Namibia:

Key Populations' Strategic Priorities

Introduction

Namibia has made significant progress in controlling HIV, tuberculosis and malaria, with high ART coverage and declining AIDS mortality. The country is on the verge of achieving HIV epidemic control. However, key populations (KPs)—including gay, bisexual and other men who have sex with men(GBMSM), sex workers (SW), transgender (TG) individuals, people who inject or use drugs (PWID/PWUD), and other marginalised youth—continue to experience disproportionately high rates of HIV infection, stigma, discrimination, and barriers to vital HIV services. The sudden freeze of US funding has jeopardised hard-won progress, targeting in particular programmes serving KPs. PEPFAR-funded investments over the past decade have been instrumental in bending the trajectory of Namibia's HIV epidemic.

Focused programmes for KPs have yielded measurable public health benefits: declining new infections, higher treatment coverage, and reduced community viral load. Namibia is now one of the first high-burden countries to nearly control its HIV epidemic, thanks in part to these targeted interventions:

- **Near Epidemic Control:** With U.S. support, Namibia has achieved 93–95–98 against UNAIDS targets – 93% of people living with HIV know their status, 95% of diagnosed individuals are on ART, and 98% of those on treatment are virally suppressed. Viral suppression at this level means fewer HIV transmissions; indeed, HIV incidence among adults has plummeted to about 0.36% annually in recent years (~4,500 new HIV cases/year, down from tens of thousands at the epidemic's peak). These outcomes are directly linked to the coverage of prevention and treatment services expanded under PEPFAR.
- **Prevention for Key Populations:** USAID's KP-STAR project (2020–2025) rapidly scaled up tailored prevention for KPs. In fiscal year 2024 (FY24) alone, KP-STAR aimed to reach over 22,000 KP members with comprehensive prevention packages. Services included peer-led education, condom distribution, PrEP (pre-exposure prophylaxis), HIV testing, and linkage to care. Such targeted outreach has been critical: HIV prevalence among SWs and MSM in Namibia is significantly higher than in the general population, but intensive prevention efforts have helped avert new infections and detect cases early. USAID-supported programmes were also finding and linking to treatment a substantial portion of new HIV cases – helping to break chains of transmission among these networks.
- **Improved Health Outcomes:** By funding community organisations and clinics that specialise in KP-friendly services, USAID helped Namibia overcome stigma and reach marginalised groups. Over the past five years, thousands of MSM, SWs and other KPs have been initiated on ART and PrEP through PEPFAR-supported initiatives, contributing to overall treatment success and prevention of onward spread of HIV. These programmes have also provided essential HIV related services such as screening for tuberculosis, distribution of clean needles for PWID, and offering sexual and reproductive health care including STI screening and family planning. As a result, overall public health has improved – not only is HIV incidence down, but co-infections and related risks are better managed, and communities have been empowered to support their peers. According to USAID, its HIV programmes in Namibia "continue to reduce transmission…and improve health outcomes" for vulnerable populations, even as the country approaches epidemic control[1].

PEPFAR's investment in services for KPs has paid off substantially: Namibia is closer than ever to achieving the goal of an AIDS-free generation. The Government of Namibia is also demonstrating strong ownership of the HIV response. A "Sustainability Roadmap" for HIV, TB, viral hepatitis, and malaria control was launched in November 2024; the Social Contracting for Health Policy, launched in October 2023, is being operationalised to finance civil society-led services. Namibia's High Court also struck down colonial-era sodomy laws in 2024, removing a key legal barrier for MSM seeking services. These steps underscore Namibia's dedication to an inclusive, sustainable response.

[1] Namibia Sustainability Roadmap, 2024,

Before January 2025, Namibia's core KP service delivery programme had included:

- Clinical services and social services provided by mobile community outreach vans, including moonlight outreach, through the Walvis Bay Corridor Group (WBCG) and Namibia Planned Parenthood Association (NPPA)
- Drop-in Centres (DICs) supported by NPPA (KP-friendly) and WBCG (KP-led)
- Case management: KP-led community based organisations (CBO) case managers and peer navigators
- Quality assurance - data clerk, data tracker and monitoring and evaluation (M&E) officer
- Referral and Linkage
- Initiation and adherence support
- Psychosocial support and mental health care
- GBV, human rights, and safety and security

KP experience, capacity and implementation skills feature:

