measurement of individual and departmental performance.

The City recognised its mandate in the area of HIV/AIDS coordination and management as articulated in the Paris Declaration and the National Strategic Framework on HIV/AIDS. The Mayor of Windhoek, in his capacity as the Champion of the Paris Declaration in Namibia, committed to and facilitated community mobilisation and engagement for elimination of mother-to-child transmission (eMTCT) in partnership with the Office of the First Lady, and with support from the Ministry of Health and Social Services and the Joint United Nations Programme on HIV/AIDS (UNAIDS). In this role, the Mayor initiated the City's first Men's Health and Wellness Campaign advocating for increased male involvement in the uptake of HIV/AIDS and sexual and reproductive health services, and he encouraged other mayors across Namibia to do the same. This initiative resulted in collaboration with the MHSS and UNAIDS, with the CoW developing a Policy Paper on Male Engagement in Cities (March 2018) aimed at improving male engagement in HIV and SRH services in Namibia's urban settings.

In order to implement the Fast-Track Cities Initiative, an FTCI Steering Committee was established, comprising of the City of Windhoek, UNAIDS, IAPAC, the MHSS and other stakeholders from different civil society organisations. The FTCI work plan is aligned to the city's HIV/AIDS Strategic Plan and more than 70% of the plan has been implemented

The following programmes were implemented successfully: Hosting the Men Engagement Campaign and commemoration of World AIDS Day, KAP survey on HIV/AIDS, launch of the Male Engagement Policy, visits to increase city level engagement with mayors, presentation of abstracts in FTC conference, and hosting annual boys and girls conferences on HIV and SRHR. Other accomplishments included the implementation of key population HIV response interventions through social contracting, the production of the "HIV Profile in Windhoek" with assistance from UNAIDS and the MHSS, as well as the development of the City Dashboard

and monthly and quarterly reporting. Communication is done through the FTCI Steering Committee. USAID, UNAIDS and IAPAC have been funding the project for the past five years. FTCI core partners worked with Fast-Track Cities to set targets, assess local resources and mobilise funds, and the internal budget of the Council makes provision for funding some of the HIV programmes.

Coordinating and harmonising activities with the MHSS and CSOs, and political changes, such as national elections or turnover among mayors, have posed challenges, and necessitated ongoing efforts to renew political commitment, leadership and accountability. There is limited technical and human capacity, with few staff dedicated to the AIDS response. Strategic information – including baseline data on 90-90-90 and now 95-95-95 and other Fast-Track targets, and data on key and vulnerable populations – is often limited. Where data exists, it is not always in the public domain. Other challenges include conflicting priorities or programmes, grant management issues at some CSOs**,** the number of staff members trained in M&E and the lack of an M&E plan.

Recommendations include the MHSS working with cities to produce annual city-specific HIV profiles to direct HIV response programming; increased stakeholder and community engagement; and increased information sharing among local and global stakeholders, i.e., meetings and city-specific dashboards. There is a need for the formalisation of partnerships through MOUs, integration with related programmes in existing CoW work plans, and endorsement and adoption of the FTCI Steering Committee by the Regional Council in order to give power and accountability to the committee to successfully implement activities. There is need for continued advocacy to leadership and lobbying for commitment from political leaders, together with civil society engagement.

Apart from donor agency staff, there is a need to train FTCI Steering Committee members to manage the City Dashboard and to maintain the city-specific dashboards on the Global FTCI web portal with internal/external communication links. Furthermore, there is a need to develop a resource mobilisation plan, to outline an FTCI concept in the NSF and roll it out to other cities or towns in Namibia, and to align city work plans with local, regional and national strategic plans on HIV to ensure ownership and sustainability. MOUs between cities/towns and the MHSS need to be developed, and Fast-Track Cities need to be provided with support to develop a communications plan and a programme sustainability module.

4.3.2 Other Cities

As the Champion of the Paris Declaration in Namibia, the Mayor of Windhoek committed to facilitate the signing of the declaration by other mayors and the development or alignment of HIV/AIDS strategic plans of all local authorities in Namibia. As at 2018, 57 local authorities have signed the declaration and are receiving support for the development and/or alignment of their strategic plans.

4.4 Preparedness for Future Pandemics

The COVID-19 pandemic impacted negatively on healthcare delivery and uptake in general, and HIV services in particular, creating unprecedented treatment interruptions. The potential devastating impacts of the pandemic were cushioned by quick action and innovative

interventions by the MHSS, civil society and communities. Much of the ripple effect, however, was unavoidable and many infections, illnesses and deaths resulted. In terms of the consequences of COVID-19 for the national response to HIV and AIDS and other disease epidemics, the H-C19 NCESP[5] characterised the pandemic as a two-pronged (i.e., TYPE I and TYPE II) challenge or "problem" as follows:

- TYPE I – Impairment of health services delivery by service providers, and diminution of uptake by users due to anxiety and fear of infection by both health workers and health service seekers alike.
- TYPE II – Exacerbation of social and psychosocial pressures on individuals and communities resulting in increased instances of issues such as intimate partner violence (IPV), gender-based violence (GBV), child abuse, sexual abuse, etc. (NANASO, 2022a)[6].

In addition to its biomedical and psychosocial impacts, the pandemic steeply worsened the decline in funding for community actors, who mostly rely on international donors, who have, in any event, been downscaling funding for Namibian civil society for over a decade.

The most significant lingering effect of COVID-19 is that it displaced and diverted attention and resources away from HIV/AIDS. The following areas are programmed in this NSF:

1) The specific impact of COVID-19 on the HIV response in Namibia
2) The national, regional and district level preparedness for future pandemics (e.g., a new wave of COVID-19), natural disasters, bioterrorism emergencies, chemical emergencies, radiation emergencies, and other agents, diseases and threats

The health and related systems in Namibia are fairly resilient and sustainable, with related components like social and health insurance, and the overall multi-sector response adequately addressed previous emergencies, including COVID-19 and its effects on human rights, gender, provision of HIV/AIDS services, and synergies with other issues (e.g. NCDs, TB, SRHR, climate change, etc.).

The Namibian National Health System and multi-sectoral response at national, regional and district levels and its various sub-sectors, like the community systems, NGO sector and private sector, responded well to the COVID-19 pandemic and the ensuing economic crisis exacerbated by the war in Ukraine. The community systems issues were reviewed under the community systems section.

The Public and Environmental Health Act 2015 (Act No. 1 of 2015) controls epidemics, and gives the Minister of Health the powers to declare health emergencies, impose quarantines and set up committees to manage epidemics. It also deals with international health regulations. These powers were deployed by the health sector in the management of COVID-19.

The country was well-prepared for COVID-19, because due to persistent natural disasters, such as floods and the severe drought in 2019, the National Disaster Response System was in place and capacitated, as evidenced by its effective response to the 2019 drought. The National Disaster Risk Management Committee, based in the OPM, is the lead agency on disasters, and

[5] HIV COVID-19 National Community Engagement Strategy and Plan (H-C19 NCESP) 2022-2026
[6] Also see the costed implementation plan (NANASO, 2022b)

derives its powers from the National Disaster Risk Management Act, which puts the onus on each ministry and region to make provision for disasters in their budgets.

The Disaster Risk Management Committee is cascaded down to the regions, constituencies and municipalities. Before the COVID-19 pandemic, the National Disaster Risk Management Committee had already conducted vulnerability assessments, prepared SOPs and put in place a functional operations centre.

The global pandemic of SARS-CoV-2 (COVID-19) infections that spanned almost two years is widely believed to have caused a dent in the gains that Namibia had previously made in terms of its HIV response.

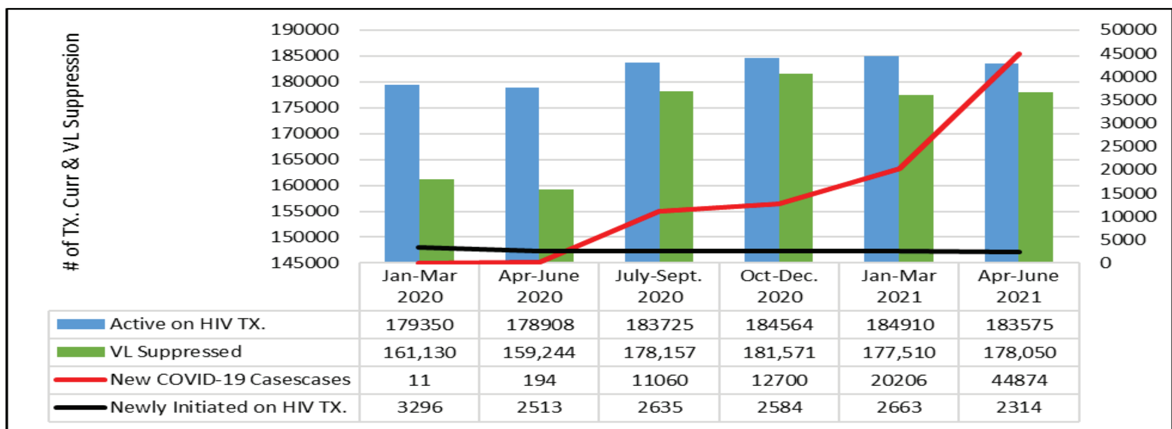
In particular, UNAIDS partnered with three civil society organisations working in three regions with the highest burden of HIV and COVID-19, namely Oshana, Erongo and Khomas, which account for 36% of people living with HIV, 52% of COVID-19 cases and 42% of COVID-19-related deaths nationally. These civil society organisations have done remarkable work to address the needs of key populations, adolescent girls and young women (AGYW), and people living with HIV, using existing HIV infrastructure and systems[7]. Responding to disruptions to HIV prevention services, including referrals, testing and PMTCT, led to people being at higher risk of not knowing their HIV status, and therefore, of not accessing treatment and running the risk of unknowingly infecting others[8]. Trends indicated that services are progressively resuming, but efforts to regain progress lost in 2020 must be increased significantly in order to get back on track to ending HIV as an epidemic by 2030. As at January 2023, COVID-19 statistics show 61 new cases of infection, 170,430 cumulative cases (WHO , 2023), 4,082 deaths and 166,197 recovered patients (Worldometer, 2023).

Box 1: The Impact of COVID-19 on the HIV Care and Treatment Programme

The COVID-19 pandemic disrupted HIV treatment and care services due to pandemic containment measures resulting in the following:

- Temporary closure of services at facilities offering ART due to COVID-19 infection among staff members.
- Lockdown restrictions affected the movement of clients to service delivery points, including cross-border populations. The governent responded by issuing a policy to allow for up to 6-month ART supply (6MMD), setting up special cross-border service points, ART community adherence groups, and home ART delivery models.
- Suspension of community-based outreach activities limited access to HIV testing and treatment services.
- Inability of mentors to visit facilities to offer on-site mentorship (resorted to virtual mentoring).
- ART staff were reassigned to COVID-19-related duties, compromising the quality of ART care.
- Increased turnaround times for viral load test results.

[7] UNICEF, 2021
[8] Global Fund, 2020



	Jan-Mar 2020	Apr-June 2020	July-Sept. 2020	Oct-Dec. 2020	Jan-Mar 2021	Apr-June 2021
Active on HIV TX.	179350	178908	183725	184564	184910	183575
VL Suppressed	161,130	159,244	178,157	181,571	177,510	178,050
New COVID-19 Casescases	11	194	11060	12700	20206	44874
Newly Initiated on HIV TX.	3296	2513	2635	2584	2663	2314

Figure 17: Impact of COVID-19 pandemic on HIV care[9] (GRN, 2021a)

The graph in Figure 17 shows the COVID-19 epidemic curve overlapped with quarterly performance reports on key HIV programme indicators, namely the number of new HIV cases diagnosed, number of PLHIV active on treatment, and number of PLHIV on treatment with a suppressed viral load between January 2020 and June 2021. The graph shows a clear decline in the number of PLHIV newly initiated on ART following the countrywide COVID-19 lockdown, particularly during the first six months (January – June 2020) of the pandemic in Namibia. There was also a slight decline in the number of patients with suppressed HIV viral load in the period from January to June 2021. One would expect this decline to continue during the months of July and August, but data was not available at the time this report was produced. Key factors explaining this phenomenon include missed clinical appointments for medication refill and skipped viral load tests associated with travel restrictions during this period.

The Surveillance Unit falls under the MHSS, while, as stated earlier, the Disaster Committee is part of the OPM at national level, and the Disaster and Risk Committee is part of the Governor's Office at the regional level. International health regulations fall under the activities of the Surveillance Unit under the Epidemiology Division of the MHSS.

At the technical level, institutional changes initiated by COVID-19 included the activation of the creation of the Emergency Operations Centre based in the MHSS, with the appointment of an Incidence Manager, followed by the development of a plan with 14 pillars:

- All 14 pillars were activated under the incidence management system
- Pillars included surveillance and laboratories, among other things

Thereafter, all relevant documents were developed, for example SOPs for each pillar.

4.5 Monitoring and Evaluation

A functional national HIV M&E system provides essential data for monitoring the epidemic and improving response management (UNAIDS, 2009). Specifically, M&E data are vital for the following:

a) Guiding the planning, coordination and implementation of the HIV response

[9] MHSS, 2021

b) Assessing the effectiveness of HIV programmes and identifying areas for programme improvement
c) Ensuring accountability to those infected or affected by HIV and AIDS and those providing resources

The M&E system for HIV/AIDS is contributing to understanding the response to the HIV epidemic, including progress made towards achieving the commitments and global targets set out in the new Political Declaration on HIV and AIDS, adopted in June 2021, and the linked Sustainable Development Goals (UNAIDS, 2022b).

The M&E system of the Namibia HIV/AIDS response is guided by national and global sets of indicators, including the 2022 Global AIDS Monitoring Indicators, compiled in the NSF Results Framework, with details that include indicator definition, targets, data sources and assigned responsibilities. There are also country-specific custom indicators that will provide granular data during the period of the NSF, as well as a prioritised HIV/AIDS research agenda that supports the effective generation of strategic information to guide the multi-sectoral HIV and AIDS response.

About 349 public health facilities consistently report on the HIV/AIDS response through the various programmes at the national level in the various directorates. HIV-related data is then transmitted to the Response Monitoring and Evaluation sub-division of the DSP and utilised to support the ministry and stakeholders, including civil society, the private sector and development partners, in managing the HIV/AIDS programme.

Besides other sources, the analysis of gaps and recommendations significantly pivots on the 2022 MHSS Health Information Systems' (HIS) assessment for HIS strengthening interventions needed to facilitate the successful implementation of the eHealth Strategy (GRN, 2022l).

4.6 Governance, Coordination, Leadership and Accountability

The body charged with the implementation of the NSF for HIV/AIDS is the Ministry of Health and Social Services. Government, through the MHSS, has a well-established HIV and AIDS mechanism and structures in place. The coordination framework that was developed in 2010 is in place, with the Committee of Senior Civil Servants and NAEC at its apex, and with TACs and TWGs, which are committees of the NAEC. This structure has delivered several successes, such as the epidemic control of HIV/AIDS, ART, screening for cervical cancer, etc. The organogram for the National Coordination Framework of the multi-sectoral response is shown in Figure 19 in section 5.1.9, and the mandates, roles and membership of the national coordinating structures are described in Annex 1.

The MHSS has successfully driven both the health and the non-health response in the challenging environment of the NSF 2017/18 – 2021/22, with dwindling domestic and external resources, the COVID-19 pandemic and food insecurity.

Despite the existence of national coordination guidelines, coordination remains complex and demanding. During the implementation of the NSF, capacity has been strengthened to ensure efficiency and effectiveness, good governance and leadership of the national response.

Noticeable political will and commitment is apparent, e.g., through resourcing of the health sector, leadership, and functional RACOCs and CACOCs at the regional level. In addition, CSOs, CBOs and traditional authorities have been fully involved in the HIV response. The TACs and TWGs did well despite the above constraints.

- Cabinet
- Meeting of Senior Servants
- National Executive Committee
- Regional AIDS Coordinating Committees (RACOCs)
- Constituency AIDS Coordinating Committees (CACOCs)
- Sector Steering Committees

This section reviews governance and coordination in line with the NSF Coordination Framework. It reviews the roles of key actors in the NSF sphere in the country. The roles of the OPM and the NPC in supporting HIV mainstreaming as described in earlier sections is related to the roles assigned to them in the NSF Coordination Framework.

National Level

Cabinet is the apex body and the Meeting of Senior Civil Servants (Executive Directors) falls below it. The National AIDS Executive Committee (NAEC) then falls below the Meeting of Senior Civil Servants. The NAEC is mandated to provide technical leadership, facilitate programme development and planning, and support capacity development. The NAEC is solely dedicated to HIV/AIDS, and is based in the MHSS and chaired by the Deputy ED of the MHSS.

Annex 1 shows the mandates, roles and membership of the national coordinating structures. The Technical Advisory Committees are created under and report to the NEAC. They are listed in Annex 1.

The existing TACs are:

1) Combination Prevention
2) Response Coordination and Management
3) M&E and Research

The TACs create TWGs.

To conduct the ETRR, five working groups were established, which are aligned to the pillars of the NSF and draw on the membership of existing Technical Advisory Committees (TACs). The working groups and their tasks are listed below:

1) Prevention
2) Treatment, care and support
3) Mitigation
4) MGEPESW-led mitigation TAC / OVC permanent task force
5) Cross-cutting issues
    a. Merger of response management and resource mobilisation TACs
    b. Human rights and gender
6) M&E WG – RM&E TAC
    a. Ensure availability of updated and quality data and assist in reviewing OC and OP indicators as well as updating the M&E plan

b. Health financing and costing

Table 1: High-level bodies in the National Coordination Framework

Name of Body	Existing body to which HIV/AIDS, TB and malaria issues are taken for high-level decision making	Body created under the National HIV/AIDS Coordination Framework and solely dedicated to decision making about HIV/AIDS issues
Cabinet	X	
Meeting of Senior Civil Servants (Executive Directors)	X	
National AIDS Executive Committee (NAEC), based in the MHSS		X

Regional, Constituency and Village Levels

The coordination at regional level is vested in the RACOCs, at the constituency level in the CACOCs, and at the village level in the VACOCs.

- The MHSS, which is the Deputy Chairperson of RACOCs, successfully drove both the health and the non-health response in the challenging environment of the NSF 2017/18 – 2021/22, despite dwindling domestic and external resources, COVID-19 and food insecurity, etc.
- The TACs and TWGs did well in spite of the above constraints
- The same applies to the functional RACOCs and CACOCs
- Resourcing of the involvement of traditional authorities in the response
- Great political will and commitment, e.g., the sector, leadership, etc.

4.6.1.1 Gaps and Challenges in Governance and Coordination

1) The NAEC was not well linked with the TACs, as the TACs did not give adequate input into the agenda of NAEC meetings. The NAEC met regularly, but the TACs and TWGs did not escalate all relevant issues to NAEC meetings.
2) Better coordination is needed among the key ministries – OPM, NPC, Health and Finance.
3) The TAC on Response Coordination and Management, solely dedicated to HIV/AIDS, did not meet as often as needed. The challenges with the NAEC and the TAC on Response Coordination and Management explain the weakness in the non-health response. In addition, there were no TWGs for some key areas, such as Finance and Resource Mobilisation.
4) The decentralisation of the MHSS to the regions is incomplete, meaning that at the regional level, not all Regional Health Directors are invited to or attend meetings of the Regional Management Development Committee (RMDC). This led to weak reporting on the HIV/AIDS programme from the MHSS to the RMDC, partly explaining the inadequate prioritisation of HIV by the RMDC, and the RACOC could not bridge this gap. MHSS budgeting and procurement are still centralised.

5) The position of an officer for HIV mainstreaming and interface between the OPM and the NPC in the DSP has been vacant for a year, leading to challenges in the coordination between ministries and offices. There is a need to devise a clear job description for the position to ensure it fulfills its intended purpose.
6) Participation by faith-based institutions and the private sector in the coordinating structures was limited.
7) The decentralised response is fragmented, with the role of the MURD in the HIV response being unclear, especially with regards to M&E.
8) Not all RACOCs and CACOCs are functional, and the political leadership for the RACOCs is not stable – currently led by political leaders.
9) There is no system for community-based data and reporting, especially for non-health data.
10) There are no donor and development partner coordination mechanisms for health and HIV.
11) There is limited capacity development for policy development, multi-sectoral coordination, strategic planning, etc., especially for non-health staff.

CHAPTER 5 Strategic Orientation of the National Response

Based on the situation and response analysis, the key gaps, challenges and lessons learnt were described in the previous chapter. The vision, mission, goals, specific objectives and implementation mechanisms for the NSF 2023/24 – 2027/28 are presented in this chapter.

5.1.1 Vision of the NSF 2023/24 – 2027/28

The vision of the NSF is to see an AIDS-free Namibian nation.

5.1.2 Mission of the NSF 2023/24 – 2027/28

The mission of the NSF is to contribute to the attainment of the objective of the National Development Plan (NDP5) to build capable and healthy human resources.

The Namibia National Strategic Framework for HIV and AIDS Response (NSF) 2023/24 – 2027/28 is a five-year document guiding the planning, programming, resourcing and implementation of the national multi-sectoral and decentralised HIV and AIDS response in the country. The NSF 2023/24 – 2027/28 is also important for the implementation and coordination of the provision of non-health services that have an influence on the success of the health sector response.

The NSF 2023/24 – 2027/28 is aimed at leveraging resources (human, financial and technological) and best practices, engaging communities and civil society, intensifying implementation at all levels, increasing coverage, and targeting populations at higher risk of HIV infection and mortality.

5.1.3 Goal of the NSF 2023/24 – 2027/28

The goal of the NSF is to attain epidemic control by 2028 and end AIDS as a public health threat by 2030. The NSF 2023/24 – 2027/28 aims to attain the following three targets by 2028:

- Reduce the number of people newly infected with HIV per year to less than 1 out of 1,000 people (0.1% of the general population)
- Reduce the number of people dying of AIDS-related causes per year to less than 1 out of 1,000 people (0.1% of the general population)
- The number of people newly infected with HIV per year is less than the number of people dying of AIDS-related causes

5.1.4 Strategic Objectives of the NSF 2023/24 – 2027/28

The strategic objectives of the NSF are to end inequalities and attain epidemic control to end AIDS as a public health threat by 2030.

5.1.5 Orientation of the NSF 2023/24 – 2027/28 and its Relationship to Other Plans

At the national level, the NSF 2023/24 – 2027/28 is aligned with the objectives of Namibia's Vision 2030, the fifth National Development Plan (NDP5) and the National HIV/AIDS Policy (2017). The NSF is also aligned with African regional and global strategic documents, such as the Sustainable Development Goals (SDGs), the Global AIDS Strategy 2021 – 2026 (in particular the 95-95-99 treatment targets, 60-80-30 targets on community-led service delivery,

and the 10-10-10 human rights and gender equality targets), the WHO Global Strategy for Women, Children and Adolescent Health (2016 – 2030), the WHO Global Health Sector Strategy on HIV, Hepatitis and STIs (2022 – 2030), the Global Fund to Fight AIDS, Tuberculosis and Malaria Strategy 2023 – 2028, the United Nations Political Declaration on HIV and AIDS 2021, the United Nations Political Declaration on Universal Health Coverage 2019, the African Union Agenda 2063, the African Union Catalytic Framework to End AIDS, TB and Eliminate Malaria by 2030, and the United Nations High-level Political Declaration on Ending AIDS, in which Namibia committed to empowering people living with HIV (PLHIV) and at-risk communities to take up their critical leadership roles in the HIV response.

Namibia is aligned to the Sustainable Development Goals (SDGs), particularly SDG Target 3.3 on ending communicable diseases, including the AIDS epidemic, by 2030, and the SDGs that address poverty, hunger, education, gender equality and unemployment to reduce all forms of inequalities among different groups in society (UN, 2015). The Namibian Government (GRN) has recognised education, health, agriculture and rural development and housing, as the four priority sectors within the National Development Plan (NDP5) under the social progression pillar (GRN, 2018b), which aligns with the United Nations Partnership Framework (UNDAF) programming principles of human rights, gender equality and women employment (United Nations, 2019). Among others, these documents, including the African Union Agenda 2063, influences the drivers of inequality towards an integrated approach for HIV response. The aim is to address the pervasive unequal gender norms that inhibit mostly women's and girls' voices and access to education and economic resources, as well as active participation in meaningful programmes to improve their social-wellbeing (Ekholuenetale M, 2021).

5.1.6 Priorities of the NSF 2023/24 – 2027/28

The priorities were determined by stakeholders during regional and national consultations and by thematic groups, composed of representatives from government line ministries, CSOs, faith-based organisations, the private sector and individual experts, who wrote the various thematic chapters of this NSF.

5.1.6.1 Health Systems Strengthening (HSS)

There is a need to improve the PSM function within the health system to avoid stock-out of commodities and drugs, and to initiate a better coordinated and more cost-effective mechanism for inserting emerging issues in the curriculum of health training institutions and by so doing, reduce the cost of providing in-service training for vast numbers of health workers. This would be complemented by using cost-effective mixed methods training to provide the unavoidable in-service training that needs to be done for the efficient and qualitative delivery of HIV/AIDS services.

5.1.6.2 Service-Based Prevention

Service-based prevention aims to ensure regular and uninterrupted supply of condoms and lubricants, scale-up of VMMC and its integration into the routine health system, scale-up and dual elimination of mother-to-child transmission of HIV and syphilis, and acceleration of the plan for triple elimination of HIV, syphilis and viral hepatitis B. In addition, PEP and PReP

would be scaled up, and point-of-care testing would be rolled out on a wider scale to improve access to viral load testing and early infant diagnosis.

5.1.6.3 Population-Based Prevention
The priorities would be AGYW, ABYM and other populations at high risk of HIV infection.

5.1.6.4 Treatment
Under treatment, the underserved groups of AGYW, children and adolescents on ART, and men who have low enrolment and retention on ART would be prioritised.

5.1.6.5 CSS, Gender and Human Rights and Stigma Reduction
The priorities would be scaling up efforts to reduce GBV and promoting community-led service delivery and monitoring. Stigma reduction would be tackled through advocacy and social mobilisation and capacity building targeted at health workers, judicial officers and the security services (police, immigration and correctional services).

5.1.6.6 Multi-Sectoral Response
In the multi-sector response, the priorities are addressing poverty and hunger, with better targeting of social welfare grants for vulnerable PLHIV, who are either unable to afford transport to visit clinics to keep appointments, or do not have enough food, and therefore cannot take their ARVs.

5.1.6.7 Finance
One priority would be to increase domestic resources. In addition, the government should provide funds to CSOs and CBOs under the Social Contracting Policy, which would build sustainability as it provides predictable domestic funding, as opposed to variable donor funding, to CSOs and CBOs, whose inputs by way of providing peer education, support for treatment adherence and community-led monitoring are indispensable for the efficient and qualitative delivery of HIV/AIDS services.

5.1.7 Specific Objectives of the NSF 2023/24 – 2027/28
Based on the strategic objectives and priorities, the new NSF 2023/24 – 2027/28 prioritises the achievement of the following nine specific objectives:

(i) Reduce HIV-related mortality rate from 1.06 % in 2023 to 0.66 % by 2027
(ii) Reduce TB/HIV-related deaths among PLHIV from 1,100 in 2023 to 300 by 2027
(iii) Reach 95% of the populations at high risk of HIV infection, including AGYW and ABYM, in all regions with combination HIV prevention interventions
(iv) Reduce HIV vertical transmission rate among HIV-exposed infants from 4.6% in 2023 to less than 3% by 2027
(v) Increase treatment coverage within all sub-populations, age groups and geographic settings, including children living with HIV, from 97% in 2023 to 99% by 2027
(vi) Reduce to less than 10% the number of women, girls and people living with, at risk of and affected by HIV who experience gender-based inequalities and sexual and gender-based violence by 2027
(vii) Thirty percent (30%) of HIV testing and treatment services, 60% of programmes supporting social enablers, and 80% of HIV prevention services delivered by community-led organisations for populations by 2027

(viii) By the 2025, initiate three (3) pilot projects towards converting the vertical HIV/AIDS programme into an integrated programme in the health system
(ix) By 2025 reduce inequalities in access to HIV testing, ART treatment and viral load suppression by 50% of the 2023 baseline levels

The first four objectives have targets, and are aligned with the results framework, while the remaining objectives are new indicators and have no baselines.

5.1.7.1 High Impact Programmes and Interventions

To achieve the specific objectives, the NSF 2023/24 – 2027/28 prioritises the following 13 high impact programmes and interventions, which are referred to as thematic areas:

1) Adolescent girls and young women (AGYW)
2) Adolescent boys and young men (ABYM)
3) Populations at high risk of HIV infection
4) Condom promotion and distribution
5) ARV-based prevention
6) Voluntary medical male circumcision (VMMC)
7) Elimination of mother-to-child transmission (eMTCT)
8) HIV testing services (HTS)
9) Treatment care and support (provision of ART)
10) Treatment of opportunistic infections
11) Resilient health systems that include laboratories, commodity management, and preparedness for pandemics, food crisis and humanitarian disasters
12) Addressing gender equality, stigma and discrimination
13) Community Systems Strengthening (CSS) and community responses, which include community-led programme design, service delivery and monitoring

5.1.7.2 Conceptual Diagram of the NSF

The planned response in this NSF rests on four pillars, which supress new infections in the community, and its strategic results feed into the attainment of the goals of the National Development Plan, as illustrated in the conceptual diagram in Figure 18.

NATIONAL DEVELOPMENT PLAN

STRATEGIC RESULTS

Reduction of infections

Reduction of AIDS deaths

PILLAR 1	PILLAR 2	PILLAR 3	PILLAR 4
HEALTH RESPONSE	NON-HEALTH RESPONSE	SOCIAL ENABLERS	SUSTAINABILITY

Community

New HIV Infection

Figure 18: Conceptual diagram for NSF

The design of the NSF is premised on the Investment Framework, Results-Based Management (RBM), and Health-in-All-Policies (HiAP) approaches. The Namibian Government has adopted HiAP and has developed a draft HiAP strategic framework as part of its multi-sectoral and whole-of-society approaches to health governance. The NSF 2023/24 – 2027/28 is a catalytic document that will support the delivery of the innovations and best practices that are necessary to ensure the provision and sustainability of a quality and comprehensive national HIV response.

5.1.8 Sustainability

The programme would be sustainable because hitherto the GRN has paid about 60% of the cost of the NSF, and as social contracting is introduced, it would pay more of the costs currently being borne by donors. These costs are critical because the CSOs and CBOs provide peer education, support for treatment, etc., which are vital and indispensable for the success of the NSF. The advantage of social contracting is that, over time, domestic resources would replace donor funding.

5.1.9 Programme Implementation and the National Coordination Framework

There is effective coordination and leadership of the multi-sectoral stakeholders who are working in different sectors at the national, regional, district, municipal and community levels.

At the national level, the institution charged with the implementation and coordination of the NSF for HIV/AIDS is the Ministry of Health and Social Services, specifically the Directorate for Special Programmes. Government, through the MHSS, has a well-established HIV and AIDS coordination mechanism and structures in place. The coordination framework has the Committee of Senior Civil Servants (which is composed of Executive Directors, the most senior civil servants in each ministry, agency or parastatal) at its apex, followed by the NAEC and TACs and TWGs. Over the years, it has delivered success towards attaining epidemic control, prompt placement on ART after a positive HIV test result, screening for cervical cancer, etc. The organogram for the National Coordination Framework is shown in Figure 19, while the mandates, roles and membership of the National Coordinating Structures are described in Annex 1.

The National AIDS Executive Committee (NAEC) has a direct reporting line to Cabinet. The NAEC is composed of the Deputy Executive Directors of the line ministries, agencies and parastatals, and is tasked with oversight of the response, while the TACs are responsible for coordination of implementation, and the line ministries, CSOs, private sector and faith-based organisations, etc. are responsible for implementation. The TACs create various technical working groups, as needed.

The Regional AIDS Coordinating Committees (RACOCs) are the implementing stakeholders at regional level, while Constituency AIDS Coordinating Committees (CACOCs) implement at the community level. Other implementing partners are government organisations, ministries and agencies, civil society organisations (CSO), the private sector, and faith-based organisations (FBOs). The multi-sectoral participation comprises those organisations/institutions representing specific thematic areas, such as education, gender (OVC), defence, home affairs, prison and correctional services, agriculture and other relevant partners. The National Coordination Framework for the multi-sectoral HIV and AIDS response in Namibia has not changed since 2014 (GRN, 2014). A review of the coordination framework was one of the major items in the review of the NSF, and it was decided that the existing coordination framework would be retained, but made more efficient.

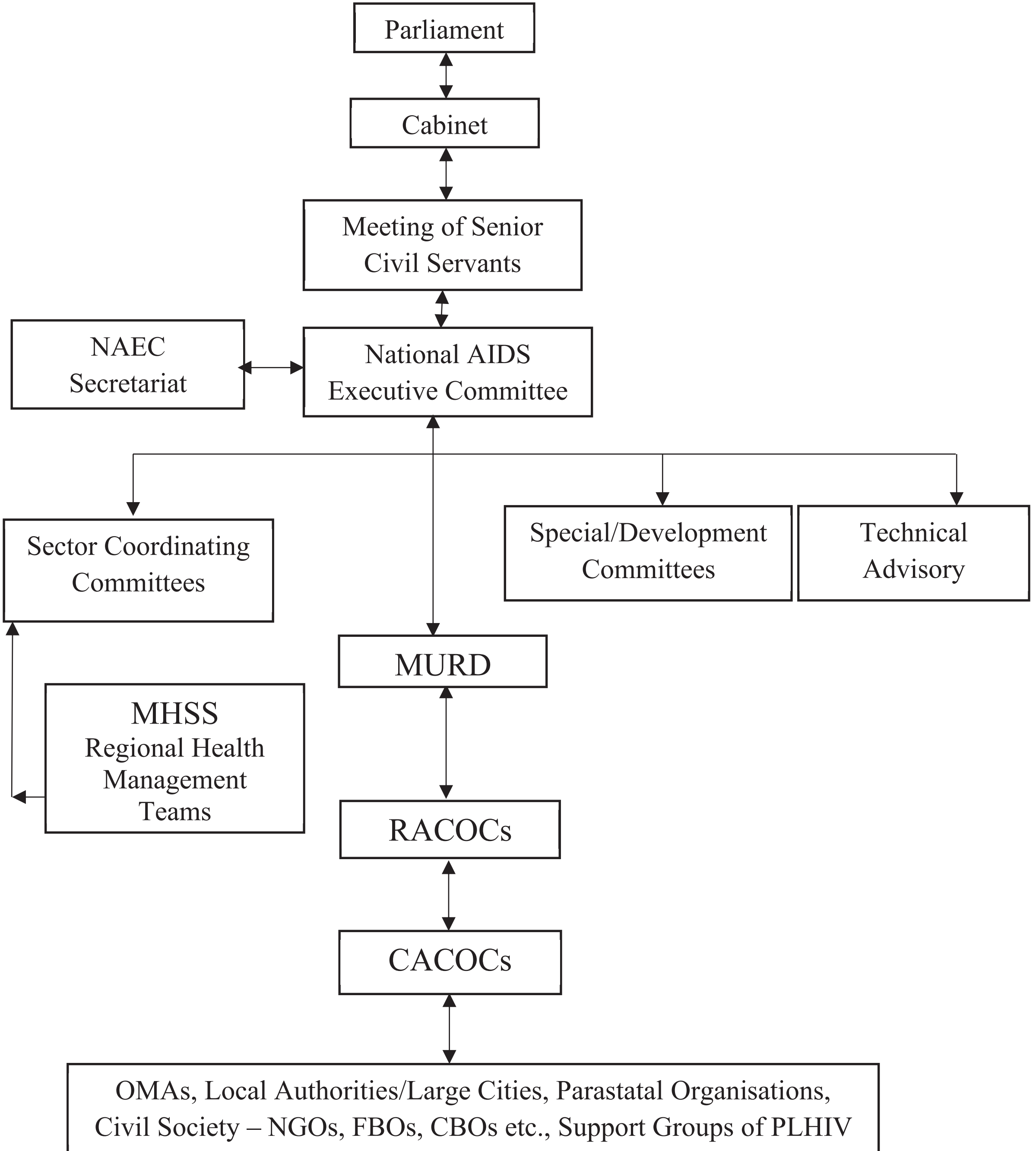


Figure 19: National Response Coordination Framework

The NAEC, line ministries, RACOCs, CACOCs and VACOCs, including representatives from traditional authorities, faith-based organisations, CSOs and the private sector, all participated in the design of the NSF.

The development of the NSF was a participatory and inclusive process, with all the stakeholders listed above giving their input. The End-Term Review was developed first, and formed the basis for developing the HIV NSF 2023/24 – 2027/28. The main thematic areas covered were: Combination prevention, treatment and testing; Resilient and sustainable

systems for health, including community systems strengthening for health; Human rights and gender; Health financing and costing; Monitoring and evaluation; and Governance, accountability and leadership of the new NSF.

In reviewing these areas, mixed methods of qualitative and quantitative data gathering were applied, composed of desk review, stakeholder consultations at national and regional levels, interviews with key informants, focus group discussions and validation meetings, use of primary and secondary information, analysis of national and international strategies, and policies and guidelines to obtain latest evidence. Sources of information included HIV estimates (2021), IBBS (2019), the Priorities for Local AIDS Control Efforts study (PLACE, 2019), community-led monitoring findings, and COVID-19 surveillance and monitoring data etc.

