Republic of Namibia

National Strategic Framework for HIV and AIDS Response in Namibia 2010/11 – 2015/16

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Foreword

HIV and AIDS remains the gravest development challenge for Namibia. With 23% of deaths being AIDS-related, the impact of the epidemic is deep, multi-sectoral, and intergenerational. We will live with the consequences of AIDS for generations to come. Because of AIDS, expected life expectancy at birth has declined (instead of increased, as has been the case before the HIV and AIDS pandemic) from 62 years in 1991 to 49 years in 2001 (NDP3, pg. 40). Many children in our country – approximately (250,000) 247,400, more than a tenth of our population – are vulnerable or orphaned, many of them because of AIDS. Almost one in every five persons in our communities is living with HIV: an incurable, lifelong infection that is robbing our communities of their bread winners, leaders and the knowledge and skills necessary to sustain livelihoods and economic development. Twenty eight percent of Namibians live in poor households, and with such high numbers of people in our community living with or being personally affected by someone with HIV, we expect the situation to worsen, unless we act now. As more people succumb to the epidemic, a vicious cycle is created: the capacity to absorb and utilize existing resources for socio-economic development is reduced, contributing to deepening poverty and even more vulnerability of our people and the economy.

We must take cognisance of what is driving the epidemic among us, and intervene, quickly, systematically, intensifying our interventions at policy and service delivery levels. When addressing the epidemic drivers, we must strengthen our capacity and commitment to assess our individual and collective behaviours that put us at risk. It is our duty to safeguard ourselves and through our actions promise and guarantee a better tomorrow for our children.

It is important that leaders at all levels provide the necessary and sustained political leadership and commitment to our people, in order to help them achieve the goals we set for ourselves as a nation. Without such commitment and leadership, we as leaders will have failed our people in securing the future. The people of Namibia must remember that our future will depend on what we do now.

As we plan how to improve our response to HIV even more in the future, it is important to remember that we are not helpless. As Namibians, we will not sit back and watch HIV reverse our hard-fought socio-economic gains and prevent our beautiful motherland from providing the prosperity that we wish for every Namibian. We need to be wise, strategic, systematic and bold. We need to work together, coordinate our efforts and create synergies between the efforts of different sectors of society. We need to be focused and assertive in our pursuit of the results defined in this National HIV Strategic Framework. We also need to care, with empathy and dignity, for those who are living with HIV, their families and communities. We need to remember that although individually, we are like grains of sand, together we are the majestic dunes of the Namib. We can be powerful and majestic, *together*.

It is not the first time that the Government of Namibia is planning an HIV response. We have been working on, learning from, adapting and responding to the multiple challenges that AIDS poses for almost 20 years. We established our first National AIDS Control Programme in 1990 (one of the government's first priorities after independence), followed by three Medium Term Plans (MTPs). These plans have put us on

the road to success: they have guided the country's expanded multi-sectoral and multi-layered response to HIV and AIDS. We are now beginning to see the first-fruits of our hard work. The proportion of people in our country with HIV has stabilized, and is expected to reduce in the future. We have put most of those who need life-prolonging treatment on the drugs that they need, and more of our people who are affected by HIV are being cared for and supported. In the past 20 years, Namibia has also strengthened HIV and AIDS coordination and management structures at national, regional and community levels, and in our coordination with development partners. By mainstreaming HIV and AIDS in development programmes, government sectors are increasingly becoming active in the national response.

These successes have been possible because of the hard work of every person involved in Namibia's HIV response. To each of you, I say thank you. We cannot, however, rest on our laurels. Much needs to be done if we want our children's children to live in a world free of HIV. There is a saying 'If you want to walk fast, walk alone, but if you want to walk far, walk with others.' We want to go beyond that with our new NSF: we want to walk *both* far and fast with our partners by planning, implementing, building capacity where needed, all with the same aim in mind – to exceed the results defined in this NSF.

While we continue to provide comprehensive and quality care for those already infected, we must do more and intensify our prevention interventions. It is the only way we shall reduce new HIV infections especially among young people. We must act today because the future is in our hands.

I wish every person who uses this NSF to plan their own HIV response, strength, wisdom and courage to do what is right, tirelessly, with boldness and empathy. Let us be dunes of success, unstoppable in rolling back the damage that HIV has done to our beautiful motherland.

H.E Hifikepunye Pohamba
President - Republic of Namibia

Preface

The National Strategic Framework for HIV and AIDS (NSF) 2010/11 – 2015/16 defines how we as Namibians – all sectors of society at all levels – are going to respond to HIV and AIDS in the next six years. In developing a National HIV Strategic Framework (as opposed to another Medium Term Plan - MTP), Namibia has shifted the planning paradigm from focusing on service delivery only, to understanding how the service delivery efforts will lead to changes in the lives of the targeted audiences, and therefore impact on the epidemic itself. In so doing, Namibia has identified national priorities and articulated national targets (results) that all stakeholders will collectively contribute to. In this new strategy, we have mainstreamed gender and human rights in the implementation, and monitoring and evaluation strategies.

It is general knowledge that HIV and AIDS are a major development challenge as much as they are a health and human rights challenge. The planning for HIV and AIDS in the context of the NSF has taken cognisance of the development dimensions of the response and the need to align and harmonise the NSF with other national strategic policy frameworks such as Vision 2030, the Third National Development Plan (NDP3), the Poverty Reduction Strategy and the millennium Development Goals among others. The National HIV and AIDS Policy (2007) complemented by the National Health Policy provided the overall policy guidance for NSF development. Anchoring the HIV and AIDS response in the overall socioeconomic development widens the scope and provides strategic opportunities for addressing key epidemic drivers that are closely linked to development issues.

The planning of the NSF and the process of identifying national priorities and results has been informed by a wide range of studies and surveys that have provided the evidence required for the results based management of the response. Among the key studies include the Namibia Demographic and Health Survey 2006/07, the 2008 National HIV Sentinel Survey, the HIV and AIDS in Namibia: Behavioural and Contextual Factors Driving the Epidemic, the National Tuberculosis (TB) and HIV and AIDS Targets, the MOHSS / Spectrum models of Estimates and Projections, and the Gap Analysis report among others. The studies and surveys have provided insights on the epidemic drivers, and the trends of new infections. Available data show that infections are on the decline among young people aged 15-19 and 20-24, while it is on the increase among adults (25+ years).

The NSF has described results at three levels i.e. impact, outcome and output. These results are linked to key services that will be provided during the five year period. The Framework has also provided detailed information on key strategies and priority actions. The operationalisation of the NSF is through the accompanying National Operational Plan (NOP), Regional Operational Plans (ROP), and Sector Operational Plans which are aligned to the NSF. The Ministry of Health and Social Services (MOHSS) in collaboration with other development partners will continue to provide technical support to other stakeholders in-order to ensure effective and efficient implementation of the proposed activities. All partners are urged to review and harmonise their strategic plans with the NSF and in particular to take cognisance of the national priorities and results (targets).