- KP-led CBOs that have implemented USAID's KP projects as subgrantees since 2010.
- Roll out of PEPFAR's KP-STAR project (2020-2025), to increase the quality and accessibility of HIV services for KPs, managed by IntraHealth Namibia with WBCG, MPower Community Trust, Voice of Hope Trust and Rights Not Rescue Trust as implementing partners
- KP-led CBOs supported data collection for the most recent IBBSS, although the IBBSS was halted midway because of U.S. government funding cuts.
- KP-led CBOs served as implementing partners on the EpiC grant managed by Palladium (2024 - 2025) and Lift-Up initiative for human rights.
- KP-led CBOs have participated as sub-sub recipients of Global Fund grants since inception. The Global Fund Country Coordination Mechanism (CCM) also has representation for KPs including, SWs, GBMSM, and TGs. PWID/PWUD are not represented as yet.
- Diversity Alliance of Namibia (DAN) is a consortium of KP CBOs working across the spectrum from healthcare to human rights. DAN has been working towards becoming an investment hub for KP-led grant management in Namibia
- Young Feminists Movement (Yfem) has recently acquired a guesthouse in Okahandja, and this has also served as a referral for safehouse in case of emergency removal of KPs from danger.
- Programming for PWID/PWUD has not yet started but a network of people who use drugs is in the process of being founded.

These gains are fragile. They depend on continuous support and coverage of services for those most at risk. As PEPFAR's own strategy recognises, maintaining momentum in the HIV response requires not leaving KPs behind. The transition to a fully domestically funded HIV response will take time, and continued U.S. partnership is critical now to prevent service gaps. Abruptly cutting off funding reverses national progress by removing the very interventions that made this progress possible.

Since the start of 2025, Namibia's HIV programme has been grappling with the fallout from the freeze in U.S. assistance. USAID-funded activities—which primarily supported HIV prevention, testing, and community-based services—have been suspended. The immediate effects have been deeply concerning: services have stalled, performance indicators are dropping, and unmet needs are growing. This endangers Namibia's gains against HIV and leaves its most vulnerable groups without critical support. Immediate action is needed to release the blocked funds and re-engage support for these life-saving services.

Programme performance data from the first quarter of 2025 (Q1 2025) shows a stark decline in key treatment and prevention outcomes for KPs compared with generally positive trends since Q1 FY24, up to the last quarter before the funding cut.

Namibia's KP Programme Performance under KP-STAR

Indicators	Annual Targets	FY24 Q1 Achievements	FY24 Q2 Achievements	FY24 Q3 Achievements	FY24 Q4 Achievements	FY25 Q1 Achievements
PrEP_NEW	4734	1294	1367	726	1126	769
PrEP_CT	2706	904	1056	794	934	651
PP_PREV (MWPS)	501	-	279	107	161	112
HTS_TST	13687	2949	3293	2155	2949	1445
HTS_TST_PO	1658	283	314	269	290	174
HTS YIELD	12%	10%	10%	12%	10%	12%
HTS_SELF	21987	2713	5834	6525	6597	3497
TX_NEW	1609	276	311	267	287	174
Linkage to ART	97%	98%	99%	99%	97%	82%
TX_CURR	5019	3442	3742	3879	4074	3272
TX_PVLS_NUM	4355	2693	2942	3163	3308	2955
TX_PVLS_DEN	4584	2746	2995	3221	3351	2985
VL SUPPRESSION RATE	95%	98%	98%	98%	99%	99%
VL COVERAGE RATE	100%	92%	93%	94%	92%	93%
TX_ML	-	503	414	324	191	164
TX_RTT	-	190	368	262	273	223

Figure: Sharp declines in achievement of HIV prevention, care and treatment targets immediately following the HIV funding freeze. New PrEP initiations and HIV tests conducted in Namibia fell significantly from FY24 Q4 (before USAID's withdrawal) to FY25 Q1 (after withdrawal).

What does the data say about HIV prevalence among KPs in Namibia[2]?

- **FSW:** 21.35 in Windhoek, 20.3% in Walvis Bay and 44.2% in Katima Mulilo
- **MSM:** 8.4% in Windhoek, 9.7% in Walvis Bay/Swakopmund
- **PWUD:** N/a
- **TGs:** N/a

Where was Namibia on the 95/95/95 track[3]?

Namibia has achieved 93/95/98. However, the HIV prevention and treatment cascades for KPs reveal a different picture: for FSW in Windhoek: 50/73/52; and MSM in Windhoek 64/82/76.

The blocked funding for KP HIV services in Namibia is far more than just a budgeting issue – it is a life-or-death issue with implications for the country's public health and for the global goal of ending AIDS by 2030. Namibia has shown exemplary leadership, by achieving near-epidemic control and committing to sustain the response through innovative policies like social contracting and bold legal reforms. The current funding gap, if not addressed, threatens to unravel this progress, particularly among groups that have historically been underserved and stigmatised.

KP Community Core Priorities

1.Antiretroviral Therapy (ART) and Service Continuity

The end of PEPFAR's USAID funding for KP services has meant a closure of targeted community-based services for all KP groups in Namibia. While HIV services are available at public health facilities across the country, stigma and an expectation of discrimination from health care providers, fear of exposure of sexual and gender identity, has prevented many KPs from accessing services at public health facilities. Funding for comprehensive HIV treatment services provided by KP-led community groups in DICs and through mobile community vans has been stopped. In response, KP groups are innovating to try to continue providing vital services to community members. This innovation conveys how many of the clients in their case management systems still contact them and ask them how to navigate the public health service for refills of their ART or PrEP.

