NAMIBIA
PrEP Ring Situation Analysis

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PEPFAR

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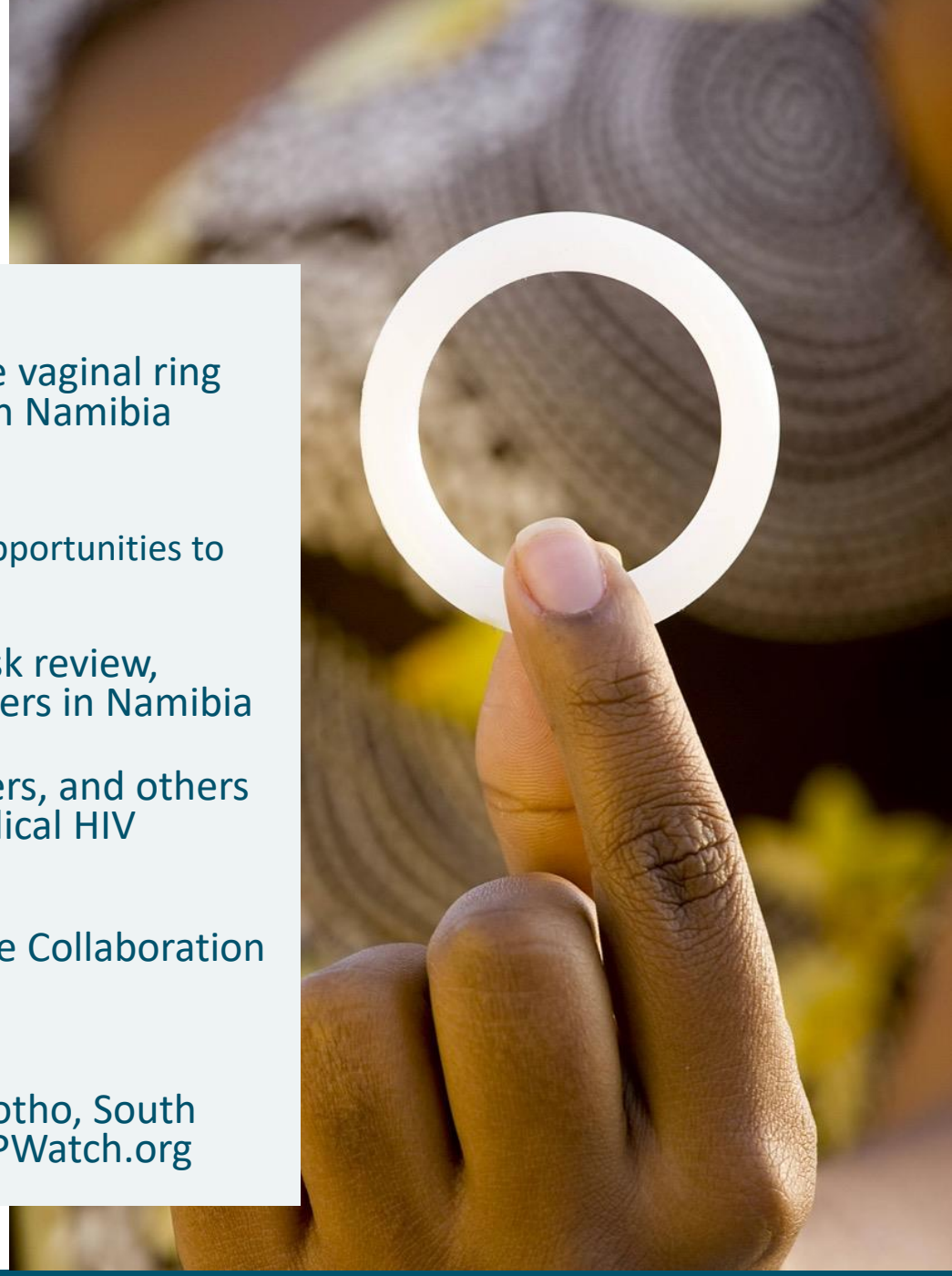
Introduction

- This analysis can support introduction of the dapivirine vaginal ring (the pre-exposure prophylaxis [PrEP] ring or the ring) in Namibia across two dimensions:
  - Considering and prioritizing delivery channels for the ring
  - Identifying critical steps for ring introduction, including opportunities to build on the introduction and scale-up of oral PrEP
- This analysis is based on several inputs, including a desk review, secondary research, and interviews with key stakeholders in Namibia
- This analysis can be used by policymakers, implementers, and others planning for introduction of the ring and other biomedical HIV prevention methods in Namibia
- This analysis was developed in 2021 by members of the Collaboration for HIV Prevention Options to Control the Epidemic (CHOICE) collaboration
- Summaries of similar analyses for Eswatini, Kenya, Lesotho, South Africa, Zambia, and Zimbabwe will be available on PrEPWatch.org



Note on terminology

In efforts to be more precise and not contribute to the stigmatization of people living with HIV (PLHIV) or those who may benefit from HIV prevention products, we have made a few language shifts:

- **Serodifferent instead of serodiscordant**. This change reinforces that while the HIV status of people can be different, it does not put them in discord. It is completely okay for people to have different HIV serostatuses.
- **Minimizing use of the terms "risk" and "risky"**. The terms can have so many different definitions and may stigmatize certain behaviors, impose labels on clients, or stigmatize living with HIV itself.
- Using **gender neutral terms when text is not specifically about gender**. The terms are more inclusive of various gender identities.