The development of the NSF was a broad and participatory process, a reflection of the multi-sectoral

and multi-stakeholder nature of the national response. Government agencies, private sector, civil society, regions, youth and development partners participated in the conceptualisation and development of the NSF. The process has set the stage for consolidating the Three Ones principle of having one national coordinating authority, one national strategic framework and one national monitoring and evaluation framework. The NSF is a living strategy that will be reviewed from time to time. Similarly while the epidemic generates its own dynamics, stakeholders involved in the implementation of the national response must be prepared to amend their strategies in such a way that the strategic impact and outcome level results of the NSF remain within target. The guiding principles contained in this document provide us all with the lasting values that will ensure that we do what is right when we implement this plan.

The successful implementation of the NSF will depend on our ability to strengthen health systems, our strategies for delivery and our efforts in mobilising communities to access and utilise available services. It is our responsibility to ensure an enabling social, policy and legal environment for the national response implementation.

I strongly believe that the NSF provides a comprehensive strategy for effective management and control of the HIV and AIDS epidemic and its direct consequences in Namibia. I want to encourage all the stakeholders to use it as a tool and a road map in the expanded national response to HIV and AIDS.

Hon. Dr. R.N. Kamwi, MP
Chairperson
National AIDS Committee (NAC)

Ministry of Health and Social Services
Minister's Office

Acknowledgements

The development of the Namibian National Strategic Framework (NSF) for HIV and AIDS 2010/11 – 2015/16 was commissioned by the Government of the Republic of Namibia in collaboration with other stakeholders involved in the implementation of the national multi-sectoral HIV and AIDS response. The process started in June and was completed in October 2009. A key feature of the process was the intensive and participatory nature that ensured meaningful involvement of all stakeholders in conceptualising and developing the framework. Approximately 6000 people representing government, development partners, private sector, civil society organisations, traditional leaders, traditional health practitioners and regional, sector and community representatives participated in various ways during the process of developing the NSF. Stakeholders' consultative meetings were held at national and regional levels.

The Government of Namibia is grateful to all development partners who provided financial and technical support. In particular special appreciation goes to the UNAIDS and its Technical Support Facility (TSF), other United Nations (UN) agencies, the World Bank (Global AIDS Monitoring and Evaluation Team / AIDS Strategy and Action Plan Service) and the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM) without whose support the development of the NSF would not have been possible.

The Government of Namibia is equally grateful to the Ministry of Health and Social Services (MOHSS) for the leadership it provided through the Directorate of Special Programmes (DSP). The Directorate played a strategic role in mobilising, facilitating and organising stakeholders, technical working groups and National AIDS Executive Committee (NAEC) consultative meetings. These meetings helped to improve the quality, comprehensiveness and relevance of the NSF strategies and results (targets).

Special appreciation goes to the RACOC and sector coordinators for facilitating the regional and sector consultations. This was valuable in ensuring that the NSF was comprehensive and representative of the views of all stakeholders. The sector and regional consultations were critical in setting the stage for regional and sector plans.

Finally the Government of Namibia is grateful to all the consultants, the NSF secretariat and the staff of Directorate of Special Programmes for their dedicated efforts during the development period of the NSF.

Mr. K.S.M. Kahuure
Chairperson
National Multisectoral AIDS Coordinating Committee (NAMACOC)

Table of Contents

List Tables and Figures

List of Tables

List of Figures

Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
AMICAALL	Alliance of Mayors and Municipal Leaders on HIV and AIDS in Africa
ANC	Anti Natal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral medicine
BCC	Behaviour Change Communication
CACOC	Constituency AIDS Coordinating Committee
CBO	Community Based Organisation
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHBC	Community Home Based Care
COMBI	Communication for Behavioural Impact
CMS	Central Medical Stores
CPT	Cotrimoxazole Preventative Therapy
CRC	Convention on the Rights of the Child
CTX	Cotrimoxazole
DNA	Deoxyribonucleic Acid
DSP	Directorate of Special Programmes
ECD	Early Childhood Development
EMIS	Education Management Information System
e-PMS	electronic Patient Monitoring System
FBO	Faith Based Organisation
FY	Financial Year
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GRN	Government of the Republic of Namibia
HAART	Highly Active Anti-Retroviral Treatment
HBV	Hepatitis B Vaccine
HCT	HIV Counselling and Testing
HIS	Health Information System
HIV	Human Immuno-Virus
HIV-DR	HIV Drug Resistance
IEC	Information Education and Communication
IMAI	Integrated Management of Adult Illness
IPPF	International Planned Parenthood Federation
IPT	Isoniazid Preventative Therapy
KAPB	Knowledge, Attitudes, Practices, Behaviour
M&E	Monitoring and Evaluation
MARPS	Most At Risk Populations
MC	Male Circumcision
MCP	Multiple and Concurrent Partnerships
MDR-TB	Multiple Drug Resistant Tuberculosis
MGECW	Ministry of Gender Equality and Child Welfare
MOHSS	Ministry of Health and Social Services
MRLGHRD	Ministry of Regional and Local Government, Housing and Rural Development
MSM	Men who have Sex with Men
MTP	Medium Term Plan
NABCOA	Namibia Business Coalition on AIDS
NAC	National AIDS Council
NaCCATuM	Namibian Coordinating Committee for HIV and AIDS, TB and Malaria
NAEC	National AIDS Executive Committee

NAMACOC	National Multi-sectoral AIDS Coordination Committee
NAMBTS	Blood Transfusion Service of Namibia
NANASO	Namibia Network of AIDS Service Organisations
NANGOF	Namibia Non Governmental Forum
NDHS	Namibia Demographic and Health Survey
NDP3	Third National Development Plan
NGO	Non Governmental Organisation
NIP	Namibian Institute of Pathology
NOP	National Operational Plan
NPC	National Planning Commission
NSF	National Strategic Framework
NUNW	National Union of Namibian Workers
OC	Outcome Result
OI	Opportunistic Infection
OP	Output Result
OMA	Offices, Ministries, Agencies (of Government)
OPM	Office of the Prime Minister
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction (a test on DNA)
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan For AIDS Relief
PICT	Provider Initiated Counselling and Testing
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnership
RACOC	Regional AIDS Coordinating Committee
RBM	Results Based Management
ROP	Regional Operational Plan
SACU	Southern African Customs Union
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TUCNA	Trade Union Congress of Namibia
TTI	Transfusion-Transmissible Infections
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIVand AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WACPU	Women and Child Protections Units
WBCG	Walvis Bay Corridor Group
WHO	World Health Organisation
WPP	Workplace Programmes
XDR-TB	Extensively Drug Resistant TB

The Structure of the NSF

The Namibia National Strategic Framework (NSF) 2010/11 – 2015/16 is organised in the following sections.