The task was undertaken by a team with a national consultant, as the counterpart to the lead international consultant, which enabled both country ownership and the facilitation of access to various stakeholders. The team had seven international consultants and two national consultants, all contracted by UNAIDS to execute the End-Term Review of the NSF 2017/18 – 2021/22 and to develop the new NSF 2023/24 – 2027/28.

CHAPTER 6 Programme Objectives, Target Populations, Priority Geographic Areas and Strategies

Introduction

The indicators and targets are included in Annex 3.

6.1 Combination HIV Prevention

Namibia will continue to implement combination HIV prevention that is premised on human rights, is gender-responsive and evidence-informed. By 2028, 95% of key populations (KP) and 90% of AGYW and ABYM, including orphans and vulnerable children, will be reached with combination HIV prevention interventions. Table 2 summarises the population and service-based combination HIV prevention interventions.

Table 2: Combination HIV prevention programme

Population-based Interventions	Service-based Interventions
• Adolescent girls and young women (AGYW), including OVC • Adolescent boys and young men (ABYM) • Populations at high risk of HIV infection	• Condom and lubricants • ARV-based prevention • Male circumcision • Elimination of mother-to-child transmission of HIV, syphilis and viral Hepatitis B • SRH, STIs, SGBV, mental health services and SBCC/demand creation

6.2 Population-Based Interventions

6.2.1 Adolescent Girls and Young Women (AGYW) and Vulnerable Children

6.2.1.1 Programme Objective

By 2028, 90% of AGYW and vulnerable children will be reached with combination HIV prevention and sexual reproductive health (SRH) interventions.

6.2.1.2 Target Population

Primary Target Population

The primary target population is adolescent girls and OVC aged 10 – 24 years in and out of school. "Adolescents" refers to girls, including OVC, 10 – 19 years old, and "young women" refers to women 20 – 24 years old. There is a need to programme according to the different stages of adolescence and early adulthood, as follows: Early adolescence (10 – 14 years), mid and late adolescence (15 – 19 years), and early adulthood/young women (20 – 24 years).

Secondary Target Population

Secondary target populations include sexual partners, parents, educators, community gatekeepers, legal practitioners, law enforcement, service providers and youth officers.

6.2.1.3 Priority Geographic Regions

Combination HIV prevention targeting AGYW will be implemented in all 14 regions in Namibia. However, high-risk districts (with an incidence of ≥1% among AGYW) will be prioritised under the AGYW programme.

6.2.1.4 Programme Strategies for AGYW and Vulnerable Children

a. *Strengthen AGYW programme policy, coordination and monitoring*

Under this strategy, the MHSS will strengthen the national and sub-national coordination structure for the AGYW programme, which includes staffing and Technical Working Groups (TWGs); train programme staff at national and sub-national levels on AGYW programme interventions and monitoring; strengthen multi-sectoral coordination platforms, joint planning, and review for relevant sectors like MoEAC and MGEPESW; and provide orientation on relevant policies, laws, guidelines and strategies for all service providers and educators, including healthcare providers, community health workers and community gatekeepers.

In collaboration with partners, the MHSS will develop a standardised AGYW programme strategy and tools, including locally contextual risk screening tools for all AGYW/ABYM programme actors; and implement coordinated supportive supervisory visits to AGYW programmes at all levels. In addition, the MHSS will develop clear AGYW programme indicators and conduct joint annual/semi-annual reviews and reporting of AGYW programme performance at national and sub-national levels.

Finally, the MHSS will use the AGYW Community Engagement Framework to monitor programme performance; and, in collaboration with partners, conduct national surveys and studies to examine high-risk behaviours and their root cause, such as intergenerational sex, multiple sexual partnerships, and substance abuse among AGYW.

b. *Scale up and improve the quality of mentors and peer-led HIV programme interventions for AGYW*

Under this strategy, the MHSS, in collaboration with partners, will scale up mentor and peer-based AGYW packages of services to all the regions targeting high-risk AGYW and OVC. Participation of high-risk AGYW in mentor and peer-based interventions will increase from 50% in 2021 to 90% by 2028. High-risk AGYW and OVC will be prioritised for multi-session peer and mentor-based interventions. The MHSS will introduce a self-administered risk screening tool (android-based digital screening tool) to identify high-risk AGYW and OVC to participate in peer and mentor-based AGYW intervention packages.

In collaboration with partners, the MHSS will evaluate and scale up the multi-session peer and mentor-based AGYW package of interventions. The evaluation findings will be used to revise the discussion guide, the number of sessions and the integration of AGYW intervention to reduce cost, improve efficiency and eventually ensure sustainability.

To ensure continuity of peer and mentor-based programmes for AGYW moving from place to place for various reasons, the grassroots implementers of the peer and mentor-based

interventions will create a mechanism of transfer out and transfer in for those moving from one programme area to another.

The MHSS will enhance the multi-sectoral approach in AGYW implementation to ensure that safe spaces are available at the community level (e.g., Ministry of Youth – Youth Centres) and create job opportunities; and build capacity and scale up the use of electronic, social media, and digital applications for demand creation and SBCC among AGYW.

c. *Strengthen life skills-based HIV education and school health programmes for AGYW*

The proportion of AGYW receiving life skills-based HIV education in schools will increase from 88% in 2021 to 98% in 2028. In collaboration with the MHSS, the MoEAC, will improve the quality and scale of implementation of life skills-based HIV education in all schools in Namibia; and train teachers on life skills-based HIV education. The MoEAC will develop standardised teacher in-service training through the National Institute of Educational Development (NIED) on life skills-based health education training curriculum; and integrate life skills-based health education into the teachers' training curriculum. Furthermore, in collaboration with the MHSS, the MoEAC will strengthen life skills-based health education for the in-service training of teachers as part of continuous professional development; and update the life skills-based health education curriculum and standardise its implementation in schools across the country. The MHSS will strengthen the quality and frequency of school health programmes by increasing the number of providers, supplies and resources, while the MoEAC will strengthen and scale up collaboration between schools for sharing lessons learned and best practices. Partners and CSOs will support the implementation of and improve the quality of life skills-based health education in Namibia.

The MHSS, in collaboration with CSOs, will implement a community engagement framework to strengthen the quality and scale of life skills-based HIV education and school health programmes. In collaboration with the MoEAC and CSOs, the MHSS will clarify the values of teachers, parents, and learners about condoms, PrEP and FP, through dialogue platforms, media campaigns and engagement of religious and community leaders; and scale up boys' and girls' clubs to all schools and provide life skills teachers with HIV prevention and SRH information to disseminate on in-school communication channels and platforms.

In collaboration with the MHSS, the MoEAC will strengthen supportive supervision and monitoring of life skills-based HIV education and school health programmes; and will conduct annual and bi-annual reporting of progress of life skills-based HIV education and school health programmes.

d. *Improve access to and utilisation of HIV/SRH services among AGYW*

The proportion of AGYW accessing two or more combination HIV prevention interventions will increase from 50% in 2021 to 90% by 2028. To this end, the MHSS will scale up the provision of integrated adolescent youth-friendly health services (AYFHS) at all health facilities; train providers on adolescent youth-friendly services and clarify values; and support youth-led monitoring of youth-friendly services to improve service provision based on users' demands and experiences. The MHSS, partners and CSOs will avail family planning method

mix and condoms to AGYW through community health workers and health facility-based services integrated with the HIV programme through static and mobile services.

The MHSS and partners will improve HIV treatment outcomes among AGYW with a scale-up of adherence support and differentiated service delivery models, including through teen clubs, while the MHSS, partners and CSOs will strengthen SGBV screening, care, treatment and referral to social welfare services and incoming programmes.

The MHSS will launch the HPV vaccine targeting adolescents; and provide training to health workers and introduce the HPV vaccine programme at all health facilities. The HPV vaccine will be provided at all health facilities and as part of school health programmes. In collaboration with CSOs, health extension workers and schools, the MHSS will conduct community mobilisation through multiple channels. Finally, the MHSS will integrate HPV vaccine data into existing electronic data systems.

e. ***Address structural barriers to services among AGYW and OVC***

Every year, 5% of vulnerable AGYW will be provided vocational and entrepreneurship skills training and start-up capital to establish and run income-generating activities. The MHSS will collaborate with CSOs and other sectors to provide entrepreneurial skills training, create job opportunities, provide intensive internship programmes, and link AGYW to job opportunities. In addition, sectors (public, private and CS) will play their role in addressing the economic, social, and health needs of AGYW through the implementation of the public private partnership framework.

The attitude of the community, parents and sexual partners is a serious barrier to AGYW's access to HIV/SRH services. The MHSS and partners will enhance AGYW programme communication and demand creation to target and influence groups such as teachers, parents and male sexual partners. Furthermore, the MHSS will collaborate with partners and CSOs to build the capacity of parents on effective parenting skills to improve child-parent communication and positive parenting; and integrate life skills-based HIV education and SRH in the adult literacy programme, while partners and CSOs will scale up parent and child communication programmes on AGYW sexual and reproductive health and rights.

The MHSS, MoEAC, partners, CSOs and communities must address stigma and discrimination, misconceptions and myths about condom use, SRHR and HIV prevention services through community dialogue, media campaigns, school events, social media platforms, and life skills-based HIV education. They will work to enhance parental and caregivers' capacity to manage children's behaviour and offer alternatives to physical punishment, as a response to lack of positive, non-violent parent-child relationships and to reduce corporal punishment as a means of discipline; will promote norms and values that support non-violent, respectful, positive, nurturing and healthy relationships and ways of child discipline to combat harmful practices; equip children with the relevant knowledge on legal literacy and capacities to protect themselves and their peers, so that they know where and how to seek help; and develop campaign strategies to increase awareness of violence against children.

6.2.2 Adolescent Boys and Young Men (ABYM) and Vulnerable Children

6.2.2.1 Programme Objective

By 2028, 90% of high-risk ABYM and OVC will access combination HIV prevention interventions. Namibia will improve access and utilisation of combination HIV prevention services for high-risk adolescent boys and young men.

6.2.2.2 Target Population

Primary Target Population

The primary target population is high-risk adolescent boys and young men aged 10 – 24 years in and out of school. HIV incidence among adolescent boys and young men is below 0.3% in Namibia. Therefore, the ABYM programme will focus on high-risk adolescent boys and young men, screened using a risk screening tool. A national risk screening tool will be adapted for the ABYM programme.

Secondary Target Population

The secondary target population includes parents, educators, community gatekeepers, legal practitioners, law enforcement, healthcare workers and youth officers.

6.2.2.3 Priority Geographic Regions

Combination HIV prevention targeting ABYM and OVC will be implemented in all regions.

6.2.2.4 ABYM Programme Strategies

a. ***Strengthen ABYM and OVC programme policy, coordination and monitoring***

The MHSS will assign staff at the national and sub-national levels to coordinate the ABYM programme, and revise the Terms of Reference of the AGYW TWG to include ABYM and change the name to AYP TWG.

In collaboration with partners, the MHSS will develop a national ABYM programme strategy and guidelines. The MHSS will also integrate ABYM components into existing AGYW training and advocacy tools: and in collaboration with partners, will build the capacity of staff to reach ABYM with a differentiated combination of HIV prevention, HIV testing, care and treatment services.

Since the ABYM programme needs to focus on high-risk ABYM, the MHSS will develop a national risk screening tool to identify and target high-risk ABYM.

b. ***Scale up peer and mentor-based HIV interventions, life skills-based HIV education and school health targeting for ABYM***

In collaboration with partners, the MHSS will develop peer and mentor-based session guides for ABYM; train peer facilitators and mentors; and implement ABYM peer and mentor-based sessions targeting high-risk ABYM, screened using a standard national risk screening tool.

Partners and CSOs that work with AGYW must include high-risk ABYM as part of their project beneficiaries to deliver combination HIV prevention services through community and peer-based programmes.

The MHSS will develop an HIV prevention communication strategy and materials targeting ABYM; and, in collaboration with partners, will design and implement communication to address high-risk behaviour, pervasive cultural norms, poor risk perceptions and sub-optimal health-seeking behaviour among ABYM; and scale up the use of electronic, social and print media to reach ABYM. Together with the MoEAC, the MHSS will organise campaigns at schools, workplaces and community settings to reach ABYM who are in and out of school.

c. *Scale up access to and quality of HIV/SRH services to ABYM*

The MHSS will make health facilities friendly to ABYM; and train providers on adolescent and youth-friendly services and arrange service hours convenient for ABYM, which includes off-working hours and weekends.

Furthermore, the MHSS will design and implement differentiated HIV prevention, testing, care and treatment services targeting ABYM at health facilities, schools, workplaces and in community settings; will work with partners on outreach and peer-based service delivery models to reach in and out of school ABYM.

The MHSS will advocate for enforcement of the provisions of the Labour Act; and support sectors to develop and operationalise the National Occupational Health Safety Act. In addtion, the MHSS will advocate for and strengthen wellness programmes in private and public workplaces; and in collaboration with CSOs, will advocate for and provide support to revive the business coalition concept to address health and wellness interventions in the private sector.

6.2.3 Key and Vulnerable Populations (KVP), Adolescents and Vulnerable Children

The UNAIDS Global AIDS Strategy 2016 – 2021 considers gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and inmates as the five key population groups that are particularly vulnerable to HIV infection and frequently lack adequate access to services. Vulnerable populations are locally defined population groups that are at increased risk of HIV infection. in Namibia, the following groups are defined as key and vulnerable populations:

Key populations

- Men who have sex with men (MSM): Gay men and other men who have sex with men
- Sex workers: Female, male and transgender sex workers
- Transgender people (TG)
- People who inject drugs (PWID)
- Inmates

Vulnerable Populations

- People with disability (PWD)
- Mobile and migrant workers: Long distance truck drivers, workers in largescale farming, construction and mining, and seafarers
- People in uniformed services

- Orphans and Vulnerable Children

6.2.3.1 Key Populations

Based on available data, there are an estimated 30,819 KPs in Namibia. The national KP size estimation for Namibia is outlined in Table 3:

Table 3: National KP size estimation[10]

Key population	Size estimation
Female sex workers[11] (FSWs)	14,883
Gay men and other men who have sex with men (MSM)	8,476
People who inject drugs (PWID)	930
Transgender people (TG)	2,030
Inmates	4,500
Total	**30, 819**

6.2.3.1.1 Programme Objective

The objective is to reach 95% of KPs with combination HIV prevention intervention by 2028.

6.2.3.1.2 Target Population

Primary Target Population

The primary target populations are key populations that include gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and inmates.

Secondary Target Population

The secondary target population consists of service providers, lawmakers, law enforcement, community leaders, media, community workers, community-led organisations, CSOs, NGOs and donors.

6.2.3.1.3 Priority Geographic Regions

Combination prevention, care and treatment services targeting KPs will be implemented in all regions. However, high-risk districts will be KP programme priorities.

6.2.3.1.4 Strategies for the KPs Programme

a. ***Address policy, legal and social barriers to KPs' access to services***
b. ***Strengthen governance, coordination and monitoring of the KP programme***

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[10] *National estimate developed based on data from 2014 and 2019 Namibian IBBS conducted in three regions*
[11] *Estimates not available for male and TG sex workers*

The MHSS will strengthen national and sub-national structures for the KP programme with staffing and TWGs; will build the capacity of national and sub-national KP programme staff through training on KP programming; will strengthen the coordination and joint planning with other sectors to implement structural interventions in violence prevention, social security and economic empowerment of KPs; and strengthen KP programme planning, coordination and regular review of the performance with partners, CSOs and community-led organisations at the national and sub-national levels.

Furthermore, the MHSS will strengthen monitoring of the KP programme; and strengthen data systems to support national-level needs for reporting on KPs in multiple programme areas. In collaboration with the Namibia Statistics Agency and partners, the MHSS will conduct IBBSS to provide sufficient national-level data on MSM, FSW, TG, PWIDs and inmates.

The MHSS will also develop national guidelines and standard operating procedures (SOPs) for district-level hotspot mapping and size estimation of KPs; and, in collaboration with partners, train national and district-level programme staff and community-led organisations on national guidelines and SOP on granular-level KP hotspot mapping and size estimation. Regional offices and partners will conduct regular KP hotspot mapping and size estimation at the district level in all districts, in collaboration with community-led organisations.

c. *Scale up access to and improve the quality of HIV/SRH information and services for KPs*

Together with partners, CSOs and community-led organisations, the MHSS will scale up peer-led and community-based outreach services (including moonlighting and venue-based services) for KPs targeting the hotspots' peak hours and days. The MHSS will scale up differentiated HIV testing, including HIV self-testing, PrEP, and ART service delivery and adherence support through task-shifting, peer-led and community-based service delivery models.

The MHSS ensures that health facilities deliver KP-friendly HIV, SRH and mental health services. In collaboration with partners, the MHSS will train health service providers on KP-friendly services, including training on human rights, diversity and inclusion, with the engagement of community members. Public health facilities will arrange more flexible hours (evenings and Saturdays) for KPs to access core HIV prevention, testing and treatment services in hotspot areas. The MHSS and partners will scale up QuickRes, a web-based platform that will allow KPs to make reservations for services in public facilities and to access MHSS clinics without disclosure.

The MHSS, in collaboration with partners and CSOs, will pilot and scale up drop-in-centres (DICS) and KP clinics in hotspot towns to enable KPs (SWs, MSM and TG people) to access services. Partners and CSOs will support community-led organisations to scale up the use of virtual spaces for service delivery among KPs (social media, digital applications and other virtual platforms).

The MHSS will develop national guidelines, train providers and integrate SGBV and mental health screening and management for all KPs, hormonal therapies for transgender people in the community, and facility-based HIV prevention, care and treatment programmes.

d. ***Strengthen HIV/SRH information and services to inmates at correctional facilities***

The MHSS will strengthen collaboration with the Department for Correctional Services and provide technical and financial support for joint planning, review and implementation of combination HIV prevention for inmates. In addition, the MHSS will provide guidance and technical support to correctional facilities to deliver combination HIV prevention, treatment and care services, including condoms, lubricants, PrEP and PEP in correctional facilities; and will advocate for the distribution of PrEP, PEP, condoms and lubricants in prison settings.

e. ***Introduce and scale up harm reduction and opioid substation therapy for PWID***

f. ***Design and implement social and behavioural change communication and demand creation targeting KPs***

The MHSS will scale up the use of human-centred design for communication targeting KPs to address alcohol abuse, multiple sexual partnerships, and low condom use. In collaboration with partners, the MHSS will deliver behavioural change communication in a non-judgemental manner, alongside other prevention interventions and with the involvement of peers. Together with partners and community-led organisations, the MHSS will use digital, social and print media to educate and inform KPs about safe sexual behaviours and HIV/SRH services. The MHSS will avail IEC materials and resources on HIV, sexual and reproductive health, SGBV, mental health, and legal and human rights to KPs at community and health facility settings.

6.2.3.2 Vulnerable Populations

6.2.3.2.1 Programme Objective

By 2028, 90% of vulnerable populations will be reached with combination HIV prevention interventions.

6.2.3.2.2 Target Population

Primary Target Population

The primary target population is vulnerable populations, which includes:

- People with disability
- Mobile and migrant workers: Long-distance truck drivers, workers in largescale farming, construction and mining, and seafarers
- People in uniformed services
- Orphans and vulnerable children

Secondary Target Population

The secondary target population groups are service providers, lawmakers, law enforcement, community leaders, media, community workers, private sector, CSOs, NGOs, development partners and donors.

6.2.3.2.3 Priority Geographic Regions

The vulnerable population programme will be implemented in all regions and districts, targeting the hotspots for vulnerable populations.

6.2.3.2.4 Strategies for Vulnerable Populations Programme

a. *Strengthen vulnerable populations programme policy, leadership, coordination and monitoring*

The MHSS will develop a strategy and guidelines for the implementation of the vulnerable population programme; designate a coordination structure for vulnerable populations; and assign and train staff on vulnerable population programmes targeting vulnerable populations at national, regional and district levels.

b. *Improve access to and quality of HIV/SRH services for people with disability (PWD)*

The MHSS will strengthen collaboration, technical and financial support for people with disability (PWD) communities and associations to identify the main challenges they face in accessing HIV prevention, testing and treatment services; and provide technical support and funding to associations of PWD and CSOs to scale up peer-led and community-based combination HIV prevention services for PWD. The MHSS will also conduct a study on the risks and burden of HIV among PWD, in collaboration with partners and the National PWD Federation.

The MHSS will work closely with associations of people with disability to reach PWD with a customised combination of HIV prevention services; and to scale up demand creation and SBCC targeting PWD through audio, braille and sign languages. The MHSS, partners and PWD associations will train PWD as peer service providers.

In addition, the MHSS will develop a policy that supports and funds facility friendliness to PWD; train providers on special needs and communication with PWD; and ensure that health facilities infrastructure allows for physical access (ramps and escalators) for PWD. Health facilities will assign staff who can communicate with PWD through sign language; and will use audio educational materials and information for people with visual impairment.

c. *Improve access to and quality of HIV/SRH services for mobile and migrant workers*

The MHSS will strengthen collaboration with ministries and the private sector to implement combination HIV prevention interventions targeting mobile and migrant workers. The MHSS will develop a joint plan and monitor the implementation of HIV workplace policies by public and private sector employers; and, in collaboration with partners, ministries and the private sector, will scale up static and outreach combination prevention services targeting mobile and migrant workers. The MHSS will ensure that migrant workers and foreigners can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens. In collaboration with partners and CSOs, the MHSS will scale up community and workplace HIV prevention, care and treatment services through outreach to work places and community-based outlets.

d. *Improve access to and quality of HIV/SRH services for people in uniformed services*

The MHSS will work closely with the Namibian Defence Force and the Namibian Police Force to provide technical support to scale up SRH and combination HIV prevention, HIV testing, care and treatment services targeting people in uninformed services.

e. ***Improve comprehensive care and HIV prevention services to vulnerable children and adolescents ages 0 - 19***

Due to the lack of a comprehensive package of care and HIV prevention services, including case management to vulnerable children, strategies should include the provision of case management services at household and community level, including linkage to health services, violence against children response and birth registration services; the provision of services to build parenting skills and economic strengthening support to caregivers and older vulnerable adolescents; and the provision of education support and psychosocial support services.

6.3 Service-Based Interventions

6.3.1 Condom and Lubricants Programme

6.3.1.1 Programme Objectives

By 2028, 95% of populations at high risk of acquiring HIV will use condoms at last sex with non-regular partners. By 2028, 90% of SWs will use condoms at last sex with clients.

By 2028, 90% of adults 15 – 59 years old will use condoms at last sex with non-regular partners. By 2028, 90% of AGYW and ABYM 15 – 24 years old will use condoms at last sex with non-regular partners.

The condom programme promotes and distributes male and female condoms and lubricants.

The estimated annual condom needs range from 27.8 million in 2023 to 35 million in 2028. The condom needs are quantified for all adults.

Table 4: Condom needs quantification 2023 – 2028

Indicator	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**
Total number of male condoms needed	27,873,803	29,110,511	30,632,425	32,674,126	35,048,334
Total number of female condoms needed	377,461	486,902	596,342	705,782	815,223
Lubricants[1]	1,329,249	1,329,249	1,329,249	1,329,249	1,329,249

6.3.1.2 Target Population

Primary Target Population

The primary target population for male and female condoms includes all people at risk of HIV transmission.

Secondary Target Population

The secondary target population consists of teachers, community and religious leaders, parents of AGYW and ABYM, service providers, the private sector, non-governmental organisations, civil society and the media.

6.3.1.3 Priority Geographic Regions

All regions and districts will be included in the condom and lubricants programming.

6.3.1.4 Condom and Lubricants Programme Strategies

a. ***Strengthen condom and lubricants programme coordination and monitoring***
b. ***Strengthen condom and lubricants quantification, procurement and supply chain management***
c. ***Scale up condom and lubricants promotion, distribution and skills building***

6.3.2 ARV-Based Prevention

6.3.2.1 Programme Objectives

By 2028, all adolescent girls and young women (AGYW), populations at high risk of HIV infection, pregnant and breastfeeding women (PBFW), sero-different couples, ABYM and men at substantial risk of HIV infection will have access to ARV-based prevention services.

By 2028, 80% of FSWs, 95% of HIV-negative partners of sero-different couples, 50% of MSM and TG, 15% of inmates, 5% of AGYW, and 5% of PBFW will be on PrEP.

By 2028, 90% of people at risk of acquiring HIV will be provided with PEP, according to national guidelines.

By 2028, U=U communication will scale up to reach all PLHIV to enhance adherence to treatment and attain viral suppression, with a focus on HIV-positive AGYW and ABYM.

6.3.2.2 Target Population

Primary Target Population

The primary target population for PrEP is HIV-negative people at substantial risk of acquiring HIV, the primary target population for PEP includes all people who have medical and non-medical exposure to HIV, and the primary target population for U=U is all HIV-positive people.

Secondary Target Population

The secondary target population includes the general population, service providers, teachers, PLHIV, parents of AGYW and PBFW, media personnel and community workers.

6.3.2.3 Priority Geographic Regions

The geographic targets for PrEP are all regions. PrEP geographic priorities for the AGYW programme are districts with a high-level risk category (HIV incidence ≥1%). The PrEP target

for AGYW for this priority district can be up to 50%. All other districts are classified as moderate risk and the PrEP target is 5% of all AGYW.

6.3.2.4 ARV-based Prevention Strategies

a. ***Strengthen ARV-based prevention programme coordination and monitoring***
b. ***Improve access, acceptance and retention in ARV-based prevention***

6.3.3 Voluntary Medical Male Circumcision (VMMC)

6.3.3.1 Programme Objective

By 2028, 90% of men 15 – 29 years old will be circumcised. A total of 159,099 VMMC and 51,690 infant male circumcisions will be performed during the strategic period. There will be 31,820 VMMC performed each year during the strategic period. The MHSS will implement routine infant male circumcision (IMC) as part of routine health services. Infant male circumcision will be performed on 3,455 infants in 2023/24 to reach 17,209 infants by 2028. A minimum package of HIV prevention services will be integrated with VMMC delivery.

6.3.3.2 Target Population

Primary Target Population

The primary target population is HIV-negative men aged 15 – 59 years, with an additional priority being HIV-negative men 15 – 29 years old. In addition, male infants and young boys younger than 15 years old will be primary targets for routine male circumcision services.

Secondary Target Population

Service providers, sexual partners, parents, community and religious leaders, teachers and the media make up the secondary target population.

6.3.3.3 Priority Geographic Regions

VMMC will be implemented in all 14 regions of Namibia.

6.3.3.4 Male Circumcision Programme Strategies

a. ***Strengthen male circumcision programme policy, coordination and monitoring***
b. ***Scale up and improve the quality of VMMC and infant male circumcision (IMC) services***
c. ***Strengthen demand creation for male circumcision***

6.3.4 Prevention of Mother-to-Child Transmission (PMTCT)

6.3.4.1 Programme Objectives

The PMTCT programme objectives are to attain triple elimination of mother-to-child transmission (eMTCT) of HIV, syphilis and viral Hepatitis B by 2028, to reduce the rate of mother-to-child transmission of HIV to less than 2%, and to reduce the MTCT of HIV and syphilis case rate to less than 250 per 100,000 live births.

6.3.4.2 Target Population

Primary Target Population

The primary target population is pregnant and breastfeeding women (PBFW) and HIV-exposed infants (HEI).

Secondary Target Population

The secondary target population consists of sexual partners of PBFW, service providers, community health workers, PLHIV associations, and community and religious leaders.

6.3.4.3 Priority Geographic Regions

The PMTCT programme will be implemented in all regions and districts.

6.3.4.4 PMTCT Programme Strategies

- **a.** *Strengthen strategic partnerships and coordination at all levels of the health system between the public, private and CSO sectors to improve management, access and quality of PMTCT services*
- **b.** *Capacity building through training and mentorship of health facility and community-based staff in service provision for triple elimination of MTCT of HIV, syphilis and viral Hepatitis B*
- **c.** *Strengthen continuous quality improvement in the eMTCT programme to improve and maintain case identification, treatment, follow-up of mother-baby care and outcome documentation*
- **d.** *Strengthen the PMTCT/MCH commodity supply chain management, including related non-HIV commodities*
- **e.** *Develop and implement a PMTCT demand creation communication strategy and tools based on human-centred designs to ensure women attend ANC early and mother-baby pairs remain in care for PMTCT services until the end of the breastfeeding period*
- **f.** *In collaboration with partners and CSOs, strengthen the bi-directional referral system for PBFW and their infants between health facility and community level*
- **g.** *Strengthen communication and counselling to improve the uptake of PrEP among PBFWs*
- **h.** *Introduce and scale up point-of-care or near point-of-care testing approaches to ensure women and their infants receive HIV, syphilis and HBV test results on the same day, including EID and viral load*
- **i.** *Develop and implement strategies aimed at reducing turn-around times for laboratory test results (address sample transportation, gaps in electronic transmission (LIS), and tracking of cases for return of results and use of alerts)*
- **j.** *Develop and implement a male engagement strategy in PMTCT*
- **k.** *Enhance the integration of FP in HIV prevention, care and treatment services*
- **l.** *Strengthen the M&E systems, including the recording of PMTCT client level records, for improved management, tracking and documentation of final outcomes*

6.3.5 Sexual Reproductive Health Rights, Sexually Transmitted Infections and Demand Creation

6.3.5.1 Programme Objectives

The programme objectives state that by 2028, 90% of people with STIs will be diagnosed and treated; all health facility and community HIV prevention, care and treatment services will

integrate SGBV and mental health screening and management; and 90% of adults of all ages will have comprehensive knowledge of HIV prevention and transmission. In addition, HIV and SRH/FP will be integrated at all health facilities.

6.3.5.2 Target Population

Primary Target Population

There are different primary target populations for the different programme elements:

- STIs: All adults at risk of STI infection
- SBCC: AGYW, ABYM and other vulnerable groups
- GBV: Vulnerable groups

Secondary Target Population

The secondary target populations are educators, community gatekeepers, artists and champions, the media, CSOs, implementation partners, other sector ministries and the private sector.

6.3.5.3 Priority Geographic Regions

SRHR, STIs and HIV demand-creation interventions will target all regions.

6.3.5.4 SRH/STI, SBCC and Demand Creation Strategies

a. ***Improve coordination, integrated management and monitoring of HIV/SRHR/SGBV and mental health services***

b. ***Improve access to and quality of SRHR/SGBV and mental health services integrated with HIV programmes***

c. ***Improve quantification, procurement and supply management for SRHR/FP/SGBV/mental health commodities***

d. ***Strengthen demand creation and social behavioural change communication intervention for HIV/SRHR/SGBV/mental health***

6.4 HIV Testing and Treatment

6.4.1 HIV Testing Services

6.4.1.1 Programme Objective

The objective of the HIV testing services programme is to ensure that 97% of all PLHIV across all regions and sub-populations are diagnosed by 2027.

6.4.1.2 Target Population

The primary target population is the general population, including children (5 – 9 years), young men and women (25 – 29 years), adult men, and pregnant and lactating women.

6.4.1.3 Priority Geographic Regions

Regions where case-finding and treatment gaps exist will be targeted.

6.4.1.4 Strategies

a. *Recruit, retain and strengthen the capacity of HTS service providers to enable provision of high-quality case finding interventions in diverse settings*

b. *Strengthen the coordination and management of the supply chain for commodities, including rapid HIV test kits, across various stakeholders, including relevant programme staff, to inform programme needs and to monitor stock status*

c. *Strengthen data management and use data for case identification programme implementation*

d. *Implement a system to identify "re-testers/known positives"*

e. *Strengthen routine offer for HIV testing in STI, TB, nutrition, family planning and MCH settings*

f. *Expand infrastructure (create more space) for counselling clients to promote privacy and confidentiality*

g. *Improve index testing coverage by scaling up safe and ethical ICT in both facility and community-based settings*

h. *Expand distribution and use of HIV self-testing for hard-to-reach, high-risk HIV-negative target populations*

i. *Strengthen continuous quality monitoring and data quality assurance (QA) for HIV case finding through various activities*

6.4.2 HIV Treatment Services

6.4.2.1 Programme Objective

The programme objective for ART is to ensure that at least 97% of all PLHIV in Namibia are on Antiretroviral Therapy (ART) by 2027.

6.4.2.2 Target Population

Primary Target Population

The primary target population is all PLHIV, including children (under 15 years), adolescent boys and girls (10 – 19 years), youth, both males and females (20 – 29 years), adult men and women, and all populations at risk of HIV infection.

Secondary Target Population

The secondary target population includes treatment supporters, family members of PLHIV and civil society organisations working on HIV treatment.

6.4.2.3 Priority Geographic Regions

All 14 regions in Namibia will be targeted under this programme.

6.4.2.4 Strategies

a. *Improve the workforce and its capacity: Strengthen the recruitment, incentives for and training of the health workforce that is required for the provision of quality and comprehensive HIV services*

b. *Improve paediatric adherence to treatment: Strengthen the paediatrics ART programme through the use of the HIV disclosure package for children and adolescents living with HIV, the roll-out of teen clubs and the Namibia Adolescence Treatment Supporters (NATS) programme nationally, and support for caregivers/guardians of CALHIV, using the appropriate training package*

c. *Strengthen the psychosocial support system for CALHIV (including boarding schools, caregivers, etc.)*
d. *Strengthen collaboration among stakeholders, including line ministries, to support OVC and CALHIV through social services*
e. *Scale up targeted interventions to address challenges of populations that are lagging behind, e.g. men, farm workers, seasonal workers, seafarers and others*
f. *Strengthen the supply chain and inventory management systems for medicines and other related commodities*
g. *Scale up interventions to address issues that are related to interruption in treatment*
h. *Empower PLHIV to improve their socio-economic status through collaboration with stakeholders and line ministries*
i. *Strengthen the management of patients with advanced HIV disease (AHD)*
j. *Strengthen advocacy and social mobilisation efforts through community gatekeepers to address stigma associated with HIV and promote the integration of HIV services into community health programmes*
k. *Reform the training curricula for in-service training to fall under the pre-service medical and nurse training curricula*
l. *Develop and operationalise an HIV and TB framework for public-private partnerships to enable meaningful engagement with the private sector (by March 2025)*
m. *Strengthen data capturing systems through collaboration between the Health Information and Research Directorate (HIRD), ministries and other directorates to enable tracking of patients across health facilities to minimise data discrepancies (by March 2025)*

6.4.3 Differentiated Service Delivery (DSD) for HIV Services

6.4.3.1 Programme Objective

The programme objective is to scale up DSD models that are client-centred and meet the preferences and values of recipients of care (ROC) in all regions.

6.4.3.2 Target Population

The primary target population is all PLHIV sub-populations.

6.4.3.3 Priority Geographic Regions

The Fast-Track model will be prioritised in the following communities:

- Seasonal, farm and sea workers
- Truck drivers, and other populations at high risk of HIV infection
- Communities affected by seasonal floods

6.4.3.4 Strategies

a. *Scale up the deployment of diverse person-centred models of care, tailored to the preferences of different populations, utilising existing resources effectively*
b. *Strengthen the existing community health workers programme to cater for a wider range of basic healthcare services at the community level*
c. *Review existing policies to address the specific healthcare requirements of diverse groups to optimise health outcomes for special population categories*
d. *Address funding challenges for CSOs to support the government to reach all communities through community-based service delivery*

6.4.4 *Service Integration, Prevention and Management of Opportunistic Infections including TB/HIV Collaborative Activities*

6.4.4.1 Programme Objectives

The programme objectives are to increase the proportion of PLHIV screened for TB at every visit from 88% to 100%; to scale up cervical cancer screening and treatment of precancerous lesions to 100% of sites providing ART services; and to reduce cervical cancer-related morbidity and mortality among eligible WLHIV.

6.4.4.2 Target Population

Primary Target Population

The primary target population is all PLHIV in general, and women living with HIV aged 20 – 49 years for the cervical cancer prevention programme.

Secondary Target Population

The secondary target population is HIV-negative women 25 – 49 years old.

6.4.4.3 Priority Geographic Regions

All 14 regions will be targeted.

6.4.4.4 Strategies

a. *Strengthen the capacity of all HCWs to co-manage HIV and other comorbidities, such as TB, cervical cancer and mental health screening and treatment*
b. *Strengthen TB screening platforms for PLHIV, and CXR and molecular platforms, including TB LAM to widen access to TB diagnosis*
c. *Address demand forecasting, service, maintenance and repairs and routine monitoring of stock status of laboratory reagents*
d. *Enhance mortality audits for TB/HIV co-infected cases and introduce quality improvement measures*
e. *Update the national ART guidelines to incorporate clear guidance (SOPs and job aid) on the management of common mental health disorders among PLHIV*
f. *Introduce and scale up new high-performance screening tests to improve accuracy*
g. *Scale up nutrition interventions for PLHIV through routine screening and management*

6.4.5 *Resilient and Sustainable Systems for Health and Related Social Protection Schemes Relevant for HIV/AIDS*

6.4.5.1 Overall Objective

The overall objective is to develop and maintain systems for health and social protection schemes that support wellness, livelihoods, and enabling environments for people living with, at risk of, or affected by HIV to reduce inequalities and allow them to live and thrive.