However, the systems set up through USAID-funded programmes such as data collection, case management and community health services are now all halted; clients are redirected to the nearest public health facility for management of their risk and chronic health management. Peer navigators, case managers and adherence support services essential for ensuring retention in care have been terminated. In theory, facility-based ART services have so far remained largely intact (the government procures ARVs and PEPFAR's CDC-supported clinical programmes were temporarily allowed to continue). However, community components of treatment support have been hit hard. Community health workers who provided adherence counselling and tracked down patients missing appointments lost their funding. Consequently, programmes report a rise in patients loss to follow-up. Data show a decline in the number of KP patients on ART: one programme tracking KP clients saw a drop from ~4,074 to 3,272 on treatment in the quarter, suggesting that without community outreach, some patients defaulted or were not counted. Viral load testing and reporting has also suffered some setbacks in quality control due to resource constraints. While the government has ensured ARV drug supply is stable, the wrap-around support that keeps people on therapy has weakened, raising concerns about retention and re-suppression of those who interrupt treatment. Linkage and retention by peer navigators must be bolstered, in order to close the gaps in the treatment and care cascade. This remains important even as integration into primary healthcare centres (PHC), social contracting and domestic financing are being implemented.

[2] Source: Namibia Integrated Biological and Behavioural Surveillance Survey (NAM- IBBSS) 2019 [3] (Source: NAM-IBBSS 2019).

Non-negotiable Priorities:

- **Restart KP mobile clinics:** KP clinics are critical to service delivery. The return of KP service delivery is needed to ensure that KPs have safe space to access services and will improve program outcomes.
- **Assign KP experts to NAPPA clinics.** General populations sites that are currently absorbing new KP clients with already stretched staff members with little knowledge of the KP service delivery need to also absorb KP experts to support them with integrating KP services.
- **Restore peer cadres:** Peer cadres are essential to finding and retaining KPs. The program needs to restore essential workers to ensure that the KP program has the necessary people to support clients' knowledge and demand.
- **Gender affirming care for TG (started in COP22).** Restore and expand TG program to increase demand and access to services. Decentralize services and strengthen capacities at the provincial and local levels, particularly in areas affected by humanitarian crises and restore mobile clinics and community fixed points that have been reduced, limiting access to testing and prevention services.

Strategic Element	Current Status	Annual Funding Gap	Key notes
ART commodities	Only available at government facilities, Namibia Planned Parenthood Association (NAPPA) and Walvis Bay Corridor Group (WBCG)	$16,431	Clients are not comfortable accessing these services from government facilities, due to stigma and discrimination
Peer Cadres	Non-existent as they were retrenched	$57,600	The absence of peer cadres in Namibia, following the cessation of PEPFAR funding, has weakened community linkages to HIV and ART services. This has led to reduced treatment adherence, delayed ART initiation, and decreased support for people living with HIV. In addtion the cessation also weekend PrEP and other prevention interventions.
KP-Specific ART Sites	KP-led facilities are non-existent	$349,000	KP-led facilities are currently non-existent in Namibia, limiting access to tailored, stigma-free HIV services for KPs. However, organisations like the WBCG and NAPPA clinics remain somewhat KP-friendly, helping to partially bridge the

			gap in inclusive service delivery for a limited number of people.
KP-Friendly Public Sites	Ministry of Health (hospitals, clinics, health centres), NAPPA & WBCG clinics but these are not sufficient	$349,000	Lack of funding has severely limited access to KP-friendly services, despite support from NAPPA, WBCG), and some public facilities. KPs now face reduced access to safe, stigma-free healthcare.
TB Diagnosis & Treatment	Ministry of Health (hospitals & clinics) prevention done at NAPPA clinics (TPT)	$4,000	With no funding for community interventors, TB prevention, diagnosis, and treatment efforts are limited to health facilities, reducing outreach and early detection. This gap hinders timely care, especially in hard-to-reach areas, increasing the risk of TB transmission and poor treatment outcomes.
Viral Load Access	Some services at Ministry of Health facilities, NAPPA and WBCG clinics are ongoing, with regular monitoring by community implementers	$4,000	Limited funding—currently only provided by the government—restricts community-level case management for viral load access. This impacts timely follow-up, adherence support, and viral suppression, especially among hard-to-reach populations.

ART Funding Gap: Approximately **$780,031** annually to restore comprehensive, peer-supported ART services for KPs.