HIV prevention context

Oral PrEP context

PrEP ring introduction planning

Desk review sources

HIV in Namibia

In 2020, HIV prevalence among people ages 15-49 was 11.6% nationally, which corresponds to approximately 200,000 people over the age of 15 living with HIV.[1] HIV prevalence was 14.7% among females and 8.3% among males of the same age group (ages 15-49).[1] In 2017, HIV prevalence among women peaked in those ages 45-49 (30%) and among men ages 50-54 (26.4%), while regional HIV prevalence varied widely from 7.6% in Kunene to 22.3% in Zambezi.[2]

KEY STATISTICS (2020)

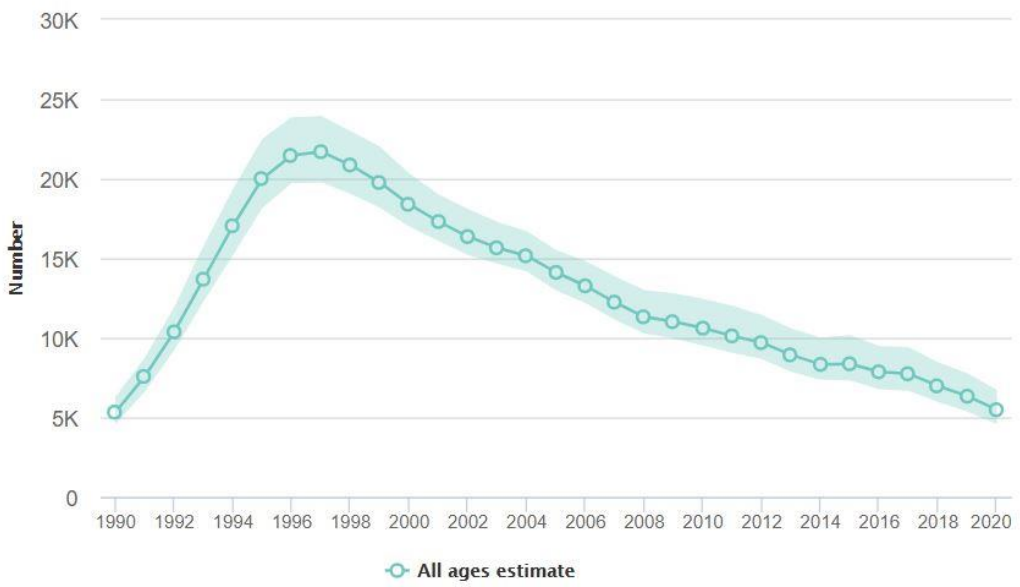
HIV prevalence (ages 15-49) is 11.6%[1]

- Prevalence for females (ages 15-49) is 14.7% and 5.1% for those ages 15-24
- Prevalence for males (ages 15-49) is above 8.3% and 2.6% for those ages 15-24
- Prevalence among key populations (KPs) is only available in selected towns with hotspots
  - In 2018, the average prevalence for sex workers (SW) was 29.2% (range of 20.9%–43.6% in 4 key towns)[3]
  - In 2019, the average prevalence for men who have sex with men (MSM) was 8.9% (range of 7.9%–10.2% in 4 key towns)[3]
  - No data are available for transgender (TG) persons, people who inject drugs, and prisoners[3]

The **HIV incidence rate** (ages 15-49) has been in decline over the last few years and in 2020 was 4.23 individuals per 1,000 population[1]

- The 2020 estimate for females is 3.4 individuals per 1,000 population; for males, the estimate is 1.7 individuals per 1,000 population

Trend in new HIV acquisitions in Namibia since 2010[1]