This section contains programmes and strategies for the following:

- Health systems strengthening, with the following sub-sections:
  - Laboratory systems and services strengthening and scale up
  - Community systems strengthening for health
- Related Social Security schemes

- Integration of HIV/AIDS, TB and malaria programmes into primary healthcare

6.4.6 Health Systems Strengthening (HSS)

The World Health Organization (WHO) defines health systems strengthening (HSS) as "the process of identifying and implementing the changes in policy and practice in a country's health system, so that the country can respond better to its health and health system challenges." It seeks to harmonise innumerable points of healthcare service delivery to ensure equitable access, utilization and distribution of health with an aim of improving health outcomes.

The situation analysis of Namibia's health system is included in Chapter 3.

6.4.6.1 Programme Objective

The programme objective is to strengthen health system capacity to deliver services through improved human resources; procurement and supply chain management; monitoring and evaluation; governance and management; health information systems; policies; and sustained and adequate funding to address the prevention of HIV/AIDS and the continuum of care needs of people living with HIV by 2028.

6.4.6.2 Target Population

Primary Target Population

The primary target population is the public sector.

Secondary Target Population

The secondary target populations are the private sector and civil society organisations.

6.4.6.3 Priority Geographic Regions

Priority geographic regions are the regions with high rates of new HIV infections, poor adherence to ART, high teenage pregnancy rates, high stigma and discrimination, and high socio-economic inequalities, such as Omaheke, //Kharas, Hardap, Kavango East and West, and Erongo. The regions with the highest rates of HIV burden are also included.

6.4.7 Human Resources for Health (HRH) Relative to HIV Services

This NSF recommends that the MHSS increase the number of health assistants (community counsellors and health extension workers) from 387 in 2022 to 1,336 in 2025 within the staff establishment to provide comprehensive HIV testing services, and that the DSP **train at least 60% of all nurses in HIV rapid testing** to widen entry points for HIV testing, prioritising OPD, IPD, maternity wards, primary healthcare (ANC and PNC), TB and STI clinics.

Paediatric and Adult ART Treatment

There is a need to strengthen the capacity (skills, competence and confidence) for paediatric ART management through training of at least 60% of doctors and 60% of nurses. The MHSS/DSP should introduce a rapid HIV testing training and certification programme, integrated in the pre-service basic nursing training, and should increase its allocation of resources to the HIV programme to fill in emerging gaps. The national ART programme should train doctors, nurses and pharmacists in HIV management to address knowledge gaps in OPD

and inpatient departments. It should strengthen the mentorship programme and take quality improvement initiatives across all regions, and create mentorship positions within the MHSS health establishment to enhance the sustainability of the programme.

The MHSS/ART programme should intensify training and mentorship for health workers on mental health screening and management of PLHIV, and ensure that the mentorship programme is effective. In addition, it should scale up cervical cancer screening and management (VIA) to all sites providing ART services in Namibia, and prioritise formal VIA training for doctors and nurses working at ART sites.

The ART programme will scale up nutrition screening and management to all sites providing ART, according to national guidelines. Mentors should capacitate staff working at ART sites to routinely offer nutrition screening and management to PLHIV at every visit and to make appropriate referrals.

TB/HIV

The Directorate of Primary Healthcare of the MHSS should review and expand the scope of work and train health extension workers to perform additional tasks, such as community-based HIV/TB services, including DSD, so that CHWs are empowered to manage both HIV and TB patients. It should strengthen the capacity of all HCWs to co-manage TB and HIV, including NIMART training for TB clinic staff, and build capacity for screening and early diagnosis of TB. The DSP would build the capacity of all CHWs (both those employed by the government and those who are partner-funded) to manage TB, HIV and comorbidities within the community.

Non-KP and non-youth friendly services in government health facilities

Key populations and youth expressed a very strong preference towards CSO-run health facilities, and lamented the closure of a clinic run by a CSO. They reported negative experiences at government health facilities, for example, health workers asking transgender females why they wanted a Pap smear. In addition, staff were reported to be very unfriendly and as not easily accommodating and booking new dates for patients who missed previous appointments, leading to a significant number of patients being unable to make or keep follow-up appointments.

Harmonisation of capacity building for HRH

The challenge with the vertical interventions described above will be the ability of the government to absorb the wage bill to recruit new staff, and to fund the recurrent costs of the various in-service training programmes. Therefore, alternative and innovative means of service delivery need to be found.

The government should recruit, retain (incentivise) and train the health workforce that is required for the provision of quality and comprehensive services for all its citizens, inclusive of HIV services as described above. However, the MHSS should engage and facilitate revisions of pre-service medical and nurse training curricula to help reduce in-service training-related costs. It could conduct refresher training programmes for lecturers at pre-service training centres and institutionalise capacity building through the National Health Training Centre to create a sustainable training programme across all HIV programmes. The MHSS will develop

an integrated training package for HIV to be delivered through blended learning platforms, with emphasis on virtual training to reduce costs.

A major focus of capacity building would be the training of health workers to reduce stigma and discrimination.

Strategies for Resilient and Sustainable Systems for Health

Human Resources for Health (HRH)

- **a.** *Improve the deployment and coordination of CHW between the MHSS and CSO partners for efficiency*
- **b.** *Develop a standardised CHW package (Note: The Revised Draft National Policy on Community Based Health Care 2022 is currently under review)*
- **c.** *Institutionalisation/formalisation of the workforce of domestically-financed CBOs, community-led organisations, NGOs, etc. using the Social Contracting Policy, to ensure the sustainability of programmes and service delivery*
- **d.** *Implement an incentive scheme to attract and retain skilled health workers in areas which are difficult to stay in and which are deprived*
- **e.** *Strengthen domestic resource mobilisation, e.g., private sector partnerships for HRH*
- **f.** *Strengthen health worker performance and productivity at all levels of service delivery*
- **g.** *Conduct a comprehensive HRH analysis to determine the HRH implication in terms of cadres, numbers, roles and location for delivery of HIV and other health services*
- **h.** *Align health workforce production capacity and quality to match population HIV and health needs and economic demand so that the HRH implications for delivering HIV and other health services, including implications for sustaining epidemic control, are known to guide government and donor HRH investments*
- **i.** *Use evidence to advocate for revision of the government staff establishment to expand positions for the critical cadres in HIV services based on need, to eliminate inadequate or lack of posts in the government structure for several cadres critical to the provision of HIV and other health services, such as health assistants, M&E cadres, and other medical professionals*
- **j.** *Implement an HR information management system to address the MHSS information needs and to track health workers' registration, licensure and availability, and ensure access to comprehensive HRH data to inform policies, plans, management and HRH investment decisions*
- **k.** *Build capacity of HR practitioners and managers in data management and evidence generation, and for use in decision making*
- **l.** *Implement the National Health Workforce Accounts (NHWA) and national health workforce observatory*
- **m.** *Conduct operational HRH research to identify and address emerging HRH issues*
- **n.** *Strengthen network infrastructure for iHRIS and HRM by replacing limited and old ICT equipment*
- **o.** *Develop a sustainability plan for donor supported positions; many of the positions are not aligned to the government structure in terms of roles, naming, training, person specifications, remuneration, benefits, etc.*
- **p.** *Initiate the process of streamlining the donor-supported positions to government structures as a first step in sustainability planning*
- **q.** *Streamline and strengthen the management of CHW to ensure coordinated and sustainable provision of quality health services at community level*
- **r.** *Strengthen partnerships with key stakeholders to address CHW priorities*

- **s.** *Streamline/integrate vertical health programmes into the MHSS and staffing norms to HRH to ensure sustainability*
- **t.** *Ensure efficient utilisation of the available health workforce, including task shifting/sharing*
- **u.** *Accelerate implementation of the MHSS' comprehensive HRH strategic plan that was developed in 2019*
- **v.** *Support implementation of priority HRH that affect delivery of HIV services, including incorporating emerging HRH priorities for sustaining epidemic control and UHC*
- **w.** *Strengthen the functionality of the HRH TWG and related structures to ensure stakeholder involvement in addressing jointly identified HRH issues to redress coordination of stakeholders on HRH within the MHSS (across directorates) and with other stakeholders, including other sectors, donors and other key stakeholders*

Policy and Governance

- **a.** *Reprioritise all issues, as COVID-19 de-prioritised all other health issues, and focus on innovative and sustainable methods of delivering services to vulnerable populations who were neglected due to COVID-19*
- **b.** *Advocate for the finalisation and roll-out of the Civic Organisations Partnership Policy 2005 to strengthen coordination with civil society organisations*
- **c.** *Finalise and operationalise the Social Contracting Policy 2022*
- **d.** *CSO strengthening and capacity development: Twinning, etc., with special focus on community-led organisations, to reduce over-resourcing and capacitating only specific CSOs*
- **e.** *Strengthen sector responses for coordination and service delivery, e.g., LEA implementation*
- **f.** *Engage in equity-based resource distribution*
- **g.** *Strengthen accountability through the implementation of the Public Service Code of Conduct and also include CLM as a strategy to increase accountability*
- **h.** *Undertake regular quality assurance mechanisms*
- **i.** *Community capacity strengthening and human-rights education to enhance the implementation of the Patient Charter*
- **j.** *Comprehensive response to address stigma from health workers, by sensitising health workers on human rights, and increase monitoring of services by senior MHSS staff to ensure ethical delivery of care, and ensure health workers do not post inappropriate content on social media; and develop a self-taught online training on stigma for health workers, which is a cost-effective option, given the large number of the health workers*
- **k.** *Strengthen and rebuild partnerships between the MHSS and the line ministries that have the mandate for social protection and economic empowerment (e.g. Ministry of Gender Equality, Poverty Eradication and Social Welfare, and Ministry of Agriculture, Water and Forestry) and with CSOs, faith-based organisations and the private sector, so that PLHIV and vulnerable populations on ART adherence can access the support they need*
- **l.** *Standardise disability and vulnerability assessment tools*
- **m.** *Advocate for the annual review to ensure that the Social Protection Policy (2022) strengthens linkages with HIV and mainstreams HIV*
- **n.** *Institutionalise regular joint planning and reviews between all directorates at MHSS headquarters to ensure collaboration and coordination for efficient delivery of interventions, with oversight from senior management meetings of the MHSS, composed of the directors and the executive director (ED), to ensure that joint planning and reviews take place*

- **o.** *Advocacte for the finalisation of the Health in All Policy (HiAP describes interventions to reduce alcohol abuse through awareness campaigns using mass media, social media, peer education, etc., including community mobilisation)*
- **p.** *Conduct size estimation of PWID in Namibia to inform human resource distribution*
- **q.** *Advocate for the enforcement of the Liquor Act and carry out related public education on drug abuse*

Procurement and Supply Chain

- **a.** *Integrate community-based service delivery and distribution of commodities, e.g. condoms*
- **b.** *Review CMS guidelines on service delivery points*
- **c.** *Develop SOPs to enhance decentralised commodity distribution*
- **d.** *Update and implement the condom programming strategy*
- **e.** *Use pooled procurement to eliminate the delays associated with procurement which lead to stock-outs and sourcing out of tenders for condoms to the private sector*
- **f.** *Advocate for the reintroduction of social marketing for condoms, and scale up condom dispensers in public spaces*
- **g.** *Government to consider budgeting for lubricants*
- **h.** *Improve supply chain management to ensure timely delivery of ARV and commodities*
- **i.** *Introduce new female-friendly and acceptable HIV prevention technologies, including female condoms*
- **j.** *Strengthen social and behaviour change communication programmes*
- **k.** *Promote broad-based political and social mobilisation to prevent and respond to HIV, ensuring that national responses involve a wide range of sectors and institutions*
- **l.** *Wider dissemination of lubricants to the general population, and strengthening combination HIV prevention*
- **m.** *Strengthen partner coordination for generalised service delivery to cover all regions*
- **n.** *Develop clear guidelines and SOPs for procurement*
- **o.** *Consider pooled procurement and overall procurement reforms*
- **p.** *Improve supply chain planning, forecasting and quantification of commodities*
- **q.** *Consider alternative transport modes for medication, e.g. drones, motorbikes, trains, Namibia Post Office couriers, etc.*
- **r.** *Logistics: Improve fleet management, with prompt disposal of unserviceable vehicles, and funds used to purchase new ones; potentially review the embargo on the procurement of new vehicles by the Ministry since 2018; and create better synergy with development partners, as they have their own rules governing disposal of assets*

Service Delivery: Configuration (including HR Configuration Options), Coverage and Quality

- **a.** *Institute priority-based allocation of resources for the regions to ensure equitable distribution of resources, and eliminate duplication and overlap between government and development-partner-funded CSOs in the delivery of health extension services, as the health extension system is fragmented, with CHW employed by the government and CSOs operating in the same geographic space (some CSOs supported by donors are not operating in districts where the need is greatest, leaving some disadvantaged regions uncovered, while some regions are over-served)*
- **b.** *Institutionalise HIV and AIDS spending assessments to assess equity is resource allocation*
- **c.** *Strengthen and unify the health extension service for better service delivery: Create a unified extension service with better coordination at district and regional levels*

between CHW employed by MHSS and those employed by CSOs. The management of these health extension workers needs to be unified and performance targets need to be set. The MHSS should borrow best practices, like allocation of specific geographic areas to each CHW and target setting and monitoring, from the agriculture extension system in the Ministry of Agriculture. This would provide an opportunity to harmonise the CHW employed by HIV/AIDS, TB and malaria services.

- **d.** *Strategise to reduce poor treatment adherence of AGYW on ART in order to address failure to effectively initiate and manage those who abscond from treatment (viral load of females on treatment increases from reinfection from partners, who are not tested or not on treatment)*
- **e.** *Roll out innovations, such as the QuickRes web application which is not yet rolled out to relevant stakeholders; and institute service feedback mechanisms to the duty bearers*
- **f.** *Strengthen the roll-out of MMD*
- **g.** *Strengthen PSM to enhance forecasting and quantification of ARVs, including producing quality bidding documents and contract management*
- **h.** *Develop clear guidelines and SOPs for the accelerated integration of HIV into/with primary healthcare, as appropriate, to avoid parallel systems*

HMIS Health Passports

- **a.** Undertake a Stigma Index study
- **b.** Strengthen social and behaviour change communication on HIV, GBV, couple counselling, disclosure, etc.
- **c.** Fast-track the implementation of the unique identifier for health services

6.4.8 Laboratory Services and Scale-Up

Programme Objective

The objective of laboratory services is to provide comprehensive quality laboratory services to support the provision of HIV testing, treatment and care.

Target Population

Primary Target Population

The primary target population includes people living with HIV, and people living with HIV diagnosed with TB, STIs and other opportunistic infections.

Secondary Target Population

Health facility managers, development partners, MHSS stakeholders and laboratory service providers make up the secondary target population.

Priority Geographic Regions

All 14 regions in Namibia will be targeted.

Strategies for Laboratories

- **a.** *Strengthen the laboratory division to provide strategic laboratory oversight for the country*
- **b.** *Develop and implement a laboratory policy and a point–of-care policy, which will give strategic direction to the laboratory division and improve the management of POC*
- **c.** *Develop and implement a National Specimen Tracking System to improve specimen transport and results tracking*
- **d.** *Improve ISO 15189 accreditation of laboratories from 28% to 60%*
- **e.** *Decentralise testing services to ensure availability and accessibility of quality laboratory services*

f. *Strengthen the collaboration between the MHSS and partners, including the private sector, to improve laboratory services for the HIV response*

6.4.9 Community Systems Strengthening for Health

6.4.9.1 Programme Objective

The CSS programme objective is to ensure that civil society organisations and community groups and networks are supported technically and financially to better organise and coordinate themselves as they contribute to the national response. The investments corresponding to this objective will ensure the effectiveness and sustainability of civil society and community systems and structures, in addition to ensuring that they are adequately resourced. The unique comparative advantages of affected populations and communities will be leveraged in fast-tracking the HIV response towards epidemic control.

6.4.9.2 Specific Objectives

Pursuant to this objective, the following interventions will be prioritised during the implementation period:

a. ***Enabling environment:*** *Strengthen the enabling environment to optimise the civic space*
b. ***Capacity building:*** *Increase capacity building investments in structures and systems (and their accountability) through the strengthening of governance, financial management, programme management, human resource management, knowledge management, stakeholder management, strategic communication and information sharing, etc.*
c. ***Coordination and leadership:*** *Enhance sub-national and sub-regional coordination and leadership*
d. ***Legal recourse for the vulnerable:*** *Enable and upscale legal recourse for the poor (communities/individuals whose inalienable rights are violated through denial of access to health services)*
e. ***Community-led service delivery:*** *Broaden and deepen community-led service delivery in line with the 30-80-60 targets described in the section on Namibia's Commitment to CS&R*
f. ***Ending stigma and discrimination:*** *Engage gatekeepers more intensely to end stigma and discrimination. This will include the intensified engagement of (1) lawmakers, (2) leaders and other gatekeepers in the cultural and religious sectors, (3) key print, broadcast and social media personalities and influencers, and (4) other opinion leaders and policymakers in the HIV response to address structural barriers and negative social norms*
g. ***Community-led monitoring:*** *Expand and entrench community-led monitoring duly supported by ICT-enabled knowledge management to preserve civic institutional memory and create a reference database to inform continuous improvements in reporting and feedback, as well as a community-led research agenda that will, in turn, strengthen the evidence base for community-led advocacy*
h. ***Social contracting:*** *Expedite the implementation of social contracting to ensure the availability of sustainable financing and resourcing of community systems and for networks and organisations of people living with HIV (PLHIVs) and key and vulnerable populations (KVPs) such as AGYW, sex workers, and the LGBTIQ+ community (GRN, 2022b)*

i. ***Strategic lobbying and advocacy:*** *Capacitate and enable community-led strategic lobbying and advocacy*

6.4.9.3 Community Systems Strengthening Strategies

Strengthen the enabling environment to optimise the civic space and participation

a. *Capacitate and support civil society and communities with the necessary financial and technical resources to design, schedule and implement a programme of civil society-led policy audits as a well-coordinated and continuing feature of the civic space.*
b. *Increase financial and other investments to increase the civic space and enable greater civic participation in the country's various deliberative platforms and processes, including the CCM, TWGs, RACOCs, CACOCs, TACs, etc.*
c. *Advocate for the expedited finalisation and implementation of the Health-in-All-Policies (HiAP) to include the mainstreaming of health generally, and HIV in particular, in the job accountabilities of policy makers and decision makers ("Health-in-All-Job-Descriptions") across all the sectors of government, at both the national and regional levels, to raise the profile of HIV.*
d. *Enhance civil society and communities' contributions to national health and other emergency preparedness and responses by ensuring their involvement and participation in the design, development and dissemination of related strategies and plans.*

Increase capacity building investments

e. *Capacitate local civil society to participate more broadly and accountably in the design, service delivery, monitoring and feedback, and facilitation and support (including demand creation and coordination) of HIV programmes according to their comparative advantages. Civil society involvement in HIV programmes should include the necessary transparency and accountability mechanisms to ensure the effective engagement of communities by the MHSS through civil society and through community groups. Candidate capacity-building approaches that may be considered for this purpose include Pact Namibia's suite of innovative and customised participatory approaches aimed at promoting positive organisational change for improved service delivery (Pact Namibia, 2013).*

Enhance sub-national and sub-regional coordination and leadership

Financial and other investments will be made in the following strategic interventions to strengthen coordination and leadership at all levels and across all sectors nationwide:

f. *Reinstate the CACOC Coordinator role in the staffing establishment of the regional councils to rehabilitate and strengthen the civil society interface between councilors and their constituents and reinvigorate the involvement of community groups.*
g. *Finance the RACOCs' HIV programming and related civil society involvement and community engagement efforts towards the increased availability, accessibility, acceptability and quality (AAAQ) of health services.*

Enable and upscale legal recourse for the poor

h. *Increase investments targeted at upscaling the availability and affordability of public interest legal services, such as those provided by the Legal Assistance Centre (LAC)*

i. *Complement these investments with capacity building and related investments and interventions to embed paralegal services within communities.*

Broaden and deepen community-led service delivery

j. *Increase and broaden support to community-led interventions, especially those targeting populations at high risk of HIV infection and other vulnerable populations, such as PWDs, migrant workers and people living in informal settlements.*
k. *Create, capacitate and enable models and pathways for the optimization of space for community-led models of service delivery, monitoring and feedback to fast-track the much-needed improvements in service availability and quality on the one hand, and health outcomes on the other. This transition to community-led models will have to be informed by a well-conceived and structured mapping of the comparative advantages of civil society and communities.*

Engage gatekeepers more intensely to end stigma and discrimination

l. *Capacitate and empower civil society to intensify awareness-building, training and involvement of community gatekeepers and service providers, including traditional leaders, civic leaders, etc., in the development and implementation of strategies aimed at achieving total epidemic control.*
m. *Leverage the reach and influence of churches and other faith-based groups to increase the breadth and depth of coverage of HIV and AIDS prevention, treatment, care and support services.*
n. *Leverage the reach and influence of community radio stations, media personalities and other opinion leaders in the efforts to promote awareness, prevention and health-seeking behaviour by the entire population.*

Expand and entrench community-led monitoring

o. *Enable the expanded roll-out of community-led monitoring and build the necessary feedback and advocacy channels to enable civil society to contribute community-led evidence to the strategic information base.*
p. *Mandate and mainstream the roll-out and implementation of social accountability mechanisms and tools, depending on the setting and issues at hand. This expansion and entrenchment of social accountability must leverage social audit methods (i.e., institutionalised community-led interventions to check and demand accountability and transparency from public officials in public policy and budget cycles) and other community-led approaches.*
q. *Enable and strengthen community-based knowledge management and horizontal information-sharing as well as vertical reporting into the nation's official strategic information systems through the operationalisation and broad-based deployment of the Multi-sectoral Information Management System (MIMS). The operationalisation of MIMS will enable the elimination of blind spots by going deeper than the district level to identify and locate the vulnerable groups that have so far been left behind.*

Expedite the implementation of social contracting

r. *Consolidate the commendable progress achieved so far in the area of social contracting by expediting the finalisation of the draft Social Contracting Policy and its translation into appropriate supporting laws and regulations in a way that will secure a level*

playing field for civil society community groups, while maximising the thematic space and economic opportunity for them.

Ignite and expedite private sector contracting and private sector participation

- **s.** *Strengthen engagement with the private sector to create more contracting opportunities for CSOs and CGs in their areas of comparative advantage and hence increase the scope for domestic resource mobilisation (DRM).*
- **t.** *Increase the scale and scope of private sector participation in the national response through direct outreach to business and trade associations and individual companies, especially with a focus on the mining, fishing, transport, tourism and agriculture sectors, among others.*

Capacitate and enable community-led strategic advocacy

- **u.** *Increase investments and strengthen coordination, capacities and linkages in the civil society and community space to enable the development of effective knowledge management mechanisms among civil society organisations and community groups, that will inform the development of a unified national advocacy agenda, strategy and action plan addressing the various constituencies' persisting concerns. Develop a unified ICT-enabled CS/CG knowledge management system to support proactive knowledge and information-sharing by and among civil society organisations and community groups and to preserve institutional memory.*
- **v.** *Operationalise the Multi-sectoral Information Management System (MIMS) to enable the incorporation of community-driven evidence into the government's strategic information base.*
- **w.** *Advocate for the optimisation of efficiency gains and health service integration, and structure advocacy for investment case issues, investment in frontloading, replenishment, etc.*

6.5 Related Social Protection Schemes

Strategies for sustainable social protection systems

- **a.** *The MHSS will engage other relevant line ministries, such as the Ministry of Gender Equality, Poverty Eradication and Social Welfare for OVC and social services to support drought relief for caregivers; the Ministry of Education, Arts and Culture to support children in school; and the Office of the Prime Minister and other stakeholders to provide psychosocial support and care to CALHIV, as children under 15 years old have a lower viral load suppression rate at 84%, compared to 93% across all age groups.*
- **b.** *Incorporate and strengthen community economic empowerment activities as part of the multi-sector response to HIV/AIDS, to address the high rate of poverty and unemployment due to lack of skills and knowledge.*
- **c.** *Expand provision of social welfare grants to indigent PLHIV on ART, where indicated, to support them to adhere to treatment.*
- **d.** *Approve and scale up soup kitchens at the community level, by the private sector via the Chamber of Commerce, FBOs, CSOs, CBOs and the government, teaming up to build a strong coalition to support PLHIV with food etc.*
- **e.** *Improve availability and accessibility to remote areas via transport and road networks. The regional council should consider the payment of a transport stipend as part of its support to PLHIV, as poverty affects successful treatment as PLHIV, besides not being*

able to afford food, cannot afford transport to keep clinic appointments in vast regions like //Kharas and Hardap, particularly those in remote areas with inadequate road networks.

f. *Promote greater involvement of the Agricultural Extension Agents in the management of farms and vegetable gardens established by PLHIV.*

6.6 Integrating HIV/AIDS and TB Response in the Primary Healthcare System

6.6.1 Programme Objective

Develop the conceptual framework for integration and engage in intensive advocacy and stakeholder mobilisation in the first year of the NSF period, so that pilot projects can be started in the first year of the NSF, evaluated in the second year, and a clear road map for scaling up developed in the second year, so that by the mid-term of this NSF, a costed implementation plan for integration for the entire country and the required resources would have been developed.

6.6.2 Background

As Namibia moves from the emergency response posture of the past 30 years into sustaining the epidemic control status, there is a need to integrate vertical HIV/AIDS programming more efficiently and effectively into the general health service delivery infrastructure of the country. Where possible, Namibia will appropriately and carefully integrate HIV and TB programming into strengthened public health systems to manage tuberculosis, high burden non-communicable diseases, sexual reproductive health, rights and services, as well as other health priorities that impact PLHIV with the aim of protecting HIV/AIDS gains and strengthening health and economic outcomes.

The vertical HIV/AIDS and TB programmes are very expensive, duplicate services and are under pressure due to recent shortfalls in both domestic and donor funding. The graph in Figure 37 in the finance chapter (Chapter 9) shows that domestic funding has plateaued in the last five years. Integrating HIV/AIDS and TB programmes in the general health system would be efficient and lead to significant cost savings, freeing up funds that could be invested in other parts of the system. The financing of HIV and TB responses is also planned for integration into national and local health financing systems.

The End-Term Review found evidence of ongoing service integration across the following programmes:

- Over 90% of visited HFs offered condoms, oral contraceptive pills and injectables (Depo Provera) within ART clinics as a one-stop shop service
- Nutrition screening and management was being offered routinely in 86% of facilities visited during clinical consultations
- STI screening and management was integrated in all the facilities visited
- ART patients had blood pressure checks at each clinical consultation visit
- Cervical cancer screening and management for WLHIV was offered at 82% and 57% of the facilities visited, respectively

Therefore, integration is already taking place; however, the aim to accelerate integration and phase out the vertical HIV/AIDS programme. The integration would mean that primary

healthcare doctors and medical doctors in the general outpatient departments would be trained to treat uncomplicated cases of TB and HIV/AIDS and refer only complicated cases to specialists. It is recommended that HIV/AIDS testing services remain a vertical programme over the medium term. Integration is achievable, but challenging, given the multi-faceted dynamics and group interests. Hence there is a need for advocacy to develop a common understanding among the various stakeholders.

The above would be evaluated in terms of the current situation versus what is expected in one, three and five years from now in order to identify gaps to be closed during those periods.

There would be a need for a coordinating task force, broken into siloed or overlapping working groups, as there could be a need to modify structures or reporting lines (after functions have been clarified and agreed upon).

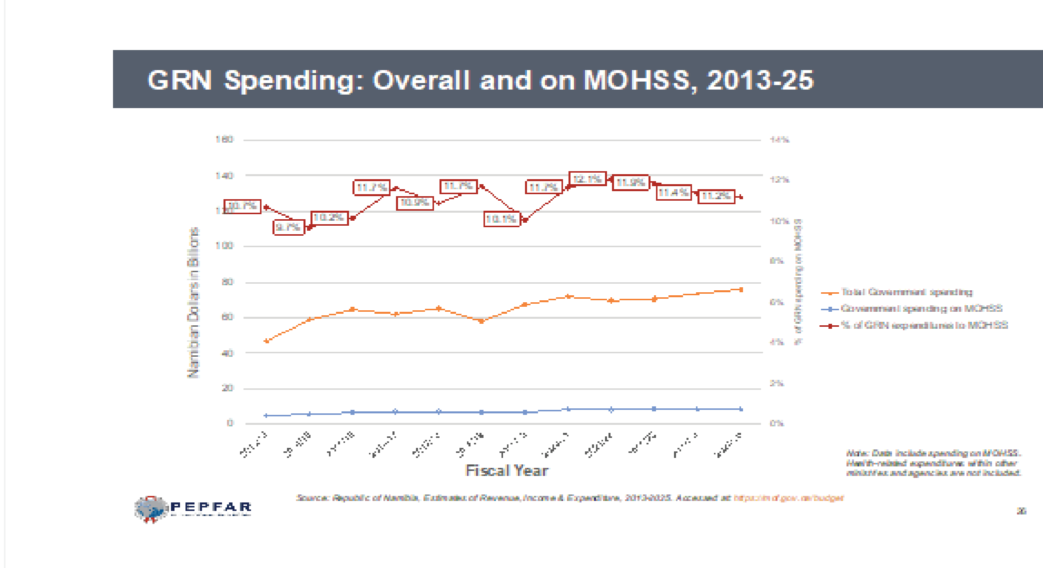


Figure 20: GRN spending: Overall and on MHSS, 2023 – 2025

6.6.3 Strategies for Developing the National Road Map for Integration

A pilot study on integration is recommended for Aranos District, where HIV and TB patients are currently being managed at separate facilities. In general, HIV and TB services tend to be separated in the bigger facilities situated in town, while services are usually integrated at the smaller rural clinics.

In the clinical setting, gaps identified in Aranos town and in similar settings where HIV and TB services are not integrated, include the following:

- Delay in ART initiation for TB patients who test HIV-positive
- Failure to dose adjust ART medications for patients co-infected with TB to cater for drug interactions
- Clients are lost to care at the ART clinic, while active at the TB clinic and vice versa
- Clients initiated on TPT at ART clinic, while still on TB treatment at the TB clinic
- Increased financial costs for clients as well as time away from employment or family as clients need to visit ART and TB clinics separately

- Duplication of recording and reporting due to parallel M&E systems for the HIV and TB programmes

Table 4: Road map for pilot study on the integration of HIV/AIDS and TB into PHC

Gaps/Challenges	Strategies	Main Activities	When	Who
Policy				
Absence of theoretical framework and roadmap for integration	Establish a TWG on integration	Inaugurate the coordinating body; Train TWG on concepts and principles; Define institutionalisation in the Namibian context	Month 1, Q1, Year 1	Deputy ED, MHSS, who is the Chairperson of the NAEC
Lack of certainty and definitiveness	TWG on institutionalisation to develop a five-year transitional plan	Promote and implement the plan	Month 3, Q2, Year 1	Chairperson of the TWG
Absence of proof of the concept	Develop pilot studies at sites in average, under-resourced and over-resourced settings	Windhoek, Aranos District in Hardap Region and other locations (still to be selected)	Month 10, Q4, Year 1	Regional Health Directors
Financing and Budgeting (from Domestic Funds)				
Inadequate awareness of the economic cost and unsustainability of the existing vertical programmes in HIV/AIDS, TB and malaria (the pilot would test the financing of HIV care delivered in primary care settings through health benefit packages or directly by the national or local budget)	Develop advocacy materials targeted at senior clinicians in academia/post-graduate medical colleges and government	Develop costed national plan for integration; Hold advocacy events; Identify PHC structures, systems and programmes to integrate the HIV/AIDS programme in existing PHC system and programmes; Possible scale-up of institutionalising HIV services nationally	Month 3 – 6, Q3, Year 1	Chairperson of the Advocacy Sub-committee of the TWG
Procurement and Supply Chains (for Pharmaceuticals, Diagnostic Equipment, Lab Supplies, etc.)				
Lack of data on PSM implications of integration	Develop a PSM plan	Cost the PSM plan	Month 3 – 6, Q3, Year 1	Chairperson of the PSM Sub-committee of the TWG

Gaps/Challenges	Strategies	Main Activities	When	Who
Service Delivery: Configuration (including HR Configuration Options), Coverage and Quality				
Absence of standard SOPs to integrate HIV/AIDS programmes to PHC programmes; Inadequate capacity to treat HIV/AIDS and TB patients in general outpatient clinics and community systems in the pilot sites	Develop SOP, guidelines, etc.; Develop capacity building for doctors and nurses, so that HIV and TB patients are treated in general outpatient clinics in the three pilot sites	Establish working group from different directorates and, if needed, other ministries; Gain experience from other countries (virtual or in-person); Implement in-person and virtual training events; Constant onsite mentoring support and supervision; Quality improvement initiatives	Month 10, Q4, Year 1	Clinical Mentor, PHC Supervisor, and Data Quality Managers
Weak local management and monitoring of health systems that maintain ongoing access and delivery of client-centred HIV services in the long term to scale up the institutionalisation agenda	Improve government stewardship of HIV services through establishing simple platforms at national and regional level	Improve PHC system performance across facility and community settings in leading the platforms; Gradually strengthen the health and community system's capacity	Q1, Year 1 and continuous	Directors of DSPs, PHC and Clinical Services
Learning and Implementation Research				
Lack of implementation experience	Select pilot sites; Develop research protocol	Start pilots and run them for six months	Month 11, Q4, Year 1	Chairperson of the Implementation Sub-committee of the TWG
Programme Evaluation				
Conduct evaluation of the pilot sites	Develop evaluation protocol	Evaluate pilot	Q3, Year 2	Chairperson of the Evaluation Sub-committee of the TWG
Lack of learning and knowledge management on integration	Develop learning and knowledge management strategy on integration	Disseminate lessons learnt from pilot by holding a national dissemination workshop	Q3, Year 2	Chairperson of the Knowledge Management Sub-committee of the TWG
Lack of regional consensus on integration	Disseminate lessons learnt on integration	Host regional seminar on integration	Q3, Year 2	Chairperson of the Knowledge Management Sub-

Gaps/Challenges	Strategies	Main Activities	When	Who
				committee of the TWG

6.7 Human Rights and Gender Equality

6.7.1 Programme Objective

The objective of the human rights and gender equality (HRG) programme under Namibia's NSF 2023/24 – 2027/28 is to ensure that no one is discriminated against, stigmatised and violated on the basis of their HIV status, gender, sex and sexuality, socio-economic status, ability, choice of work and geographical location.

The human rights and gender equality programme has five strategic objectives:

- **Strategic Objective 1:** Address the legal, policy and human rights barriers that hinder access to HIV services
- **Strategic Objective 2:** Address the underlying sociocultural factors, gender and structural inequalities that drive the HIV epidemic in Namibia
- **Strategic Objective 3:** Eliminate stigma and discrimination in accessing HIV services
- **Strategic Objective 4:** Eliminate gender inequality and gender-based violence among persons living with HIV (PLHIV), women, adolescent girls and young women (AGYW) and key and vulnerable populations (KVPs)
- **Strategic Objective 5:** Scale up human rights and gender equality programming, resourcing, service delivery and advocacy through data generation and management

6.7.2 Target Populations

6.7.2.1 Primary Target Population

The primary target populations for the human rights and gender equality programme are:

1) Sex workers in their diversities (female sex workers (FSWs), male sex workers (MSWs) and transgender sex workers (TGSWs))
2) Men who have sex with men (MSM)
3) Transgender persons (TG)
4) PLHIV across their diversities (women, men, transgender persons and gender non-conforming persons)
5) Young people (adolescent girls and young women (AGYW) and adolescent boys and young men (ABYM))
6) Children including orphans and vulnerable children (OVC)
7) People with disability (PWD) in their diversities
8) Mobile populations (long-distance truckers, plantation workers, miners, construction workers, fisherfolk, seafarers, refugees and other migrant workers)
9) Lesbian, gay, bisexual, intersex, queer and gender non-conforming persons (LGBTIQ+ persons)
10) Persons who inject drugs (PWID)
11) People in congregate settings (inmates, people in police holding cells and others)

The above primary target populations have been prioritised in the NSF 2023/24 – 2027/28 because of their vulnerability to HIV infection, high prevalence rates, historically not being reached by existing HIV programming, and being vulnerable to stigma, discrimination and violations. In addition, some primary target populations, especially women, AGYW and KVPs, are prioritised due to their vulnerability to gender-based violence (GBV), as research shows that there is a cause-effect relationship between GBV and HIV, with GBV being a risk factor for HIV infection.