Executive Summary	**Executive Summary:** The executive summary provides a synthesis of the NSF and in particular highlights its key issues and milestones. It also provides a brief summary of the results framework.
Section 1	**Introduction:** The section provides background information on the NSF development, the country text and the purpose of the NSF.
Section 2	**The epidemiology of HIV and AIDS in Namibia**. The section traces the evolution of the epidemic and provides an analysis of emerging trends. The section also describes the epidemic drivers and the socioeconomic impacts.
Section 3	**MTP-III: Assessment of Achievements, Gaps and Challenges.** Highlights the achievements, challenges and gaps of the national HIV and AIDS multi-sectoral response. The section also explores the opportunities of the national response in the context of a decentralized, multi-sectoral and multi-layers stakeholders' participation. It provides the policy and legal environment necessary for the operationalisation of the NSF.
Section 4	**Strategic Orientation.** The section provides the strategic orientation of the NSF including discussion on policy orientation, the shift in planning paradigm focusing on evidence and results based management approaches. The section articulates the linkages between the NSF and other national strategic policy frameworks such as Vision 2030, the Third National Development Plan, the Poverty Reduction Strategy and the National Policy on HIV and AIDS.
Section 5	**NSF Strategic Interventions**. Section 5 provides detailed information on the proposed evidence and results based multi-sectoral response to HIV and AIDS. The section is presented by thematic areas i.e. Prevention, Treatment Care and Support, Impact Mitigation and Response Management. Under each thematic area specific priority programmes, strategies and priority actions are discussed. Each section presents the anticipated outcome and output results. The Section also provides the main activities under each of the programme areas. In the operational plans the main activities are further broken into several specific and detailed sub activities. It is advisable to refer to the national Operational Plan (NOP) for detailed implementation activities.
Annexes	**Annexes**. This section contains the annexes to the NSF.

Executive Summary

Introduction

The National Strategic Framework (NSF) for HIV and AIDS 2010/11 -2015/16 succeeds the MTP-III that came to an end in March 2010. The framework provides strategic policy, planning and implementation guidance and leadership for the national HIV and AIDS multi-sectoral response. The national response is premised on the understanding that HIV and AIDS remains the greatest socioeconomic development challenge in Namibia.

The NSF marks a paradigm shift for the national response from doing "business as usual" to evidence and results based multi-sectoral and decentralised planning. NSF has mainstreamed gender and human rights in all aspects of the response planning and service delivery. The framework is aligned to the Three Ones principle.

The National HIV and AIDS response priorities

The priority for the NSF is to prevent the occurrence of new HIV infections in the country. It aims to reduce HIV incidence rates by 50% by 2015/16. Namibia acknowledges that investing in HIV prevention will have significant benefits not only on the overall quality of life, but will also reduce the economic and social burdens being experienced as a result of epidemic's impact. Prevention remains a national priority sustainability strategy for the HIV and AIDS response.

The prevention strategy will capitalise and sustain the current trends in the reduction of HIV prevalence among several age groups, in particular young people aged 10- 14 and 15-24 years. The 2008 National HIV Sentinel Survey shows that HIV prevalence declined from 12% (2000) to 5% (2008) among 15-19 year old women, and from 20% (2000) to 14% (2008) amongst women aged 20-24 years. According to Spectrum modelling in 2009, new infections in adults aged 15 years and older are projected to decline to 3,025 during fiscal year 2010/11 and to 2,877 by 2012/13. The NSF strategy is to ensure that these projections are not only achieved but also sustained.

Interventions targeting behavioural, biomedical and structural drivers of the epidemic will be intensified and implemented through a combination strategy. The priority will be to focus on the drivers of the epidemic. These drivers include multiple and concurrent partnerships, inconsistent use of condoms, low male circumcision, low levels of HIV testing, alcohol abuse, inter-generational sex and transactional sex. Specific interventions will be implemented to address the incorrect risk perceptions of HIV at a personal level. Interventions aimed at the reduction or elimination of mother to child transmission of HIV will be scaled up and intensified.

The capacity of implementing partners will be strengthened to address structural drivers of the epidemic ranging from poverty, gender and income inequalities, to gender violence and other social norms. Such interventions will be linked to other development programmes and initiatives addressing similar social and development challenges.

Provision of life skills-based HIV education will be scaled up for both in and out of school youth. HIV and AIDS youth friendly services will be initiated and incorporated in on-going youth development and recreation programmes.

HIV and AIDS education and awareness will be intensified for all people and in particular targeting most at risk and vulnerable groups. Communities and community leaders will be mobilised and empowered to address epidemic drivers and promote key prevention behaviours. The involvement and participation of people living with HIV (PLHIV) in HIV prevention will be strengthened and scaled up in community and health facility settings. Specific interventions will be initiated targeting most at risk populations (MARPS).

The second priority is improving the quality of life of PLHIV by reducing morbidity and mortality through provision of comprehensive treatment, care and support services. It is anticipated that people will live longer and hence life expectancy will have increased. Namibia has revised the National Anti-Retroviral Therapy (ART) guidelines from eligibility criteria of CD4 200 to CD4 350 in line with WHO guidelines. These will enable more people to access treatment earlier and hence live longer. Recent studies have also shown that when ART is provided and patients adhere to treatment, it has great potential for reducing HIV infections. Provision of ART will be complemented by nutrition, palliative care and psychosocial support among other services. Similarly, treatment of opportunistic infections such as TB, sexually transmitted infections (STIs) and Hepatitis B will be scaled up. The NSF will support and promote HIV counselling and testing (HCT) as a strategic entry point for treatment. HCT services in the community and at health facilities will be strengthened to cater for increased demand resulting from intensified community mobilisation, education and awareness. Innovative strategies such as mobile testing units and youth friendly testing centres will be implemented. Service providers will be supported to provide friendly and accessible HCT services for MARPS.

Community home based care services will be improved and scaled up through strategic partnerships with civil society and private sector institutions. Given the impact of ART, home based care services will be reviewed and aligned to current demands by PLHIV. The existing referral system will be strengthened, improved and consolidated.

In the area of impact mitigation, the priority will be to strengthen the coping mechanisms for people living with HIV and those living with AIDS. Interventions will aim at addressing the factors that contribute to individual or household vulnerability and empower people to move towards self-reliance. Specific target groups will include orphans and vulnerable children (OVC), PLHIV, the elderly, women and the girl child. Special attention will be paid to vulnerability issues affecting children aged 10 and 14 years. The NSF will promote and support children enrolment and retention in schools, social protection efforts and enforcement of legislations that protect vulnerable children.

Prioritised impact mitigation interventions will include addressing household poverty, food security, income generation and human rights. Poverty reduction initiatives will be linked to initiatives under the Poverty Reduction Strategy and Action Plan for sustainability purposes. Such initiatives will include but not be limited to organised grassroots community revolving micro credit schemes, backyard and community gardens, and small livestock and poultry initiatives. These activities will contribute to

increased household and community income. Communities will be trained in relevant management skills such as marketing, project and financial management. It is anticipated that these interventions will contribute to reducing household vulnerability and strengthening social safety nets.

Orphans and vulnerable children (OVC) are the most visible impacts of HIV and AIDS. A revised National Plan of Action for OVC will guide provision of services to OVC including education, social protection, respect for their basic rights, care and support, health and nutrition. In and out of school OVC will be offered life skills-based HIV education to strengthen their coping mechanisms. While service providers will be oriented on their roles and obligations as "duty bearers", OVC will also be sensitised on their responsibilities as "rights holders".