What is the cost of inaction? Namibia had been approaching the target of HIV epidemic control, while solidifying national leadership and stewardship of the HIV response among government and civil society. PEPFAR's complete withdrawal of funding for HIV treatment and support services targeting KPs is already undermining this incredible progress, according to most recent programme data. KPs are facing increased risk of unsuppressed viral load, leading to unmanaged HIV infection, disease progress, and new transmissions of HIV among KPs and their partners. Investment is needed now to replace peer cadres, rebuild stand alone KP service delivery sites and wraparound KP support services.

2. Primary Prevention

Namibia's sustainability roadmap emphasises the fundamental importance of prioritising service delivery for KPs in order to achieve epidemic control. It states: "sustainable prevention efforts need to be targeted toward KPs who are most at risk of infection, for example, MSM, PWID, SWs, TG individuals, and young women in high- prevalence regions. Preventing infections in these populations is crucial for controlling the epidemic". It also emphasises the importance of promoting human rights and reducing stigma: "A key component of the sustainability roadmap is ensuring that prevention services are accessible to all, including marginalised and stigmatised populations. Stigma and discrimination often prevent individuals from accessing testing, prevention, and treatment services."

Namibia's KP prevention programme had included KP-targeted outreach services providing community level HIV testing (including HIV self testing), PrEP, outreach, condom and lubricant distribution using mobile vans and moonlight outreach with a focus on KP hotspots ensuring HIV prevention access for the most hard-to-reach communities. This programme was abruptly stopped as a result of US funding cuts which stopped enrolment of most at risk individuals at hotspots.

Namibia must reinstate community-led KP prevention services- DICs, mobile testing and enrolment, condom and lube distribution and start harm reduction services for PWID/PWUD, scale up HIV self-testing and aggressively expand PrEP enrolment.

The number of HIV tests conducted in Q1 2025 was 1,445, barely half of the tests done in the previous quarter (2,949 in Q4 2024). Fewer tests mean fewer new diagnoses, which in turn means untreated individuals who can unknowingly spread the virus. This also affects HIV prevention efforts where only 769 individuals were newly enrolled on PrEP in Q1 2025, a 32% drop from 1,126 in Q4. This suggests that many who could benefit from PrEP (especially young women, SW, and MSM in high-incidence areas) are now vulnerable.

Outreach and Coverage Gaps: Notably, the KP-STAR programme reported no data for key population reach in Q1 2025, indicating that outreach activities to MSM, SWs and other KPs effectively ground to a halt during the funding hiatus. Peer educators and outreach workers, many funded through USAID partners, stopped or scaled back their work due to lack of funds. Indeed, some implementing NGOs had to terminate staff and shut down services when cash flow suddenly halted. This has left hotspots without condom distribution, risk reduction education, or DICs that provide safe spaces for KPs. The proportion of new HIV-positive individuals being linked to treatment has also fallen – linkage to ART dropped from ~97% to 82% in the affected quarter (many newly diagnosed were not immediately enrolled on treatment). Every unlinked patient is a missed opportunity to achieve viral suppression, save lives and prevent further transmission.

Prevention Stockouts and Supply Chain Interruptions

Condom and lubricant stock-outs are worsening, HIV prevention outreach and PrEP services have been cut back, and community-led HIV testing and support programmes have been scaled down or halted. PrEP supplies are inadequate and people being referred to public clinics for PrEP are being told PrEP is reserved for discordant partners only. Thousands of at-risk Namibians are now left without prevention and care, putting the broader population at risk of a resurgence in infections and disrupting community prevention campaigns.

Additionally, PEPFAR Namibia, in partnership with the government and CBOs had developed a plan for two-monthly injectable CAB-LA introduction to start this year which would have continued to improve and expand HIV prevention programming, and pave the way for additional new products like six-monthly injectable lenacapavir. The funding halt interrupted this momentum and plans for introducing new products are now uncertain.

While there are significant barriers to introduction, these new PrEP products represent real opportunities for rapidly reducing new infections, controlling the Namibian epidemic, and improving care for KPs. Plans for the country should include solutions for resourcing new product introduction as part of a choice agenda, including demand creation and differentiated service delivery.

Finally, post-exposure prophylaxis (PEP) has been a largely under-utilized intervention to date. Studies conducted in other countries have shown some clients prefer PEP over PrEP, it's a relatively inexpensive option, and can be easily delivered through differentiated services. PEP should be included in the Namibian prevention plan going forward.

Key Estimates of Reductions (January-June 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
PrEP access point for KPs	There are no stand-alone KP sites, but strategic partnerships with MoHSS, WBCG, and NAPPA have enabled limited KP service delivery through integrated programming.	The lack of stand-alone KP sites limits safe and dedicated access to PrEP services for KPs. Although MoHSS, WBCG, and NAPPA provide integrated support, these sites primarily prioritise pregnant and breastfeeding women, leaving many KPs underserved due to stigma, limited outreach, and inconsistent access.
PrEP New Initiations	MoHSS, WBCG and NAPPA	Limited KP-friendly facilities and low sensitisation, especially for adolescent KPs, hinder access to appropriate services, leading to stigma, low uptake, and poor health outcomes.