6.7.2.2 Secondary Target Population

The secondary target populations for the human rights and gender equality programme are:

1. Men who purchase sex/clients of sex workers
2. Healthcare providers
3. Educators (teachers, school administrators and academia)
4. Parents, guardians and community gatekeepers
5. Statutory commissions (especially the Law Reform Commission and the National Planning Commission)
6. Justice actors (especially the Ombudsman, judiciary, judicial officers, prosecutors, etc.)
7. Law enforcement and uniformed services (especially NAMPOL, NCS and army)
8. Law makers (especially the Namibian Parliament and the SADC Parliamentary Forum)
9. Traditional authorities (leaders, customary courts, etc.)
10. Faith-based organisations
11. Public sector (especially the following OMAs: Office of the Prime Minister; Ministry of Health and Social Services; Ministry of Education, Arts and Culture; Ministry of Gender Equality, Poverty Eradication and Social Welfare; Ministry of Justice; Ministry of Urban and Rural Development; Ministry of Labour, Industrial Relations and Employment Creation; Ministry of Finance and Public Enterprises, Ministry of Works and Transport; and Ministry of Environment and Tourism)
12. Private Sector (especially labour unions, the Employers' Federation, Economic Council Forum, Tourism Board, private healthcare providers, etc.)
13. Civil society organisations

6.7.3 Priority Geographical Regions

The human rights and gender equality programme will be undertaken nationally so as to ensure that *"No One Is Left Behind"*. The following regions will be prioritised:

- Kavango East, Kavango West and Kunene: These three regions have the highest manifestations of harmful social-cultural norms and practices, such as child marriage, and high rates of teenage pregnancy due to defilement
- Central northern regions (Omusati, Oshikoto, Oshana, Ohangwena): These four regions have the highest rate of gender-based violence (GBV) and are deeply influenced by traditional norms, culture and religion
- Erongo, Zambezi, //Kharas, Ohangwena and Omaheke: These regions are ports of entry for mobile populations (miners, plantation workers and truckers)

- Otjozondjupa and Khomas: These regions are central hubs for commerce, education, employment and migration; and Khomas is the national administrative capital of Namibia
- Hardap and //Kharas: These two regions are transit regions that have higher numbers of migrant workers, such as plantation and mine workers

6.7.4 Strategies

HRG Strategy 1: Legal and Policy Reform

a) Fast-track legal and policy reform and advocacy on: (i) Presidential assent and implementation of the National Health Act 2015 (Act No. 2 of 2015); (ii) Review National Policy on HIV/AIDS (iii); Engagement with lawmakers on constitutional amendments on the right to health inclusion in the Bill of Rights; (iv) Decriminalise same-sex relations, and the criminalised sections of sex work and drug use; (v) Repeal provisions of the abortion law that prevent women and AGYW from accessing antenatal and HIV care; (vi) Repeal harmful provisions of the Public and Environmental Health Act 2015 (Act No. 1 of 2015); (vii) Review the National Disability Policy to ensure it is responsive to HIV and AIDS; (viii) Fast-track the review of the Legal Practitioners Act 1995 (Act No. 15 of 1995) to make provisions that oblige legal practitioners to provide pro bono legal services; (ix) Enactment of a Human Rights Enforcement Act for increased accountability of duty bearers and public institutions
b) Conduct routine community sensitisation on relevant laws and policies
c) Fast-track implementation of recommendations of the 2016 and 2022 Legal Environment Assessments (LEA) and LEA for KVPs
d) Conduct a follow-up LEA in 2026

HRG Strategy 2: Eliminate Stigma, Discrimination and Gender-Based Violence

a) Digitalisation of health passports
b) Review the existing health service provider training curriculum to include updated modules on human rights, stigma and discrimination
c) Development of standardised HIV and human rights training curriculum for pre-service and in-service training of justice actors
d) Scale up pre-service and in-service training for justice actors and healthcare providers on legal provision, human rights, gender, stigma and discrimination
e) Develop and disseminate IEC materials on HIV and AIDS-related stigma, discrimination and violence, including through the use of new innovative technologies
f) Scale up one-stop GBV centres in the regions that provide a cross range of services, and capacitate SGBV Units with GBV-specialised law enforcement agents
g) Scale up the provision of legal aid to victims and survivors of HIV-related stigma and discrimination, GBV and SGBV
h) Scale up legal camps for the provision of psychosocial, legal, health and post-rape emergency support services
i) Build capacities of CSOs and networks of PLHIV in human rights and gender, and engage peers in delivery and monitoring of human rights in HIV services and support for community feedback mechanisms
j) Undertake community engagement dialogues with faith-based institutions, traditional authorities and other community leaders on stigma, discrimination and violence

k) Strengthen capacities of CSOs, community-led structures, PLHIV organisations and networks to engage traditional structures in addressing stigma, discrimination and violence
l) Scale up community-level monitoring, reporting and documentation of human rights violations and support communities to undertake the documentation of rights violations
m) Develop, publish and disseminate annual HIV reports

HRG Strategy 3: Address Sociocultural Drivers of the HIV Epidemic

a) Develop and roll out a national strategy on HIV and AIDS for faith-based institutions, traditional authorities and community leaders
b) Scale up human rights and gender equality training for norm-shift actors (especially faith-based institutions, traditional healers and traditional authorities)
c) Enhance human rights and gender equality capacities of community and regional structures (CAGs, RACOCs and CACOCs)

HRG Strategy 4: Address Human Rights and Gender Barriers in Access to HIV Services for Key and Vulnerable Populations

a) Strengthen capacities of justice actors and health service providers in human rights, gender and sexual diversity for delivery of stigma-free KVP-friendly services
b) Scale up human rights awareness, legal literacy programmes and provision of legal aid services for KVPs
c) Capacitate KVP peer educators and community paralegals through training and scale up peer-led community outreach
d) Capacitate KVP-led organisations and networks and support safe spaces through community-based and facility-based Drop-in Centres (DICs)
e) Scale up strategic interest litigation and policy advocacy by CSOs to address legal, social and institutional barriers for KVPs' access to health, SRHR and HIV services
f) Scale up the provision of mental health interventions for KVPs as part of the HIV package of services

HRG Strategy 5: Upscale Programmes for Sub-Populations Left Behind

a) Develop and roll out a robust HIV and AIDS programme for people in congregate settings
b) Develop, resource and roll out the HIV Prevention and Education Strategy targeting people in congregate settings
c) CSO advocacy on the provision of comprehensive HIV prevention services for prisoners and detainees, which includes, among others, male and female condoms, lubricants, PEP and PrEP
d) Develop and roll out a robust mobile health HIV and AIDS programme and define a minimum package of services for long-distance truckers
e) Develop and roll out a robust harm reduction programme for people who inject drugs (PWID)

6.8 HIV Mainstreaming in the Multi-Sectoral Response and Preparedness for Future Pandemics and Disasters

The involvement of the entirety of the government system, complemented by CSOs, CBOs, the private sector and faith-based organisations, is required to mount a successful response to HIV/AIDS, COVID-19 and any future pandemic or disaster. In the government system, this

response is mounted by the line ministries, and coordinated by the OPM or the Presidency, as the case may be, with the sector that is responsible for the specific issue playing a prominent role.

Therefore, the response to both HIV/AIDS and COVID-19 is spearheaded by the MHSS. Capacitating the health sector and the related social protection systems to better discharge this responsibility was the focus of the previous chapter. In this chapter, under mainstreaming, the roles and responsibilities and capacity building needed for the other key sectors, like education, agriculture and the security services, is programmed.

6.8.1 Programme Objective for HIV Mainstreaming in the Multi-Sectoral Response

The programme objective is to expand the scope and coverage of the national HIV multi-sectoral response by galvanising and catalysing development sectors to undertake HIV mainstreaming in their internal and external programmes and projects, to ensure that their planning and budgeting takes into consideration mitigating the impact of HIV on their sectors.

6.8.2 Target Populations

Primary Target Population

The primary target population consists of sector planners and financial advisors.

Secondary Target Population

The secondary target populations are stakeholders involved in the implementation of the HIV/AIDS response.

6.8.3 Priority Geographic Regions

National coverage of all 14 regions will be prioritised.

6.8.4 Overall Strategies for HIV Mainstreaming in the Multi-Sectoral Response

- **a.** *Review and update the national HIV policy*
- **b.** *Strengthen donor coordination and enhance consultations to support national priorities*
- **c.** *Increase funding and capacity development for CSOs*
- **d.** *Strengthen the integration of HIV in all sectoral policies, strategies and programmes, particularly in the welfare policy*
- **e.** *Review and update HIV mainstreaming guidelines, with a clear M&E framework and indicators*
- **f.** *Strengthen capacity development on mainstreaming for the public sector*
- **g.** *Strengthen synergies with the development sectors to ensure the prioritisation of HIV in the NDP and related plans and strategies*
- **h.** *Integrate HIV mainstreaming in the KPIs of the Executive Directors*
- **i.** *Increase resources for the coordination of the NSF*
- **j.** *Strengthen coordination between the NAEC and TACs*

6.8.5 Specific HIV Interventions to be Implemented by Line Ministries

6.8.6 Education

Strategies for HIV mainstreaming in the education sector

- **a.** *Provide health education for all according to their needs*
- **b.** *Improve collection of routine data to track re-integration programmes for pregnant learners and the number of pregnant learners who have completed their education*
- **c.** *Engagement of other line ministries by the MHSS to enhance support: Ministry of Gender Equality, Poverty Eradication and Social Welfare for OVC and social services, and drought relief for caregivers; Ministry of Education, Arts and Culture to support children in school; and Office of the Prime Minister and other stakeholders to provide psychosocial support and care to CALHIV, as children under 15 years old have a lower viral load suppression rate at 84%, compared to 93% across all age groups*

6.8.7 Agriculture, Water and Forestry

Strategies for HIV mainstreaming in the sector

- **a.** *Scale up soup kitchens at the community level in the short term, while finding permanent solutions to food insecurity and hunger among PLHIV, such as their inclusion in bigger and better managed farms and initiation of economic empowerment projects*
- **b.** *Transfer all vegetable gardens from health workers to extension workers of the Ministry of Agriculture, Water and Forestry*
- **c.** *Substitution of Plumpy'Nut with local options to reduce the need for importation*

6.8.8 Judiciary

Background

The judiciary supports GBV interventions through ensuring charged offenders are reprimanded. There is a need to sensitise all employees of the justice sector, including judicial and non-judicial personnel, on human rights and non-discrimination.

Strategies for HIV mainstreaming in the judiciary

- ***a.*** *Review and update the National HIV Policy of 2007 to widen the provision of HIV services to all those who are in need and eliminate bottle necks.*
- ***b.*** *Develop and enforce HIV police for all sectors*
- ***c.*** *Develop guidelines and educational materials for personnel on HIV services.*

6.8.9 Home Affairs, Immigration, Safety and Security

Strategies for HIV mainstreaming in the Namibian Police Force and correctional services

- **a.** *Advocate for offenders to have access to healthcare services equivalent to the services provided at public health facilities*
- **b.** *Strengthen collaboration with the Ministry of Home Affairs, Safety and Security to ensure continuum of care for offenders upon release*
- **c.** *Advocate for offenders to have access to medication during incarceration*

d. *Liaise with the ministry to collect HIV/AIDS and TB data for people in incarceration*
e. *Build capacity of healthcare workers within correctional facilities and police holding cells on relevant treatment guidelines and SOPs*
f. *Promote adequate quantification, procurement and stocking of medication within these settings*
g. *Develop capacity building programmes for currently employed police officers*

Strategies for HIV mainstreaming in the Namibian immigration services

Formalize the provision of HIV services to non-Namibians in all the guidelines to guide implementors.

Develop agreements and MOUs with neighbouring countries to offer comprehensive HIV and TB services.

6.8.10 Correctional Services

a) *Develop and roll out robust HIV and AIDS programs for people in congregate settings.*
b) *Develop, resource, and roll out the HIV Prevention and Education Strategy targeting people in congregate settings.*
c) *CSO advocacy on the provision of comprehensive HIV prevention services for prisoners and detainees that includes among others: male and female condoms, lubricants, PEP and PrEP.*

6.8.11 Works

Strategies for HIV mainstreaming in the roads sector

a. *Alleviate the challenges posed by poor road infrastructure and remoteness of areas in the vast regions that make it difficult for community members and particularly PLHIV to access health and other services*
b. *Improve road network to increase accessibility to health services*
c. *Introduce a levy for road contractors towards the HIV Trust Fund*
d. *Create awareness of GBV, STIs and HIV/AIDS and provide HIV/AIDS services for construction workers*

6.8.12 Information, Communication and Technology

Background

The poor network and radio coverage in some areas makes information dissemination difficult, and the potential of ICTs to support preventive education, service delivery, tele-medicine and edutainment for young people is under-utilised.

Strategies for HIV mainstreaming in the ICT sector

a. *Improve network and radio coverage to enhance information dissemination*
b. *Increase utilisation of ICTs for preventive education service delivery, tele-medicine and edutainment for young people*
c. *Promote digital health, especially with regards to DSD and out of health facility support, referral, etc., particularly systems for PLHIV*
d. *Introduce a levy for ICT companies, especially telecoms, towards the HIV Trust Fund*

6.8.13 Environment and Tourism

Strategies for HIV mainstreaming in the environment and tourism sector

- **a.** *Develop new events in collaboration with regions and districts to attract tourists or encourage them stay longer, either as stand-alone new events or as additions to existing tourism events and attractions, e.g., donkey cart race in Hardap Region and Aranos District*
- **b.** *Generate data about HIV prevalence on mobile populations*
- **c.** *Link renewal of business licences for mining companies to HIV reporting*

6.8.14 Sports, Youth and National Service

Strategies for HIV mainstreaming in the sector

- **a.** Scale up the use of sports to teach life skills, leadership, discipline and HIV prevention services to AGYW and AGYB

6.8.15 Urban and Rural Development

Strategies for HIV mainstreaming in urban and rural development

- **a.** Conclude the decentralisation of the MHSS to the regional level
- **b.** Revitalise and strengthen non-functional RACOCs and CACOCs and build their capacity
- **c.** Arrange capacity building for political leaders and newly-elected District and Regional Councilors
- **d.** Develop a reporting format for the non-health response under the MIMS
- **e.** Follow up with the Khomas Regional Council to obtain/assist it with the compilation of its report on the impact evaluation that it conducted on its nutrition support for PLHIV, so that the national level and other regions can learn from the results

Some of the recommendations above are relevant to the coordination and governance framework and should thus be cross-referenced with that section.

6.8.16 National Planning Commission, Office of the President

Strategies for HIV mainstreaming in the national socio-economic planning sector

The National Planning Commission should ensure that line ministries and agencies involved in the multi-sectoral response to HIV/AIDS include the activities as described in the National HIV/AIDS strategic plan in their sectors' input into the National Development Plan (NDP).

6.8.17 Office of the Prime Minister (OPM)

Strategies for HIV mainstreaming in the sector

- **a.** *Improve the coordination of the HIV/AIDS response by building better synergies between the DSP MHSS and the OPM*
- **b.** *Develop additional performance measures and KPIs for school principals to ensure that they prioritise CSE and the health of AGYW and ABYM*

6.8.18 Private Sector

Strategies for HIV mainstreaming in the private sector

- **a.** *Advocate for the setting up of a new body to coordinate the private sector response to HIV/AIDS, COVID-19, future pandemics, climate change and any resulting humanitarian crises, etc.*
- **b.** *Include the private sector in stakeholder coalitions, the TACs and TWGs, to ensure the private sector is fully invested in the NSF and not just invited to solicit donations*

6.8.19 Local Governments

Strategies for City of Windhoek and Other Large Urban Cities

- **a.** *FTCI concept to be outlined in the NSF and rolled out to other cities or towns in Namibia; city work plans to be aligned with local, regional and national strategic plans on HIV to ensure ownership and sustainability; and support cities, like regions, to update their HIV/AIDS strategic plans*
- **b.** *Strengthen the Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL) and ensure that it is active in the national coordination framework*
- **c.** *MHSS to work with cities and produce annual city-specific HIV profiles to direct HIV response programming*

6.9 Analysis of the Impact of COVID-19 on HIV Response and Preparedness for Future Pandemics and Disasters

Programme Objectives

The programme objective is to develop a fully-prepared and resilient HIV response that protects people living with, at risk of and affected by HIV in humanitarian settings and from the adverse impacts of current and future pandemics and other shocks.

Target Populations

The entire population is targeted for pandemic and disaster preparedness, consisting of education and social mobilisation, while those impacted are targeted for service delivery in the medical and humanitarian responses, as the case may be.

Priority Geographic Region

The areas of the country impacted by the pandemic or disaster will be prioritised.

Background

School closure and cessation of the school feeding programme during the COVID-19 pandemic adversely affected children and learners. Multi-disease epidemiologic surveillance systems and lab diagnostic/testing platforms were inadequate, and community systems and accompanying human resources were lacking.

Globally, donors did not provide new funds for the COVID-19 response. However, in the case of Namibia, new funds were mobilised from the Global Fund, the UN, USG, multilateral donors, etc.

The Surge Register is inadequate, and while annual drills and simulations are covered in the Blueprint for Emergency Medical Teams, they are not implemented adequately in all sectors.

Strategies

- **a.** *Develop the capacity to switch from school feeding to feeding the vulnerable in communities during future pandemics, as school meals fortified with nutrients are often the only meal available to vulnerable children*
- **b.** *Strengthen multi-disease epidemiologic surveillance systems and lab diagnostic/testing platforms, as well as community systems (not only of HIV, but rather integrated between HIV, other diseases and a broader health focus)*
- **c.** *Strengthen multi-disease capacity by capacitating human resources*
- **d.** *Maintain and improve Namibia's ability to mobilise bilateral and multilateral funding by maintaining excellent foreign relations with a diverse array of nations and multilateral agencies to mobilise adequate resources to implement the NSF*
- **e.** *Intensify implementation of the recommendations made under RSSH about the HRH recruitment and retention strategy and the need to increase investment in the health workforce (while Namibia has done well in this regard, more should be done, and brain drain should be prevented by improving wages for government health workers)*
- **f.** *Integrate HIV in the NDP6/HPP so that HIV programmes can be fully funded in subsequent annual budgets*
- **g.** *Surge Register: Keep and update a government database of all relevant emergency personnel, including those who retired in the last 10 years; formalise the database and provide the opportunity for interested nationals to apply, be assessed and placed on the register; and strengthen the capacities of those on the register*
- **h.** *Conduct annual drills and simulations in all sectors involved in emergency preparedness to test readiness and correct lapses and short falls*

CHAPTER 7 Monitoring and Evaluation, Surveillance and Knowledge Management

7.1 Monitoring and Evaluation, Surveillance and Knowledge Management

Chapter 7 describes the gaps and challenges regarding M&E and surveillance systems and provides strategies for addressing the identified issues.

7.1.1 Programme Objective

The overall objective of strategic information, surveillance and knowledge management is to provide comprehensive, timely and accurate data to inform policy, planning, service delivery and resource allocation for the NSF period from 2023/24 to 2027/28.

7.1.2 Strategic Objectives

The monitoring, evaluation, surveillance and knowledge management section has three primary objectives:

1. To track the inputs, outputs, outcomes and impacts outlined in the NSF
2. To ensure a systematic process for generating, collecting, analysing, synthesising and sharing knowledge to inform the progress of the NSF
3. To provide timely data to meet reporting obligations in line with national and international commitments

7.1.3 Target Population

The target audience for M&E includes the following stakeholders:

- National HIV/AIDS programme officers
- Regional health management teams
- Development partners (bilateral and multilateral)
- Other key stakeholders from NGOs and academic institutions
- Other organisations responsible for the planning and implementation of HIV prevention and treatment services

7.1.4 Strategies to Strengthen M&E, Surveillance and Knowledge Management

Human Resource Capacity and Skills

- **a.** *Implement the revised human resources structure for M&E, considering declining donor funding, and solicit the integration of regional M&E positions into the government staff structure*
- **b.** *Strengthen RME and epidemiology division collaboration and identify synergies and collaboration areas*
- **c.** *Conduct an ongoing structured mentoring and training programme for M&E staff*

Data Monitoring Systems and Processes

- **d.** *Fast-track e-health solutions at point-of-care in line with the e-health strategy*
- **e.** *Advocate for more resources with the government to strengthen ICT infrastructure at the sub-national level*
- **f.** *Strengthen feedback mechanisms within the national and sub-national levels on programme performance*

g. *Disseminate reporting guidelines to all stakeholders, and implement infrastructure and human resources solutions to ensure timely reporting*

h. *Develop policies that enforce data reporting into the national M&E system by the public and private sectors*

i. *Strengthen data reporting through the MIMS by the private sector and provide feedback on data through quarterly data review meetings*

j. *Develop an interface for integrating evidence from the CLM into the MIMS*

Evaluation and Research

k. *Improve collaboration on resource mobilisation and technical support with academic institutions, the MHSS, the National Planning Commission (NPC), the National Statistics Agency (NSA) and donors in research and evaluation*

l. *Ensure that all the critical surveys and evaluations are conducted during the NSF period*

Partnership and Coordination

m. *Strengthen coordination and collaboration through the existing M&E and HIS TWGs.*

Monitoring and Evaluation Plan

n. *Develop and roll out a systematic way of updating the M&E plan in line with programmatic adjustments and emerging data needs during the implementation of the NSF*

Data Quality Assessments

o. *MHSS to implement Data Quality Assurance (DQA) standards and conduct combined DQAs at all levels, in conjunction with development partners*

p. *RME to provide more support to the regions in data quality assurance before final data submission for reporting purposes*

q. *Strengthen feedback loops on the results of the DQA at the national and sub-national levels*

r. *Conduct ongoing focused engagements with various stakeholders to identify strategies that can reduce the double counting of clients accessing HIV/AIDS services from these sectors*

Knowledge Management

s. *Develop a systematic and structured way of analysing, synthesising and sharing knowledge on the status of the HIV/AIDS epidemic in Namibia*

t. *Develop guidelines for data and information use for the national and sub-national levels*

7.2 Monitoring and Responding to Inequalities

Inequalities, such as age, rural-urban, education and wealth-related inequalities, among others, undermine efforts to end AIDS by 2030. Therefore, examining and identifying socio-economic and cultural factors associated with and contributing to the socio-economic inequalities in the 95-95-95 cascade among PLHIV, including men, women and adolescents, is paramount. The country will use a population-based HIV impact assessment, data from the Demographic and

Health Survey, and other qualitative research studies to assess inequalities undermining the attainment of each stage of the 95-95-95 cascade.

A programmatic response would be formulated to address any evidence-based inequalities that are detected, for example intensifying rural outreach for any services found to be limited or lacking in rural areas. A task force would be established to coordinate responses to the inequalities.

The main implementation science questions include:

1) What socio-economic inequalities are affecting awareness of HIV status among PLHIV?
2) What socio-economic inequalities are affecting access to and treatment initiation for PLHIV?
3) What socio-economic inequalities are affecting the attainment of viral suppression for PLHIV?
4) Are there inequalities in HIV prevalence and incidence among populations with similar characteristics?
5) Are there inequalities in trends in HIV incidence among populations with shared characteristics?

CHAPTER 8 Costing, Resource Tracking and Efficiency

8.1 Costing, Resource Tracking and Efficiency

8.1.1 Costing of the NSF 2023/24 – 2027/28

8.1.1.1 Background

The NSF 2017/18 – 2021/22 (superseded by the RNSF 2020/21 – 2021/22) were costed using a Resource Needs Model. The Namibia HIV Investment Case 2.0 (2020) established unit costs per programme and intervention. These were based on the National AIDS Spending Assessment (NASA) 2015/16 and 2016/17, a 2017 national ART costing study (Abt Associates, 2017), national programme and policy documents, Global Fund and PEPFAR grant management documents, and scientific literature. Where reliable unit cost data were not available, an ingredients-based costing approach, relying on assumptions from key informants and data from service provider documents, was employed.

This methodology was continued in costing the NSF 2023/24 – 2027/28.

A systematic approach was followed to generate unit costs for developing the Resource Needs Estimate (RNE).

A literature review was undertaken to identify relevant service unit costs from published economic studies or grey literature relevant to HIV interventions in Namibia. Unpublished information, including programme budgets and expenditure analysis reports from government departments and development partners, were also reviewed. In summary, the main sources for unit costs were:

- Government of Namibia resource tracking reports for health and HIV for 2015/16 – 2017/18
- Namibia national ART costing study (Schutte et al 2019)
- MHSS internal budgets and expenditure reports
- Global Fund budgets
- Namibia Investment Case 2.0
- Various studies conducted in SADC countries

An ingredients-based costing approach was employed to develop unit costs for interventions where reliable unit cost data were not available. Updated unit cost values were validated through an internal quality assurance process and compared to regional data.

Where reliable and relevant unit costs were not able to be sourced, the unit costs from the Namibia Investment Case 2.0 were used, after adjusting values for inflation.

Unit costs used in this costing have been listed and described in the UNAIDS NSP Transparency Checklist. These unit costs were kept constant throughout 2023/24 – 2027/28.

At the time of conducting this costing, a national time-driven activity-based costing and management study was being conducted by Abt Associates, with results expected after March 2023.

Programme support costs, programme enablers, development synergies and RHSS were costed as annual amounts, based on a percentage of direct costs.

8.1.1.2 Results

The Resource Needs Estimate for the NSF 2023/24 – 2027/28 is **US$1,431,317,999** over the five-year period of the NSF.

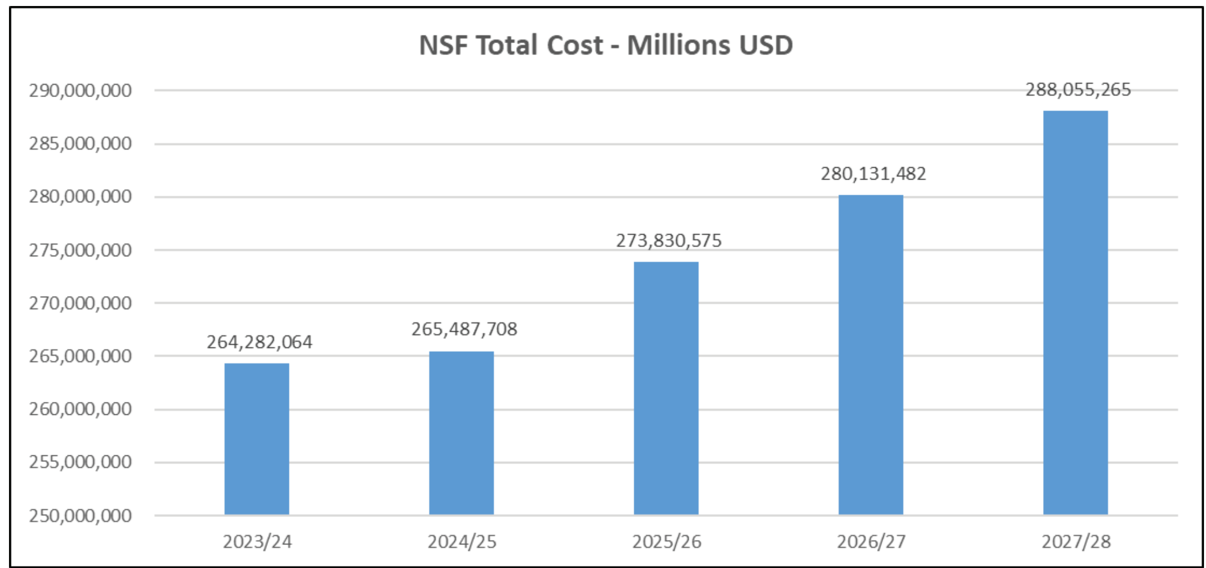
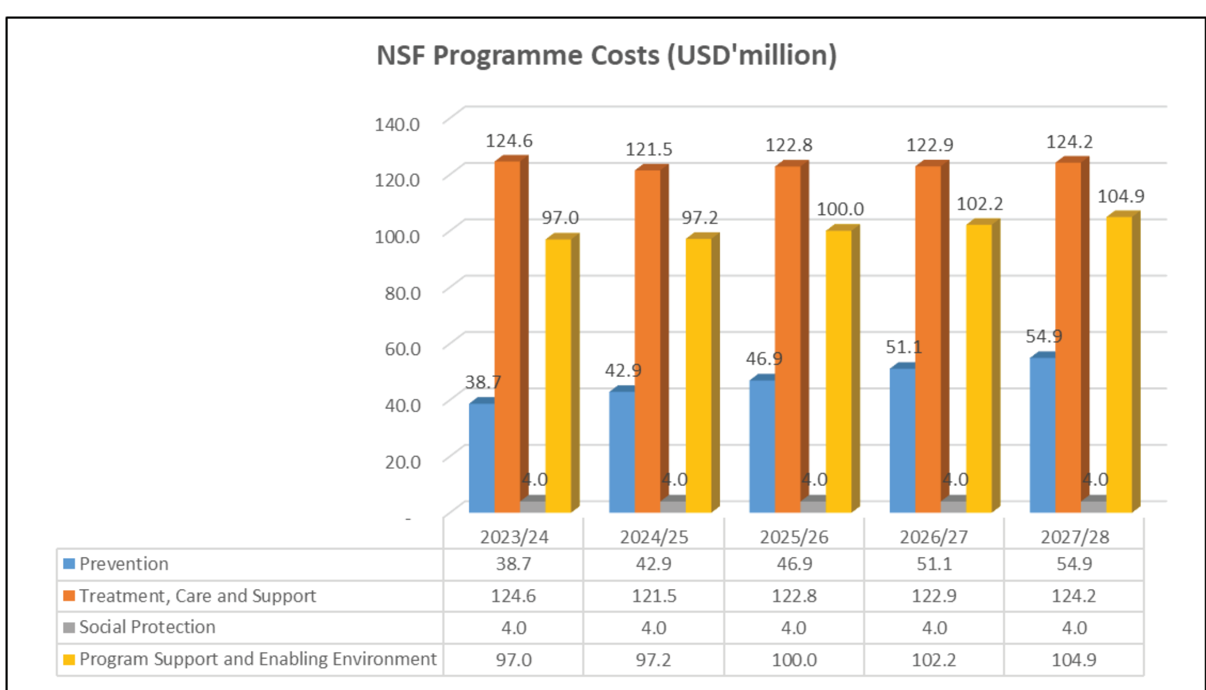


Figure 21: NSF 2023/24 – 2027/28 total cost

The largest cost component is *Treatment, Care and Support* at 45% of the total NSF cost. This suggests that efforts to achieve technical efficiencies in ART, laboratory services and HTS would yield the highest gains. Resources for *Prevention* account for 17%, while *Programme Support and Enabling Environment* (including *Systems Strengthening*) account for 37%.



	2023/24	2024/25	2025/26	2026/27	2027/28
Prevention	38.7	42.9	46.9	51.1	54.9
Treatment, Care and Support	124.6	121.5	122.8	122.9	124.2
Social Protection	4.0	4.0	4.0	4.0	4.0
Program Support and Enabling Environment	97.0	97.2	100.0	102.2	104.9

Figure 22: NSF 2023/24 – 2027/28 resource needs by thematic area

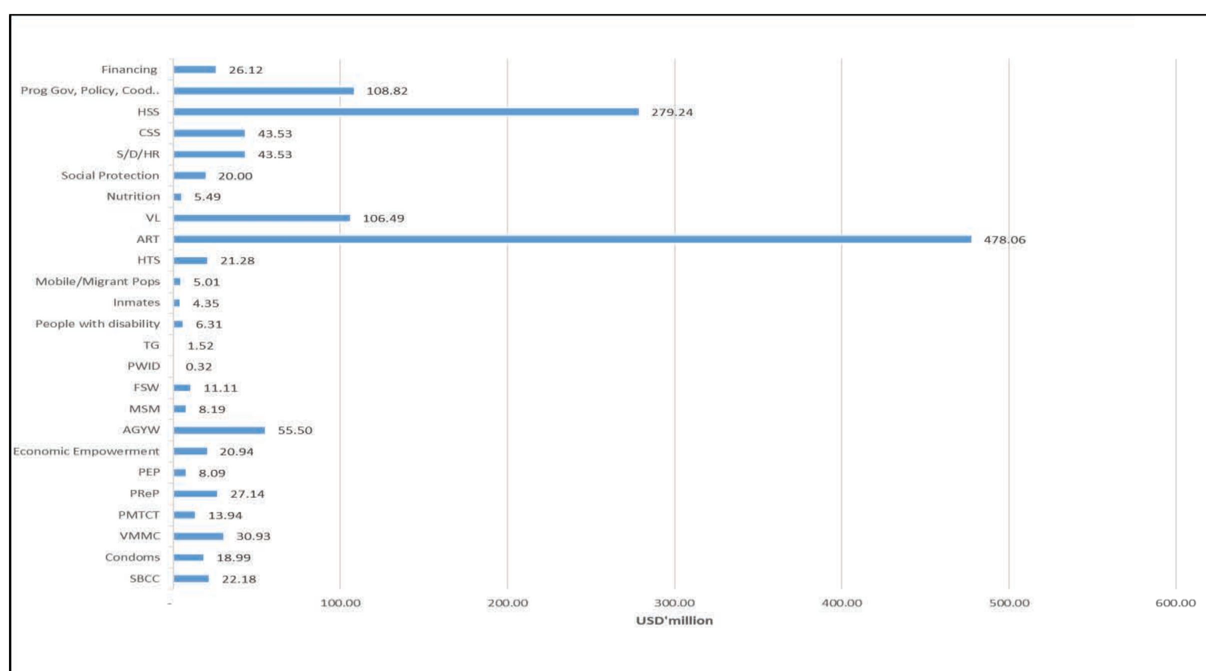


Figure 23: NSF 2023/24 – 2027/28 resource estimates by intervention

Under *Prevention*, resources are driven by AGYW followed by interventions for VMMC and PrEP.

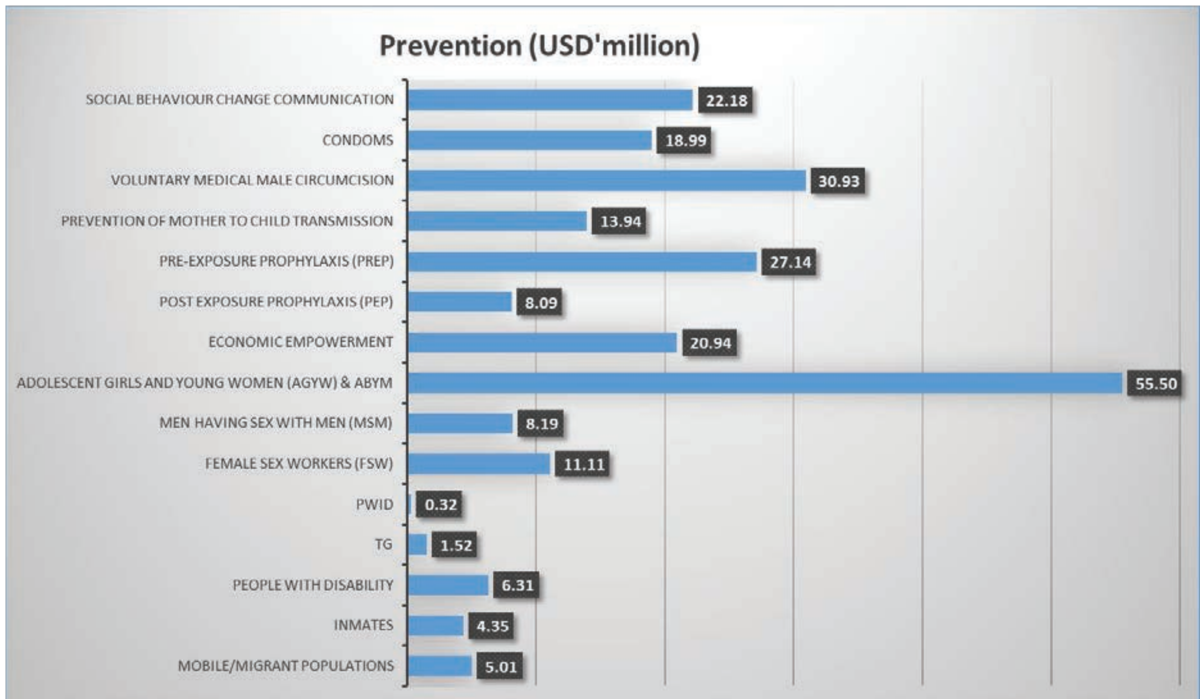


Figure 24: NSF 2023/24 – 2027/28 resource needs for prevention programme

ART resources dominate *Treatment, Care and Support* interventions.

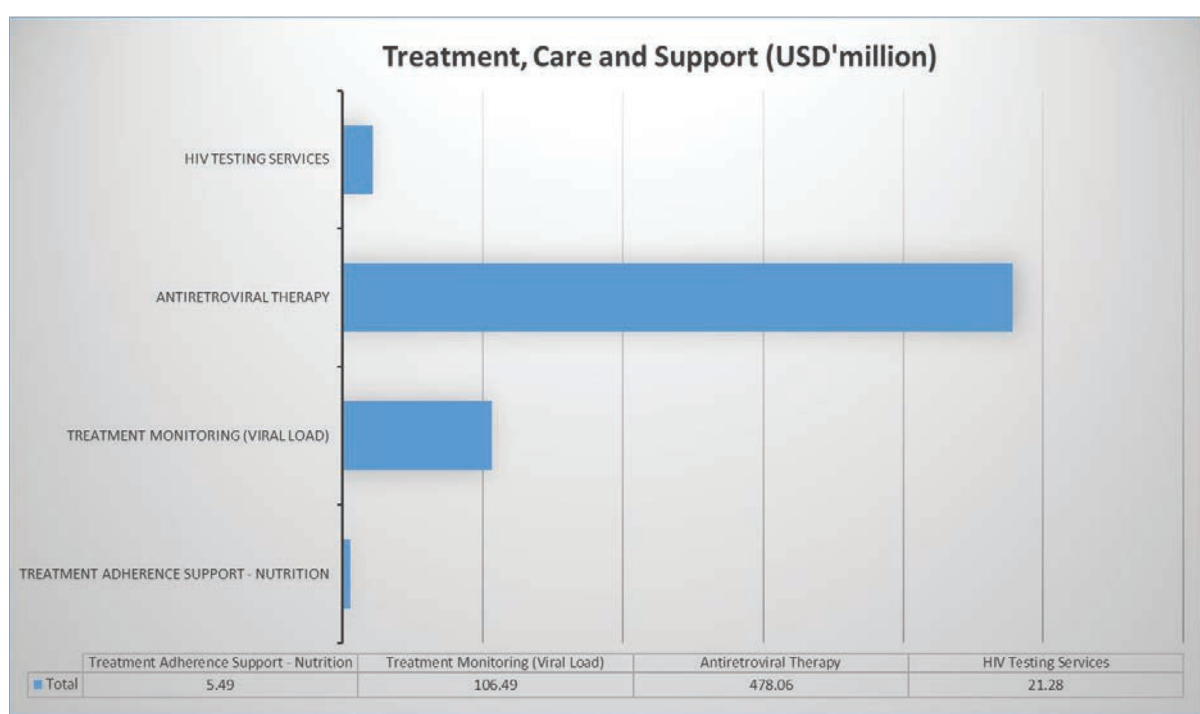


Figure 25: NSF 2023/24-2027/28 resource needs for treatment, care and support

Under *Programme Support, RSSH and Enabling Environment*, resource allocation has been increased to ensure the NSF 2023/24 – 2027/28 objectives that cover community systems, human rights and gender and the strengthening of the monitoring and research component of the response are achieved.