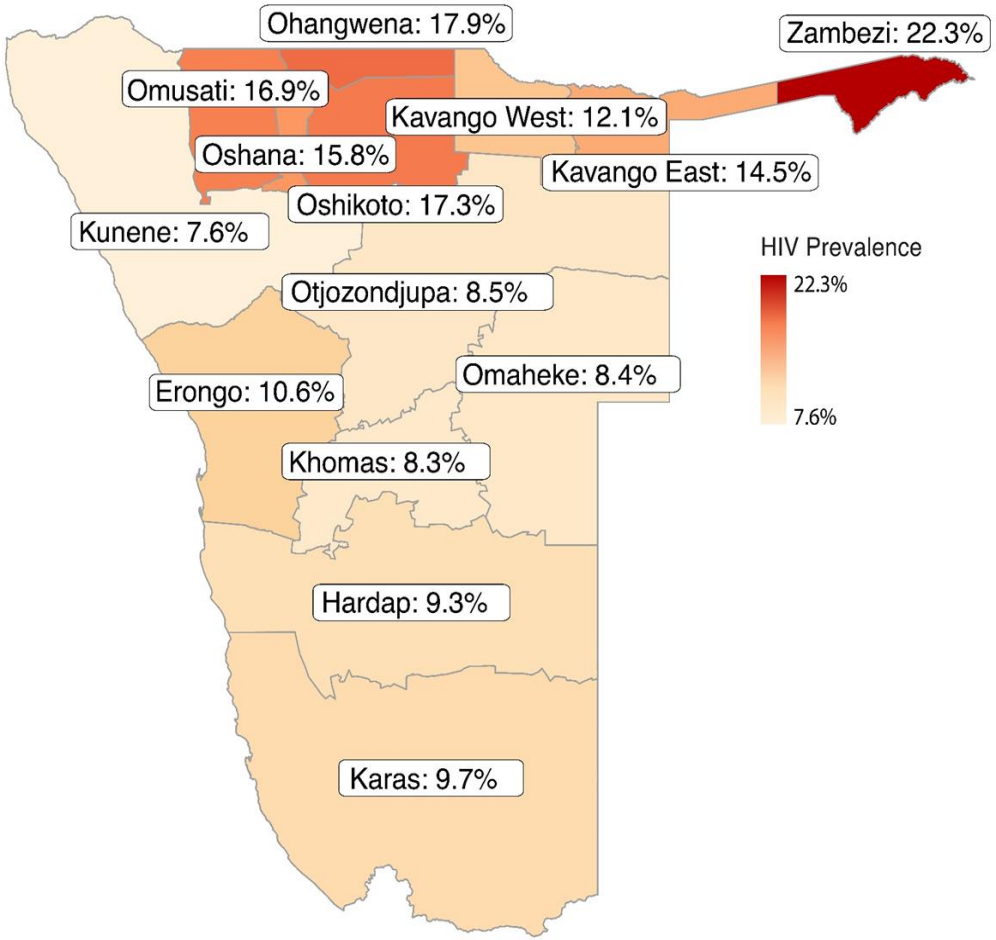


Since 2010 there has been a 48% reduction in new HIV acquisitions[1]

Sources: 1) UNAIDS 2020; 2) NAMPHIA 2017; 3) MOHSS-RME 2021

HIV in Namibia by geography

In 2017, there were an estimated 202,147 PLHIV in Namibia.[2] The map below shows the estimated HIV prevalence by region in 2017.[2]



Region	PLHIV (2017)[2]
Zambezi	13,614
Ohangwena	34,416
Oshikoto	22,710
Omusati	28,192
Oshana	26,357
Kavango East	18,403
Kavango West	9,630
Erongo	8,056
Karas	4,748
Hardap	4,481
Omaheke	4,888
Khomas	22,589
Kunene	4,063
TOTAL	**202,147**

Regional numbers estimated based on Namibia Population-based HIV Impact Assessment (NAMPHIA) prevalence and population projections for 2017[2]

Sources: 2) NAMPHIA 2017

HIV Prevention in Namibia

Namibia uses the combination HIV prevention approach, which supports implementation of biomedical, socio-behavioral, and structural interventions that are premised on human rights and gender sensitivity and are evidence-informed.[4] Interventions are contextualized to respond to local needs and specific population groups (adolescent girls and young women [AGYW], MSM, female sex workers [FSW], TG persons, and prisoners).[4] These interventions include antiretroviral therapy (ART), PrEP, voluntary medical male circumcision (VMMC), prevention of mother to child transmission, condom distribution, and other cross-cutting activities.[4]

KEY STATISTICS (2020)

Namibia is committed to achieving the 95-95-95 goals and has been making impressive progress. As of December 2020, it stands at 90-98-91.[5] The table below shows estimates using the SPECTRUM Model.[5]

Element	Estimates
PLHIV	206,736
PLHIV who know their status	185,992
PLHIV of known status on treatment	181,696
PLHIV on treatment with viral load suppression	174,469
Overall: 90-98-91% 0-14: 80-93-81% 15+: 90-98-92%	

National plans highlight several key challenges: [4]

- PrEP
  - Service providers are not fully oriented on the PrEP provisions in the most recent edition of the National Guidelines for Antiretroviral Therapy
- AGYW
  - Limited post-exposure prophylaxis (PEP) uptake and retention
  - Low coverage of adolescent-friendly services (low/limited sexual and reproductive health [SRH] and HIV integration coverage)
- Male Involvement
  - Poor health seeking behaviors among men
  - Prevalence of intergenerational and transactional sex
  - Low coverage of HIV testing services, PrEP, VMMC, and ART
- MSM & FSW
  - Low uptake of HIV prevention services (including testing)
  - High need for HIV prevention amongst MSM and FSW and prevalence of stigma, discrimination, and social exclusion, plus inadequate comprehensive knowledge, health education materials, and data on MSM and FSW
- Condom promotion and distribution, as well as VMMC uptake, still need more support in supply chains and countrywide coverage