The efficiency and effectiveness of the coordination and management of the national multi-sectoral response will be improved and strengthened. The institutional arrangement for coordination will be reviewed and restructured. The mandate, roles and responsibilities of national coordinating structures will be clarified. A National Coordination Framework will be developed that will articulate the terms of reference and the multi-sectoral membership of such structures. Advocacy work to consolidate and strengthen political commitment and leadership will be intensified at national, sectoral, regional and community levels. The existing strategic partnerships and alliances between government, private sector, civil society and development partners will be consolidated, and operational systems harmonised and aligned with national systems.

To expand the scope of the response, the Government of Namibia has restructured and redefined sectors along thematic lines. Under the NSF the sectors have been categorised in fourteen clusters (annex 4). Each of the sectors has developed a Sectoral Operational Plan that has detailed information on Sector HIV and AIDS Workplace Programmes in addition to strategies for mainstreaming HIV in development programmes. Similarly the regions have developed regional multisectoral Operational Plans. The regional and sector plans are aligned and harmonised with the National Operational Plan.

Development partner programmes will be harmonised and aligned to national priorities and strategies. The development of such programmes will be informed and guided by the NSF and the national priorities articulated in the framework. Annual joint reviews will be conducted to assess the implementation and performance of the plans in contributing to national results. A formal mid-term evaluation of the plans will be conducted in 2012/13.

A research agenda will be developed and operationalised. The agenda will guide operational research needed to generate relevant qualitative and quantitative data for the evidence and results based planning of the national multisectoral response. The capacity of stakeholders in monitoring and evaluation (M&E) and HIV research capacity will be strengthened to enable them collect, analyse and use data in decision making, policy formulation and programme planning.

Resource mobilisation efforts will focus on increasing financial, human and other resource availability necessary for the implementation of the national response. Resource tracking will be instituted and decentralised to all stakeholders. In view of diminishing resources, priority efforts will focus on developing financial and human resources sustainability strategies. In this regard the role and responsibility of the

National Planning Commission and the Ministry of Finance in mobilising resources for HIV and AIDS will be reviewed and strengthened. Strategic partnerships with PEPFAR and the Global Fund among others will also be consolidated and strengthened.

By 2015/16, it is anticipated that the implementation of the NSF will contribute to the achievement of the following impact level results.

Table 1: Impact level results

Level	Description of impact level result
National	Namibian Human Development Index (HDI) is improved from 0.542 in 2008 to 0.55 by FY2015 /16
Prevention	Annual number of new infections has reduced by 50% between FY2010/11 and FY2015/16
	% of pregnant women attending ANC aged 15-24 who are HIV infected is reduced from 11% in 2008 to 5% by FY2015/16
	% of infected infants born to HIV positive mothers is reduced from 12% in 2007 to 4% by FY2015/16
Treatment, Care and Support	Life expectancy has increased from 51.6 years in 2008 to 55 years in FY2015/16
	% of people reported dying from AIDS has decreased from 23% in 2008/09 to 18% in FY2015/16
Impact Mitigation	% poor households has decreased from 28% in 2008 to 20% in FY2015/16
	% of households with vulnerable individuals that are able to cope with the impact of HIV has increased to 50% by FY2015/16
Response management	Effective and efficient management of the response and service delivery for those infected and affected by HIV and AIDS *(NDP3 Goal 14 Programme 1 outcome)*
	% of NSF service coverage targets (output level results) that have been met in the areas of HIV prevention, treatment care and support and impact mitigation has increased from 0% in 2009 to 60% by 2013 and to 75% by FY2015/16
	% of stakeholders that have expressed satisfaction with the level and type of services provided by MOHSS has increased from 60% in 2009 to 80% in FY2015/16

Alignment to other National Strategic Frameworks

The NSF has anchored the HIV and AIDS response within the broader national social and economic development framework. Its priorities and results contribute to the achievement of the goals of ***Vision 2030***, the ***Third National Development Plan*** and the ***Poverty Reduction Strategy Plan*** among others. By aligning the NSF to these policy documents, the NSF has expanded the opportunities for a multi-sectoral response within the context of some of the structural epidemic drivers and impact mitigation initiatives. The alignment will ensure that Namibia will be responsive to its international commitment in addressing the ***Millennium Development Goals*****,** UNGASS, and Universal Access. The alignment further ensures fulfilment of regional commitments such as the African Union Abuja Declaration to increase health funding to 15% of the national budget, and the Maseru Declaration on accelerating universal access.

The NSF has also taken cognisance of the importance and contribution of other strategic plans such as the MOHSS Strategic Plan, the National Plan of Action for OVC in Namibia, and the government efforts to develop and finalise the National Gender Policy and the Gender Action Plan.

The process of developing the NSF

The development of the NSF was preceded by a number of surveys and studies to establish the current status of the epidemic and to generate data necessary for the evidence and results based management planning approach used for the NSF. The process was participatory and involved different stakeholders ranging from communities, civil society, people living with HIV, traditional health practitioners, private sector, youth, development partners and government institutions. Further consultations were held with Cabinet, Parliament and Permanent Secretaries. Additional consultations were held with fourteen (14) sectors and thirteen (13) regions. Six stakeholders' consultative meetings were organised at national level with representation from all stakeholders. Several drafts were produced and submitted to stakeholders and technical working groups for review, comments and validation. An independent peer review was also conducted by AIDS Strategy and Action Plan Service (World Bank). NSF reflects the inputs of these various multi-sectoral stakeholders. The process of developing the NSF, the National Operational Plan, the thirteen regional and fourteen sector operational plans, the National Coordination Framework, the popular version of the NSF, and the M&E work plan took twelve months.

The Guiding Principles

The development of the NSF was guided and informed by a number of strategic principles including the need to use evidence in the identification of priorities and selection of interventions and to focus on results rather than service delivery only. Other principles include mainstreaming and operationalising the Three Ones principle at all levels of the response, gender equality, equity, mainstreaming of gender, and human rights, being culturally sensitive, promoting meaningful involvement and participation of PLHIV and consolidating efforts for a multi-sectoral and decentralised approach to the national response.

Section 1: Introduction

1.1 The Purpose of the National Strategic Framework

The purpose of the NSF is to:

i. Facilitate strategies that will curb the spread of HIV and AIDS epidemic and mitigate the social and economic impacts through a multi-sectoral response.
ii. Articulate a strategic framework for the implementation of the national multi-sectoral HIV and AIDS response in Namibia. It is based on the concept of the "Three Ones" principle of having one national strategic framework, one national coordinating authority, and one national monitoring and evaluation framework.
iii. Identify and articulate national priorities and targets (results) for the multi-sectoral HIV and AIDS response.
iv. Facilitate a multi-sectoral and decentralised planning and implementation framework where sectors, regions and communities identify their strategic niche, design and implement appropriate evidence based and results focused interventions that contribute to national results (targets). All stakeholders are expected to develop and align their HIV and AIDS strategic operational plans to the NSF.

1.2 Background Information

The National Strategic Framework for HIV and AIDS 2010/11 – 2015/16 is a policy and leadership framework to guide all sectors in Namibia as to which HIV and AIDS programmes they need to implement, for which target populations, in order to achieve which results. The NSF is a successor to the Medium Term Plan (MTP-III that comes to an end in March 2010.

The NSF marks a paradigm shift: The focus is on achieving a set of quantifiable results – from service coverage targets to be achieved by sectors and programmes, to those outcomes and impacts that need to be evident in society as a result of programmes implemented. The framework has further mainstreamed gender and human rights in the strategic and prioritised interventions.