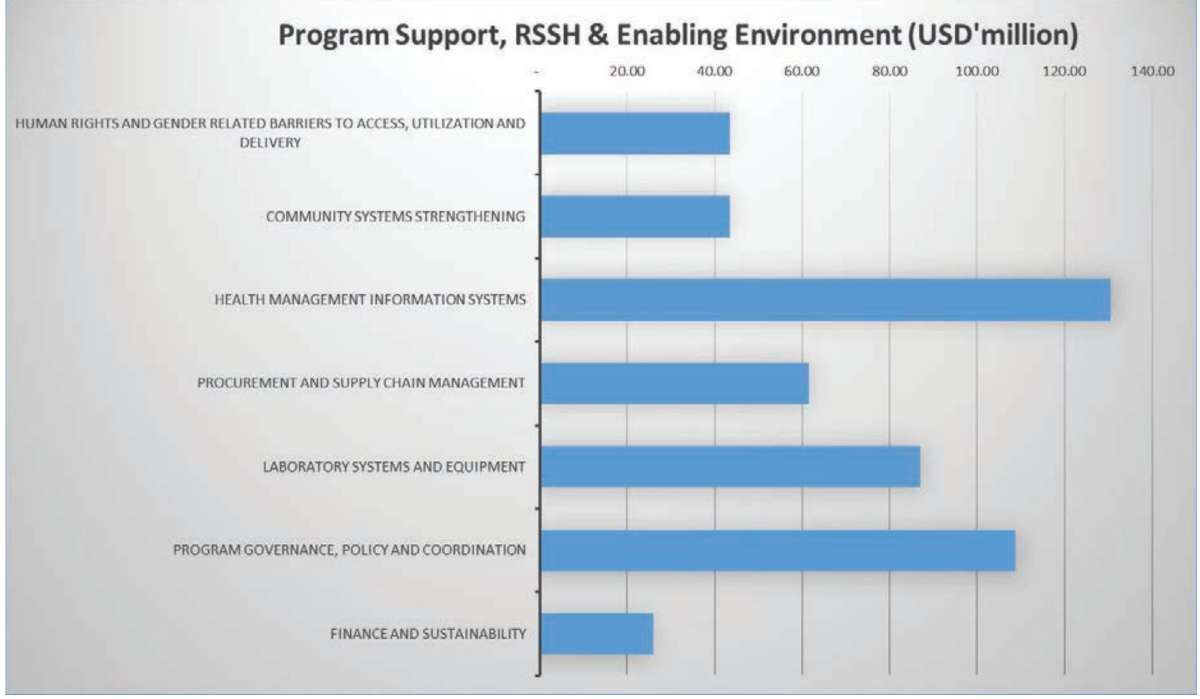


Figure 26: NSF 2023/24 – 2027/28 resource needs for programme support, RSSH and enabling environment

The year-on-year resource estimates for each component are shown in the following table.

Table 6: NSF 2023/24 – 2027/28 resource needs estimates for year-on-year programme interventions

USD'million							
	2023/24	2024/25	2025/26	2026/27	2027/28	Total	%
PREVENTION							
Social Behaviour Change Communication	3.40	4.12	4.49	4.86	5.30	22.18	1.62%
Condoms	3.22	3.47	3.75	4.09	4.45	18.99	1.38%
Voluntary Medical Male Circumcision	5.17	5.68	6.19	6.69	7.20	30.93	2.25%
Prevention of Mother to Child Transmission	2.40	2.60	2.79	2.98	3.16	13.94	1.02%
Pre-exposure Prophylaxis (PrEP)	4.38	4.89	5.45	6.01	6.40	27.14	1.98%
Post Exposure Prohylaxis (PEP)	1.62	1.62	1.62	1.62	1.62	8.09	0.59%
Economic Empowerment	4.03	4.09	4.17	4.27	4.38	20.94	1.53%
Adolescent Girls and Young Women (AGYW) and ABYM	9.07	10.02	11.03	12.11	13.27	55.50	4.05%
Men having Sex with Men (MSM)	1.24	1.45	1.66	1.87	1.97	8.19	0.60%
Female Sex Workers (FSW)	1.69	1.97	2.25	2.53	2.67	11.11	0.81%
PWID	-	-	0.09	0.11	0.12	0.32	0.02%
TG	0.23	0.27	0.31	0.35	0.36	1.52	0.11%
People with disability	0.86	1.05	1.25	1.46	1.68	6.31	0.46%
Inmates	0.66	0.77	0.88	0.99	1.05	4.35	0.32%
Mobile/Migrant Populations	0.72	0.86	1.00	1.14	1.29	5.01	0.37%
TOTAL PREVENTION	38.69	42.87	46.93	51.07	54.92	234.49	
TREATMENT, CARE & SUPPORT							
HIV Testing Services	4.25	4.25	4.26	4.26	4.26	21.28	1.55%
Antiretroviral Therapy	94.63	94.70	95.84	95.92	96.96	478.06	34.85%
Treatment Monitoring (Viral Load)	21.07	21.10	21.36	21.36	21.60	106.49	7.76%
TB Prophylaxis	3.60	0.32	0.29	0.25	0.29	4.75	0.35%
Treatment Adherence Support - Nutrition	1.08	1.09	1.10	1.10	1.11	5.49	0.40%
TOTAL TREATMENT, CARE AND SUPPORT	124.63	121.46	122.85	122.90	124.22	616.06	
SOCIAL PROTECTION							
HIV-Sensitive Social Protection	4.00	4.00	4.00	4.00	4.00	20.00	1.46%
TOTAL SOCIAL PROTECTION	4.00	4.00	4.00	4.00	4.00	20.00	
SUB-TOTAL	167.32	168.33	173.78	177.97	183.14	870.55	
Program Support & Enabling Environment							
Human Rights and Gender Related Barriers to Access, Utilization and Delive	8.37	8.42	8.69	8.90	9.16	43.53	3.17%
Community Systems Strengthening	8.37	8.42	8.69	8.90	9.16	43.53	3.17%
Health Management Information Systems & Research	25.10	25.25	26.07	26.70	27.47	130.58	9.52%
Procurement and Supply Chain Management	12.46	12.15	12.28	12.29	12.42	61.61	4.49%
Laboratory Systems and Equipment	16.73	16.83	17.38	17.80	18.31	87.06	6.35%
Program Governance, Policy and Coordination	20.92	21.04	21.72	22.25	22.89	108.82	7.93%
Finance and Sustainability	5.02	5.05	5.21	5.34	5.49	26.12	1.90%
TOTAL PROGRAM SUPPORT AND ENABLING ENVIRONMENT	96.96	97.15	100.05	102.16	104.91	501.24	
Total Millions of USD	264.28	265.49	273.83	280.13	288.06	1,371.79	100.00%

8.1.1.3 Recommendations

The recommendations on costing, resource tracking and efficiency are based on the review of budgeting systems and resource tracking carried out as part of the End-Term Review of the NSF 2017/18 – 2021/22:

a) Resource tracking should be institutionalised so that the exercises can be conducted regularly (annually).
b) In previous NASA exercises, HIV expenditure information has been extremely difficult to obtain from the private sector. Innovative ways of obtaining this data must be developed, for example, the requirement to report HIV and health expenditure could be linked to annual business licences.
c) MHSS financial management and resource planning systems should be strengthened to allow for programme-based budgeting and for the effective coordination of annual and strategic planning and budgeting.

d) Routine programme reviews need to link programmatic results to financial expenditure in order to have a full measure of the cost effectiveness of the interventions. More emphasis should be placed on financial expenditure results and how expenditure is linked to the respective programmatic targets and results.
e) The RNE for the NSF 2023/24 – 2027/28 should be revisited and updated once the latest unit cost study has been completed. This will provide a more accurate estimate of any resource requirements and funding gaps.

8.1.2 Efficiency Analysis

8.1.2.1 Background

The NSF Resource Needs Estimate provides an estimate required to implement and achieve Namibia's current national HIV targets and priorities for reaching the 97-97-97 targets in the NSF 2023/24 – 2027/28. It is determined by using the current mix of interventions and unit costs, without any savings or reallocation of funds across activities.

In an effort to focus on interventions that have the highest impact, Namibia developed the Package of HIV/AIDS Services for Sustained Epidemic Control in 2020. It identified how current HIV/AIDS services should be targeted in order to close the remaining gaps to achieve the 95-95-95 targets, particularly among key and vulnerable populations and in high-burden areas. It also defined which services are essential to sustain epidemic control.

Rather than detailing the implementation of every component of the national package, the next section discusses specific services, which encountered challenges during implementation, and where efficiencies can be further gained through enhancing or streamlining the services.

8.1.2.2 Key Strategies

Table 7: Key Strategies

Inefficiencies	Key Strategies
Laboratory Services	
Viral load testing: A high number of tests, including repeat tests, are carried out across facilities leading to high cost of lab tests to MHSS. This was mainly attributed to failure to adhere to established testing protocols.	Systems should be implemented to avoid repeat testing; tests should be requested and controlled properly; and files should be properly maintained. A system should be put in place to enable the scrutinisation of bills received from the NIP prior to payment authorisation.
Viral load testing: Pricing of tests is too high and not comparable to regional or global reference prices.	The MHSS should engage the NIP on the underlying reasons for high laboratory test prices, which are not in line with regional benchmarks.
Current lack of capacity for equipment service and maintenance within the NIP leads to high maintenance costs as all equipment service and maintenance has to be outsourced.	Biomedical engineers or similar cadre should be engaged or trained to be able to carry out equipment service and maintenance, especially for auxiliary equipment and services, e.g., calibration.

Inefficiencies	Key Strategies
	Alternatively, there is potential room for new approaches, such as shifting from direct procurement of equipment to pay-per-result/test models where equipment is owned and maintained by suppliers. This could reduce costs to NIP and provide flexibility to adopt new technologies faster, since the NIP would not be tied to old equipment.
DNA PCR for infants is only processed in Windhoek Central Lab, with turn-around-time for EID results currently being between 1 and 2 months.	The POC equipment outside the NIP network should be brought into the NIP network in order to optimise service provision, manage provision of PTs and consumables, and provide quality assurance. Multiplexing of these machines for other tests (EID, VL, TB) should be considered to reduce turn-around-time.
Some POCs (11 GeneXperts) are outside the NIP network, creating a challenge in terms of supervision and management of these POCs, which are mainly supported by partners. These sites also have stock of reagents which are not linked to the NIP network and a high volume of these reagents run the risk of expiry.	
Condom Programming	
Inaccurate forecasting and quantification lead to under-procurement of quantities of condoms. One of the reasons for inaccurate forecasting was identified as insufficient data regarding stock levels and usage.	Systems for stock management and usage should be strengthened to provide accurate information for use in stock management and quantification.
Inability to take advantage of economies of scale and discounted pricing due to the relatively small quantities of condoms procured.	Bulk purchases and the use of pooled procurement should be considered in order to attain lower unit prices.
Commodity Procurement and Supply Chain	
All procurement by government entities must be conducted as per the Public Procurement Act (including for purchases using donor funds), which may result in a protracted procurement process in order to satisfy all requirements. This tends to delay procurement and implementation timelines, resulting in lower expenditure burn rates for donor-funded programmes.	Suppliers can be pre-qualified for a period of time, e.g., 2 – 3 years, in order to shorten the lead times of the procurement process.
Many non-HIV commodities were found to be three or four times more expensive than in other countries.	Regular benchmarking to international reference prices can be undertaken to free up funds that could be used for better returns on all commodities, including HIV commodities.

CHAPTER 9 Financing and Sustainability

The NSF adopts the WHO's framework for health financing and universal health coverage (Figure 27). Sustainably financing the HIV/AIDS response requires resource generation, pooling and fund management, strategic purchasing, governance arrangements and supportive governance arrangements. Adequate financing, an enabling policy environment and appropriate governance are the underlying prerequisites for equitable resource distribution, efficiency, transparency and accountability, and ultimately, a sustainable HIV/AIDS response that ensures utilisation relative to needs, financial protection and quality.

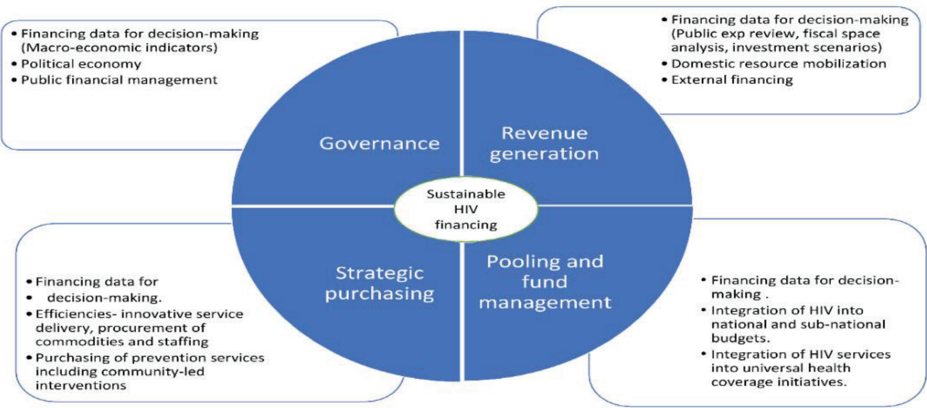


Figure 27: Conceptual framework for HIV financial sustainability

Chapter 9 summarises the situation analysis of resource generation, pooling and fund management, strategic purchasing, and governance of HIV financing in Namibia. It reflects what did and did not work well during the implementation of the NSF2017/18 – 2021/22.

9.1 Resource Generation

The government budget was the main source of funding of the National Strategic Framework for HIV and AIDS Response 2017/18 – 2021/22. The GRN also mobilised external funding, including from the Global Fund, PEPFAR, United Nations agencies, and other development partners. However, the government budget is deemed to be more sustainable and adequate in terms of level of funding. The Government of Namibia funded most of the staff, antiretroviral drugs, testing commodities and health facility infrastructure. Overall, while the GRN's fiscal policy targets allocation of 14% to the health sector, actual expenditure has been consistent at about 11% over the preceding five fiscal years. Other sources of funding are GRN allocations to the public employee medical scheme and premiums by enrolees of private medical schemes.

A key challenge in terms of HIV revenue raising is dependence on donors for HIV prevention services, a situation potentially exacerbated by the COVID-19 pandemic. Although GRN's investment in health increased from 13% to 15% of total government spending between the 2015/16 and 2017/18 fiscal years, the achievement of this target can mostly be attributed to the reduction of general government expenditure, because of the economic downturn. The GRN is

yet to meet 15% of the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases target regarding its spending through the Ministry of Health and Social Services. Government budgets are historical and incremental. Low utilisation of external funds is a key constraint to resource mobilisation. While donors have funded some posts, there is need to reprogramme such staff costs to domestic sources. HIV financing is mainly health-sector-led, limiting opportunities for more public resources from other public sectors. Dedicated value added tax, pro-health taxes on alcohol, tobacco and sugar, as well as taxes on carbon emissions and gambling/betting are untapped opportunities for improving the government fiscal space for health and HIV. Efficiency from government reforms on PSEMAS should bolster total health spending. In the private sector, corporate social responsibility, private medical schemes and philanthropic contributions remain fully untapped. Yet, limited structures, systems or mechanisms exist at national and regional levels for harvesting private sector contributions to the HIV and AIDS response. The health sector has not fully tapped into the national training levy through the Healthcare and Social Industries Skills Committee. A dedicated training levy to facilitate in-service training for staff of private health facilities will also expand the fiscal space for health.

9.2 Pooling and Fund Management

9.2.1 Integrating HIV Services into the Public Budget

The bulk of funds allocated to the HIV and AIDS response is consolidated at the Ministry of Health and Social Services, thereby improving the efficiency of the HIV and AIDS response. Nevertheless, pooling of government and partner funding in one basket has not been realised. The integration of HIV activities was a mandatory requirement of the National Planning Commission (NPC) for approval of publicly-funded projects by public sector offices, ministries, agencies and regional councils (OMARs) in order to improve the multi-sectoral HIV and AIDS response. Every OMAR has a Wellness Committee, mandated by the Office of the Prime Minister (OPM), which implements HIV activities funded through the budget. Local government (regional level) can define priorities which feed into national budget planning and preparations. The Regional AIDS Coordinating Committees (RACOCs) and Constituency AIDS Coordinating Committees (CACOC) are a good coordination mechanism and have been involved in setting priorities and need-based budgeting.

Government budget effectiveness and efficiency were constrained by lack of proper planning of budgetary needs, unrealistic costing of needs, weak partner coordination, irregular resource tracking, lack of regional prioritisation, and weak engagement between the Ministry of Health and Social Services and the Ministry of Finance. Annual HIV budgets were neither developed using participatory approaches, nor informed by evidence of the regions' disease burdens. Consequently, HIV/AIDS budgets do not adequately address the burden of HIV by regions, local government or rural priorities. Regional funding targets have not been set, mainly due to lack of capacity. Removal of HIV activities from the project identification form at the National Planning Commission undermined integration of HIV services into the budget. Wellness Committees transited from HIV Awareness Committees, de-emphasising the multi-sectoral approach. Donor funds included in the government budget are low and are not strictly aligned to the priorities of the HIV/AIDS control programmes.

9.2.2 Integrating HIV Services into Universal Health Coverage (UHC) Schemes

Some HIV services are provided by the Public Service Employee Medical Scheme (PSEMAS) and private medical schemes. PSEMAS is heavily subsidised by the government budget, and is undergoing reforms to improve operational efficiency. Universal health coverage (UHC) policy development is ongoing. Stakeholders are building consensus on the approach and understanding of roles and responsibilities of various stakeholders (public entities, private providers, and development partners). A new Health Financing Division has been created under the Policy and Planning Directorate of the Ministry of Health and Social Services. Furthermore, an essential health services package (EHSP), which includes a uniform HIV service package, is being developed. The EHSP is informed by burden of disease, equity, cost-effectiveness, budget impact and feasibility. The private medical schemes have developed and included a diagnostic-related group in their provider payment system.

HIV services have not been systematically integrated into private voluntary health insurance plans, despite existence of PSEMAS and private medical schemes (PMS). Use of social health insurance approaches to fund prevention interventions and to enrol PLHIV into schemes that provide uniform package of HIV care has not been achieved. Benefits in PSEMAS and PMS are linked to employment, but membership is not mandatory. PLHIV in the informal sector are covered by the public sector through the Ministry of Health and Social Services and donor funding. Packages of healthcare services vary with individual schemes and might reflect the cost of HIV care (N$3,702 in public facilities, N$8,530 by PSEMAS, and N$16,161 by private medical schemes), resulting in inequities in access and financial protection. Efficiency from PSEMAS must be applied to the public health system to improve health equity. The Ministry of Finance estimates that PSEMAS could potentially achieve savings of between N$500 million and N$900 million per annum. Access to benefits in PSEMAS and PMS is limited by resource caps and high co-payment, which increases out-of-pocket spending where PLHIV purchase ARVs from private pharmacies. While out-of-pocket spending might drive rational use of HIV services in the private sector, some PLHIV return to the public sector to access ARVs.

9.3 Strategic Purchasing

9.3.1 Efficiency and Effectiveness

An existing HIV sustainability framework supports value for money. Nevertheless, line-item budgeting and expenditure tracking within the Ministry of Health and Social Services makes it challenging to link spending to outputs. The GRN procures over 95% of HIV commodities, implying high domestic funding of HIV treatment and care. Government investment in ARVs increased by about 60% from 2017/18 to 2020/21, but declined almost 10% in the 2021/2022 fiscal year (Figure 28). Experience with pooled procurement of condoms and family planning commodities demonstrated value for money in terms of fair pricing and quality. The UN established a ‘bridge mechanism’ by which it pays the supplier on behalf of government and, when goods are delivered, the government reimburses the UN. Namibia received approval for US$2 million under the bridge mechanism.

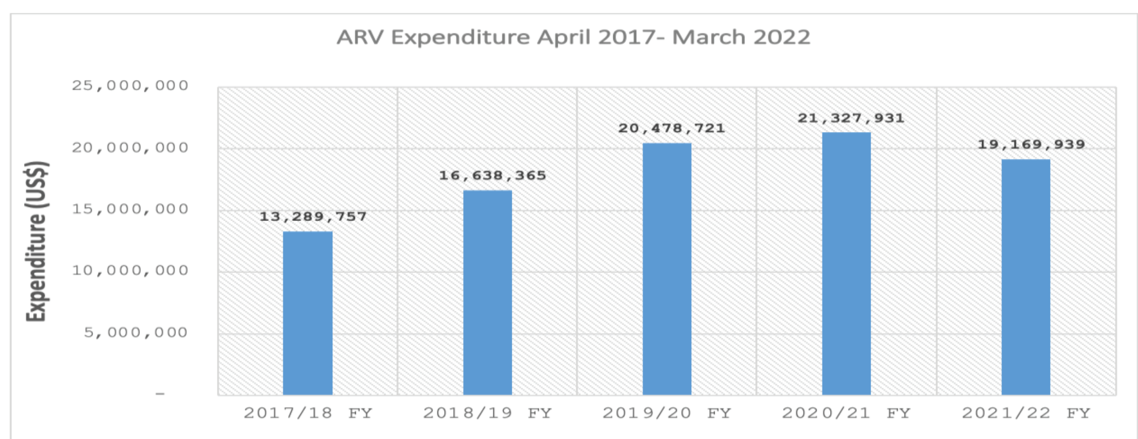


Figure 28: GRN's ARV expenditure, April 2017 – March 2022

The procurement policies between the GRN and donors are misaligned, with a lack of guidelines on how to manage this misalignment. Framework agreements with service providers are short-term. Disruptions in developing new framework agreements between the GRN and manufacturers when existing frameworks expire result in ad hoc, short-term procurement of commodities using middlemen, which is two to three times more expensive than pooled procurement. However, pooled procurement is associated with long delays and requires advance payment, which is at variance with the government law of 'pay on delivery'. The GRN did not utilise the approved bridge financing. Duplication in procurement of HIV commodities led to frequent reprogramming of costs. Reprogramming of costs during implementation is often delayed. Duplication suggests capacity gaps in priority setting and programme implementation. Health facilities order more stock than they need to prevent stock-outs, thereby creating uneven distribution of commodities and supplies.

Public spending is skewed towards curative services, with emphasis on secondary and tertiary hospital care, while little attention is given to primary healthcare. Poor integration of services at the PHC level, weak PHC laboratory infrastructure, and uneven regional distribution of community health extension workers exacerbate the inefficiencies in accessing PHC services. Human resource costs are high due to hospital-based service delivery models and annual salary increments for existing staff. The human resources cost increases by about 9% annually. As an example, personnel costs for the permanent HIV response staff of the Directorate of Special Programmes increased from US$222,000 in 2017/18 to US$323,000 in 2021/2022 (Figure 29). The GRN health staff establishment is also not fully funded. Attraction and retention of health workers in the public sector is low, with up to 40% of posts in the health sector being vacant. The shortage of publicly funded community health extension workers limits the community-led response. Consequently, donor reliance on community health workers for HIV care is high. Yet, fiscal and administrative policies limit the capacity of government to transition donor-funded staff positions to government, as donor funds decline.

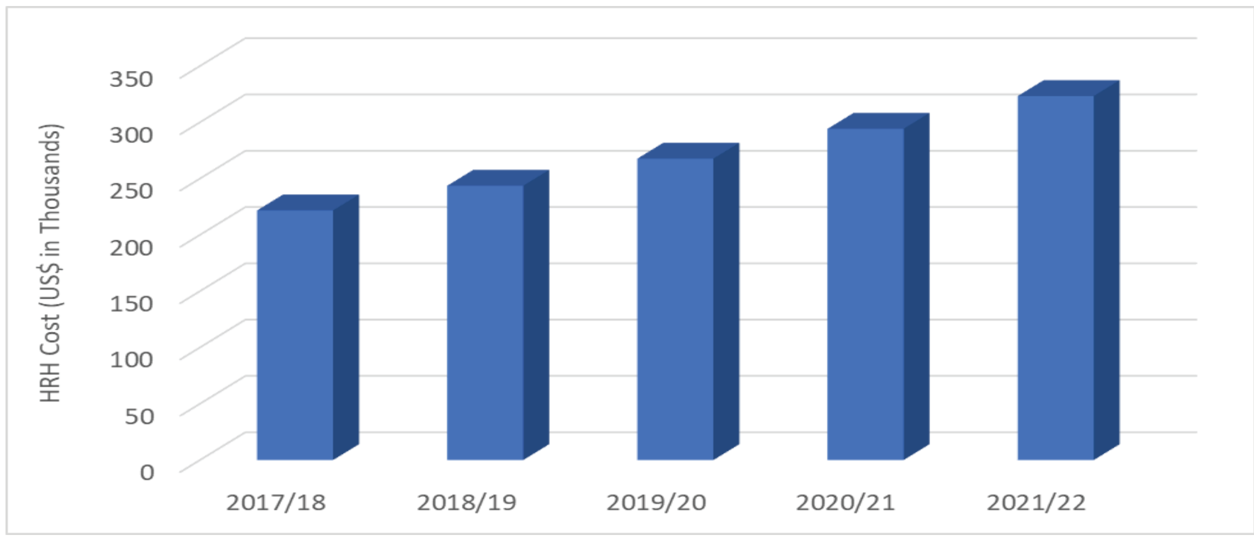


Figure 29: HIV response personnel cost, Directorate Special Programmes

9.3.2 Financing Prevention Services including Community-led Interventions

Condoms and family planning commodities have been procured using a pooled procurement mechanism. The government has a policy on engagement with civil society organisations, with Namibia committing to allocate about 15% of public resources to civil society. A draft Social Contracting Policy exists. The government and development partners have experience with funding civil society organisations. Private health sector providers are involved in VMMC through private medical schemes and reimbursement by donors.

Prevention is donor-dependent as government spending on HIV prevention, particularly community-led interventions, is low. The HIV and AIDS response is skewed to biomedical approaches led by the MHSS. Attention to behavioural interventions has declined over time. The allocation of resources to other OMARs that might be able to efficiently target the key and priority populations is deficient. Moreover, public support for financing community interventions from the government budget is low. The MHSS does not procure any lubricants. Although the Social Contracting Policy is donor-driven and an eligibility requirement for the Global Fund grants, Cabinet approval will improve ownership and accelerate its implementation. Trust between the government at a high level and civil society is lacking, despite the government's Civic Organisations Partnership Policy (2005). Consequently, access to public funding by CSOs is limited. Funding for local CSOs is limited due to compliance issues and high staff turnover.

9.4 Governance

The GRN has robust public financial management policies, including the Financial Act and the Public Procurement Act, among others. Even though a health financing Technical Working Group (TWG) has been established under the Policy and Planning Directorate in the MHSS, an HIV financing TWG does not exist. Decentralisation is high on the government's agenda, with primary healthcare prioritised through the collaboration of the MHSS and the Ministry of Urban and Rural Development. A Country Coordinating Mechanism (CCM) exists, which facilitates implementation of HIV coordination. Nonetheless, weak joint planning among the GRN and partners results in poor programmatic and financial alignment and allocative inefficiencies.

The Directorate of Special Programmes (DSP) needs to improve the capacity to mobilise domestic resources. There is need to strengthen the HIV response in NDP5. HIV control does not have a budget line as its budget is embedded in the infectious diseases budget of the MHSS. The multi-sectoral approach requires the collaboration of the MHSS and other ministries, partners and stakeholders. The budget decision-making space at regional level is narrow, with the regional offices implementing budget decisions from the centre.

The lack of health-specific MTEF, weak HIV resource tracking, limited understanding of public financial management (PFM) by HIV and AIDS response staff, lack of capacity-building on PFM issues, and low budget execution are key PFM system bottlenecks affecting the HIV and AIDS response. Although the government's total spending increased in the post-COVID-19 era, health spending has remained flat. Weak budget justification (demonstrating spending efficiencies, communicating results, MTEF issues) has been a limiting factor in increasing public spending on the HIV and AIDS response. Furthermore, accountability is weak because funding flows are not tracked against priorities, public disclosure of financial information is low, stakeholders are not regularly briefed by programme management in the absence of HIV and health review meetings, and community involvement in accountability monitoring is poor. The CSOs are fragmented and lack power to hold government and partners accountable. Health and HIV resource tracking has not been conducted since the 2017/2018 fiscal year.

9.5 Programme Objectives of the NSF 2023/24 – 2027/28

9.5.1 Overall Objective

The overall objective is to develop strategies of financing the HIV and AIDS response in the short to long term through resource mobilisation, pooling and fund management, and strategic purchasing to ensure the sustainability of provision of HIV/AIDS services that would achieve HIV-related national and global health goals.

9.5.2 Strategic Objectives and Interventions

9.5.2.1 Resource Generation

Strategic Objective

The strategic objective in terms of resource generation is to increase domestic funding for the needs of the national multi-sectoral HIV and AIDS response from 50% in 2023/24 to 60% in 2027/28.

Strategic Interventions

- **a.** *Increase public spending on MHSS from the current 11% to 15% of total government budget annually*
- **b.** *Increase the HIV budget from the current 13.5% to 15% of the government health budget*
- **c.** *Develop a health and HIV medium-term sector strategy (MTSS) and medium-term expenditure framework (MTEF) as a resource mobilisation tool*
- **d.** *Expand the health fiscal space through earmarking a portion of pro-health taxes on alcohol, tobacco and sugar, as well as on gambling/betting, towards addressing the impacts of alcoholism, etc., on new HIV infections*

e. *Advocate for health sector earmark of the training levy for annual mandatory in-service training of staff of public and private health facilities provided by the Namibian Training Authority*
f. *Establish a voluntary private-sector-led HIV trust fund as a social corporate responsibility mechanism to harvest contributions of private sector organisations, supported by a Private Sector Investment Case for Health and HIV*

9.5.2.2 Pooling and Fund Management

9.5.2.2.1 Integrating HIV Services into the Public Budget

Strategic Objective
The strategic objective is to earmark at least 6% of government spending on the HIV response for integration of HIV services into the public budget of all offices, ministries, agencies and regional councils.

Strategic Interventions
a. *Mainstream participatory, bottom-up, performance-based health budgeting and planning into health and HIV budgeting to ensure regional priorities are included in budgets*
b. *Ensure that budgets are informed by regional funding targets based on regional burden of HIV/AIDS*
c. *Build the capacity of regional bodies (regional health teams, RACOCs and CACOCs) on financial and programme oversight*
d. *Budget for HIV in all offices, ministries, agencies, and regional councils*
e. *Enforce inclusion of HIV activity in the project identification form (PIF) at the National Planning Commission*
f. *Develop an alignment framework to harmonise funding from the government, partners and stakeholders to improve basket funding of the HIV and AIDS response*

9.5.2.2.2 Integrating HIV Services into Universal Health Coverage (UHC) Schemes

Strategic Objective
The strategic objective is to integrate HIV services into all existing healthcare services and new universal health coverage initiatives.

Strategic Interventions
a. *Implement a uniform essential HIV package of care in both public and private health facilities*
b. *Ensure retention of the efficiency gains from PSEMAS in the public health system*
c. *Develop a blueprint for integrating HIV services into social health insurance schemes (once the government establishes one) to serve as an operational guideline for implementation*
d. *Build capacity of health and HIV programme staff on health insurance functions and health financing, including public financial management systems*

9.5.2.3 Strategic Purchasing

9.5.2.3.1 Efficiency and Effectiveness

Strategic Objective

The strategic objective is to strengthen efficiency, optimisation and value for money in the HIV and AIDS response.

Strategic Interventions

- **a.** *Build the capacity of health and HIV programme staff on participatory planning and budgeting/priority-setting*
- **b.** *The MHSS to revise procurement planning for pharmaceuticals and clinical supplies to a three-year rolling plan, in line with the MTEF*
- **c.** *MHSS Accounting Officer to provide a finance certificate to ensure availability of funds over three years to allow for establishing a three-year framework agreement under which purchase orders may be placed*
- **d.** *Adopt pooled procurement mechanisms (PPMs) using the bridge financing facility established by the UN agencies*
- **e.** *Ensure efficiency in the ordering and distribution of pharmaceuticals and clinical supplies to health facilities to align with disease burden*
- **f.** *Establish the required staffing and transition donor-funded staff positions to government in agreed phases and ensure continued support of donor-supported CSOs and their staffing complements through social contracting mechanisms*
- **g.** *Re-distribute and incentivise health workers to health facilities and regions according to disease burden*

9.5.2.3.2 Financing Prevention Services including Community-Led Response

Strategic Objective

The objective is to earmark at least 30% of domestic financial resources for HIV prevention and sustainability of community-led interventions.

Strategic Interventions

- **a.** *Progressively reprogramme community-led interventions from donors to domestic financing sources*
- **b.** *Establish public line budget funding for the community-led response in tandem with operationalising the Social Contracting Policy*
- **c.** *Build the capacity of government and civil society organisations on social contracting, programme management and financial management/oversight*
- **d.** *Develop and implement an accountability framework for tracking the resources appropriated to civil society organisations*

9.5.2.4 Governance of HIV Financing

Strategic Objective

The strategic objective under governance of HIV funding is to strengthen the institutional arrangements that support the financing of the HIV and AIDS response.

Strategic Interventions

- **a.** *The MHSS and stakeholders must advocate for inclusion of HIV as a priority in all subsequent National Development Plans*
- **b.** *The MHSS should ensure that the allocation of funds for the HIV and AIDS response has a separate budget code and is not embedded in the infectious diseases budget code*

c. *Develop regional HIV financing targets based on burden of disease and resource needs estimates*
d. *Establish a mechanism for systematic and continuous resource tracking of the multi-sectoral HIV and AIDS response by conducting an annual national health account/national AIDS spending assessment*
e. *Develop and implement one CSO-inclusive health and HIV financing accountability framework*
f. *Conduct joint planning to harmonise funding from the government, partners and stakeholders to improve efficiency of the HIV and AIDS response*

9.5.2.5 Funding Landscape

9.5.2.5.1 Macroeconomic Overview

9.5.2.5.2 Gross National Income Per Capita

Namibia has consistently exceeded the threshold income of US$4,000 per capita and is classified as an upper middle-income country (UMIC). The gross national income (GNI) per capita peaked in 2019, declined in 2020, and plateaued in 2021 (Figure 30). The decline in GNI per capita might be related to the contraction of the economy during the COVID-19 pandemic. As an UMIC, Namibia potentially faces a decrease in external aid and an increase in co-financing responsibility.

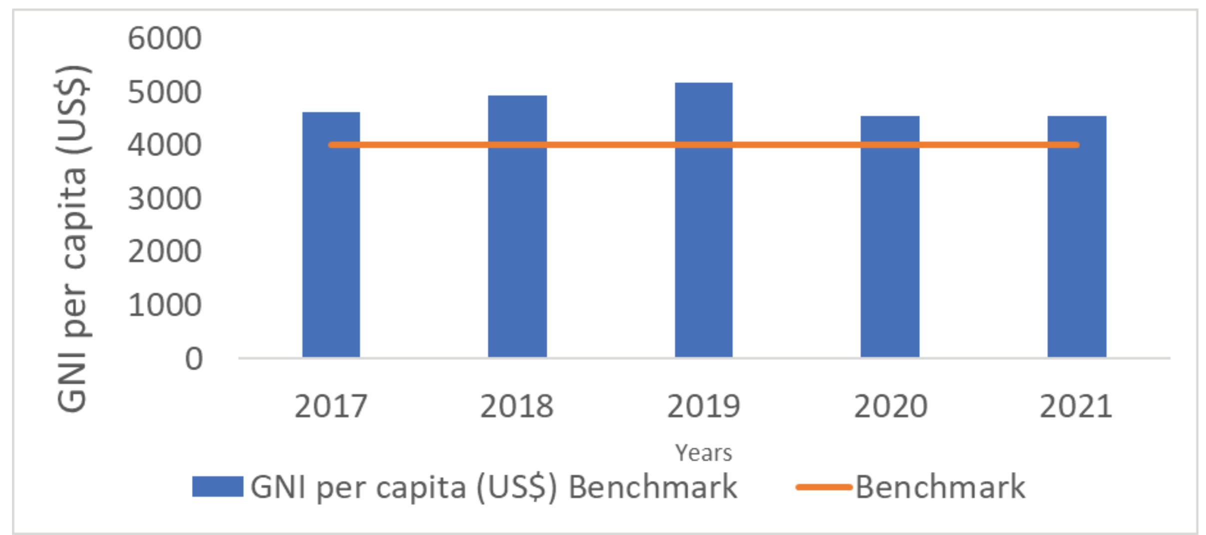


Figure 30: Trend of gross national income per capita in Namibia[12]

9.5.2.5.3 Government Revenue as Percentage of Gross Domestic Product

The government revenue as a percentage of the gross national product (GDP) grew between 2018 and 2020, but declined during 2021 and 2022 (Figure 31). While an increase is expected in 2023, the government revenue as a percentage of GDP will flatten between 2024 and 2027. This implies that the government fiscal space might remain constant during most of the NSF 2023/24 – 2027/28 period.