Sources: 4) Namibia NSF 2017/18–2021/22; 5) USAID Namibia 2020

HIV prevention context

Oral PrEP context

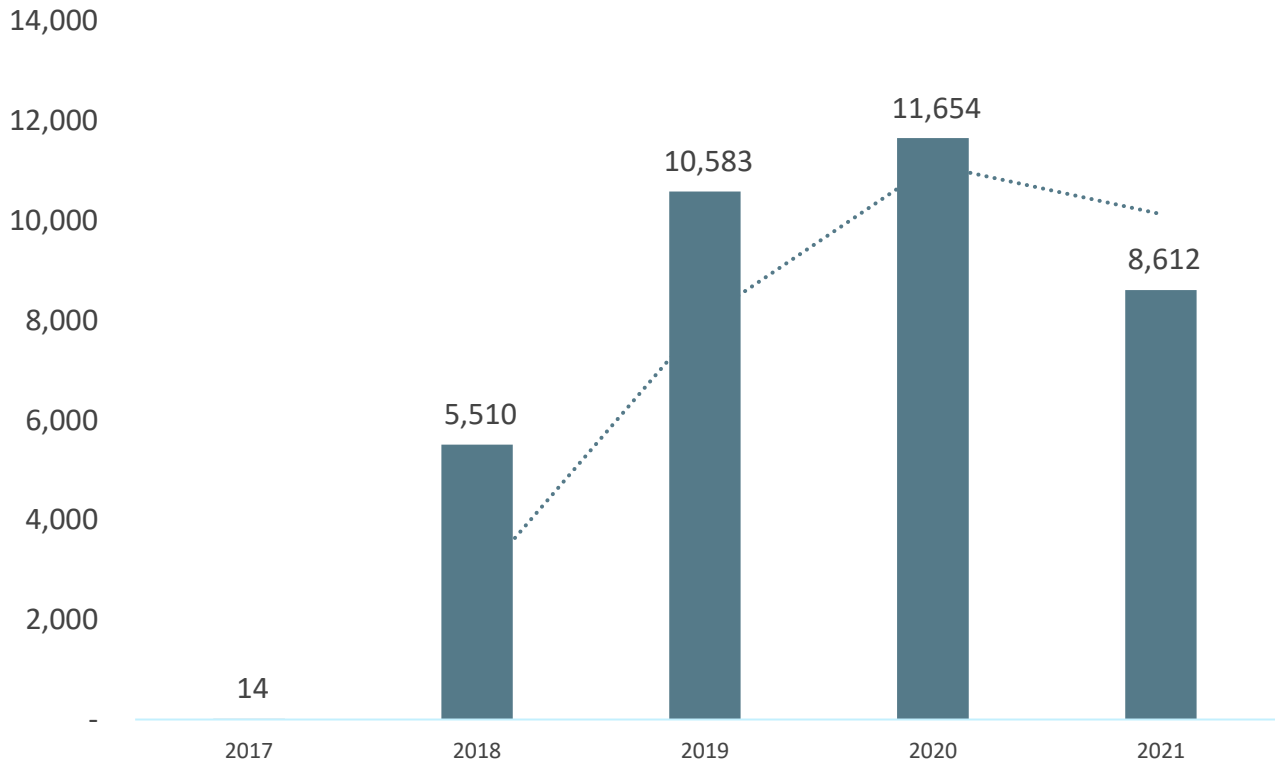
PrEP ring introduction planning

Desk review sources

Oral PrEP rollout in Namibia

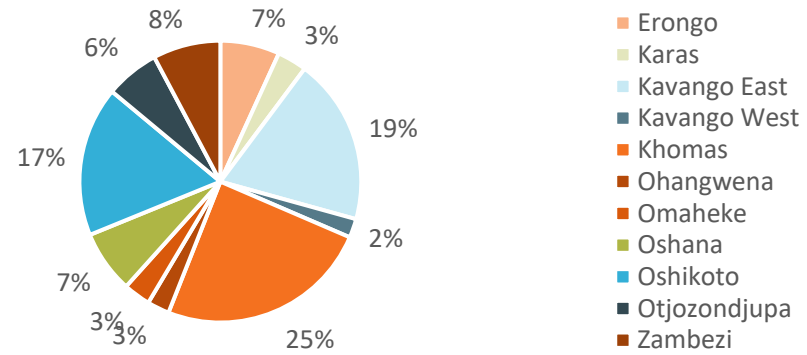
In December 2016, Namibia introduced oral PrEP in the 5th edition of the National Guidelines for Antiretroviral Therapy [6]

Annual number of new PrEP users in Namibia (2017-2021)[5]



- PrEP rollout in Namibia started slowly in 2017 and has been expanded to all districts over the years, with increasing numbers every year[3]
- Data are not available at the national level to collate all PrEP statistics; implementing partners are reporting separately to USAID or the U.S. Centers for Disease Control and Prevention (CDC) and Namibia Ministry of Health and Social Services (MOHSS)[3]
- The MOHSS is still working on finalizing a framework for monitoring and evaluation of PrEP in Namibia [3]

October - YTD regional distribution of newly enrolled PrEP users in 11 regions[7]



Source: 3) MOHSS-RME 2021; 5) USAID Namibia 2020; 6) Namibia National Guidelines for Antiretroviral Therapy 5th Ed 2016; 7) amfAR 2021