Non-negotiable Priorities:

- **Resume Critical Prevention Services for Key Populations**
  - Reinstate support for:
    - **Community-led prevention programmes targeting all KPs.** This includes reopening DICs, scaling back up the distribution of condoms and lubricant, and ensuring needle/syringe exchange and opioid substitution therapy (where applicable) continue. Priority should be given to peer outreach and education activities that were proven effective under KP-STAR. The goal should be to immediately restore contact with these communities, disseminate prevention commodities, and re-engage peer networks to prevent new infections. Without this, the risk of rapid HIV transmission in these networks is high, as evidenced by rising STI rates and anecdotal reports of people sharing injecting equipment since outreach programmes paused.

- **Fast-Track PrEP and HIV self-testing scale-up:** Provide earmarked funding to massively scale up PrEP availability and HIV self-test kits for at-risk groups. PrEP is a highly effective biomedical prevention tool, and demand in Namibia – especially among young women and KPs– was growing before the cut. A "Surge Initiative" is needed to enroll new PrEP users (for example, a target of an additional 5,000 young women and 2,000 KP clients on PrEP in the next 6 months) by supplying commodities and supporting community PrEP demand creation. Similarly, HIV self-test kits are essential for reaching those who do not attend clinics; they empower individuals to know their status. The country also needs an emergency stock of self-test kits and funding for community organisations to distribute them, coupled with referral to treatment for those who test positive. This would align with PEPFAR's New Global HIV Strategy which emphasises differentiated prevention approaches. The cost is relatively low, and the impact – preventing infections and identifying cases early – is high. Notably, self-testing and PrEP are areas that the Namibian government is keen to integrate into primary care; a renewed push now will make that integration smoother.

Strategic Element	Current Status	Annual Funding Gap	Key notes
PrEP Commodities (Oral & Injectable)	Only being provided in MoHSS, WBCG and NAPPA clinics for pregnant and breast feeding women - Scale up	$1,361,765	Advocate for PrEP injectable, oral and dapivirine, setting up and supplementing sites and commodities (Oral PrEP, CAB-LA and LEN-PrEP
PrEP Sites (Free-standing)	Non-Existent	$261,698	Could include DICs, mobile clinics, or other community pick-up point
KP-Friendly Public PrEP Sites	MoHSS, WBCG and NAPPA	$261,698	Scale up, Increase sensitisation on KP and have clear pathways on adolescent KP's
Condoms & Lubricants	Condoms: MoHSS only; Lubricants - unavailable	$2,300	Clear guidelines for KP-led organisations on ordering condoms from central medical stores and restart funding for lubricants.

HIV test kits	Limited	$3,760	Self test kits are a key testing method and increase the knowledge of HIV status among those at risk and enrolment to treatment for those who test positve
Safe Injecting Equipment	Not operationalised for KPs (PWUD/PWID)	$3,760	Recognised in the NSF plan, but no implementation framework and budget. A start up budget to cover a start up program.
PEP (Post-Exposure Prophylaxis)	MoHSS, WBCG and NAPPA	$3,760	Available nationwide to all at risk persons within the 72 hours
Demand creation		$23,000	PrEP demand creation is key to increase uptake
Support for policy adaptation for new products		$12,000	PrEP policies will be key to ensure access

Primary prevention funding gap: Approximately **$1,933,741** annually to restore comprehensive prevention services with peer support networks.

What is the cost of inaction? HIV prevention will face grave setbacks in Namibia unless effective KP HIV prevention programs are rebuilt and prioritised. National data already show harmful trends: in enrolling KPs on PrEP, in identifying new HIV positive KPs and linking them with treatment, in providing effective HIV prevention commodities such as condoms and lubricants. Fragile gains won through leadership and advocacy by KPs will be rapidly eroded unless effective HIV prevention interventions are rebuilt and expanded.

3. Community Infrastructure

Community led interventions are vital elements of a successful HIV response in Namibia–forming the foundation of effective prevention and treatment programs. Massive, abrupt funding cuts to community infrastructure for advocacy and service delivery must be remedied. Despite PEPFAR funding cuts, Diversity Alliance Network (DAN), a national KP network) remains funded for now (from Namibia's Global Fund grant and from an ongoing grant from Arcus Foundation), and has merged with Community of Action (COA) to intensify impact.

GBV and Psychosocial Services for Vulnerable Groups

The intersection of HIV and gender-based violence is well documented – violence increases HIV risk and undermines treatment adherence. Prior to the funding cut, PEPFAR supported safe spaces and referral systems for survivors (e.g., the "One-Stop Centres" and community paralegals for SWs). These need to be restored in order to reduce a key driver of new HIV infections.