[12] World Bank, 2021

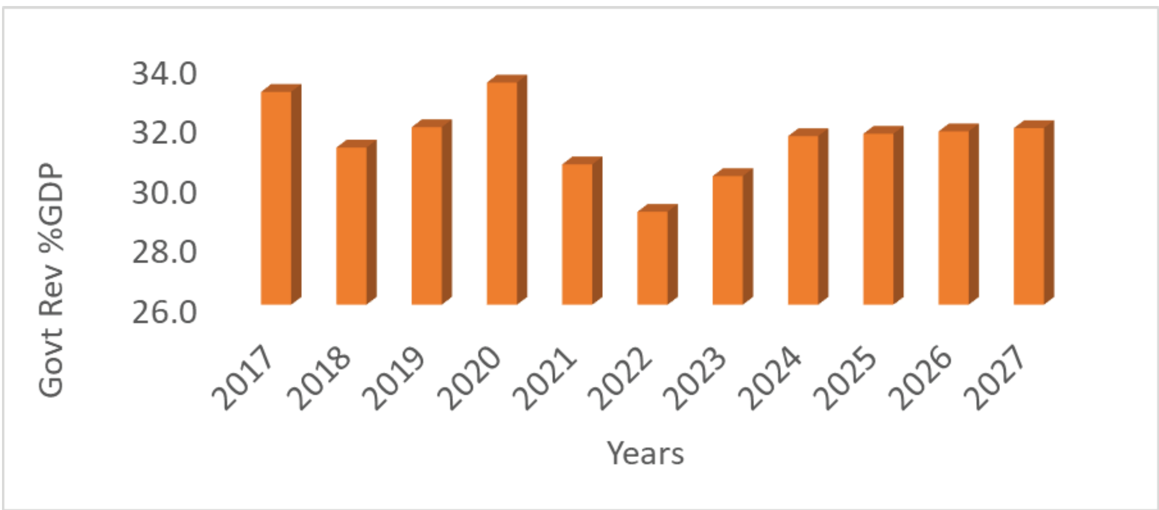


Figure 31: Government revenue as percentage of GDP[13]

9.5.2.5.4 Net Debt to Gross Domestic Product (GDP) Ratio

The net debt to GDP ratio rose from about 41% in 2017 to almost 71% in 2021, and will only marginally decline to about 68% in 2027 (Figure 32). Most of this debt is domestic and will constrain the government's budgetary room.

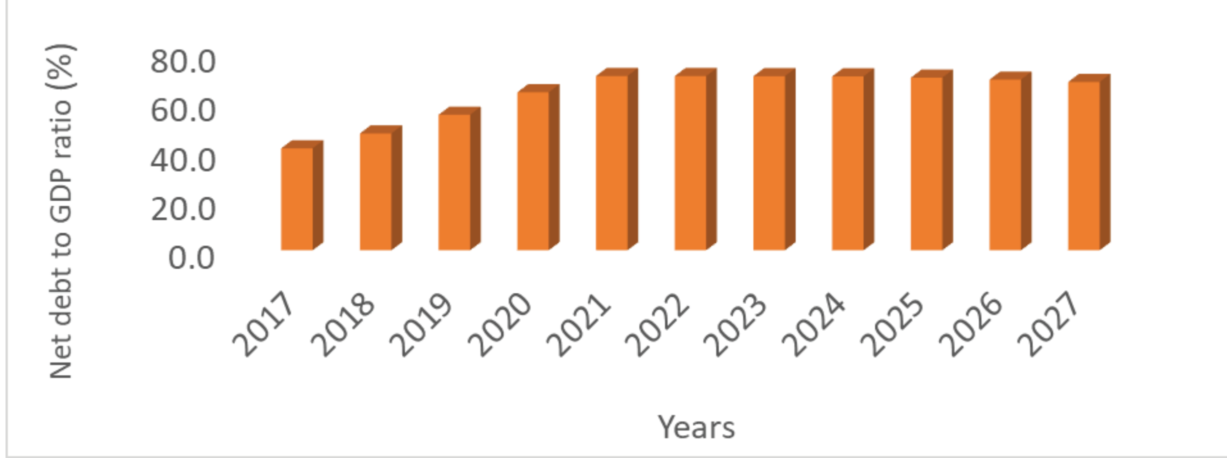


Figure 32: Net debt to GDP ratio[14]

9.5.2.5.5 Three-Year Cumulative GDP Growth Rate

Since 2016, there has been a general steady decline in the cumulative GDP growth rate in Namibia, worsening with the COVID-19 pandemic (Figure 33). Coinciding with the post-COVID-19 economic recovery period, the NSF 2023/24 – 2027/28 is likely to face challenges with domestic resource mobilisation.

[13] World Bank, 2021
[14] Ibi

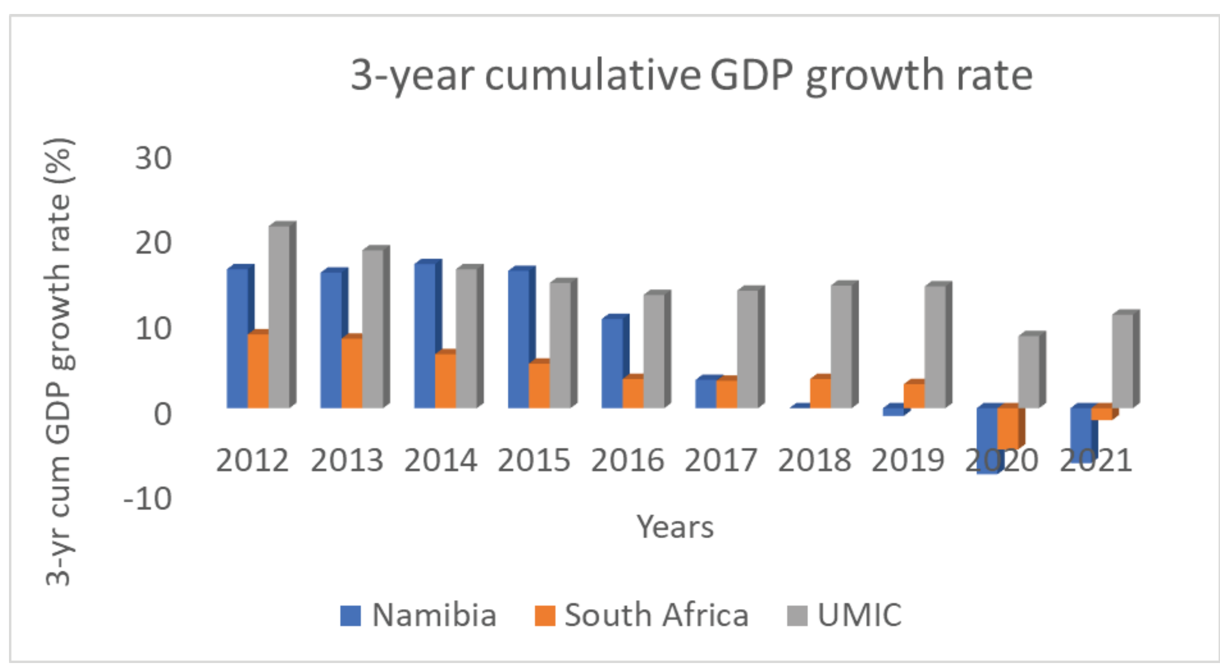


Figure 33: Three-year cumulative GDP growth rate[15]

9.5.2.6 Health Financing Trends

9.5.2.6.1 Government Health Expenditure

The GRN invests about 3.9% to 4.4% of the GDP in health, compared to South Africa's 4.6% to 5.3% (Figure 34). However, the total government health expenditure as a percentage of total government expenditure remains stable at about 11% (Figure 35).

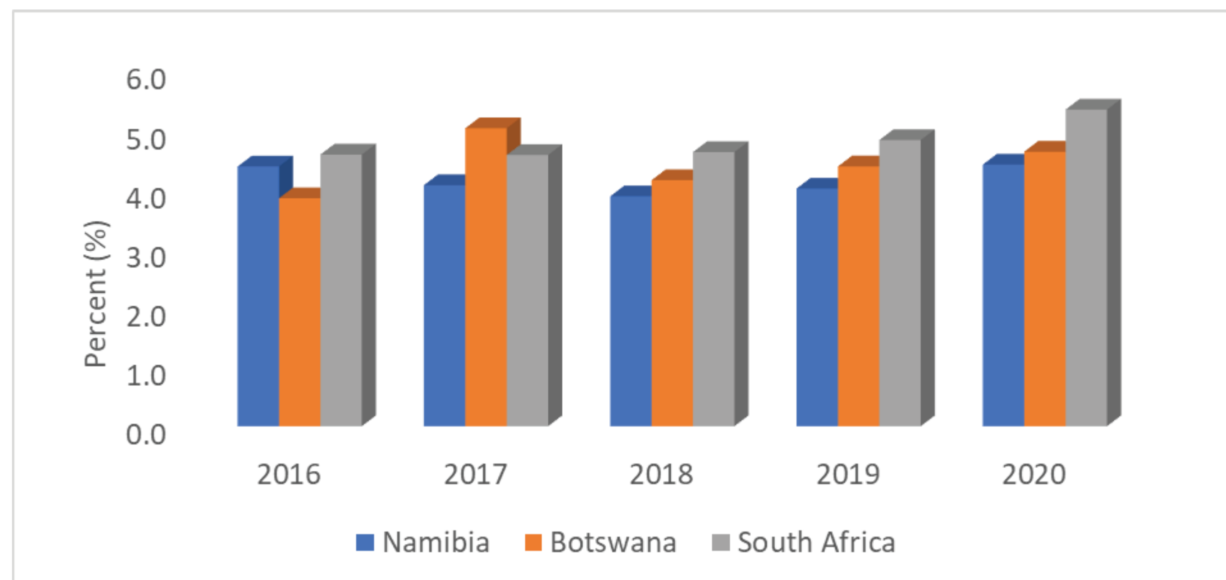


Figure 34: Total GRN health expenditure as percentage of GDP[16]

[15] World Bank, 2022
[16] Ibid

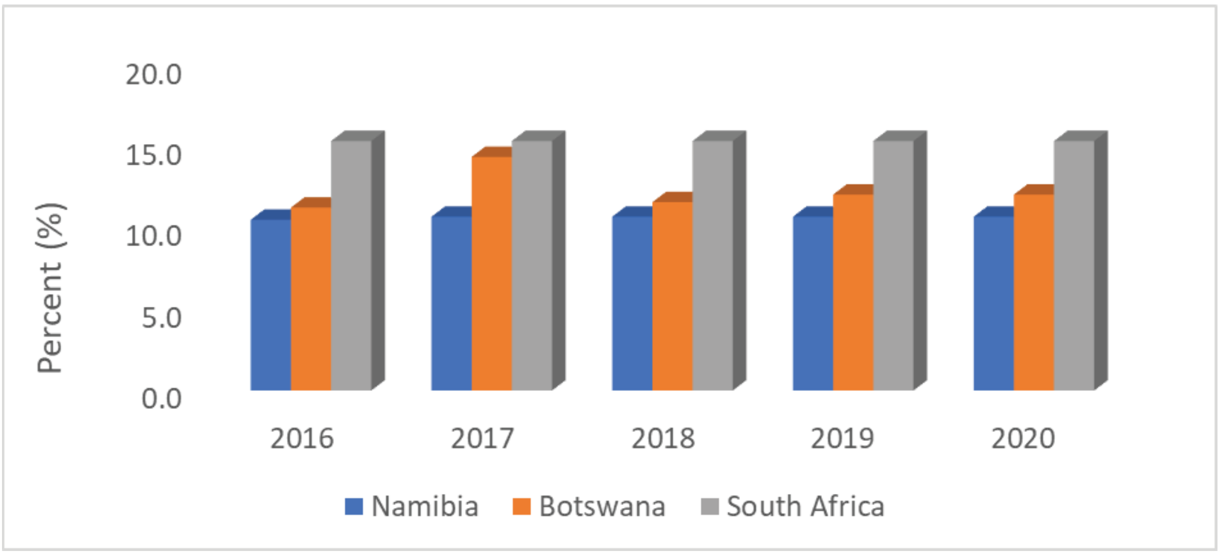


Figure 35: Total GRN health expenditure as percentage of general GRN expenditure

The GRN remains the leading financier of healthcare (average of 47%), followed by private medical schemes (average of 39%) (Figure 36). The out-of-pocket spending on health is about 8%. External financing has declined from 7% in 2016 to about 5% in 2020.

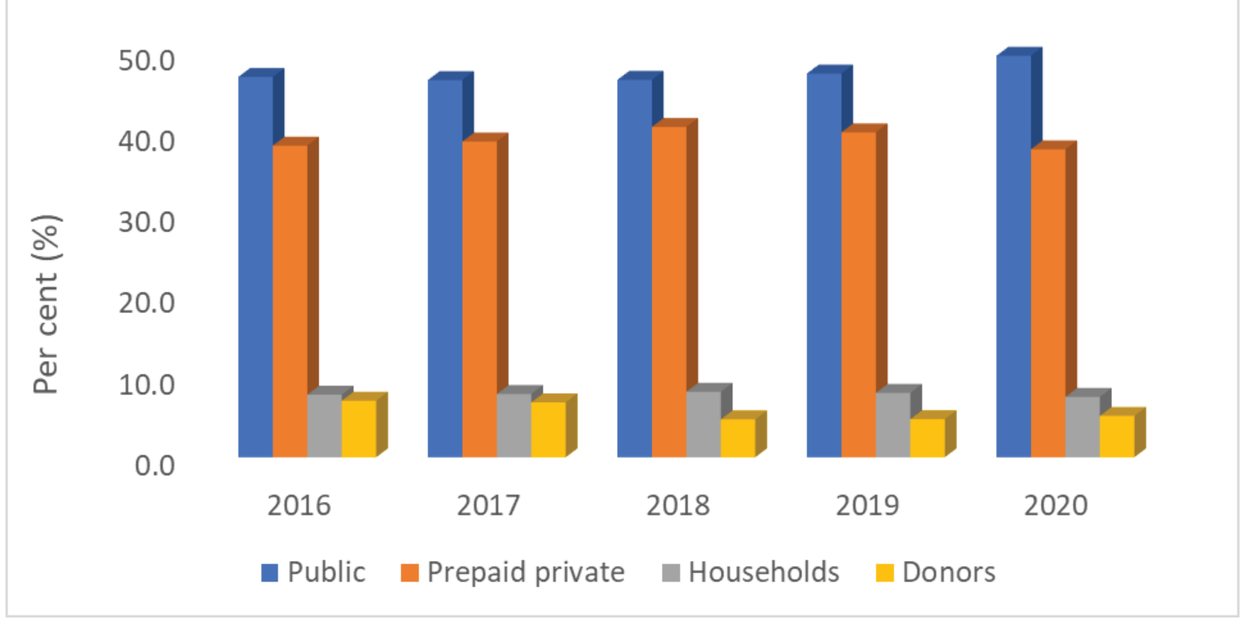


Figure 36: Total health expenditure by sources[17]

While overall government expenditure is expected to increase, government health spending is projected to remain unchanged (Figure 37). To achieve the 15% Abuja Declaration target, the GRN must increase actual health expenditure by about 4%.

[17] Global Health Expenditure Data Source, 2022

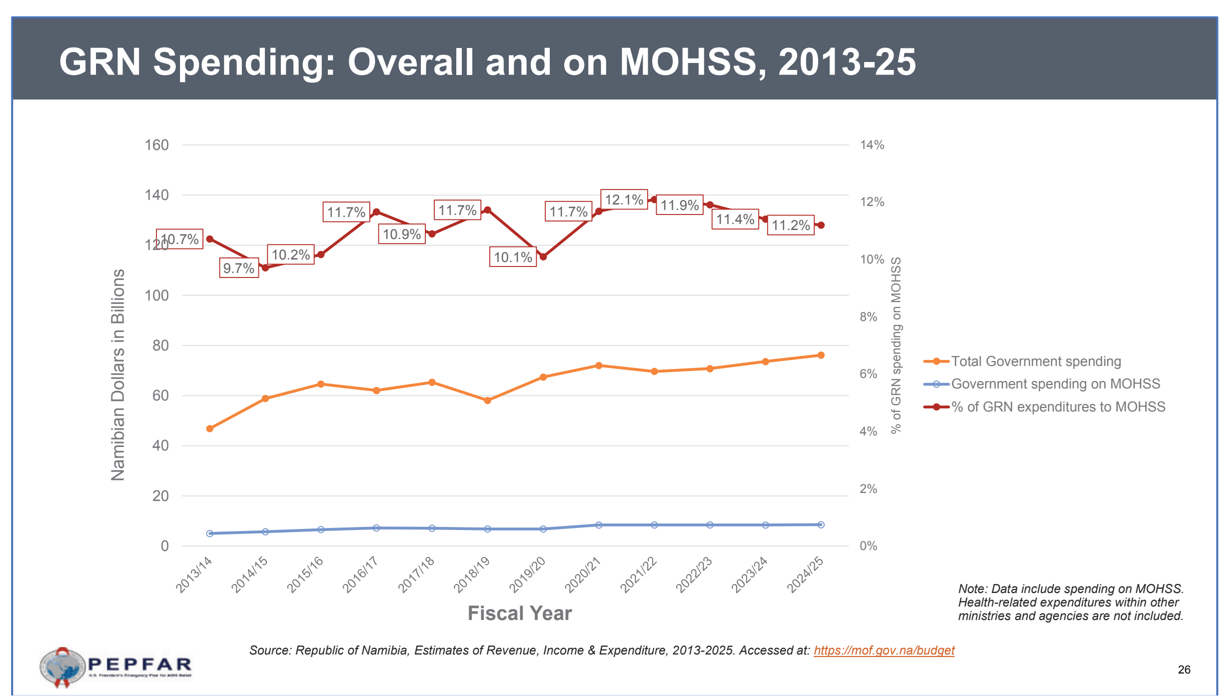


Figure 37: GRN spending: Overall and on MHSS

While 21% and 18% of health spending cover 8% (private medical schemes) and 12% (civil service scheme) of Namibians, respectively, 49% of health spending covers 80% of the population through the public health system (Figure 38). These disparities underscore the need for a universal health coverage scheme to ensure equitable financing of health service delivery and financial protection of all citizens.

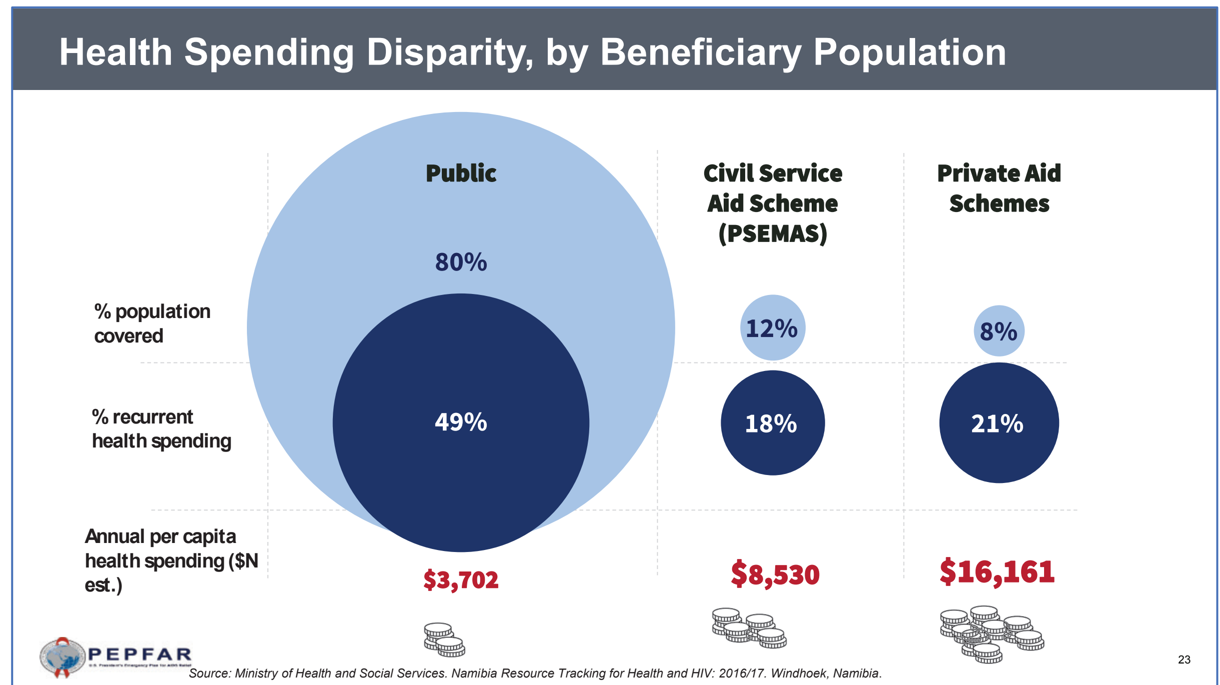


Figure 38: Health spending disparity by beneficiary population

9.5.2.7 HIV and AIDS Expenditure

The government spends about 13.5% of the health budget on HIV and AIDS (Figure 39).

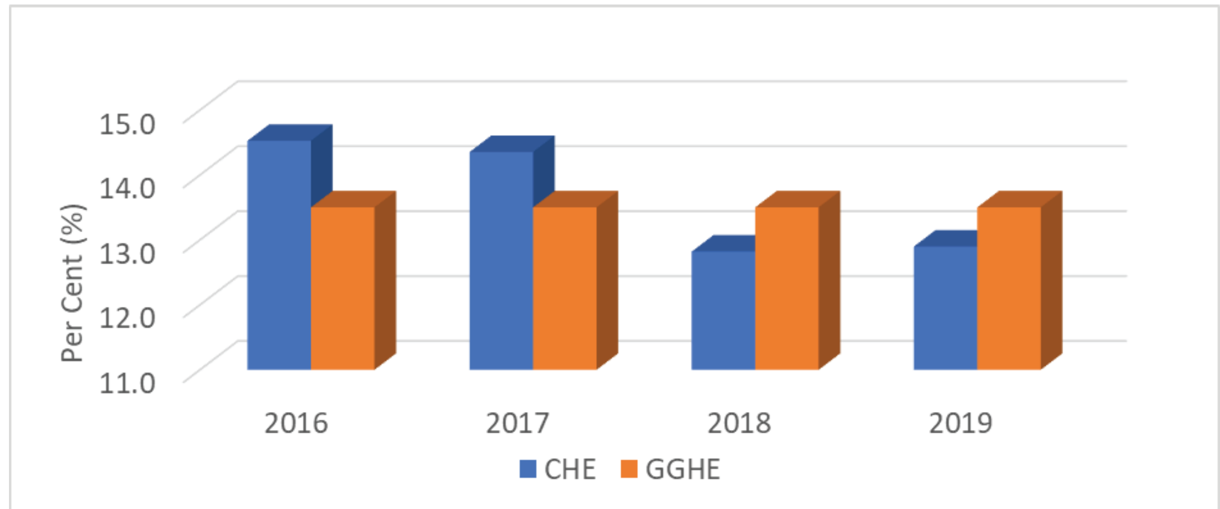


Figure 39: HIV spending as percentage of current health expenditure and general government health expenditure[18]

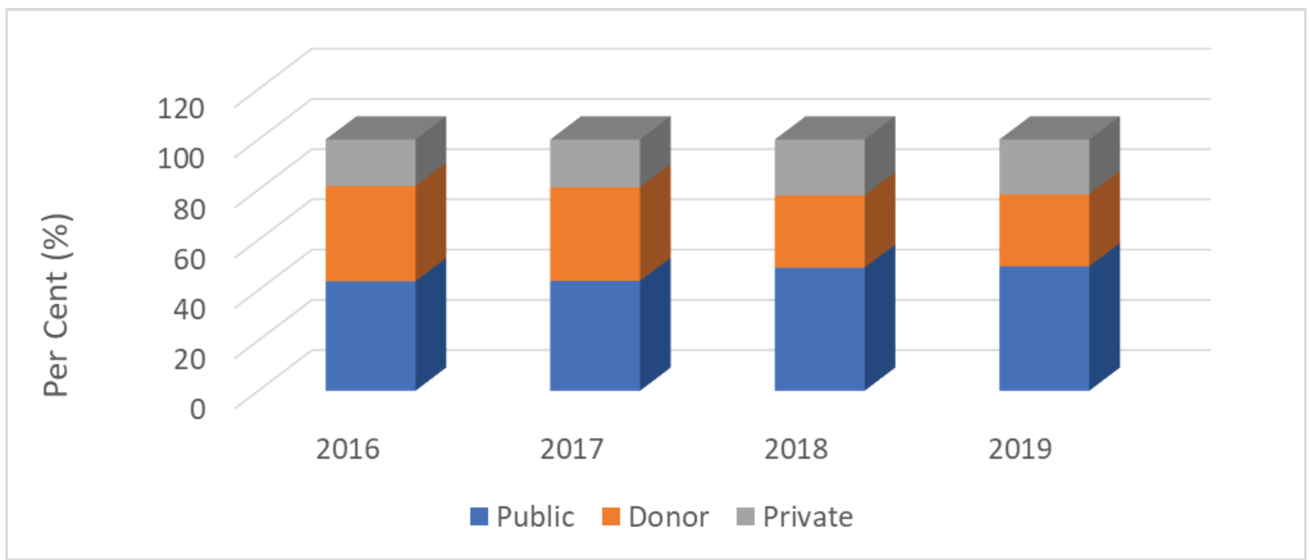


Figure 40: HIV expenditure (%) by sources

9.5.2.8 Resource Needs Estimate for NSF 2023/24 – 2027/28

Based on the resource needs estimates presented in the costing section and summarised in Table 8, it is estimated that the NSF 2023/24 – 2027/28 will cost about US$1,371.8 million only.

[18] Global Health Expenditure Data, 2022

Table 8: Resource needs estimate (US$ million)

Interventions	2023/24	2024/25	2025/26	2026/27	2027/28	Total
Prevention – Five pillars	25.4	28.3	31.2	34.3	37.0	156.2
Other prevention	13.3	14.6	15.7	16.8	17.9	78.3
ART	94.6	94.7	95.8	95.9	97.0	478.1
Other care and treatment	30.0	26.8	27.0	27.0	27.3	138.0
Social protection	4.0	4.0	4.0	4.0	4.0	20.0
Programme support & enabling environment	97.0	97.2	100.1	102.2	104.9	501.2
Total	264.3	265.5	273.8	280.1	288.1	1371.8

Data source: NSF Costing Template

9.5.2.9 Potential Sources of Funding for the NSF 2023/24 – 2027/28

The NSF 2023/24 – 2027/28 analysis of HIV health financing makes the following assumptions:

1. Government spending on health remains at 14% of total government expenditure, but could decrease to 11% or increase to 15%
2. Government spending on HIV remains at 13.5%, but could improve to 15% of the health budget at 14%, 11% or 15% of general government expenditure
3. Government spending on HIV through the MHSS represents about 97% of total public spending on HIV, with spending of other public sectors representing about 3% of total public spending on HIV
4. An exchange rate of US$1 to N$17.2920
5. Domestic private spending is at 6% of the total HIV and AIDS resource needs estimate, based on total domestic corporation (4%) and household spending (2%) in the 2017/18 resource tracking
6. The US Government's PEPFAR annual funding will decrease by 5% annually over the current NSF period
7. Global Fund's planned expenditure from 2023 to 2026: The 2026 expenditure will be held constant in 2027. It should be noted that full access to this amount is contingent upon the satisfaction of the government co-financing requirement of US$332,583,962 during the upcoming Global Fund allocation cycle. Failure to comply would lead to a reduction in the allocation of 20%. Namibia also owed US$726,034 as recoverable to the Global Fund as of 30 November 2022.
8. Funds from the United Nations Partnership Framework are estimated at 2% of the HIV and AIDS RNE, based on average funding over the preceding five years (2017 – 2022)

Table 9 summarises potential government funding scenarios, keeping the actual health expenditure as a percentage of general government expenditure (GGE) at 11%, 14% and 15%, respectively.

Table 9: Potential Government spending on HIV through the Ministry of Health (US$ million)

	2023/24	2024/25	2025/26	2026/27	2027/28
General Government Budget (GGE)	3554.4	3577.7	3648.1	3648.1	3648.1
Health budget at 14% of GGE	497.4	500.6	510.4	510.4	510.4
Health budget at 11% of GGE	391.0	393.5	401.3	401.3	401.3
Health budget at 15% of GGE	533.2	536.7	547.2	547.2	547.2
HIV Budget					
Model 1	67.1	67.6	68.9	68.9	68.9
Model 2	74.6	75.1	76.6	76.6	76.6
Model 3	52.8	53.1	54.2	54.2	54.2
Model 4	58.6	59.0	60.2	60.2	60.2
Model 5	72.0	72.4	73.9	73.9	73.9
Model 6	80.0	80.5	82.1	82.1	82.1

Explanatory note: Model 1 = 13.5% of health budget at 14%; Model 2 = 15% of health budget at 14%; Model 3 = 13.5% of health budget at 11%; Model 4 = 15% of health budget at 11%; Model 5 = 13.5% of health budget at 15%; Model 2 = 15% of health budget at 15%.

Table 10 summarises the six possible scenarios for integrating HIV financing into other public sector budgets. In the 2017/18 fiscal year, other sectors contributed about 3% of total public funding for HIV. As this NSF integrates HIV into other public sector budgets, the aim is to achieve about 6% of public spending on HIV.

Table 10: Other public sector budgets (US$ million)

Scenarios	2023/24	2024/25	2025/26	2026/27	2027/28	Total
1	4.2	4.2	4.3	4.3	4.3	21.1
2	4.6	4.6	4.7	4.7	4.7	23.5
3	3.3	3.3	3.4	3.4	3.4	16.6
4	3.6	3.6	3.7	3.7	3.7	18.4
5	4.5	4.5	4.6	4.6	4.6	22.6
6	4.9	5.0	5.1	5.1	5.1	25.2

As shown in Table 11, the overall government spending on HIV (health and other public sectors) ranges from US$285 million in the worst-case scenario to $432 million in the best-case scenario.

Table 11: Total government spending on HIV (US$ million)

Scenarios	2023/24	2024/25	2025/26	2026/27	2027/28	Total
1	71.3	71.8	73.2	73.2	73.2	362.5
2	79.2	79.7	81.3	81.3	81.3	403.0
3	56.1	56.4	57.6	57.6	57.6	285.1
4	62.2	62.6	63.9	63.9	63.9	316.6
5	76.5	76.9	78.5	78.5	78.5	388.7
6	84.9	85.5	87.2	87.2	87.2	432.0

PEPFAR will contribute about 41% of the total potential funds to be mobilised. Other main sources include the Global Fund, the United Nations Partnership Framework and the private sector (Table 12).

Table 12: Other sources of funding (US$ million)

Sources of Funding	2023/24	2024/25	2025/26	2026/27	2027/28	Total
Private sector	15.9	15.9	16.4	16.8	17.3	82.3
PEPFAR	90.3	85.7	81.5	77.4	73.5	408.4
Global Fund	6.7	8.4	8.4	8.4	8.4	40.3
UN Agencies	5.3	5.3	5.5	5.6	5.8	27.5
Total	**118.2**	**115.3**	**111.8**	**108.2**	**105**	**558.5**

Table 13 summarises the six possible funding scenarios depending on government's budget constraints. The worst-case scenario will cost about US$843.8 million, while the best-case scenario is estimated at US$990.5 million.

Table 13: Potentially available funding for the NSF 2023/24 – 2027/28 from all sources (US$ million)

Model	2023/24	2024/25	2025/26	2026/27	2027/28	Total
Model 1	189.5	187.1	185	181.4	178.2	921.2
Model 2	197.4	195	193.1	189.5	186.3	961.3
Model 3	174.3	171.7	169.4	165.8	162.6	843.8
Model 4	180.4	177.9	175.7	172.1	168.9	875.0
Model 5	194.7	192.2	190.3	186.7	183.5	947.4
Model 6	203.1	200.8	199	195.4	192.2	990.5

9.5.2.10 Funding Gap in the NSF 2023/24 – 2027/28

The annual funding gap ranges from US$381.3 million in the best-case scenario to almost US$528.0 million in the worst-case scenario, as shown in Table 14.

Table 14: Funding gap in NSF 2023/24 – 2027/28 (US$ million)

Model	2023/24	2024/25	2025/26	2026/27	2027/28	Total
Model 1	74.8	78.4	88.8	98.7	109.9	450.6
Model 2	66.9	70.5	80.7	90.6	101.8	410.5
Model 3	90.0	93.8	104.4	114.3	125.5	528.0
Model 4	83.9	87.6	98.1	108.0	119.2	496.8
Model 5	69.6	73.3	83.5	93.4	104.6	424.4
Model 6	61.2	64.7	74.8	84.7	95.9	381.3

The potential domestic funding from public and private sources is summarised in Table 15. Domestic HIV financing ranges from US$72 million (worst-case scenario) to US$75 million (best-case scenario) in Model 3, and from US$101.8 million (worst-case scenario) to US$104.5 million (best-case scenario) per annum in Model 6. Accordingly, the proportion of domestic funding as a percentage of the total potential funds mobilised from all sources for the NSF 2023/24 – 2027/28 ranges from 50% to 54% per annum in the best-case scenario (Figure 41).

Table 15: Domestic spending on HIV (US$ million)

Model	2023/24	2024/25	2025/26	2026/27	2027/28
Model 1	87.2	87.7	89.6	90.0	90.5
Model 2	95.1	95.6	97.7	98.1	98.6
Model 3	72.0	72.3	74.0	74.4	74.9
Model 4	78.1	78.5	80.3	80.7	81.2
Model 5	92.4	92.8	94.9	95.3	95.8
Model 6	100.8	101.4	103.6	104.0	104.5

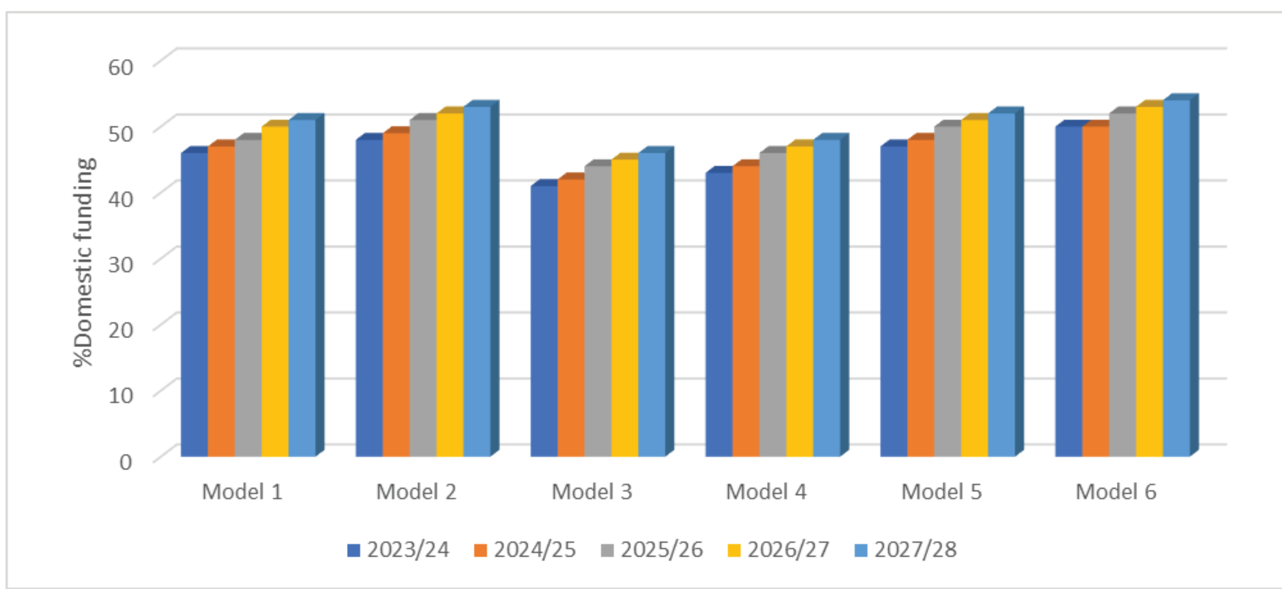


Figure 41: Domestic spending on HIV as % of total potential HIV spending

9.5.2.11 Allocation of Mobilised Resources

Table 16 provides a guide to resource allocation when funds are fully mobilised based on Model 6. The allocation to prevention services ranges from US$29.9 million to US$36.7 million annually, representing about 17% of the available funds. Treatment, care and support is estimated at US$82.8 million to US95.8 million per annum, accounting for nearly 35% of the available funds.