Key oral PrEP implementation stakeholders interviewed

Organization	Role in oral PrEP
IntraHealth Namibia	Implementing partner for USAID's KP program KP-STAR
Jhpiego (ACHIEVE sub-partner)	DREAMS project in 2 regions (PrEP for AGYW)
Ministry of Health and Social Services (MOHSS)	Overall training, implementation, and guidance on PrEP in Namibia
Namibia Planned Parenthood Association (NAPPA)	Youth Friendly Integration of FP & PrEP Services
Private medical practitioner – Oshakati region	Provision of PrEP in private practice
University of California – San Francisco (UCSF)	Research and support for HIV prevention
United States Agency for International Development (USAID)	Funding for HIV prevention services, including PrEP
WAP Pharmaceuticals	Supply of PrEP in private practice

Interviewee list

Organization	Individuals
IntraHealth Namibia	Samson Ndhlovu
Jhpiego (ACHIEVE)	Pauline Singarure
MOHSS	Rosalina Kakelo, Idah Mendai, Lylie Ndeikemona, Sam Kaliba
NAPPA	Frieda Stefanus
Private medical practitioner – Oshakati region	Julitha Sheefeni
UCSF Collaborator under CDC/MOHSS	Ntombizodwa Nyoni
USAID	Farida Mushi
WAP Pharmaceuticals	Pedzi Changunda

Oral PrEP rollout – lessons learned

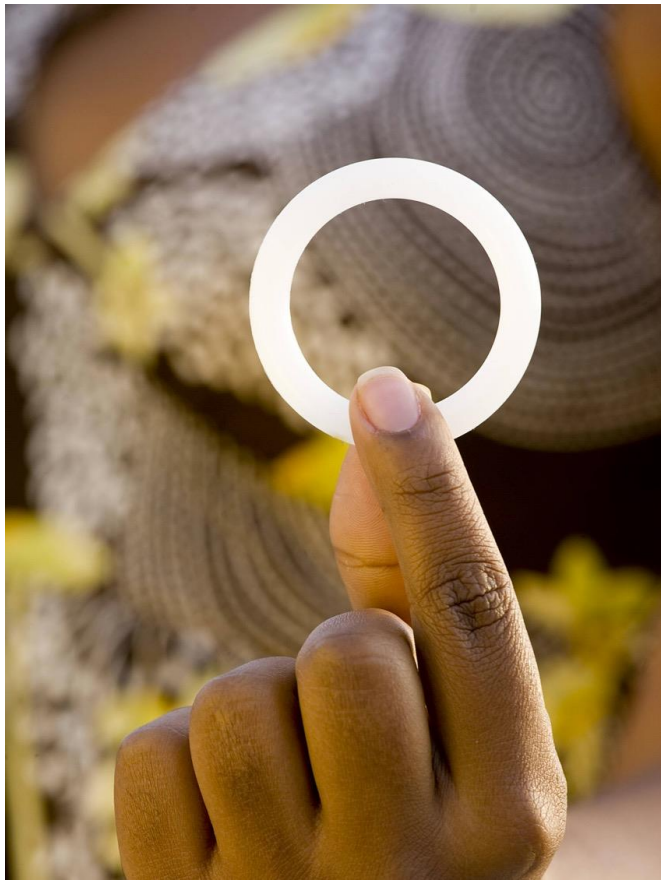
What worked well

- Dissemination of information has worked well, with information communicated through hospitals, social media, radios, etc.
- Private sector clients have arrived for services asking for oral PrEP, indicating that information sharing and demand creation did reach private sector clients
- Provision of multiple prevention options (condoms in particular) when testing occurs was helpful for AGYW
- Availability of funding from donors was beneficial to really bring the guidelines to the ground and support regions in training, visits, and capacity strengthening
- The ability to reach providers across the country with a good network of clinical mentors proved useful; networks were established for new activities related to HIV care, treatment, and prevention
    - These networks include regional clinical mentors (cadres of representatives and counselors) that can cascade efforts and awareness to the community

What was challenging

- Many people are not comfortable going to the doctor and sharing medical history, so motivation to seek services has been low and uptake impacted
- In the general population, people have information about oral PrEP but cannot easily access services and, with limited resources, may just not look for services at all; there also are not always enough providers available to render services
- There is an indirect challenge of alcohol abuse in Namibia, leading to a neglect in healthcare and consequential actions made while under the influence
- Low training coverage along the cascade
    - Facilities could not always manage all providers at a given facility and sometimes healthcare workers (HCW) kept information to themselves, did not have enough information on oral PrEP, felt a lack of confidence in dealing with antiretrovirals, or rotated frequently
    - Community providers were less receptive to cascaded training of trainers (ToT); information and communication tends to dwindle further along the cascade from regional or district trainings to community ToT
- Challenges arose with continuation, follow-up, and clear messaging around who can use oral PrEP and what it is
- There were broad challenges with reporting on oral PrEP data within the MOHSS system, lack of an electronic system, and issues with the monitoring and evaluation framework

The PrEP ring will be an important new HIV prevention method for women



Key findings from stakeholder consultations

- As a user-controlled and long-acting HIV prevention option, the ring is an important complement to other HIV prevention methods in Namibia.
- The ring may be particularly appropriate for cisgender* women, in particular cisgender AGYW and KPs, specifically SW and TG persons assigned female sex at birth who have a higher likelihood of HIV acquisition through receptive vaginal sex, and often have challenges advocating for condom use, prefer not to take a daily pill, are seeking a more discreet HIV prevention option, and/or want to avoid oral PrEP side effects.
- There is significant opportunity to build from the experience with oral PrEP to introduce the ring – for example, implementation frameworks, guidelines, supply chain logistics, and resource allocation strategies have been developed for oral PrEP that could accommodate the ring, and a technical working group (TWG) for PrEP already exists to guide ring introduction.
- The ring also presents new opportunities, specifically strengthening demand creation efforts for the growing mix of HIV prevention options; integration with FP services; development of monitoring systems for adherence, continuation, and drug resistance; community-based distribution, and implementation science research.