This focus on results is in line with Vision 2030 that has challenged the Namibian society and its allied development partners by stating that - "*Much will depend on our ability and willingness to respond with innovation and commitment to new challenges. As we march forward in implementing the programmes we should ask ourselves from time to time, if we are truly on course and on time*" – the framework will help Namibia know whether it has been successful in responding to HIV.

The development of the NSF is premised on the lessons (positive and negative) learned during the implementation of the MTP III. The process has also drawn on emerging and existing national, regional and international best practices that have proved to be effective in halting the spread of HIV, in providing quality and comprehensive treatment, care and support, in mitigating socioeconomic impacts, and in the coordination and management of the multi-sectoral decentralised response.

1.3 The Country Context

Namibia is situated in the south western part of Africa and has a surface area of 824,116 square km. The country is divided into 13 administrative regions. The population of Namibia was estimated at 1,830,330 in the 2001 Census and is estimated to increase to 2,180,000 by 2011. Forty three percent (43%) of the population is under the age of 15 years and with less than 4% of the population over the age of 65[1]. Between 1981 and 1991, Namibia experienced a high population growth rate of over 3%. However, due to a number of factors including the negative impacts of HIV and AIDS on health and longevity of the people, the population growth rate was reduced to 2.6% per annum between 1991 and 2001[2].

Namibia is classified as an upper middle income country with a gross national income per capita of US$4,200 for 2008[3]. The Namibian economy comprises two sub-economies. The first is the more formal and modern economic sector that includes mining, livestock production and fishing. The second sector is the informal, subsistence sector consisting of agriculture and herding. The mining sector is a major contributor towards the Gross Domestic Product contributing 13% in 2008[4]. In the same year agriculture and fisheries contributed 6% and 4% respectively. Namibia is however highly dependent on the Southern African Customs Union revenue pool which has resulted in a surplus of balance of payments in recent years. These revenues are however anticipated to decline in line with the economic challenges being faced at a global level.

The country has one of the highest income inequalities in the world as evidenced by the Gini coefficient of 0.6[5] and 37%[6] unemployment rate. The income disparity is associated with Namibia's colonial history and the continued unequal distribution of productive resources and capital since independence.

Namibia has a well established network of modern infrastructure such as roads, rail, telecommunication, and port facilities. Subsistence agriculture plays a major role in household food security. While Namibia may be food secure at a macro level, many rural households are food insecure. Agriculture production is affected by the fluctuating climatic and weather conditions, and lack of adequate water. Livestock is the backbone of the agriculture sector and in 2005 it contributed 67% to agriculture exports.[7]

Since independence, the Government has pursued policies and programmes to reduce poverty, including the formulation of a Poverty Reduction Strategy in 1998. These policies and programmes are also reflected in Vision 2030. Most of the poor live in rural areas, as do the majority (more than 60%) of the total population. The effects of poverty are manifesting themselves in different forms including income consumption inequality, low human development, social exclusion, ill-being, lack of capacity, relative deprivation, vulnerability, including uncertain livelihoods and lack of means to meet the basic needs.

[1] NPC 2003, 2001 *Population and Housing Census. National Report. Basic Analysis with Highlights*.
[2] OP (Office of the President) 2004, *Namibia Vision 2030*.
[3] World Bank website*: www.web.worldbank.org/wbsite/external/datastatistics*
[4] African Economic Outlook 2008, *African Development Bank*
[5] World Bank 2008, *Country Brief - Namibia*
[6] World Bank Group 2008, *World Development Indicators*
[7] Republic of Namibia 2008, *Third National Development Plan (NDP3) 2007/2008 – 2011/12*. NPC *(pg 98)*

Appropriate policies, strategies and plans have been designed but additional resources are required to constructively and decisively reduce poverty[8].

Twenty eight percent of the population lives under the poverty datum line with 4% considered as severely poor. In Namibia 27.6% of the general population is considered poor, of whom 13.8%[9] are considered to be extremely poor.

[8] NPC 2007, *An analysis of the Economic Challenges of Namibia and How the Donor Community should Assist* - Country Paper for the International Conference on Development Cooperation with Middle Income Countries (MICs), Madrid, Spain.
[9] Central Bureau of Statistics NPC 2008. *A review of poverty and inequality in Namibia*.

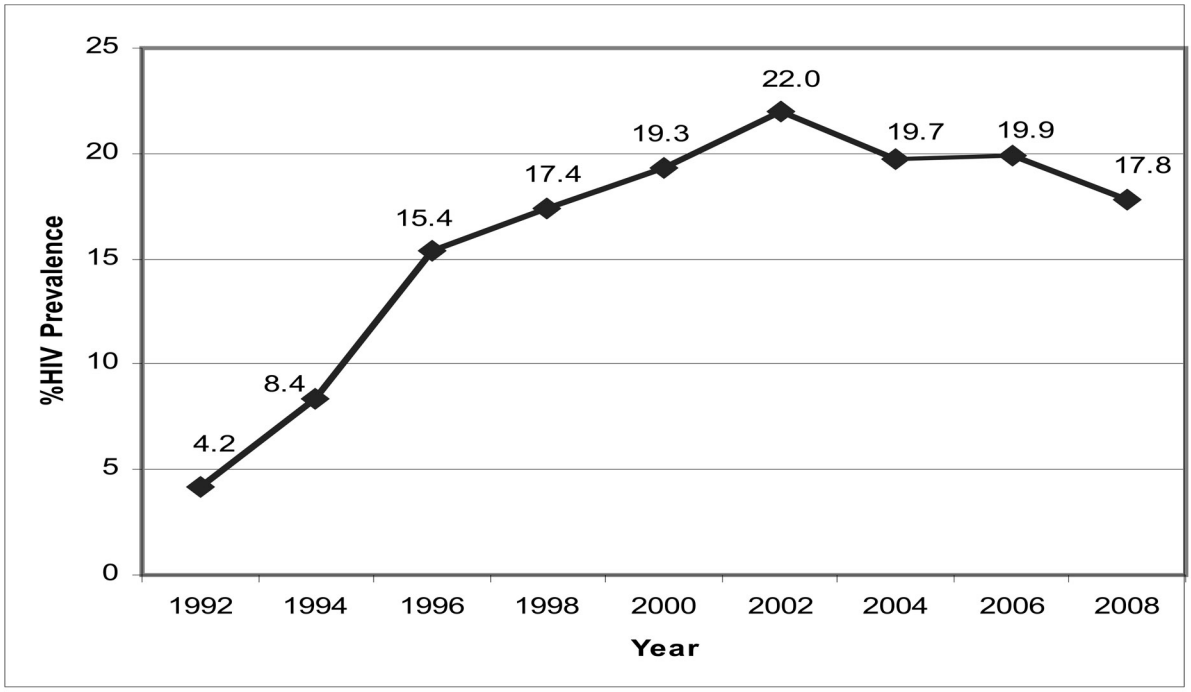
Section 2:
Epidemiology of HIV and AIDS in Namibia

2.1 HIV Prevalence Levels and Trends

Magnitude: Namibia has a generalised, mature epidemic with HIV primarily transmitted through heterosexual means. The first case of HIV infection was reported in 1986. It is estimated that the HIV prevalence of the general population aged 15 to 49 years in Namibia was 13.3% in 2008/09[1], resulting in around 6,130 AIDS-related deaths in 2008/09 which amounts to approximately 23% of all deaths in Namibia. In the financial year 2008/09, approximately 5,830 people were infected with HIV, with about 16 new infections occurring each day (MOHSS 2009). This steady stream of new infections over a long period of time has resulted in an estimated 174,000 adults and children living with HIV and AIDS (PLHIV) in Namibia by the end of the financial year 2008/09. Approximately 250,000 children 18 or younger are orphans or vulnerable children (OVC). Around 28% of these OVC (69,000) had been orphaned by AIDS by end of the financial year 2008/09 (MOHSS 2009, NDHS 2006/7[2], and population projections 2001 to 2031[3]).