Table 16: Allocation of mobilised resources to HIV interventions (US$ million)

Interventions	2023/24	2024/25	2025/26	2026/27	2027/28	Total	%
Social behaviour change communication	2.6	3.1	3.3	3.4	3.5	15.9	1.6
Condoms	2.5	2.6	2.7	2.9	3.0	13.6	1.4
Voluntary medical male circumcision	4.0	4.3	4.5	4.7	4.8	22.2	2.2
Prevention of mother-to-child transmission	1.8	2.0	2.0	2.1	2.1	10.0	1.0
Pre-exposure prophylaxis (PrEP)	3.4	3.7	4.0	4.2	4.3	19.5	2.0
Post exposure prophylaxis (PEP)	1.2	1.2	1.2	1.1	1.1	5.9	0.6
Economic empowerment	3.1	3.1	3.0	3.0	2.9	15.1	1.5
AGYW and ABYM	7.0	7.6	8.0	8.4	8.9	39.9	4.0
Men having sex with men (MSM)	1.0	1.1	1.2	1.3	1.3	5.9	0.6
Female sex workers (FSW)	1.3	1.5	1.6	1.8	1.8	8.0	0.8
PWID			0.1	0.1	0.1	0.2	0.0
Transgender people (TG)	0.2	0.2	0.2	0.2	0.2	1.1	0.1
People with disability	0.7	0.8	0.9	1.00	1.1	4.5	0.5
Inmates	0.5	0.6	0.6	0.7	0.7	3.1	0.3
Mobile/migrant populations	0.6	0.7	0.7	0.8	0.9	3.6	0.4
Sub-total Prevention	**29.9**	**32.5**	**34.0**	**35.7**	**36.7**	**168.5**	
Treatment, care & support							
HIV testing services	3.3	3.2	3.1	3.0	2.8	15.4	1.6
Antiretroviral therapy	72.7	71.6	69.6	66.9	64.7	345.6	34.9
Treatment monitoring (viral load)	16.2	16.0	15.5	14.9	14.4	77.0	7.8
TB prophylaxis	2.8	0.2	0.2	0.2	0.2	3.6	0.4
Treatment adherence support – nutrition	0.8	0.8	0.8	0.8	0.7	4.0	0.4
Sub-total Treatment, Care & Support	**95.8**	**91.8**	**89.2**	**85.8**	**82.8**	**445.6**	
Social protection							
HIV-sensitive social protection	3.1	3	2.9	2.8	2.7	14.5	1.5
Sub-total Social Protection	**3.1**	**3**	**2.9**	**2.8**	**2.7**	**14.5**	
Programme support & enabling environment							
Human rights & gender-related barriers to access, utilisation & delivery	6.4	6.4	6.3	6.2	6.1	31.4	3.2
Community systems strengthening	6.4	6.4	6.3	6.2	6.1	31.4	3.2
Health management information systems & research	19.3	19.1	18.9	18.6	18.3	94.3	9.5
Procurement & supply chain management	9.6	9.2	8.9	8.6	8.3	44.5	4.5
Laboratory systems & equipment	12.9	12.7	12.6	12.4	12.2	62.8	6.3
Programme governance, policy & coordination	16.1	15.9	15.8	15.5	15.3	78.6	7.9
Finance & sustainability	3.9	3.8	3.8	3.7	3.7	18.9	1.9
Sub-total Programme Support & Enabling Environment	**74.6**	**73.5**	**72.6**	**71.2**	**70**	**361.9**	
GRAND TOTAL	**203.1**	**200.8**	**199.0**	**195.4**	**192.2**	**990.5**	100

CHAPTER 10 Governance, Leadership, Accountability, Coordination and Management of the Response

10.1 Programme Objective

The objective under this programme of the NSF is to improve and strengthen efficiency and effectiveness of coordination across all stakeholders, sectors and regions to ensure a coherent, cohesive, mutually accountable, effective and equitable multi-sectoral and community-led HIV response by 2028.

10.2 Target Population

Primary Target Population

The primary target population includes political, community, private sector, religious, traditional and CSO leaders.

Secondary Target Population

The secondary target population consists of planners.

10.3 Priority Geographic Regions

All 14 regions will be targeted.

10.4 Strategies to Improve Governance and Coordination

- **a.** *Enhance coordination mechanisms and review the membership of the NAEC, TAC and TWGs*
- **b.** *Strengthen and develop a more consolidated structure for the coordination of HIV and health issues, especially for the key ministries – OPM, NPC, Health and Finance*
- **c.** *Strengthen sectoral leadership to manage and coordinate the NAEC, TAC and TWGs*
- **d.** *Include Ministry of Justice and relevant CSO partners in Response Coordination and Management TAC (e.g., LEA and other recommendations)*
- **e.** *Strengthen all TWGs*
- **f.** *MURD to accelerate the MHSS decentralisation process to enhance financial resource management, leadership, procurement and other critical functions*
- **g.** *MHSS to amend job descriptions of Regional Health Directors to include their representation on the Regional Management Development Committee*
- **h.** *Review the terms of reference for the HIV mainstreaming position in the DSP of the MHSS and fast-track recruitment*
- **i.** *CACOC and RACOC reforms to include other issues that they deal with – social development, food security, etc.*
- **j.** *CROs to chair RACOC and HIV mainstreaming to be one of their KPIs*
- **k.** *NCCI and CCN to lead the participation of the private sector and faith-based organisations in the HIV response*
- **l.** *Clarify the roles and responsibilities of MURD in the HIV response – operationalisation of HIV coordination to be clarified*
- **m.** *Revise MIMS and roll-out of community-led monitoring, with CLM indicators to be integrated into MIMS*
- **n.** *Build synergies with the development structures – NPC to work with the DSP of the MHSS to ensure that multi-sectoral HIV mainstreaming is prioritised and contained in the NDP6, to support adequate funding and monitoring*

o. *Improve coordination and synergy of the multi-sectoral response to complement the health component, with the NPC and OPM supporting the DSP of the MHSS by executing their own inherent mandates for coordination*
p. *Institutionalise training and capacity development initiatives for technical and planning staff – HIV mainstreaming, policy development, etc.*
q. *Involve other key institutions, e.g. NIPAM*

Refer to section 5.1.9 for the National Coordination Framework.

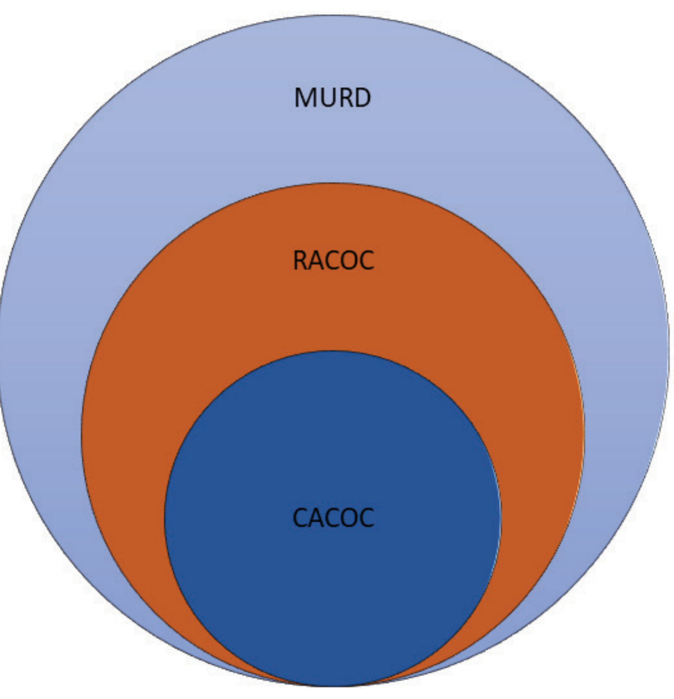


Figure 42: Relationship between MURD, RACOCs and CACOCs

CHAPTER 11 Operationalising the NSF

Introduction

The NSF is a multi-sectoral plan that guides all implementers of the HIV response at national and decentralised levels. The NSF provides guidance on the priority programmes and critical enablers necessary to achieve the desired outcomes. The NSF will be operationalised through different avenues – policy, planning, monitoring and direct service delivery. Implementation will take place at national, regional, municipal and community levels. Key implementers will include the MHSS, other government OMAs, civil society organisations, the private sector, development partners and technical partners. Communities will be involved in service delivery, as well as being beneficiaries. Each implementer will participate in the implementation of the NSF according to its mandate.

11.1 National Operational Plan

The National Operational Plan (NOP) will transform the strategies into action. This will involve the development of two-year rolling plans updated annually and coordinated by the DSP. Sectoral and line ministry HIV operational plans will also be developed to ensure that streamlining occurs at all levels. Existing partner and stakeholder operational plans, such as the PEPFAR COP and Global Fund grant, will be incorporated into the NOP. Going forward, subsequent partner operational plans will be able to use the NOP as the starting point for their processes, since the NOP will contain up-to-date information on the country's needs and funding gaps.

The NOP will be fully costed using activity-based costing to reflect the operational nature of the plans and provide planners with more accurate forecasts of funding needs.

A system for tracking financial resources and target achievements will be key for successful implementation of the NOP. The structure of the NOP will allow for expenditure tracking for use in implementation monitoring. Linkages will also be made to national indicators and targets derived from the NSF. Monitoring will include periodic (preferably quarterly) review meetings where implementation progress will be monitored. This system will also allow for timely and effective collation of HIV expenditure data for use in regular national resource tracking exercises.

11.2 Programme Technical Working Groups (TWGs)

Technical Working Groups will be established/strengthened at the national level to coordinate programmes. The TWGs will review overall progress in implementation of all key areas of the NSF, namely Prevention; Treatment, care and support; Health systems strengthening; Enabling environment; Financing of the NSF; Coordination and advocacy; and Strategic information and research. The DSP will convene and serve as a secretariat to these TWGs.

11.3 Regular Review of NSF Implementation

An inter-sectoral committee will be established to review progress towards achievement of the NSF targets, identify bottlenecks and propose solutions. Such a committee will draw its membership from the management level of all sectors to enable the committee to make

decisions. The reviews will be based on progress reports generated from the M&E system, the tracking of NOP implementation, and feedback from the TWGs. In line with the decentralisation of the HIV response, RACOCs will play a similar role at regional level, and will review implementation progress and bottlenecks specific to each region. At both national and regional levels, the participation of AGYW, ABYM, and key and vulnerable populations will be ensured.

An executive dashboard will be developed to provide user-friendly data presentation and enable the inter-sectoral committee at national level and regional level to review progress against selected key indicators.

11.4 Advocacy and Communication

Advocacy and communication for the HIV response will be undertaken at national, regional, municipal and community levels, as well as international level. Advocacy will be intensified to ensure implementers focus on the prioritised programmes and strategies and align their plans accordingly. At the regional level, advocacy will be aimed at influencing and sustaining the integration of the HIV response to existing community structures, and promote community involvement. At the national level, advocacy will be undertaken to sustain government commitment to the HIV response. International partners will also be targeted for advocacy to sustain financial and technical support, and to showcase Namibia's successes in the HIV response.

11.5 Financing

To resource the implementation of the NSF 2023/24 – 2027/28, the financing strategies outlined in Chapter 9 of this NSF will be implemented. An HIV financing committee will be established to lead resource mobilisation. The DSP will support the work of this committee. In addition, a mechanism to undertake expenditure tracking and other efficiency analysis activities will be put in place.

11.6 Regular Annual Reviews and Annual Review Reports

The monitoring of the NSF 2023/24 – 2027/28 will be strengthened through implementation of the strategies laid out in Chapter 7 of this NSF. In addition, an M&E plan will be developed to guide all monitoring activities. The M&E plan will be fully costed, detailing M&E activities and the institutions responsible for their implementation. Operational processes for M&E will be put in place to ensure efficient data flow and use. Monitoring data will inform decision making at all levels.

11.7 National Level

11.7.1 Immediate Actions at the National Level

1. Present the NSF to Cabinet, the Meeting of Senior Officers, the NAEC, the MURD, etc., to be followed by circulars from the MHSS to relevant ministries in the non-health response, detailing, immediate, medium-term and long-term actions.
   1.1. The National Planning Commission must ensure that line ministries and agencies involved in the multi-sectoral response to HIV/AIDS include activities as described in the national HIV/AIDS strategic plan in their sectors' input into the National

Development Plan (NDP) to ensure that the NDP can be well resourced, and included in the annual plans for the various ministries.

1.2. Implement new coordination mechanisms at regional levels, under which HIV/AIDS is taken to the meeting of the Regional Management Development Committees (RMDC) by the Regional Director for Health, where high-level decisions are made, while RACOC meetings will be attended by intermediate/subordinate officers.

1.3. The OPM under its Directorate of Performance Improvement, which sets the KPIs for school principals, should add relevant KPIs and prioritise CSE and the health of AGYW and ABYM. Principals should be evaluated on their implementation of these interventions. The high costs of pregnancy, STIs and HIV/AIDS amongst adolescents and young adults place a heavy burden on the economy.

2. Develop national and regional operational plans
3. Decentralise the MHSS to the regions
4. Establish task forces for:
    - Unifying the health extension system
    - Disadvantaged or high-burden districts
    - Reduction of inequality in access to HIV testing, ART treatment and viral load suppression
5. Institute annual reviews, with reports from each ministry
6. Establish a task force for integration of the vertical HIV/AIDS programme into the primary healthcare system
7. Establish a TWG for the non-health response

11.7.2 Medium-term Actions at National Level

Conduct the mid-term review.

11.7.3 Long-term Actions at National Level

Conduct the End-Term Review.

11.8 Regional Level

11.8.1 Immediate Actions at the Regional Level

1. Each region, in collaboration with the national level, must develop a process for setting regional targets for the NSF
2. Organise advocacy and dissemination to the regions, composed of:
    2.1. Sensitise MURD
    2.2. Sensitise Governors
    2.3. Sensitise CROs
    2.4. Sensitise RACOCs and CACOCs
    2.5. Sensitise municipalities and their mayors, focusing initially on priority cities

11.8.2 Medium-term Actions at the Regional Level

Conduct regional mid-term reviews, to feed into the national mid-term review.

11.8.3 Long-term Actions at the Regional Level

Conduct regional End-Term Reviews, to feed into the national End-Term Review.

11.9 Municipality, District and Constituency Levels

The operational plans for these lower levels will be compiled and implemented by the regions, with technical assistance from the national level. Particular attention will be paid to the plans

for the large cities under the Fast-Track Cities Initiative. In addition, the geographic areas covered by districts, constituencies and PHC centres need to be carefully aligned.

REFERENCES

Abt Associates. (2017). *Unit Cost and Quality of Health Services in Namibia.* Bethesda, MD.

AfroBarometer. (2022). *Afrobarometer Survey of GBV in Namibia.* Windhoek: AfroBarometer, IJR and Survey WareHouse.

Amnesty International. (2021). *Namibia: "We don't feel well treated": Tuberculosis and the Indigenous San peoples of Namibia.* London, UK: Amnesty International.

Chipanta, D. (2022). Socio-economic inequalities in the 90-90-90 target amongst people living with HIV in 12 sub-Saharan African Countries-Implications for the 95-95-95 target-Analysis of population-based surveys. *eClinicalMedicine*.

Ekholuenetale M, O. H. (2021). Socioeconomic Inequalities in Human Immunodeficiency Virus (HIV) Sero-Prevalence among Women in Namibia: Further Analysis of Population-Based Data. *Int J Environ Res Public Health*, 10.3390/ijerph18179397.

Global Fund. (2017). *THE GLOBAL FUND STRATEGY 2017-2022 Investing to end epidemics.* Geneva: Global Fund.

Global Fund. (2020). *The Impact of COVID-19 on HIV, TB and Malaria Services and System for health. ASNAP.* Geneva: Global Fund.

GRN. (1990). *Namibian Constitution.* Windhoek: Republic of Namibia (GRN).

GRN. (2000). *Value-Added Tax Act 10.* Windhoek: Namibia Revenue Agency The Namibia Revenue Agency (NamRA), Republic of Namibia (GRN).

GRN. (2005). *Republic of Namibia Civic Organisations Partnership Policy.* Windhoek: Republic of Namibia.

GRN. (2008). *Vocational Education and Training Act.* Windhoek: Namibia Revenue Agency The Namibia Revenue Agency (NamRA), Republic of Namibia (GRN).

GRN. (2011). *Namibi Population and Housing Census Main Report.* Windhoek: Republic of Namibia (GRN), Namibia Statistics Agency (NSA).

GRN. (2012a). *National Policy Framework.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).

GRN. (2012b). *Poverty Dynamics in Namibia: A Comparative Study Using the 1993/94, 2003/04 and 2019/10 NHIES Surveys, November 2012.* Windhoek: Republic of Namibia (GRN), Namibia Statistics Agency (NSA).

GRN. (2012c). *The 2012 Education Management Information System (EMIS) Report.* Windhoek, Namibia: Republic of Namibia (GRN), Ministry of Education Arts and Culture (MEAC).

GRN. (2013). *The Namibia Demographic and Health Survey 2013.* Windhoek, Namibia, and Rockville, Maryland: Republic of Nambia (GRN), Ministry of Health and Social Services (MHSS); ICF International.

GRN. (2014). *Namibia Demographic and Health Survey 2013.* Windhoek and Rockville, Maryland: Republic of Namibia (GRN), Namibia statistics agency (NSA); National Institute of Pathology (NIP); United States Agency for International Development (USAID).

GRN. (2014). *National Coordination Framework for the Multi-sectoral HIV and AIDS Response in Namibia 2013-2017.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).

GRN. (2015a). *Central Procurement Board of Namibia Act 2015 (Act no. 15 of 2015).* Windhoek: Republic of Namibia (GRN).

GRN. (2015b). *Results of the 2012-2014 Integrated Biological and Behavioral Surveillance Studies (IBBS) among Female Sex Workers (FSWs).* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS), Directorate of Special Programmes (DSP).

GRN. (2016). *National Guidelines on Health Services Intergration.* Windhoek: Republic of Nambia (GRN), Ministry of Health and Social Services (MHSS), Directorate of Primary Health Services.

GRN. (2017a). *Namibia Population-Based HIV Impact Assessment (NAMPHIA).* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).

GRN. (2017b). *Namibia Population-based HIV Impact Assessment (NAMPHIA) 2017: Final Report.* Wndhoek Namibia: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).

GRN. (2017c). *Namibia Population-Based Impact Assessment (NAMPHIA).* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).

GRN. (2017d). *Namibia Public Health Impact Assessment (NAMPHIA).* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).

GRN. (2017e). *The National Strategic Framework for HIV and AIDS Repsonse in Namibia 2017/18 to 2021/22.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS). Directorate of Special Programmes (DSP).

GRN. (2018a). *HIV and AIDS Stigma and Discrimination Survey in Namibia.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS). Directorate of Special Programmes (DSP).

GRN. (2018b). *National Development Plan 5 2018 -2022.* Windhoek: Republic of Namibia (GRN), National Planning Commission (NPC).

GRN. (2018c). *The HIV Stigma Index.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).

GRN. (2019a). *Education Management Information System.* Windhoek: Republic of Namibia (GRN), Ministry of Education Arts and Culture (MEAC).

GRN. (2019b). *Namibia Integrated bio-behavioral Surveys among key populations 2019.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).

GRN. (2020a). *Expanded mid-term review report of The National Strategic Framework 2017/2018 – 2021/2022.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).

GRN. (2020b). *Revised National Strategic Framework for HIV and AIDS Response in Namibia (R-NSF) 2020/21 - 2021/22.* Windhoek Namibia: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS), Directorate of Special Programmes (DSP).

GRN. (2020c). *The National Condom Strategy.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).

GRN. (2021a). *COVID-19 Monthly reports.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).

GRN. (2021b). *COVID-19 update, 29 June 2022.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).

GRN. (2021c). *Food and Nutrition Policy.* Windhoek: Republic of Namibia (GRN), Ministry of Agriculture, Water and Forestry (MAWF).

GRN. (2021d). *Anual Report for 2021 -2022.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).

GRN. (2021d). *Social Protection Policy 2021-2030.* Windhoek: Republic of Namibia (GRN); Ministry of Gender Equality, Poverty Eradication and Social Welfare (MGEPESW).

GRN. (2021e). *Revised Food Securuty and Nutrition Policy.* Windhoek: Republic of Namibia (GRN), Office of the Prime Minister (OPM).

GRN. (2021f). *Primary Health Care Facility Quality Standards, 1st Edition.* Windhoek: Republic of Namibia.

GRN. (2021g). *National Quality Management Strategic Plan 2021/2022 – 2025/2026.* Windhoek: Republic of Namibia.
GRN. (2021h). *National Quality Management Policy 2021/2022 – 2025/2026.* Windhoek: Republic of Namibia.
GRN. (2021i). *HIV /AIDS spectrum estimates 2021.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).
GRN. (2021k). *HIV /AIDS Spectrum Estimates 2021.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).
GRN. (2022a). *EMIS Education Statistics, 2021.* Windhoek: Republic of Namibia (GRN), Ministry of Education Arts and Culture (MEAC).
GRN. (2022b). *National Voluntary Medical Male Circumcision strategy (2023-2028).* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).
GRN. (2022b). *Social Contracting & Payment for Results: The panacea of epidemic control 2022 - 2030 (Draft).* WIndhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS), Directorate of Special Programmes (DSP).
GRN. (2022c). *Program performance report 2022.* Windhoek: Republic of Namibia (GRN), Ministry of Heallth and Social Services (MHSS).
GRN. (2022d). *Namibia National Quantification for Reproductive and Maternal Health Commodities.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).
GRN. (2022e). *National Social Welfare Policy.* Windhoek: Republic of Namibia (GRN), Ministry of Gender Equality, Poverty Eradication, and Social Welfare (MGEPESW).
GRN. (2022f). *Annual Report 2021-2022.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).
GRN. (2022g). *Namibia National Quantification for Reproductive and Maternal Health Commodities.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).
GRN. (2022h). *National Voluntary Medical Male Circumcision Strategy.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).
GRN. (2022j). *Mimimum Package of HIV and TB Services for People in Correctional Services and Police Holding Cells.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).
GRN. (2022k). *Spectrum Model.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).
GRN. (2022l). *Health Information Systems Assessment Report.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS).
GRN. (2022m). *FNS-Policy-launch-brochure.pdf.* Windhoek: Republic of Namibia (GRN), Office of the Prime Minister (OPM).
GRN. (September 2014). *Results of the Namibia Men's Health Study: Integrated Biological and Behavioral Surveillance Studies (IBBS) among Men who have Sex with Men in Namibia.* Windhoek: Republic of Namibia (GRN), Ministry of Health and Social Services (MHSS), Directorate of Special Programmes (DSP).
GRN. (Unpublished). *The Namibia Health in All Policies Strategy 2019-2024 (Draft).* Ministry of Health and Social Services (MHSS): Republic of Namibia (GRN).
Iheme, B. C. (2009, February 2). Reformist Leaders and Civil Society: The Legal and Regulatory Framework for Civic Organizations in Namibia. *The International Journal of Not-for-Profit Law, 11*(2).
ILO. (2020). *Disability Inclusive Social Protection Response to COVID-19 Crisis.* Geneva, Switzerland: International Labour Organization (ILO).

ILO: IDA. (2019). *Joint Statement: Towards Inclusive Social Protection System Supporting Full and Effective Participation of Persons with Disabilities.* Geneva, Switzerland: International Labour Organization (ILO); International Disability Alliance (IDA).

IWGIA. (2019, April 29). *Indigenous World 2019: Namibia*. Retrieved from International Work Group for Indigenous Affairs (IWGIA): https://www.iwgia.org/en/namibia/3506-iw2019-namibia.html

Jones, C., Guthrie, T., & Mbeeli, T. (2018). *Achieving institutionalization of resource tracking by combining methodologies for health and HIV: The Namibian experience.* Windhoek, Namibia.

Kneen, J. (2013). *The Africa Mining Vision: A Limited Field of View?* Retrieved February 16, 2022, from https://miningwatch.ca/es/blog/2013/8/22/africa-mining-vision-limited-field-view

Moyo. (2022). The Political Economy of Zimbabwe's Food Crisis, 2019–2020. *Sage Journals*.

Muchena, D. (2021). *Namibia: Discrimination deprives Indigenous San people of the right to health as TB poses serious risk to their lives*. Retrieved February 9, 2022, from Amnesty International: https://www.amnesty.org/en/latest/news/2021/10/namibia-discrimination-deprives-indigenous-san-people-of-the-right-to-health-as-tb-poses-serious-risk-to-their-lives/

N. Ruswa, N. M. (2019). Second nationwide anti-tuberculosis drug resistance survey in Namibia. *National Library of Medicine*, 858–864.

Namibia Statistics Agency (NSA). (2018). *The Namibia Labour Force Survey 2018 Report.* Windhoek: NSA.

NANASO. (2022a). *HIV COVID-19 National Community Engagement Strategy and Plan (H-C19 NCESP) 2022- 2026.* Windhoek, Namibia: Namibian Network of AIDS Service Organisations (NANASO).

NANASO. (2022b). *HIV COVID-19 National Community Engagement Strategy and Plan (H-C19 NCESP) 2022- 2026: Costed Implementation Plan (CIP).* Windhoek, Namibia: Namibian Network of AIDS Service Organisations (NANASO).

Nibogora B. and Shemiah N. (2018). *A Policy Advocacy Guide on Sexual Reproductive Health and Rights [SRHR] for Young Key Populations [YKPs].* Johannesburg, SA: AMSHeR.

NID. (2015). *Study on the Status, Role and Performance of Regional and Local Government Development Committees in Selected Regions of Namibia.* Retrieved from The Namibian Institute for Democracy (NID): https://www.nid.org.na/projects-activities/election-support-program/13-publications/138-regional-and-local-government-development-committee-3

NID. (2023). *Civil Society Support Programme (CSSP)*. Retrieved from Namibia Institute for Democracy (NID): https://www.nid.org.na/projects-activities/civil-society-support-programme

NSA. (2022). Windhoek: NSA.

NSA. (2018). Namibia Labour Force Survey: Windhok. NSA

OHCHR. (2013). *Report of the Special Rapporteur on the rights of indigenous peoples, James Anaya: The situation of indigenous peoples in Namibia.* Geneva, Switzerland: The United Nations Human Rights Council.

O'Neill, A. (2021). Youth unemployment rate in Namibia. *Statista https://www.statista.com/statistics/812268/youth-unemployment-rate-in-namibia/*.

Pact Namibia. (2013). *Building capacity of civil society organisations in Namibia: Pact approaches to take organisations to the next level.* Windhoek, Namibia: USAID; Pact Namibia.

PEPFAR. (2021). *NAMIBIA PrEP Ring Situation Analysis* . Windhoek: PEPFAR.

PEPFAR. (2021). *NAMIBIA PrEP Ring Situation Analysis* . Windhoek: PEPFAR.

PEPFAR. (2022a). *Namibia Country Operational Plan Strategic Direction Summary.* Windhoek: PEPFAR.

PEPFAR. (2022b). *Namibia Country Operational Plan 2022 Strategic Direction Summary.* Windhoek: PEPFAR Namibia.

Perez, S. (2021). *Community-Led Monitoring and Advocacy (CLM&A) Implementation Strategy 2021-2023.* Windhoek: Unpublished.

Pharos Global Health Advisors and Avenir Health. (2020). *Namibia HIV Investment Case 2.0.* Windhoek, Namibia.

Putzel, L., Kelly, A., Cerutti, P., & Artati, Y. (2014). *Formalization of natural resource access and trade: Insights from land tenure, mining, fisheries, and non-timber forest products.* Bogor, Indonesia: Center for International Forestry Research.

Shihomeka, S. P. (2017a). *Engaging citizens: New media and political engagement in Namibia.* Windhoek, Namibia.

Shihomeka, S. P. (2017b). *Mobile Phones and Digital Divide: An Ethnographic Analysis of Youth Participation in Politics in Ohangwena Region, Namibia.* Windhoek, Namibia.

Shumba, T. W., & Moodley, I. (2018). Implementation of disability policy framework in Namibia: A qualitative study. *The South African journal of physiotherapy, 74*(1 400). doi:doi:10.4102/sajp.v74i1.400

SusDAf. (2014). *Health Vulnerabilities of Mobile Populations and Affected Communities in Selected Ports of Southern Africa – Walvis Bay, Namibia.* Windhoek, Namibia: International Organization for Migration (IOM).

Teklehaimanot, H. D., & Dijk, P. H.-v. (2018). *Evaluation of the Namibian Community Health Workers Programme.* Windhoek: Republic of Namibia, USAID, Maternal and Child Survical Programme, UNICEF.

The Global Fund. (2020). *The Impact of Covid-19 on HIV, TB and Malaria Services and Systems for Health: A Snapshot from 502 Health Facilities Across Africa and Asia.* Geneva, Switzerland: The Global Fund.

The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). (2022). *The Global Fund Strategy 2023-2028.* Geneva: GFATM.

The Global Fund, Institute for Global Public Health & University of Manitoba. (2022). *Implementation of outcome measurement in Global Fund supported adolescents' girls and young women programs in Namibia.* Windhoek: The Global Fund, Institute for Global Program.

The United Nations Human Rights Council (HRC). (2021). *Namibia Unuversal Peer Review Report 2021 A/HRC/WG.6/38/NAM/1.* Geneva: UN and GRN.

Tshabalala, S. (2015, July 16). *These charts show why Namibia doesn't want to be called an upper middle income country*. Retrieved from Quartz: https://qz.com/africa/454505/these-charts-show-why-namibia-doesnt-want-to-be-called-an-upper-middle-income-country

UN. (2015). *Sustainable Development Goals.* Geneva: UN.

UNAIDS. (2009).

UNAIDS. (2016). *UNAIDS Global AIDS Strategy 2016-2021.* Washington DC: Joint United Nations Programme on HIV/AIDS (UNAIDS).

UNAIDS. (2017). *Ending AIDS - Progress Towards 90-90-90 Targets.* UNAIDS.

UNAIDS. (2018). *HIV Prevention 2020 Road Map: Accelerating HIV prevention to reduce new infections by 75%.* Geneva: UNAIDS.

UNAIDS. (2018). *Undetectable = Untransmitable Public Health and Viral Load Suppression* . unaids.org: UNAIDS.

UNAIDS. (2021a). *Estimates.* Windhoek: UANIDS.

UNAIDS. (2021b). *UNAIDS Global AIDS Strategy 2021–2026. End Inequalities, End AIDS.* Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS).
UNAIDS. (2021c). *UNAIDS Global AIDS Strategy 2021-2026.* Washington DC: UNAIDS.
UNAIDS. (2021d). *Spectrum Model.* Windhoek: UNAIDS.
UNAIDS. (2021e). *Final Report on District-specific HIV and COVID-19 Profiles.* Windhoek: UNAIDS.
UNAIDS. (2021f). *GAM.* Windhoek: UNAIDS.
UNAIDS. (2021g). *Global HIV & AIDS statistics*. Retrieved from AIDSInfo.
UNAIDS. (2021h). *HIV Estimates.* Windhoek: UNAIDS.
UNAIDS. (2022a). *Dangerous inequalities: World AIDS Day report 2022.* Geneva: Joint United Nations Programme on HIV/AIDS; Licence: CC BY-NC-SA 3.0 IGO.
UNAIDS. (2022b). *Global AIDS Monitoring Report.* Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS).
UNAIDS. (2022c). *Namibia HIV Draft Estimates.* Windhoek: UNAIDS.
UNAIDS. (2022d). *Spectrum 2022.* Windhoek.
UNAIDS And UNDP. (2012). *Understanding and Acting on Critical Enablers and Development Synergies for Strategic Investments* . Geneva and New York: UNAIDS And UNDP.
UNDP . (2022). *Human Development Report 2021-22: Uncertain Times, Unsettled Lives: Shaping Our Future In A Transforming World.* New York: United Nations Development Program (UNDP).
UNDP. (2016). *Namibia Legal Environment Assessment of HIV And AIDS.* Windhoek: UNDP .
UNDP. (2018). *Statistical Update: Human Development Indices and Indicators.* New York.: UNDP.
UNDP. (2022). *Statistical Update: Human Development Indices and Indicators.* New York.: UNDP.
UNFPA, WHO & PATH. (2018). *condom programming for HIV prevention: an operations manual for programme managers.* New York: UNFPA.
United Nations. (2019). *United Nations Partnership Framework (UNDAF) 2019-2023.* Windhoek: United Nations.
United Nations. (2019). *United Nations Political Declaration of the High-level Meeting on Universal Health Coverage: "Universal Health Coverage: Moving Together To Build A Healthier World, UN Plenary Meeting held on 23rd September 2019.* New York: The United Nations.
United Nations. (2021). *United Nations Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030, Declaration 75/284 74th Plenary Meeting held on 8th June 2021.* New York: The United Nations.
United Nations. (8th June 2021). *United Nations Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030, Declaration 75/284 74th Plenary Meeting held on 8th June 2021.* New York: The United Nations.
United States Department of State. (2020). *Country Reports on Human Rights Practices for 2020: Namibia* . Washington DC: USG: Bureau of Democracy, Human Rights and Labor.
USAID & Intrahealth Namibia. (2022a). *Hot spot mapping and key population size estimation in nine priority geographic areas.* Windhoek: Unpublished.
USAID & Intrahealth Namibia. (2022b). *Hot spot mapping and key population size estimation in nine priority geographic areas.* Windhoek: Unpublished.
USAID. (2012). *The Namibia Gender Assessment 2012* . Washington DC: USAID.

USAID. (2020). *International Centre for Not-for-profit Law (ICNL) 2020 Civil Society Organization Sustainability Index.* Washington, DC: United States Agency for International Development (USAID).

WFP. (2020). *Namibia Annual Country Report 2020: Country Strategic Plan 2017 - 2022.* Rome, Italy: World Food Programme (WFP).

WHO . (2023, January 14). *COVID-19 (WHO African region) (EPR/HIR)*. Retrieved from https://who.maps.arcgis.com/apps/dashboards/0c9b3a8b68d0437a8cf28581e9c063a9.

WHO. (2021, March). Updated recommendations on HIV prevention, infant diagnosis, antiretroviral initiation and monitoring. Geneva, Switzerland.

WHO. (2021a, March). Updated recommendations on HIV prevention, infant diagnosis, antiretroviral initiation and monitoring. Geneva, Switzerland.

WHO. (2021b). Global guidance on criteria and processes for validation: elimination of mother-tochild transmission of HIV, syphilis and hepatitis B virus. Geneva. Retrieved from http//WHO.int: https://www.who.int/initiatives/triple-elimination-initiative-of-mother-to-child-transmission-of-hiv-syphilis-and-hepatitis-b

WHO. (2021b). Namibia aiming to eliminate malaria through eco-friendly preventive strategies. *OCHA Services*.

WHO. (2022). *Differentiated and simplified pre-exposure prophylaxis for HIV prevention: update* . Geneva: WHO.

World Bank. (2021). *Namibia Systematic Country Diagnostic.* Washington, DC:: World Bank Group, License: Creative Commons Attribution CC BY 3.0 IGO. http://creativecommons. org/licenses/by/3.0/igo.

World Bank. (2022). *d HUMAN DEVELOPMENT REPORT 2021/2022.* UN Plaza, New York, NY 10017 USA: World Bank.

World Bank. (2022). *INEQUALITY IN SOUTHERN AFRICA: AN ASSESSMENT OF THE SOUTHERN AFRICAN CUSTOMS UNION.* Washington DC 20433: World Bank.

Worldometer. (2023, January). *Worldometer*. Retrieved from https://www.worldometers.info/coronavirus/country/namibia/#coronavirus-cases.