*Cisgender is a term used to describe a person whose sense of personal identity and gender corresponds with their sex assigned at birth. E.g., Cisgender women were assigned female sex at birth and identify as women.

HIV prevention context

Oral PrEP context

PrEP ring introduction planning

Desk review sources

PrEP ring introduction framework

This value chain framework has been used across countries to support planning for oral PrEP introduction. It has been adapted for the ring to identify necessary steps for ring introduction and scale-up across five major categories and across priority delivery channels. It can also be used to track progress towards ring introduction by different partners.

Value Chain for PrEP Ring

PLANNING & BUDGETING

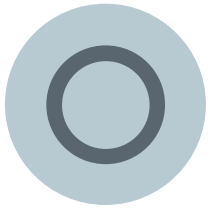
National and county plans are established to implement ring guidelines for priority end user populations

SUPPLY CHAIN MANAGEMENT

Ring is available and distributed in sufficient quantity to meet projected demand via priority delivery channels

PREP RING DELIVERY PLATFORMS

Ring is delivered by trained healthcare workers in priority delivery channels to effectively reach end users



UPTAKE & EFFECTIVE USE

End users know about and understand the ring and are able to seek, initiate, and effectively use the ring

MONITORING

The ring is effectively integrated into national, county, sub-county, facility, community, and program level monitoring systems

Namibia PrEP ring introduction situation analysis

This framework highlights critical elements of ring introduction and assesses the current state across these elements in Namibia

PLANNING & BUDGETING

- Convene new or existing **technical working group**/subcommittee for the ring
- Identify **focus populations** for ring use
- Engage **community** stakeholders to inform planning for ring rollout
- Develop impact, cost and/or cost-effectiveness **analyses** to inform ring planning
- Include the ring in national HIV prevention and other relevant **plans** (e.g., FP)
- Develop **implementation plan and budget** to guide initial ring introduction and scale-up

SUPPLY CHAIN MANAGEMENT

- **Register** the ring and include the ring on the national essential medicines list (EML)
- Update **supply chain guidelines and logistics systems** to include the ring
- Establish **monitoring, demand forecasting, and distribution systems** to avoid stock-outs

PREP RING DELIVERY PLATFORMS

- Issue standard **clinical guidelines** for delivery and use of the ring
- Dedicate resources to conduct regular **HIV tests, initiate ring use, and support refills**
- Develop trainings and materials for **healthcare workers** on the ring
- Establish **referral systems** to link clients from other channels to sites dispensing the ring
- Integrate support for **partner communication** and intimate partner violence (IPV)

UPTAKE & EFFECTIVE USE

- Develop and implement **demand creation strategies** that include ring promotion
- Address social norms/stigma to build **community and partner acceptance** of ring use
- Develop **information and tools for clients** to guide product choice and support ring use
- Support **adherence and continuation** for ring users
- Develop and communicate plans for sanitary **disposal** of used rings

MONITORING

- Establish **monitoring tools** to support data collection and analysis on ring use
- Establish systems for **pharmacovigilance** and to monitor drug resistance
- Conduct **implementation science** research to inform policy and scale-up

COLOR KEY

- Opportunity to easily build on oral PrEP rollout
- Will require new effort, but no anticipated challenges
- Requires significant consideration specifically for the ring

Namibia situation analysis summary findings

Summary findings from the Namibia situation analysis are below, with recommended next steps included on the following slides

PLANNING & BUDGETING

- An **existing TWG for PrEP** will likely guide introduction of the ring
- **The aim is to reach as large a focus population as possible**; prioritization will occur depending on funding
- **Stakeholder engagement initiated by the Ministry of Health (MoH)** but largely led by community organizations and implementing partners
- **Cost analyses will contribute to assigned pharmaceutical budget** for the ring
- **The ring will be incorporated into existing national guidelines** (HIV prevention and ART); pharmaceutical registration will be required
- Integrating the ring **into the existing implementation plan should be easy**

SUPPLY CHAIN MANAGEMENT

- **Approval will be required from the Pharmaceutical Board** for registration; clinical guidelines are to be developed first and the process facilitated by the **National Medicine Regulatory Council** (NMRC)
- The **ring would fall under existing supply chain guidelines**; logistics established during tendering process
- No anticipated challenges with monitoring or distribution systems; **use existing Electronic Dispensing Tool for ART services** and **Facility Electronic Stock card** for stock management