Overall trends: Available data from the National HIV Sentinel Surveys indicate that HIV prevalence among pregnant women attending ANC rapidly increased from 4.% in 1992 to 18% in 2008 (Figure 1). HIV prevalence among pregnant women reached a peak of 22.3% in 2002, before it started showing some signs of stabilization and a statistically significant decline.

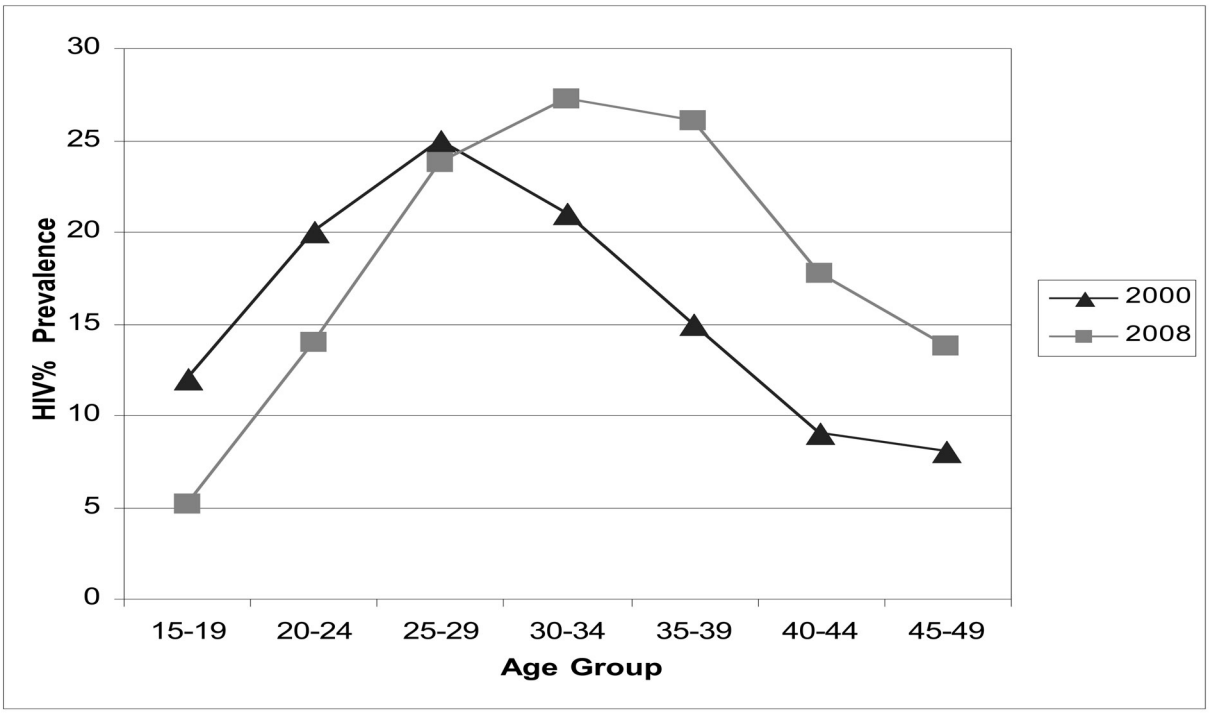
Figure 1: ANC HIV Prevalence trends between 1992 and 2008



[1] MOHSS 2009, *Estimates and Projections of the Impact of HIV/AIDS in Namibia, 2008/9*
[2] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*
[3] NPC 2006, *Population projections 2001-2031, Namibia: National and regional figures*

Geographic homogeneity and age-related heterogeneity: The 2008 Sentinel Survey[4] report (which is a report of HIV prevalence trends amongst pregnant women) further found that HIV prevalence was the same in rural and urban areas. While prevalence in older adults is the highest (27% among women aged 30-34 years) and has increased between the last 3 rounds of sentinel surveillance, the prevalence amongst younger women declined from 12% (2000) to 5% (2008) among 15-19 year old women, and from 20% (2000) to 14% (2008) amongst women aged 20-24 years (Figure 2). This is indicative of a maturing epidemic and fewer new infections. It is anticipated that new infections will decline in the future. According to Spectrum 2009, new infections in adults aged 15-years and above are projected to decline to 3,025 during fiscal year 2010/11 and to 2,877 by 2012/13. The prevalence rates for the same age group will decline from 11.1% in 2010/11 to 10.0% by 2012/13.

Figure 2: Shift in age-specific HIV prevalence among pregnant women between 2000 and 2008



2.2 Sources of new HIV Infections

Namibia has a generalised epidemic that has permeated throughout the society. As mentioned above, 16 new infections occur each day (25% amongst infants aged less the one year, 31% amongst youth aged 15-24, and 37% in persons aged 25 or older)[5]. The main mode of HIV transmission is heterosexual and the epidemic has sustained itself through specific sexual practices, community norms and practices, alcohol abuse that affect decisions on sexual behaviour, in addition to low levels of male circumcision and HIV risk perceptions as described below. Other sources of new infections are from mother to child transmission (around 25% of new infections). Namibia has attained 100% voluntary non-remunerated blood donation and 100% screening of transfusions for transmissible infections. HIV infection through blood transfusion is therefore unlikely.

[4] MOHSS 2008, *Report on the 2008 National HIV Sentinel Survey*.
[5] MOHSS 2009, *Estimates and Projections of the Impact of HIV/AIDS in Namibia, 2008/9*

The 2008 Sentinel Survey shows an overall decrease in prevalence among the 15 -24 age group, which corresponds to a reduction in new infections from amongst the youth (from 39% of all new infections in 2002 to 31% of new infections in 2008) as estimated using Spectrum models (MOHSS 2009[6]). The report further estimates that over 54% of the new infections in 2008 were women and 32% from children under 15 years. Early sexual debut may also fuel the epidemic. By age 18, four in ten women (36%) and half of men (49%) have had sexual intercourse (MOHSS 2008[7]).

As part of "know your epidemic" exercise, Namibia in collaboration with other stakeholders conducted a study on behavioural and contextual factors driving the epidemic and produced a report in 2009[8]. This study highlighted the proximate and distal drivers that fuel new infections. These drivers are of a biological, behavioural, social and structural nature.