1Annex 1: Coordination Framework – Mandates, Roles and Membership of the National Coordinating Structures

Name of Structure	Mandate	Roles	Membership
Cabinet	Cabinet is the highest policy making body on HIV/AIDS in Namibia. The membership is composed of sitting Ministers. The function of Cabinet is to approve the National HIV/AIDS Policy and National HIV/AIDS Strategic Framework.	✓ Ensure periodical review of the National HIV and AIDS Policy and other national, and sector policies to mainstream HIV and AIDS. ✓ Ensure that the multi-sectoral HIV and AIDS response in Namibia is aligned to the long-term social and economic development goals articulated in Vision 2030, NDPs and Global and Regional targets. ✓ Ensure equitable distribution, availability, access, and utilisation of HIV and AIDS services. ✓ Ensure enforcement and compliance with relevant HIV and AIDS policies and legislation. ✓ Ensure adequate and sustained funding of the national HIV and AIDS multi-sectoral response. ✓ Maintain HIV and AIDS agenda on the national socio-economic and political development agenda.	➢ All Cabinet Ministers ➢ Director General National Planning Commission ➢ Auditor General ➢ Attorney General ➢ Ombudsperson

Meeting of Senior Civil Servants	This is a monthly meeting of Permanent Secretaries (PS). It has the responsibility of ensuring harmonization and alignment of the national response with government policy frameworks, in addition to overseeing the HIV mainstreaming in different public sectors. At individual sector level, Permanent Secretaries are responsible for reviewing and approving sector specific HIV mainstreaming action plans and budgets.	✓ Ensure alignment of the national HIV and AIDS response with government policies and legislation ✓ Provide leadership, support and facilitate resource mobilisation and allocation for internal and external mainstreaming of HIV and AIDS response in the sector development plans. ✓ Receive and review reports from NAEC. The Committee can approve recommendations by NAEC, unless in their opinion the decision is required from Cabinet. ✓ Ensure strengthening	➢ All Executive Directors, ➢ Director General ➢ National Planning Commission
		synergies between the sectors and the national HIV and AIDS response.	
National AIDS Executive Committee (NAEC)	The composition is multi-sectoral with representation from all stakeholders drawn from public and private sectors, civil society and development partners with a mandate to provide technical leadership, facilitate programme development and planning, oversee capacity development and technical assistance, partnership strengthening and management of strategic information. The committee also reviews programme coordination, policies and legislation and makes recommendations to Cabinet for approval and meets on a quarterly basis and reports to the Meeting of Senior Civil Servants and to Cabinet if required. NAEC work through technical advisory committees, sector steering committees, programme and specialised committees that may be established from time to time.	✓ Ensure harmonization and alignment of stakeholder's priorities with the national priorities. ✓ Ensure the existence and availability of an updated National HIV and AIDS policy. ✓ Ensure joint (multi-sectoral) development and implementation of the National Strategic Frameworks (NSF), sector and regional plans, and the National Operational Plan (NOP). ✓ Monitor compliance by stakeholders with existing policies, ✓ Legislation and technical programme guidelines and protocols. ✓ Commission Joint mid-term review and End-Term Evaluation of the NSF. ✓ Ensure effective monitoring and reporting on the implementation progress of the NSF. ✓ Facilitate research to generation of new knowledge or data to fill in strategic policy and programme gaps. ✓ Facilitate resource mobilisation, investments in high impact interventions and tracking of resources for HIV and AIDS.	➢ All Deputy Permanent Secretaries ➢ Chairperson – Chamber of Mines ➢ Chairperson – Chamber of Commerce and Industry ➢ Director – AMICCALL ➢ Country Director - CDC ➢ Country Director - GIZ ➢ UNAIDS Country Coordinator ➢ Country Coordinator – PEPFAR ➢ Director - Association of Local Authorities' Declaration on HIV/AIDS (ALAN) ➢ Director – GFATM Programme Management Unit ➢ Director - NABCOA ➢ Director – NANASO, (also representing NANGOF) ➢ Representative, Outright Namibia ➢ Representative, Rights Not Rescue ➢ Director General – Electoral Commission ➢ Namibian National Women's Association ➢ National Union of

			Namibian Workers (NUNW) ➢ Representative of a faith-based organisations ➢ Representative of Organisations of people living with HIV ➢ Representative of the National Youth Council ➢ Representatives of UN Agencies ➢ Representative of other Development partners (EU, DFID etc.) ➢ Representative – Regional Association of Councils ➢ Sector Coordinators
The Combination Prevention Strategy (CPS) TAC	The mandate of the CPS–TAC is to provide strategic technical support to NAEC and participating implementing partners in planning and implementation of integrated HIV prevention, treatment, care and support interventions within the context of the multi-sectoral HIV and AIDS response.	✓ Provide technical guidance to NAEC and NSF implementing partners in the planning and implementation of high impact prevention interventions. ✓ Ensure that the NSF strategies, policies, programmes and services are evidence-based and are adapted to the Namibian context.	All Prevention ➢ Programme Coordinators ➢ Representatives of civil society, including faith-based organisations ➢ Representative of private sector ➢ Representative of key development partners involved in prevention activities ➢ A representative of human rights organisation

		✓ Provide oversight on the implementation of combination prevention interventions. ✓ Facilitate the identification of policy and programme gaps in HIV prevention, treatment, care and support. ✓ Facilitate the development and revision of prevention targets for the NSF implementation. ✓ Have an oversight responsibility to ensure the quality, relevance, cultural and national sensitivity of prevention messages and interventions.	➢ Coordinator of the public sector workplace HIV and AIDS / Wellness programmes
Response Coordination and Management TAC	The mandate of the RCM–TAC is to provide strategic technical support to national and decentralised coordinating structures, in-order to enhance efficiency and effectiveness in all aspects of the response.	✓ Ensure effective coordination and management of the many and diverse implementing partners at national, regional and community levels. ✓ Provide technical guidance and support in developing and strengthening the capacity of coordinating structures at all levels. ✓ Provide technical assistance in developing and implementing sustainable financing strategies for the national response. ✓ Ensure strengthening of strategic partnerships and alliances with development partner's communities and community-based organisations.	➢ Office of the Prime Minister – Coordinator for the Workplace /Wellness programmes ➢ Representative of MURD ➢ UNAIDS Country Coordinator ➢ Director PEPFAR ➢ Director Global Fund PMU ➢ Director CDC ➢ Director USAID ➢ All HIV Sector Coordinators ➢ Chairs of the CPS and RM&E TACs ➢ Director Health Works Business Coalition ➢ Director NANASO ➢ Walvisbay Corridor Group ➢ WHO ➢ UNFPA ➢ UNDP ➢ UNICEF

M&E and Research TAC	The mandate of the M&ER-TAC is to support NAEC efforts in strategic information generation, management and dissemination of new knowledge on HIV and AIDS, in addition to advocacy on the use of evidence-based information for planning and resource mobilisation and allocation.	✓ Support efficient and effective routine data collection, and reporting by all stakeholders ✓ Support periodical reviews and evaluation of the national HIV and AIDS response.	➢ M&E Personnel from implementing partners ➢ M&E Officer – Global Fund PMU ➢ UNAIDS Strategic Information Adviser Officers M&E officers from CDC, PEPFAR, GIZ, ➢ M&E officer – National

		✓ Ensure harmonisation and alignment of indicators, targets, data collection and reporting tools, ✓ Facilitate the development and implementation of the national HIV research agenda, ✓ Advocate for increased access and utilisation of empirical data by stakeholders and in particular decision and policy makers. ✓ Advocate for the development and implementation of M&E and research capacity. ✓ Advocate for the establishment and maintenance of national HIV and AIDS database linked with other relevant databases such as the Health Information Systems (HIS)	Planning Commission ➢ M&E Officer – MOLG ➢ M&E Officer – Office of the Prime-Minster ➢ M&E Officer – TB programme ➢ M&E Officer Khomas Regional Council

Permanent Task Force for Children	The mandate of PTF is to advocate, promote and support child welfare interventions, promote social protection, and impact mitigation for children. PTF has also assumed the responsibility of coordinating impact mitigation efforts of the NSF that were previously coordinated by the Impact Mitigation TAC. Strengthen synergies with other coordinating structures such as the NAFIN for food security and nutrition, and the National Gender Task Force, for interventions on gender-based violence.	✓ Coordinate the national multi-sectoral planning and programming for children. ✓ Facilitate the development and implementation of the National Agenda for Children and the accompanying National M&E Plan for children ✓ Facilitate networking among the key stakeholders and service providers at national, regional and community levels to provide services to children. ✓ Ensure stakeholder accountability for service to children based on the legal and social obligations of the duty bearers' and rights holders. ✓ Mobilise resources to support interventions targeting children.	➢ OMAs ➢ Representatives from UN Agencies ➢ Lifeline Childeline ➢ Women and Child Protection Units ➢ Relevant Non- Governmental Organisations ➢ Private Sector Representatives
Regional AIDS Coordinating Committees (RACOCs)	RACOC's are Multi-sectoral committees whose membership is drawn from all stakeholders operating within a specific region with the mandate to facilitate and coordinate regional level response. RACOCs are chaired by the Chairpersons of the Regional Councils and deputised by	✓ Coordinate joint and participatory planning and implementation of strategies aimed at mitigating HIV and AIDS. ✓ Facilitate resource	➢ Regional representatives of Government agencies, ministries and organisations ➢ Regional representatives of civil society organisations –

	the Chief Regional Officer and Regional Health Director or a Member of Management Committee appointed by the Regional Council. They operate under the auspices of the Ministry of Urban and Rural Development (MURD).	Mobilisation for regional responses. ✓ Advocate for stakeholders accountability and good governance of the response. ✓ Provide technical, financial and material support to CACOCs in developing and implementing their own operational plans. ✓ Identify capacity needs, develop and implement strategies to address capacity gaps. ✓ Compile quarterly regional reports for submission to the MURD through the Regional Councils and to NAEC.	NGOs, FBOs, CBOs ➢ Regional Coordinator of the Child Care and Protection Forum ➢ Representatives of Support Groups of PLHIV ➢ Chairpersons – CACOCs ➢ Representatives of private sector institutions ➢ Regional Commandants of the Namibian Police Force, the Army and Prisons Services ➢ Regional Development Planner/Economic Planner, ➢ Regional representative of the National Planning Commission ➢ A representative of regional women's organisations ➢ A representative of the Traditional Authorities ➢ A representative of local authorities ➢ Sector HIV and AIDS Coordinators

Constituency AIDS Coordinating Committees (CACOCs)	The CACOCs are responsible for coordinating community-based response and operate under the auspices of their Constituency Councils. CACOCs are chaired by the Regional Councilors of that particular constituency and deputised by the District Primary Healthcare Supervisor and Control Administrative Officer Communities are encouraged to develop and implement their own HIV/AIDS action plans with technical support from RACOCs and other stakeholders.	✓ Coordinate community-based HIV and AIDS response planning, implementation and monitoring. ✓ Facilitate establishing and Strengthening of strategic partnerships and alliances between communities and other stakeholders ✓ Support strengthening of linkages between health facilities and community structures. ✓ Facilitate community surveys and mapping to identify key populations and vulnerable groups in the communities and address their challenges. ✓ Coordinate capacity development for community-based organisations (CBOs), and support groups of PLHIV. ✓ Facilitate resource mobilisation to support community initiatives.	➢ Community based NGOs, FBOs and CBOs ➢ Support Groups of PLHIV ➢ Constituency Youth Committee ➢ Person in charge of the constituency health facility / health services ➢ Private Sector Representatives ➢ Local Authorities ➢ Public servants representing their respective sectors. ➢ Representatives of Traditional Authorities ➢ Religious leaders ➢ Representatives of Constituency Child Care and Protection Forum
Sector Steering Committees	Sector Steering Committees are responsible for facilitating the	✓ Appoint a sector coordinator, and provide logistical	➢ Chairs of the TACs ➢ Director – NABCOA ➢ Director of NANASO

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

Annex 2: Namibia Risk Categorisation according to Global Guidance[19]

Population	Criteria	Namibian Context	Risk Category
Sex workers	National adult (15 – 49 years) HIV prevalence	>3%	Very high
Prisoners	National adult (15 – 49 years) HIV prevalence	>10%	Very high
MSM	UNAIDS guidance	Proportion of populations estimated to have incidence of 0.3–3%	High
Transgender people	UNAIDS guidance	Proportion of populations estimated to have incidence of 0.3–3%	High
People who inject drugs	UNAIDS guidance	Low needle–syringe programme and opioid substitution therapy coverage	Very high
Vulnerable mobile male populations (e.g.: truck drivers, construction workers, mining workers, uniformed services, seafarers, cattle herders, etc.)	Namibia		

[19] (UNAIDS, 2021b)

Annex 3: NSF Results Framework

National Level Impact and Outcome Indicators

Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Baseline 2022/ 2023	Target 2023/ 2024	Target 2024/ 2025	Target 2025/ 2026	Target 2026/ 2027	Target 2027/ 2028	Data Source	Responsible Entity
1. National Level Impact Indicators												
1.1	Number of people newly infected with HIV in the reporting period per 1,000 uninfected population	Number of new HIV infections during reporting period	Total uninfected population	Age, Sex	2.91 (GAM 2021)	2.66	2.41	2.16	1.91	1.66	Estimates, projection/GAM	MHSS/NSA
1.2	AIDS-related mortality per 1,000 population	Number of people dying from AIDS-related causes during calendar year	Total population regardless of HIV status	Age, Sex	1.16 (GAM 2021)	1.06	0.96	0.86	0.76	0.66	Estimates, projection/GAM	MHSS/NSA
1.3	Annual TB related deaths	N/A	N/A	Age, Sex	1,300	1,100	900	700	500	300	Estimates,	MHSS/NSA

Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Baseline 2022/ 2023	Target 2023/ 2024	Target 2024/ 2025	Target 2025/ 2026	Target 2026/ 2027	Target 2027/ 2028	Data Source	Responsible Entity
	among PLHIV				(GAM 2021)						projection/GAM	
1.4	Incidence-mortality ratio	Number of people newly infected with HIV per year	Number of people dying of AIDS-related causes	Age, Sex	1.38 (GAM 2021)	1.28	1.23	1.18	1.13	1.08	Estimates, projection/GAM	MHSS/NSA

Indicator Number	Indicators Description	Numerator	Denominator	Disaggregation	Baseline 2022/ 2023	Target 2023/ 2024	Target 2024/ 2025	Target 2025/ 2026	Target 2026/ 2027	Target 2027/ 2028	Data Source	Responsible Entity
1. National Outcome Level Indicators												
1.1	Testing Services											
1.1.1	% of people living with HIV who know their HIV status	Number of people living with HIV who know their HIV status	Number of people living with HIV	0–14 years for children and 15 years and older by sex (men and women) for adults -Wealth quintile -Residence -Education level	90.3% (2021 estimate)	93%	94%	95%	96%	97%	NAMPHIA	MHSS/NSA
1.2	Combination Prevention Services – Adolescent Girls and Young Women											
1.2.1	% of AGYW reached with two or more combination HIV prevention interventi	Number of AGYW reached with two or more combination HIV prevention interventions in the	Total number of AGYW target with HIV prevention	Age, Sex	None	50%	55%	60%	65%	70%	Programme Reports/ Survey	MHSS

Indicator Number	Indicators Description	Numerator	Denominator	Disaggregation	Baseline 2022/ 2023	Target 2023/ 2024	Target 2024/ 2025	Target 2025/ 2026	Target 2026/ 2027	Target 2027/ 2028	Data Source	Responsible Entity
	ons in the preceding 12 months	preceding 12 months	Interventions									
1.2.2	% of AGYW who completed peer or mentor-based session	Number of AGYW who completed peer or mentor-based session	Total number of AGYW	Age, Sex	None	70%	75%	80%	85%	90%	Programme Reports/ Survey	MHSS
1.2.3	% of AGYW who received economic empowerment support in the preceding 12 months	Number of AGYW who received economic empowerment support in the preceding 12 months	Total number of AGYW targeted with economic empowerment support	Age, Sex	None	5%	5%	5%	5%	5%	Programme Reports/ Survey	MHSS
1.3	Combination Prevention Services – Key and Vulnerable Populations											

Indicator Number	Indicators Description	Numerator	Denominator	Disaggregation	Baseline 2022/ 2023	Target 2023/ 2024	Target 2024/ 2025	Target 2025/ 2026	Target 2026/ 2027	Target 2027/ 2028	Data Source	Responsible Entity
1.3.1	% of MSM targeted reached with one or more combination prevention interventions	Number of people in a key population responding to the survey	Number of people in a key population responding to the survey	Age, Sex	None	60%	70%	80%	90%	95%	Programme Reports/ Survey	MHSS
1.3.2	% of PWID reached with one or more combination prevention intervention	Number of PWID reached with one or more combination prevention interventions	Number of PWID responding to the survey	Age, Sex	None	60%	70%	80%	90%	95%	Programme Reports/ Survey	MHSS
1.4	Combination Prevention Services – Condom Programming											
1.4.1	Condom use among adults 15 – 59	Number of respondents 15 – 59 years who reported	Total number of respondents who	Sex Age (15-59)	70% (2013 IBBS)	75%	77%	80%	85%	90%	NAMPHIA	MHSS

Indicator Number	Indicators Description	Numerator	Denominator	Disaggregation	Baseline 2022/ 2023	Target 2023/ 2024	Target 2024/ 2025	Target 2025/ 2026	Target 2026/ 2027	Target 2027/ 2028	Data Source	Responsible Entity
	years at last sex with a non-regular partner	condom use the last time they had sex with a non-regular partner	reported having sex with a non-regular partner in the last 12 months									
1.4.2	Condom use among FSWs at last sex with clients	Number of sex workers who reported using a condom with last client	Number of sex workers who reported having commercial sex in the past 12 months	Sex (female, male and transgender) Age (<25 and 25+ years)	42.3 (IBBS, 2019)	65%	70%	75%	80%	90%	NAMPHIA	MHSS
1.5	Combination Prevention Services – Voluntary Medical Male Circumcision											
1.5.1	% of adult males 15 – 29 years circumcised	Number of male respondents aged 15 – 49 years who reported that they	Number of all male respondents aged 15 – 49 years	15 – 19 20 – 24 25 – 29 25 – 49	25.5% (NAMPHIA 2013)	70%	75%	80%	85%	90%	NAMPHIA	MHSS/ NSA

Indicator Number	Indicators Description	Numerator	Denominator	Disaggregation	Baseline 2022/ 2023	Target 2023/ 2024	Target 2024/ 2025	Target 2025/ 2026	Target 2026/ 2027	Target 2027/ 2028	Data Source	Responsible Entity
		are circumcised										
1.6	Combination Prevention Services – Elimination of Mother-to-Child Transmission											
1.6.1	% of pregnant women with known HIV status	Number of pregnant women attending antenatal clinics and/or giving birth at a facility who were tested for HIV during pregnancy, at labour and/or delivery or who already knew they were HIV-positive at the first	Number of pregnant women giving birth in the past 12 months	HIV status and test results	98% (Programme Data, 2021)	98%	98%	98%	98%	98%	Programme Reports	MHSS

Indicator Number	Indicators Description	Numerator	Denominator	Disaggregation	Baseline 2022/ 2023	Target 2023/ 2024	Target 2024/ 2025	Target 2025/ 2026	Target 2026/ 2027	Target 2027/ 2028	Data Source	Responsible Entity
		antenatal care visit										
1.6.2	% of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of vertical transmission of HIV.	Number of pregnant women living with HIV who delivered during the past 12 months and received antiretroviral medicines to reduce the risk of vertical transmission of HIV	Estimated number of women living with HIV who delivered within the past 12 months.	-Newly initiated on antiretroviral therapy during the current pregnancy. -Already receiving antiretroviral therapy before the current pregnancy. -Other (please specify regimen).	100%	98%	98%	98%	98%	98%	Programme Records	MHSS
1.6.3	% of children newly infected with HIV in the past 12 months due to vertical	Estimated number of children newly infected with HIV in the previous 12 months from	Estimated number of births to women living with HIV in	Rural/ Urban	4.6	4.0 %	3.5%	3%	3%	2%		

Indicator Number	Indicators Description	Numerator	Denominator	Disaggregation	Baseline 2022/ 2023	Target 2023/ 2024	Target 2024/ 2025	Target 2025/ 2026	Target 2026/ 2027	Target 2027/ 2028	Data Source	Responsible Entity
	transmission	vertical transmission	previous 12 months									
1.6.4	% of infants born to women living with HIV receiving a viro-logical test for HIV within two months of birth	Number of infants who received an HIV test within two months of birth during the reporting period	Number of pregnant women living with HIV giving birth in the past 12 months	Result: Positive, negative, indeterminate or rejected for testing	70%	95%	96%	97%	97%	98%	Programme Data	MHSS/NSA
1.7	Treatment											
1.7.1	% of PLHIV diagnosed with HIV linked to ART	Number of people linked to ART	Number of people diagnosed with HIV	Age and Sex - Wealth quintile -Residence -Education level	97.3% Programme data	99%	99%	99%	99%	99%	NAMPHIA	MHSS/NSA
				Adult Male	97%	99%	99%	99%	99%	99%	NAMPHIA	MHSS/NSA

Indicator Number	Indicators Description	Numerator	Denominator	Disaggregation	Baseline 2022/ 2023	Target 2023/ 2024	Target 2024/ 2025	Target 2025/ 2026	Target 2026/ 2027	Target 2027/ 2028	Data Source	Responsible Entity
				Adult Female	91%	99%	99%	99%	99%	99%	NAMPHIA	MHSS/NSA
				Children Male	66%	95%	96%	97%	98%	99%	NAMPHIA	MHSS/NSA
				Children Female	65.4%	95%	96%	97%	98%	99%	NAMPHIA	MHSS/NSA
1.7.2	% of PLHIV receiving ART for treatment	Number of adults and children currently receiving ART	Total PLHIV	Overall Adults	91.3 (Spectrum Estimates 2021)	93%	94%	95%	96%	97%	NAMPHIA	MHSS/NSA
				Adult Male		89%	91%	93%	95%	97%	NAMPHIA	MHSS/NSA
				Adult Female		95%	96%	97%	97%	97%	NAMPHIA	MHSS/NSA
				Overall Children		86%	89%	92%	95%	97%	NAMPHIA	MHSS/NSA

Indicator Number	Indicators Description	Numerator	Denominator	Disaggregation	Baseline 2022/ 2023	Target 2023/ 2024	Target 2024/ 2025	Target 2025/ 2026	Target 2026/ 2027	Target 2027/ 2028	Data Source	Responsible Entity
				Children Male		86%	89%	92%	95%	97%	NAMPHIA	MHSS/NSA
				Children Female		86%	89%	92%	95%	97%	NAMPHIA	MHSS/NSA
1.8	Viral Suppression											
1.8.1	% of PLHIV on ART with suppressed viral load	Number of PLHIV on ART with suppressed viral load during the reporting period	Estimated number of people living with HIV who are on ART	Overall Adults -Wealth quintile -Residence -Education level	93% (Spectrum Estimates 2021)	94%	95%	96%	97%	97%	NAMPHIA	MHSS/NSA
				Adult Male		93%	94%	95%	96%	97%	NAMPHIA	MHSS/NSA
				Adult Female		95%	96%	97%	97%	97%	NAMPHIA	MHSS/NSA
				Overall Children		90%	93%	96%	97%	97%	NAMPHIA	MHSS/NSA
1.9	TB/HIV Collaboration											

Indicator Number	Indicators Description	Numerator	Denominator	Disaggregation	Baseline 2022/ 2023	Target 2023/ 2024	Target 2024/ 2025	Target 2025/ 2026	Target 2026/ 2027	Target 2027/ 2028	Data Source	Responsible Entity
1.9.1	% of PLHIV screened for TB at every visit	Number of persons enrolled in HIV care whose TB status was assessed and recorded at their last visit during the reporting period	Total number of persons enrolled in HIV care and seen for care during the reporting period	Age 0 – 4 5 – 14 15+ Sex	88% (Programme Data, 2021)	92%	94%	96%	98%	100%	Programme Data	MHSS/NSA
1.10	Human Rights and Gender Equality											
1.10.1	% of people living with HIV who report internalised stigma	Number of people living with HIV who report receiving positive HIV test result and agreed	Number of respondents who report receiving a positive HIV test result	None	None	2%	4%	6%	8%	10%	Stigma Index Report	MHSS

		with the statement										
1.10.2	% of people living with HIV who report experiencing stigma and discrimination in the general community and health-care in the last 12 months	Number of people living with HIV who report receiving a positive HIV test result and who agreed that one or more of the three experiences happened to them because of their HIV status in the last 12 months	Number of respondents who report receiving a positive HIV test result	Community & healthcare setting	None	2%	4%	6%	8%	10%	Stigma Index Report	MHSS
1.10.3	% of general population who reported discriminatory attitudes	Number of respondents (15 – 49 years old) who respond no to	Number of all respondents (15 – 49 years old) who have	None	None	2%	4%	6%	8%	10%	NDHS	MHSS

	towards people living with HIV	either of the two questions	heard of HIV									
1.10.4	% of people living with HIV who experienc e physical or sexual violence	Number of PLHIV who reported that either of the incidents happened to them at least once in the last 12 months	Total number of PLHIV who responde d to the question	None	None	2%	4%	6%	8%	10%	Stigma Index Report	MHSS
1.10.5	% of women and girls who experienc ed physical or sexual violence from an intimate partner	Number of girls who experienc ed physical or sexual violence			None	<10%	<10%	<10%	<10%	<10%	Stigma Index Report Stigma Index Report	MHSS
1.11	Community Systems Strengthening											
1.11.1	% of testing and treatment	N/A	N/A	None	None	16%	32%	48%	64%	80%	Program me Reports/	MHSS

	services delivered by community-led organisations										Targeted survey	
1.11.2	% of HIV prevention programmes delivered by KP-led organisations	Number of KP-led organisations delivering HIV prevention programmes	Number of KP-led organisations	None	None	16%	32%	48%	64%	80%	Programme Reports/ Targeted survey	MHSS
1.11.3	% of programmes supporting the achievement of social enablers delivered by community-led organisations	Number of community- led organisations supporting the achievement of social enablers	Number of community-led organisations	None	None	12%	24%	36%	48%	60%	Programme Reports	MHSS

Additional Programme Level Indicators and Targets

Programme Area	Indicator Description	Baseline	Target 2023/24	Target 2024/25	Target 2025/26	Target 2026/27	Target 2027/28	Data Source	Responsible Entity
Prevention: AGYW and Vulnerable Children	Number of AGYW and OVC reached with two or more combination HIV prevention interventions	TBD	169,747	184,560	200,780	218,102	236,978	Programme Records	MHSS
	Number of AGYW and OVC who completed peer or mentor-based sessions	TBD	48,499	49,216	50,195	51,318	52,662		
	Number of AGYW who received economic empowerment support in the preceding 12 months	TBD	12,125	12,304	12,549	12,830	13,165		
	Percent of in-school AGYW who received life skills-based HIV education	TBD	90%	92%	94%	96%	98%		
	Percent of AGYW who received PrEP	TBD	5%,	5%	5%	5%	5%		

Programme Area	Indicator Description	Baseline	Target 2023/24	Target 2024/25	Target 2025/26	Target 2026/27	Target 2027/28	Data Source	Responsible Entity
	Number of AGYW who received PrEP		11,458	11,627	11,859	12,124	12,441		
	Number of in-school AGYW who received life skills-based HIV education	TBD	262,254	275,857	290,027	304,788	320,160		
Prevention: ABYM and Vulnerable Children	Percent of high-risk ABYM reached with two or more combination HIV prevention interventions	TBD	50%	60%	70%	80%	90%		
	Number of high-risk ABYM reached with two or more combination HIV prevention interventions	TBD	42,231	52,434	62,442	72,951	84,036		
	Percent of high-risk ABYM and OVC who completed peer or mentor-based sessions	TBD	20%	40%	60%	80%	90%	Programme Records	MHSS
	Number of high-risk	TBD	16,892	17,478	17,840	18,238	18,875		

Programme Area	Indicator Description	Baseline	Target 2023/24	Target 2024/25	Target 2025/26	Target 2026/27	Target 2027/28	Data Source	Responsible Entity
	ABYM and OVC who completed peer or mentor-based sessions								
	Percent of in-school ABYM who received life skills-based HIV education	TBD	90%	92%	94%	96%	98%		
	Number of in-school ABYM who received life skills-based HIV education	TBD	262,254	275,857	290,027	304,788	320,160		
Prevention: Key Populations	Percent of SWs reached with two or more combination prevention interventions	TBD	60%	70%	80%	90%	95%-		
	Number of SWs reached with two or more combination prevention interventions	TBD	8930	10418	11906	13395	14139		
	Number of MSM reached with two or more combination	TBD	5086	5933	6781	7628	8052	Program Record	MHSS

Programme Area	Indicator Description	Baseline	Target 2023/24	Target 2024/25	Target 2025/26	Target 2026/27	Target 2027/28	Data Source	Responsible Entity
	prevention interventions								
	Number of PWID reached with two or more combination prevention interventions	TBD	0	0	465	558	651		
	Percent of TG people reached with two or more combination prevention interventions	TBD	60%	70%	80%	90%	95%		
	Number of TG people reached with two or more combination prevention interventions and support services	TBD	1,218	1,421	1,624	1,824	1,929		
	Percent of inmates reached with two or more combination prevention interventions	TBD	60%	70%	80%	90%	95%		

Programme Area	Indicator Description	Baseline	Target 2023/24	Target 2024/25	Target 2025/26	Target 2026/27	Target 2027/28	Data Source	Responsible Entity
	Number of inmates reached with two or more combination prevention interventions	TBD	2,700	3,150	3,600	4,050	4,275		
	Percent of all KPs reached with two or more combination prevention interventions	TBD	60%	70%	80%	90%	95%		
	Number of MSM reached with two or more combination prevention interventions	TBD	5,086	5,933	6,781	7,628	8,052		
	Number of all KPs reached with two or more combination prevention interventions	TBD	1,8491	21,573	24,665	27,737	29,278		
	Percent PWID reached with needle syringe exchange programme at least once	TBD	0	0	50%	60%	70%		

<table>
<tr><th>Programme Area</th><th>Indicator Description</th><th>Baseline</th><th>Target 2023/24</th><th>Target 2024/25</th><th>Target 2025/26</th><th>Target 2026/27</th><th colspan="2">Target 2027/28</th><th>Data Source</th><th>Responsible Entity</th></tr>
<tr><td rowspan="4"></td><td>Number of PWID reached with needle syringe exchange programme at least once</td><td>TBD</td><td>0</td><td>0</td><td>465</td><td>558</td><td colspan="2">651</td><td rowspan="4"></td><td rowspan="4"></td></tr>
<tr><td>Percent PWID reached with opioid substitution therapy (methadone or buprenorphine)</td><td>TBD</td><td>0</td><td>0</td><td>20%</td><td>30%</td><td colspan="2">40%</td></tr>
<tr><td>Number of PWID reached with opioid substitution therapy (methadone or buprenorphine)</td><td>TBD</td><td>0</td><td>0</td><td>186</td><td>279</td><td colspan="2">372</td></tr>
<tr><td>Number of adult men who need condoms</td><td>TBD</td><td>297,599</td><td>311,456</td><td>329,985</td><td>357,232</td><td colspan="2">385,303</td></tr>
<tr><td rowspan="2">Prevention: Condom Programme</td><td>Number of male condoms needed for adults</td><td>TBD</td><td>14,879,928</td><td>15,572,786</td><td colspan="2">16,499,266</td><td>17,861,601</td><td>19,265,151</td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>Male condom use among currently married and sexually active</td><td>TBD</td><td>19%</td><td>19%</td><td colspan="2">19%</td><td>19%</td><td>19%</td></tr>
</table>

Programme Area	Indicator Description	Baseline	Target 2023/24	Target 2024/25	Target 2025/26	Target 2026/27	Target 2027/28		Data Source	Responsible Entity
	women 15 – 49 years for FP purposes									
	Number of male condoms needed for FP purposes among currently married and sexually active women 15 – 49 years	TBD	5,290,641	5,393,173	5,499,755		5,603,637	5,708,194		
	Number of FSWs who need male condoms	TBD	14,000	14,000	14,000		14,000	14,000		
	Number of male condoms needed for FSWs	TBD	3,057,600	3,292,800	3,528,00		3,763,200	4,233,600		
	Contingency (buffer, damage & expiry) 20% of total condom need.	TBD	4,645,634	4,851,752	5,105,404		5,445,688	5,841,389		
	Total number of male condoms needed	TBD	27,873,803	29,110,511	30,632,425		32,674,126	35,048,334		
	Total number of female	TBD	377,461	486,902	596,342		705,782	815,223		

Programme Area	Indicator Description	Baseline	Target 2023/24	Target 2024/25	Target 2025/26	Target 2026/27	Target 2027/28		Data Source	Responsible Entity
	condoms needed									
	Lubricants	TBD	1,329,249	1,329,249	1,329,249		1,329,249	1,329,249		
Prevention: ARV-based Prevention	Percent of FSWs receiving PrEP	TBD	40%	50%	60%		70%	80%	Programme Records	MHSS
	Number of FSWs receiving PrEP	TBD	4,763	5,953	7,144		8,334	9,525		
	Percent of MSM receiving PrEP	TBD	40%	42%	44%		46%	50%		
	Number of MSM receiving PrEP	TBD	3,390	3,560	3,729		3,899	4,238		
	Percent of PWID receiving PrEP	TBD	0%	0%	7%		12%	15%		
	Number of PWID receiving PrEP	TBD	0	0	58		99	123		
	Percent of TG receiving PrEP	TBD	40%	42%	44%		46%	50%		
	Number of TG receiving PrEP	TBD	812	853	893		934	1,015		
	Percent of inmates receiving PrEP	TBD	3%	5%	10%		15%	15%		

Programme Area	Indicator Description	Baseline	Target 2023/24	Target 2024/25	Target 2025/26	Target 2026/27	Target 2027/28		Data Source	Responsible Entity
	Number of inmates receiving PrEP	TBD	119	199	398		597	597		
	Percent of AGYW receiving PrEP	TBD	5%	5%	5%		5%	5%		
	Number of AGYW receiving PrEP	TBD	11,458	11,627	11,859		12,124	12,441		
	Percent of PBFW receiving PrEP	TBD	2%	3%	4%		5%	5%		
	Number of negative PBFW receiving PrEP	TBD	1,869	2,803	3,738		4,672	4,672		
	Percent of sero-different couples receiving PrEP	TBD	60%	70%	80%		90%	95%		
	Number sero-different couples receiving PrEP	TBD	711	830	951		1,071	1,133		
	Total number of HIV-negative people receiving PrEP	TBD	23,122	25,826	28,769		31,731	33,745		
VMMC	Percent of adult males 15	TBD	70%	75%	80%		85%	90%		MHSS

Programme Area	Indicator Description	Baseline	Target 2023/24	Target 2024/25	Target 2025/26	Target 2026/27	Target 2027/28		Data Source	Responsible Entity
	– 29 years circumcised								Program Records	
	Males 15 – 59 years provided VMMC service	TBD	31,820	31,820	31,820		31,820	31,820		
	Percent of infants circumcised	TBD	10%	20%	30%		40%	50%		
	Number of infant male circumcisions performed	TBD	3,455	6,903	1,0345		13,779	17,209		
eMTCT	HEI receiving ARV prophylaxis	TBD	96%	97%	97%		98%	98%	Program Records	MHSS
	HEI receiving CTX prophylaxis	TBD	95%	95%	95%		95%	95%		
	Percentage of PBFW who HIV retest after first ANC visit	TBD	50%	60%	70%		80%	80%		
STIs	Percentage of people 15 – 49 years with STIs (genital discharge, blister, and ulcer) diagnosed and treated	TBD	85%	87%	90%		92%	95%		

Programme Area	Indicator Description	Baseline	Target 2023/24	Target 2024/25	Target 2025/26	Target 2026/27	Target 2027/28		Data Source	Responsible Entity
	Number of people 15 – 49 years with STIs (genital discharge, blister, and ulcer) diagnosed and treated	TBD	104,480	109,035	115,050		119,853	128,432		
	Percentage of people 15 – 49 years with genital discharge diagnosed and treated	TBD	85%	87%	90%		92%	94%		
	Number of people 15 – 49 years with genital discharge diagnosed and treated	TBD	69,654	72,690	76,700		79,902	83,180		
	Percentage of people 15 – 49 years with a blister, and/or ulcer diagnosed and treated	TBD	85%	87%	90%		92%	94%		
	Number of people 15 – 49 years with a blister, and/or	TBD	46,436	48,460	51,134		53,268	55,453		

Programme Area	Indicator Description	Baseline	Target 2023/24	Target 2024/25		Target 2025/26	Target 2026/27	Target 2027/28		Data Source	Responsible Entity
	ulcer diagnosed and treated										
Human Rights and Gender Equality	Number of people trained in human rights, gender equality and legal provision	TBD	700	700		700		700	700	Program Records	MHSS
	Percentage of people who support inequitable gender	TBD	10%	10%		10%		10%	10%		
	Percentage of HIV services that are gender-responsive	TBD	10%	10%		10%		10%	10%		
TB/HIV Collaboration	Percentage of ART sites providing cervical cancer screening	TBD		15%	25%	50%		75%	100%	Programme Records	MHSS
Community Systems Strengthening	MIMS operationalised and integrated into national strategic reporting	TBD		1	1	1		1	1	Programme Records	MHSS
	Total donor funding, through local CSOs, for civil society	TBD		3,240,000	2,700,000	1,800,000		900,000	3,240,000		

Programme Area	Indicator Description	Baseline	Target 2023/24	Target 2024/25		Target 2025/26	Target 2026/27	Target 2027/28		Data Source	Responsible Entity
	coordination, capacity building and empowerment (N$)										
	Total domestic funding, through local CSOs, for civil society coordination, capacity building and empowerment (N$).	TBD		360,000	900,000	1,800,000		2,700,000	3,600,000		
	Number of local CSOs and CGs delivering HIV services under GRN contracts as primary partners	TBD		10	20	35		50	75		
	Total value of HIV services delivered under GRN contracts by local CSOs and CGs (N$)	TBD		150,000	150,000	150,000		150,000	150,000		
	Percentage of testing and treatment services delivered by	TBD		16%	32%	48%		64%	80%		

Programme Area	Indicator Description	Baseline	Target 2023/24	Target 2024/25	Target 2025/26	Target 2026/27	Target 2027/28	Data Source	Responsible Entity
	community-led organisations								
Governance	Number of OMAs providing health and wellness services for employees	TBD	21	28	36	40	46	Program Records	MHSS
	Number of private sector organisations providing health and wellness service for employees	TBD	24	24	34	44	54		
	Number of CSOs providing health and wellness services for employees (disaggregated	TBD	1	5	8	13	20		
	Number of regions with a functional community-led monitoring system	TBD	7	4	8	12	14		

Programme Area	Indicator Description	Baseline	Target 2023/24	Target 2024/25	Target 2025/26	Target 2026/27	Target 2027/28	Data Source	Responsible Entity
	Number of M&E and HIS TWG coordination meetings held	TBD	4	4	4	4	4		
Sustainability	Number of coordination meetings held	TBD	18	18	18	18	18	Program Records	MHSS