PrEP RING DELIVERY PLATFORMS

- The ring can be easily added with **an addendum to the existing combination prevention strategy guidelines**
- **It is anticipated that existing systems for service delivery will be used**, supported by the Government of Namibia and other partners
- **Materials and trainings would be developed by the MoH** based on guidelines and **disseminated through regional ToT**
- **Referrals exist between private and public** facilities but could be strengthened **within facilities and from communities to facilities**; there is **interest in more integration of services**, especially between SRH and HIV
- Partner communication support and IPV counseling occur **but not with frequency**

UPTAKE & EFFECTIVE USE

- **Limited demand creation strategy and materials**, especially at the community level and for hard-to-reach groups
- **Platforms exist for sensitization and education** but with **ongoing engagement of stakeholders at all levels** to support community uptake
- **MOHSS and implementing partners to support development** of information and tools for the ring
- **Challenges with continuation in both private and public** sectors; need for **sensitization of HCW**
- **No anticipated challenges** with sanitary disposal of the ring

MONITORING

- **Straightforward addition of the ring into existing monitoring and evaluation tools** and systems with **considerations of cost**; limited integration with other services
- **Pharmacovigilance systems exist and would be easily adapted** to include the ring; **no system for drug resistance** monitoring
- **No formal implementation science research** efforts underway

Recommended next steps: Planning and budgeting

PLANNING & BUDGETING

Convene new or existing **technical working group**/subcommittee for the ring	• Use TWG to facilitate planning process, curriculum and training development, and approval of clinical guidelines • Issue a circular for dissemination to the market once guidelines are established
Identify **focus populations** for ring use	• Expand list of focus populations to include FSW, AGYW, and individuals experiencing IPV • Use informed geographic approach and find ways to engage across geographies
Engage **community** stakeholders to inform planning for ring rollout	• Involve community stakeholders and community-led organizations in implementation planning • Strengthen consistent community engagement in planning process, including civil society organizations involved in KP and other priority population efforts • Include KP and priority population representatives in TWG processes
Develop impact, cost, and/or cost-effectiveness **analyses** to inform ring planning	• Conduct cost-effectiveness analyses as well as cost analyses in anticipation of rollout and to help kickstart procurement
Include the ring in national HIV prevention and other relevant **plans** (e.g., FP)	• Include the ring in existing plans so as not to limit planning to specific settings • Conduct consultative meetings with all stakeholders
Develop **implementation plan and budget** to guide initial ring introduction and scale-up	• Draft an additional chapter in the implementation plan for the ring with the TWG that includes both prevention and implementation components • Communicate the ring as an addition to existing PrEP options, rather than something new and standalone

Recommended next steps: Supply chain management

SUPPLY CHAIN MANAGEMENT

Register the ring and include the ring on the national essential medicines list	• Registration application submitted by the manufacturing company (which can be represented by another party) • Plan for required factory inspection by NMRC; WHO pre-qualification may make this process easier • Develop clinical guidelines after registration as reference for Pharmaceutical Board review and approval
Update **supply chain guidelines and logistics systems** to include the ring	• Complete the tender process once the ring is included on the central drugs list so that it comes through the central medical stores • Include opportunities for private sector procurement (after NMRC registration) but consider pricing differences between public and private tendering; if the government partners with an organization to bring the ring in at a cheaper price, the private sector can procure it from the government at a more affordable rate • Use target setting strategies to support quantification and engagement with Central Medical Stores (including 8-12 month maximum/minimum stock levels) • Develop a standard operating procedure (SOP) for approval of dapivirine, needed as reference for registration with the pharmaceutical directorate
Establish **monitoring, demand forecasting, and distribution systems** to avoid stock-outs	• Use the Facility Electronic Stock card to manage stock at the facility level and issue dispensing and ordering from Central Medical Stores; this tool shows stock on hand and distribution • Consider ways to use the Electronic Dispensing Tool for ART services in facilities for tracking follow-up

Recommended next steps: PrEP ring delivery platform

PREP RING DELIVERY PLATFORMS

Issue standard **clinical guidelines** for delivery and use of the ring	• Consider including private sector stakeholders in standard guideline issuance process • Coordinate effort with implementing partners and stakeholders • Incorporate WHO guidance into clinical guidelines with MOHSS, writing a circular to disseminate to providers
Dedicate resources to conduct regular **HIV tests, initiate ring use, and support refills**	• Increase necessary resources (like testing kits) calculated with estimated uptake and continuation in mind • Collaborate with the private sector on distribution of services and resources
Develop trainings and materials for **healthcare workers** on the ring	• Plan for trainings and curriculum development directly with regions and use regional councils, regional chairperson, and community leadership • Engage Global Fund and PEPFAR for support with funding for training • Conduct dissemination by both implementing partners and MoH with initial training seminars and refresher courses • Engage private sector providers more directly in training opportunities and refresher courses • Incorporate inputs on trainings and materials from ToT to establish more acceptability at the grassroots level, using mentorship groups • Arrange with regional authorities for dissemination, gain authorization, and coordinate selection of health facilities • Explore targeted distribution of the ring in venues where HIV acquisition is likely to occur or where populations with a high likelihood of HIV acquisition frequently gather
Establish **referral systems** to link clients from other channels to sites dispensing the ring	• Orient community health workers (CHW) to referral options and register system for referrals to increase usage and better document referrals • Strengthen referrals from community to facilities, especially for adolescents • Include the ring on client referral cards for within and between facilities • Train more providers on integrated service delivery to minimize multiple trips by users to or between providers, especially in larger facilities • Consider using SRH platforms for information dissemination on the ring
Integrate support for **partner communication** and intimate partner violence	• Expand and strengthen trainings for HCW on gender-based violence (GBV), including IPV, to reach more facilities, especially on best practices for counseling • Develop a clear SOP or guidance for HCW to counsel on partner communication and GBV, including IPV, and include materials for clients and job aids for providers • Consider demographic characteristics of providers and potential challenges in counseling delivered because of different social or cultural beliefs