Moreover, funding must be designated for GBV response services and mental health support for KPs, ensuring that at least one GBV case manager or support counsellor is funded per major hotspot through KP-led civil society partners.

Additionally, reinstating funding for psychosocial support groups (such as MSM support groups, teen clubs, etc.) will help maintain treatment adherence and well-being. These "soft" services are often the first to be cut, yet they are crucial for retention in care and prevention of HIV among those facing stigma and trauma. A modest investment in this area is essential in order to keep people engaged in services, thereby supporting the 95-95-95 goals.

Gender-based violence (GBV) support services for KPs, which were scaled up under PEPFAR, have been stopped (the KP-STAR programme recorded providing GBV services to 150 survivors in one quarter of 2024, versus zero reported in early 2025). Each of these gaps has human consequences: lives are at risk and individuals who had begun to trust and utilise health services may fall through the cracks.

Bolster Linkage and Retention Efforts via Peer Navigators

Community health workers and peer navigators must be funded to improve linkage to treatment and retention. As noted, linkage to ART suffered when community support was removed – dropping to 82% in Q1 2025. Considerations should be made to immediately fund the re-engagement of peer navigators from KP groups who can guide newly diagnosed individuals into care and follow up on those who miss visits. These navigators (who were trained under prior USAID programmes) can be deployed through local NGOs or even seconded to clinics. The funding would cover stipends, transport, and communication. By closing the gaps in the treatment cascade (testing > treatment > viral suppression), this intervention will prevent avoidable deaths and further halt transmission. It directly supports the country's core mission of saving lives through treatment and complements the Ministry of Health's willingness to absorb some of these cadres over time via the sustainability roadmap, but bridging support is needed now.

Support Namibia's Social Contracting and Transition Planning Efforts

Namibia had developed proposed social contracting mechanisms through USAID supported programmes that are now dormant. These must take root quickly and be activated through catalytic funding and technical support so Namibia can execute its transition plans ethically and transparently. For example, partners could fund an initial round of grants to KP-led organisations through a challenge fund, in collaboration with the Namibian government, to jump-start the social contracting process. They could also complete the joint gap analysis using UNAIDS' tools and publish a clear roadmap quantifying what resources are needed for full sustainability. By doing so, partners can ensure that any short-term resumption of funding comes with a clear exit strategy or handover plan, avoiding future cliff edges. Essentially, reprogrammed funds should both fill today's gaps and set up systems for tomorrow's self-reliance – a true win-win that honors PEPFAR's principle of country ownership.

Key Estimates of Reductions (January-June 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
GBV response programmes: safe spaces and referrals systems	100% elimination	GBV is a key driver of new HIV infections, and protecting GBV survivors while preventing HIV transmission is critical
Peer Cadres	100% elimination	Peer Cadres are critical for findng, linking and retaining KPs. The elimination of peer cadres will have a negative impact on KP service delivery
Social contracting and transition support	100% elimination	Ensuring a smooth transition requires enabling community organisations to continue service provision without the need for external funding. Social contracting and transition support is needed for a smooth transition

Non-negotiable Priorities:

- **Restart GBV Violence Prevention/Safe Space programmes:** GBV is a key driver of new HIV infections, and protecting GBV survivors while preventing HIV transmission is critical
- **Restart support for social contracting mechanism and transition planning:** Ensuring a smooth transition requires enabling community organisations to continue service provision without the need for external funding. Social contracting and transition support is needed for a smooth transition.
- **Restore funding for peer cadres.** Peer Cadres are critical for find, link and retain KPs. The elimination of peer cadres will have a negative impact on KP service delivery

Strategic Element	Current Status	Annual Funding Gap	Key notes
National KP Coalition/Network	Diversity Alliance of Namibia remains active, whereas Community of Action is currently inactive.	$14,950	Diversity Alliance of Namibia (DAN) and Community of Action (COA) to merge to strengthen and improve coalition efforts.
KP Advocacy Organisations	Most lost their funding	$55,400	Diversity Alliance of Namibia (DAN) and Community of Action (CoA) plan to broaden their reach to cover all regions
Legal & Rights Protection	Global Fund in partnership with Legal Assistance Centre are the only ones providing Legal and right support	$40,250	Provide training to key populations (KPs) to become qualified paralegals
Violence Prevention Services	All PEPFAR support is terminated	$18,343	Implement comprehensive violence prevention programming specifically tailored to protect and support key populations.
Community-Led Monitoring	Terminated	$115,000	CLM is a critical tool to Monitor the quality of services provided to KPs