Multiple and Concurrent Partnerships (MCPs): Multiple and concurrent partnerships are legitimised through deep rooted traditions of a polygamous society. Although communities disapprove of MCPs, society norms tacitly acknowledge and tolerate the sexual practices. Migratory labour has been identified as a major influencing factor of people having MCPs. In 2006, 16% of sexually active men and 3% of women reported more than one partner over the previous 12 months (MOHSS 2008). Concurrent partnerships have also been reported in other studies[9]. The widespread practice among men of maintaining multiple relationships is contributing to the high levels of HIV infection among women and in particular young women[10].

Condom use is not universal and not consistent: In the last (MOHSS 2008), rates of condom use by people with 2 or more partners and amongst people with non-regular partners is relatively high (66% women and 74% men with 2 or more partners used a condom at last sex, and 62% women and 78% men used a condom at last sex with non-regular partner). However, rates of consistent condom use was much lower – only 48% women and 58% of men with 2 or more partners reported consistently using a condom with their last partner.

Low perception of risk of HIV infection: Many people classify themselves as low risk, in-spite of many having multiple or concurrent partners or engage in higher risk sexual practices. The lack of a strong perception of HIV risk at a personal level tends to discourage consistent and correct use of condoms (MOHSS 2008).

Varying levels of medical male circumcision: Rates and methods of circumcision vary dramatically in Namibia: whilst 21% of men reported overall to be circumcised, only 11% of them were circumcised by a health practitioner. More educated men were more likely to be circumcised (35% of men with more than secondary education, compared to 15% of men with incomplete primary education), as well as men living in Kunene Region (52%), in Omaheke Region (57%) and in Otjozondjupa Region (42%).

Alcohol use and abuse is common: Many people in Namibia regularly use, and sometimes abuse alcohol: In 2000, 31% of men had at least one drink in the last 1-14 days of the month, and 24% of them

[6] *Cited just above*
[7] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*
[8] De la Torre C, et al 2009, *HIV and AIDS in Namibia: Behavioural and Contextual Factors Driving the Epidemic*. MOHSS
[9] Parker W, and Connly. Nawalife Trust. 2007. *HIV and AIDS Community survey: Rundu, Walvis Bay, Keetmanshoop, Oshakati*.
[10] De la Torre C, et al 2009, *HIV and AIDS in Namibia: Behavioural and Contextual Factors Driving the Epidemic*. MOHSS

got drunk 1-14 days of the last month. Under the influence of alcohol, many people are often unable to make informed choices and decisions about their sexual behaviour. Alcohol abuse often leads to higher risk sexual encounters, included unprotected sex, or sex with a casual partner. In 2007, 4% of young women and 5% of young men had sex when they or their partner were drunk.

In 2009, a DHS Qualitative study report[11] on alcohol consumption, sexual partners, and HIV transmission in Namibia provided further evidence on alcohol as a driver of the epidemic.

Inter-generational sex: Among women aged 15-24 years, 7% of single women and 26% of married women reported having a partner 10 years older than them (MOHSS 2008). Inter-generational sex is also associated with sexually transmitted infections and greater likelihood for having multiple and concurrent partnerships. More often, intergenerational sex introduces the HIV virus among the younger cohort, where it then spreads quickly.

Transactional sex: Qualitative data suggests that transactional sex (sex in exchange for gifts or favours) is common and even the norm in some parts of Namibia[12]. However, quantitative data is not easily obtainable, as transactional sex is much broader than sex with a sex worker (which is very low (1.4%) and measured by the NDHS). Transactional sex is commonly associated with poverty and income inequalities, where a power imbalance exists – such partnerships usually puts one person in a vulnerable position, where he/she is less likely to be able to negotiate condom use.

Oscillatory mobility and migration is a lifestyle for many Namibians: A large proportion of people in Namibia is mobile and spends considerable periods of time away from home for work related reasons. The oscillatory migration by mobile partners is considered a major factor that influences people having MCPs and HIV infection is passed on rapidly through a chain of inter-connected sexual networks.

Fewer Namibians get married or live together: The NDHS 2006/7 (MOHSS 2008) noted that over the years there has been a decline in marital or co-habiting relationships in Namibia. Whereas in 1991, 50% of Namibians were never married, this increased to 56% in the 2001 Census, and to 58% in the NDHS 2006/7. There is also great variability in types and rates of marriage between the regions, ranging from 69% of never-married persons in Karas Region to 39% of never-married persons in Kavango Region. These practices contribute to people having a greater number of sexual partners in a lifetime, a factor that is considered a strong predicator of HIV infection.

Most at Risk Populations (MARPS): Data and information on MARPS in Namibia is limited. A survey of sex workers in Katutura in Windhoek indicates high prevalence of HIV (70%) among this population however the sample was not population based and therefore cannot be extrapolated. The population sizes of sex workers and men who have sex with men (MSM) have not been determined. However, World Bank estimates suggest that there are approximately 11,000 sex workers and 2,600 MSM in Namibia. The exact sizes of these populations and HIV prevalence will be determined during the NSF and will guide the revision of services for MARPS planned during the NSF.

[11] LeBeau D., 2009 *Alcohol Consumption, sexual partners, and HIV Transmission in Namibia* - a DHS Qualitative Research Studies 16, USAID
[12] De la Torre C, et al 2009, *HIV and AIDS in Namibia: Behavioural and Contextual Factors Driving the Epidemic*. MOHSS

Section 3:

MTP-III: Assessment of achievements, gaps and challenges

The development of the NSF was largely informed by the various HIV and AIDS related surveys, studies and programme reports produced over the five years. The data from these studies and reports have provided invaluable evidence used to inform priority setting and the establishment of performance targets. The following section summaries the key achievements made during the implementation of MTP III. The section also identifies the gaps and challenges.

3.1 The Achievements

The current national multi-sectoral response to HIV and AIDS is informed and guided by the Medium Term Plan III (MTP III), which had a lifespan of up to March 2010. An analysis of the HIV response in the past five years has highlighted these strengths and weaknesses.

Prevention

HIV prevention remains the cornerstone in any HIV response strategy: we have to stop or dramatically reduce new infections, for us to live in a world without HIV. Given the decline in HIV prevalence and estimated incidence, Namibia's HIV prevention efforts have been partially successful at starting to reverse and stabilise the epidemic. Continued effort is now needed to contract the epidemic to below the threshold level. The partial success in HIV prevention efforts has been brought about by achievements in specific HIV programmes:

i. **Increases in coverage of HIV counselling and testing:** In 2000, 24% women and 25% men had ever tested for HIV and knew their status. This had dramatically increased to 51% women and 32% men by 2007.

ii. **Increases in coverage of PMTCT for all pregnant women**: The PMTCT programme has made great strides in the last 8 years. Screening of all pregnant women for HIV started in 2001 and by 2008, 58% pregnant women had received a HIV test during ANC visits. By 2007, 70% of HIV-positive pregnant women had received ARVs to reduce the risk of transmission from mother-to-child.