Recommended next steps: Uptake and effective use

UPTAKE & EFFECTIVE USE

Develop and implement **demand creation strategies** that include ring promotion	• Expand demand creation and sensitization efforts to include national-, regional-, facility-, district-, and community-level efforts, materials, and platforms; learn from efforts from VMMC and tailor materials to specific groups, as appropriate • Establish national guidance on demand creation, especially for focus populations and increase awareness campaigns for hard-to-reach groups • Continue to use social media for rapid engagement, especially of adolescents, but keep in mind different necessary modalities depending on urban or rural populations; WhatsApp, Facebook, and general websites will be useful • Explore acceptability and preference of FSW to get the ring at venue-based locations where socialization occurs
Address social norms/stigma to build **community and partner acceptance** of ring use	• Identify community entry points – both venues and individuals that would be willing to support introduction • Engage with schools, parents, religious and other community leaders, and regional working groups on prevention options education, and build community buy-in • Leverage existing engagement with regional counselors to support the ring and address misconceptions by providers and users • Build CHW confidence in communication of information
Develop **information and tools for clients** to guide product choice and support ring use	• Make packaging and information, education or communication (IEC) materials attractive and innovative; consider providing clients with other prevention methods like condoms • Continue to use different information channels such as radio, leadership meetings, regional counsels, WhatsApp/Facebook, youth forums, and on-site facility education networks • Consider materials that target ring users but are not stigmatizing to specific groups (FSW, AGYW) and can be accessed generally at clinics
Support **adherence and continuation** for ring users	• Ensure awareness of the ring in the community, as well as at the facility level, including follow-up recommendations • Engage CHW and private sector and facility-based providers in standardizing follow-up practices and changing the messaging about adherence after initiation • Sensitize HCW with more information to provide support at the facility level • Develop objective measures for adherence • Establish support groups (virtual and in-person)
Develop and communicate plans for sanitary **disposal** of used rings	• Follow similar messaging on disposal as for condoms or other sanitary waste products

Recommended next steps: Monitoring

MONITORING

Establish **monitoring tools** to support data collection and analysis on ring use	• Consider the cost of adding the ring to individual client cards • Update the new PrEP module in District Health Information Software 2 to include the ring • Centralize data tracking across different service delivery points, considering how HIV and FP/RH are not currently linked • Include community stakeholders in the monitoring process and in the development of any new tools
Establish systems for **pharmacovigilance** and to monitor drug resistance	• Recognize the cost of developing a drug resistance monitoring system • Conduct drug resistance surveys with more regularity • For the ring, follow the process for adding PrEP to the pharmacovigilance system
Conduct **implementation science** research to inform policy and scale-up	• Establish ways to fill the gap in research on implementation science, considering changes in differentiated service delivery for PrEP • Conduct implementation science research broadly and with KPs • MOHSS should conduct a literature review on oral PrEP implementation and begin building a base for implementation science research

HIV prevention context

Oral PrEP context

PrEP ring introduction planning

Desk review sources

Select desk review sources

Sources

1. UNAIDS 2020 Namibia dataset on HIV epidemiology and response: https://aidsinfo.unaids.org/

2. Namibia Population-based HIV Impact Assessment (NAMPHIA) 2017: https://phia.icap.columbia.edu/wp-content/uploads/2019/12/NAMPHIA-Final-Report_for-web.pdf

3. Namibia Ministry of Health and Social Services (MOHSS) – Research, Monitoring & Evaluation (RME) department 2021: paper/desk review documents

4. Namibia National Strategic Framework for HIV and AIDS (NSF) Response in Namibia 2017/18 to 2021/22: https://www.unaids.org/sites/default/files/country/documents/NAM_2018_countryreport.pdf

5. USAID Namibia 2020: HIV Epidemic Information & PrEP data shared with implementing partners

6. Namibia National Guidelines for Antiretroviral Therapy 5th Edition 2016: https://differentiatedservicedelivery.org/Portals/0/adam/Content/VVys6XEqAkiCUujlnxr3qA/File/na_national_guidelines_art.pdf

7. amfAR 2021 – PEPFAR Monitoring, Evaluation, and Reporting Database (amfar.org): https://mer.amfar.org/location/Namibia/PrEP_NEW

Thank You!

For more information, please visit:

- https://www.ipmglobal.org/our-work/our-products/dapivirine-ring
- https://www.prepwatch.org/about-prep/dapivirine-ring/

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