Namibia Key Populations Staffing

Category	Activity/Item	Annual Cost Estimate	Budget Narrative
STAFF	Peer Educators (48)	$114,676	The peer educator delivers HIV prevention and treatment education to key populations through outreach, awareness, and peer support. They promote safe practices, facilitate access to HIV testing, care, and treatment, and provide linkages to other sexual and reproductive health and rights (SRHR) services, helping to reduce stigma and improve overall health outcomes
	Director (13)	$266,212	Provide strategic leadership, ensure compliance, supervise teams, and represent the project at senior levels.
	Programme Manager (13)	$190,785	Lead activity coordination, stakeholder engagement, and field-level implementation of programme interventions
	Finance Manager (13)	$190,785	Responsible for day-to-day financial management, budget monitoring, reporting, and ensuring compliance with donor financial regulations.
	Human Resources Officer (13)	$110,922	Oversee recruitment, staff welfare, performance management, and HR policy compliance.
	Monitoring & Evaluation Officer (13)	$133,306	Fully dedicated to monitoring project performance, managing data systems, and supporting evidence-based reporting.
	Case Manger/ Worker (21)	$100,341	Supports key populations by facilitating linkage to care, providing treatment adherence support, conducting follow-ups, and coordinating services between clients, healthcare providers, and community programmes
	Data Clerk (13)	$79,863	The data clerk is responsible for collecting, entering, and maintaining accurate programme data. They support data quality checks, generate reports, and help track programme performance and outcomes to ensure informed decision-making.

Community Infrastructure Funding Gap: Approximately **$1,430,833** annually to rebuild essential community systems and protective mechanisms.

What is the Cost of Inaction? The lack of supported community led efforts will lead to a great loss of KPs in the HIV program, poor health outcomes and a great loss of Namibia's ability to reach KP communities. KPs rely on community efforts as they are friendly, flexible and easier to navigate the general health sites. The return of KPs to already overstretched health services will see the HIV program face more challenges retaining people in care.

4. Data and Monitoring Systems

For COP23, he Global Fund and PEPFAR Namibia intended to support the ministry of health to strengthen the collection of data into the multi sectoral information systems from activities implemented in the community. PEPFAR Namibia's support was focused on strengthening the reporting of community data by PEPFAR implementing partners and other line ministries (Ministry of Education, Gender and Youth), revision of community indicators to align with the National Strategic Framework (NSF) and regular data review meetings to ensure data is accessible to all stakeholders and supportive data quality assessments.

In COP23 year 2, PEPFAR focused on strengthening health information systems to ensure a sustainable HIV response and to improve client outcomes as challenges such as a lack of interoperability between multiple data systems, a need for digitization, limited access to existing systems for program staff at all levels, and the absence of client level data tracked through a unique identifier persisted. The funding cuts for communities meant a termination of data collection among key populations as sites, staff, outreaches and services were closed down.

To ensure that programs are evidence driven and aligned with the epidemiological need, PEPFAR Namibia intended to conduct an HIV Integrated Biological and Behavioral Surveillance Survey (IBBSS) in COP23 among KPs to ensure that KP programing is informed by the latest data on HIV burden, risk factors, and coverage of treatment and prevention services. The last IBBSS in Namibia was conducted in 2018 among FSWs and 2019 for MSM which included a disaggregation for TG. However, the (IBBS) that had just launched to gather more recent data on MSM, FSW and TG women had to be halted mid-way due to the cuts – leaving critical evidence gaps.

Non-negotiable Priorities:

- Restore high-quality, disaggregated data for an effective prevention and treatment programme for key populations to ensure quality programs.
- Restore staff who supported data collection. This includes data clerks, health records and information officers and M&E officers including peer educators and field officers/outreach workers.

Strategic Element	Current Status	Annual Funding Required	Key notes
Disaggregated data	Not collected	$38,000	Restore high-quality, disaggregated data
Data collection and entry	Terminated	$38,000	Restore data collection staff support
HIV Integrated Biological and Behavioral Surveillance Survey (IBBSS)	Halted	$38,000	Restore and finalise the IBBSS

Data and Monitoring Systems Gap: $114,000 annually to rebuild data and monitoring

What is the cost of inaction? KP date is critical for the success of HIV programs. Integration of KP program will lead to less data collection for KPs who might fear stigma and discrimination due at the general health facilities.

Summary of Proposed Cost of the Namibia Key Population Plan

Targeting and Costing Methodology

In Namibia, the methodology used the national population size estimates from PEPFAR and UNAIDS KP Atlas. Where lacking an estimate for TG, a standard percentage from the region is used. We considered the percentage of KPs that need prevention services (set initially at 90%). We further estimated KP living with HIV using HIV prevalence from PEPFAR or the KP Atlas. Where lacking prevalence data, a standard percentage from the region is used. We had considered % of KPLHIV in need of treatment services (set initially at 100%). To meet the Namibia budget, the country will focus on 100% of treatment and 100% as indicated below. Prisoners and clients of FSW are not included in the costing exercise.

The itemised costing of each intervention is found on this link: Namibia Targetting and Costing

Namibia Priorites	Costs	Total	Cost per target	General costs	GBV	Testing	TX	Biomedical Prev	STI
Priorites	Costs	$4,255,886	$185	$311,363	$13,758	$183,614	$626,132	$2,802,688	$318,331
	Percent of total			7.32%	0.32%	4.31%	14.71%	65.85%	7.48%
		National Targets							
Targets	KP Treatment	4,200							
	KP Primary Prevention	18,800							
	Total	23,000							

What should a good core package for quality key population service delivery include?

- Outreach services
- Lubricant
- Male condoms
- KP friendly HIV testing and counselling, including HIV self testing
- KP friendly HIV care and treatment
- HIV and PrEP support groups to improve continuity in care
- Psycho-social support
- Pre-Exposure Prophylaxis (PrEP)
- Post-Exposure Prophylaxis (PEP)
- Mental health services
- Linkage to justice services
- Pmtct
- Information package for sexual health services
- KP friendly STI prevention, testing & treatment services
- Gender-based violence services on-site or by referral
- Peer educators/navigators at the facility
- Vaccination, diagnosis, and treatment of viral hepatitis (including HBV, HCV)
- Prevention, diagnosis, and treatment of tuberculosis
- Counselling and risk reduction information
- Anal health services
- Voluntary Medical Male Circumcision (VMMC)
- Prostate cancer screening
- Cervical cancer screening
- Screening and treatment for ano-genital warts
- On-site and referral for other SRHR services

PWUD specific:

- On-site and referral drug dependence initiation and treatment (e.g. methadone)
- On-site and referral drug-dependence counselling and support
- Resources to take up referred services (e.g. taxi fare)
- Wound and abscess care
- Unused needles, syringes, or other injecting equipment
- Overdose management and treatment (e.g. naloxone)
- Drug dependence support group

TG specific:

- Hormone Replacement Therapy (HRT)

Methodology

This rapid strategy and budgeting exercise was designed as a structured assessment process to capture country-level impacts of foreign aid transitions and identify essential services requiring continued investment for KPs. The methodology began with orientation to a standardised Excel worksheet framework designed to systematically capture country coalitions' assessments across three critical domains: ART service delivery, HIV prevention programming, and community infrastructure (including civil society engagement, community-led monitoring, community mobilization, and advocacy capacity).

The assessment process examined three distinct time periods: baseline status at the end of 2024, immediate impacts following foreign aid transitions that began in January/February 2025, and current conditions as of June 2025. Country coalitions collected quantitative and qualitative data through surveys, key informant interviews, organisational assessments, and coalition consultations to document service disruptions, funding gaps, and programmatic changes across these timeframes.

Following data collection, coalitions engaged in facilitated consensus-building processes to analyze findings, identify priority concerns, and develop collective views on current programming status. Through these discussions, coalitions articulated their "essentials"—critical activities, services, and investments necessary to maintain effective HIV responses for KPsin their contexts. This worksheet was used as the basis for a strategy narrative, developed by the GBGMC support team, that included a summary table of priority interventions requiring funding and attention.

Acknowledgments

Namibia's Methodological Guide

Team Namibia was brought together through the leadership of Friedel Dausab, who engaged several leaders across the sex worker, transgender, feminist, LGBTQ+, and MSM movements in the country. Information about the opportunity was widely shared, underscoring the importance of convening to collectively develop recommendations, identify priority areas, and shape strategies for the continued strengthening of HIV prevention, treatment, and care services, particularly for key populations.

During the convening, a comprehensive presentation was delivered and shared with leaders in attendance. The dialogue brought together organizations and their respective representatives, including:

MPOWER Community Trust – Director Stewart Langenhoven

Harmony for All Movement – Director Natasha Coleman

Voice of Foundation – Director Ernestine Draghoender

Namibian Planned Parenthood Association – Representative Willem Tumuna

Positive Vibes Trust – Representative Gina Tibiyane

Out-Right Namibia – Representative Ou Lau

Equal Rights for All Movement – Director Rachel Love Gawases

MPOWER Community Trust - Finance Manager Elvis Hochobeb

MPOWER Community Trust, Monitoring & Evaluation Manager - Inacia Pangelasius

MPOWER Community Trust - Programme Manager - Norman Noabeb

The Team

Technical Team

Global Black Gay Men Connect (GBGMC): Maureen Milanga, Brian Kanyemba, Kingford Khanyiso, Micheal Ighodaro

Health Global Access Project: Brian Macharia, Asia Russell, Belinda Thibela

Partners

Partners: UNAIDS, KP-TNC, Kenya Key Population Consortium (KKPC), amfAR.

Contributors (research & preliminary drafting): Emily Bass, Brian White, William Miller

Technical contributors: Kent Klindera, Devynn Birx-Raybuck, Meg Densmore, Sarah Ekellogg, Sara Melillo, Ron Macinness and Brittany Parnel

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