iii. **DNA PCR testing for all HIV-exposed infants is now available**: As of 2005, all infants born from HIV-positive mothers are screened for HIV within 2 months of birth – a great achievement as previously, one had to wait up to 18 months after birth for the infant's HIV status to be revealed (a DNA PCR test detects the actual virus, whereas an HIV antibody test detects the antibodies of the infant and the mother up to 18 months after birth). With DNA PCR screening, one is therefore able to put HIV positive infants much earlier on treatment. By the end of 2006, 58 health facilities were offering DNA PCR.

iv. **Blood products in Namibia remain safe**: Namibia has attained 100% voluntary non-remunerated blood donation and has attained 100% screening of blood products for transfusions transmissible infections. A blood safety quality policy has been developed.

v. **Decline in STI prevalence**: The prevalence of STIs is on the decline. In 2006, STI prevalence was estimated at 2.9%.

vi. **Life skills education is being provided in schools and to out-of-school youth**: By March 2007, approximately 407 teachers had been trained on life skills education and over 189,327 students had benefited from life skills education. Life skills education has contributed to increases in the levels of knowledge about some HIV prevention methods, and overall has increased comprehensive knowledge of HIV and AIDS. Between 2000 and 2007, there was a decline in the levels of knowledge about condoms as an HIV prevention tool but a dramatic increase in knowledge about abstinence as a method of HIV prevention (from 35% women and 41% men in 2000, to 84% women and 86% men in 2007). In 2007, 63% of men and women in Namibia knew the 3 ways to avoid AIDS, and rejected the two most common misconceptions about AIDS (MOHSS 2008[1]).

vii. **Condom distribution and condom use has significantly increased**: During the FY2007, 28 million male and female condoms were distributed countrywide – more than a 120% increase from what was provided in 2003. Condom usage, especially during higher risk sex, also increased, and condom use by the clients of sex workers is high.

Treatment, Care and Support

Significant progress was made in ensuring availability, access and utilization of treatment, care and support services. The following achievements are notable:

i. **Anti Retroviral Therapy (ART)**: By 31st March 2009, 64,637 PLHIV were enrolled on ART in public health and mission facilities[2]. Of the people that were actively receiving ARVs, 57% were adult females, 31% were adult males and 12% were children (0 – 14 years)[3]. The number of PLHIV on treatment represented 84% of the estimated 76,727 PLHIV in need. Forty three (43) ART-sites (34 district hospitals / 9 satellite facilities) had been established. Retention of patients enrolled in the previous 12 months was estimated at 85%[4].

ii. **Tuberculosis:** The number of TB patients tested for HIV increased from 16% in 2005 to 66.9% in 2008. Of those tested 59% tested HIV positive[5]. The treatment success rate for new smear positive TB cases was 75% by 2007 and the default rate decreased from 13% to 10%.

iii. As of 2006, Community Home Based Care (CHBC) providers had reached 39,330 PLHIV in all 13 regions of the country. As a result of ART rollout, CHBC is moving towards preventive and adherence support as well as broader issues of primary health care and less towards bed-ridden care.

[1] *MOHSS 2008,* Namibia Demographic and Health Survey *2006-07*
[2] *e-PMS results for people on active ART as of March 2009 provide numerator data, while denominator data is provided by the Spectrum estimates in* MOHSS 2009*, Estimates and Projections of the Impact of HIV/AIDS in Namibia, 2008/9*
[3] MOHSS *RM&E March 2009 results*.
[4] MOHSS 2006, *Report of the 2006 Namibia HIV Drug Sensitivity Survey*
[5] MOHSS 2009, *National TB and Leprosy Control Programme 2008/9 Annual Report*

Impact Mitigation

During the period of the MTP III, impact mitigation interventions focused on strengthening national and community capacity to address the socioeconomic impacts of HIV including poverty reduction and income disparities, among others:

i. **External Basic Support for OVC**: Sixteen and half percent (16.5%)[6] of OVC were receiving at least one type of external basic support. Basic external support related to medical, emotional, social/material and educational related support.
ii. **Cash Transfers:** In 2009, there were 104,438 OVC receiving cash transfers[7].
iii. **OVC Permanent Task Force:** It was established in May 2001 and has advised, co-ordinated and monitored the implementation of the National Plan of Action.
iv. **Education:** 94.6%[8] of OVC were attending primary schools.

Coordination, Management and Enabling Environment

Creating an enabling environment entails development and implementation of policies and laws that enable people to access and use services without the fear of being stigmatized or discriminated against because of their health condition. Namibia has made some progress in this area:

i. The following **Policies** were developed and adopted:

- Education Sector Policy for OVC (August 2008)
- National Blood Policy (2007)
- National HIV and AIDS Policy (March 2007)
- National Occupational Health Policy (July 2006)
- National Policy on Community Based Health Care (March 2008)
- National Policy on Orphans and Vulnerable Children (December 2004)
- Workplace HIV and AIDS Policy for the Education Sector (2007)
- Workplace Policy on HIV and AIDS, (2007). A charter on HIV and AIDS in the workplace is being finalized

ii. Some policies relevant to the HIV and AIDS response that urgently need review include the National Policy on Infant and Young Child Feeding (2003), National Policy for Reproductive Health (2001), Policy on HIV and AIDS confidentiality, National Policy on HIV and AIDS for the Education Sector (2003), Notification, Reporting and Surveillance (2002), Research Management Policy (2003), and Food and Nutrition Policy for Namibia (1995).

iii. The following **Technical Guidelines** were developed:

- National Guidelines on Post Exposure Prophylaxis (2004)

[6] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*
[7] MGECW Datawarehouse 2009
[8] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*

- Guidelines for PMTCT (2008)
- National Guidelines for ART, 2nd edition (2007)
- National Guidelines for the Management of TB, 2nd edition (2006)
- Guidelines for Voluntary Counselling and Testing, 1st edition (2006)
- Guidelines for Outreach Counselling and Testing, 1st edition (2007)
- Rollout Plans for PMTCT, VCT, and ART.

iv. **HIV and AIDS Funding**: Government funding for HIV and AIDS is considered a sub-account of the health account. As a result it is difficult to disaggregate with precision the actual amounts of funds that are directly earmarked for HIV and AIDS. However, anecdotal information indicates that government funding for HIV has increased considerably.

- The total resource envelope for health in 2006/07 was N$3.9 billion (US$548.6 million) accounting for 8.3% of the Gross Domestic Product. In comparison to other countries in the Southern African Customs Union, Namibia's budget is the second highest after South Africa[9]. Additional funding for HIV and AIDS were received from Global Fund to Fight AIDS, TB and Malaria (GFATM) as part of the Round 2 grant, and from the Presidential Emergency Plan for AIDS Relief (PEPFAR) by the American Government in addition to substantial funding from the German and Spanish governments.
- Government has made provision for other public sectors other than health to allocate 2% of their sector budgets to HIV and AIDS. While these funds have been made available annually tracking how the funds are being used has remained a challenge.

Spending on health is now the leading priority area of donors accounting for 79% of all donor disbursements in Namibia. Donor funding has been channelled through both government and civil society organisations. Funding equity remains a concern between HIV and AIDS related programmes and other mainstream health programmes[10].

3.2 Strategic gaps and challenges experienced during the MTP-III implementation

The following have been identified as the key gaps and challenges related to prevention, treatment care and support, impact mitigation and response management.

Prevention

i. The coordination of the health sector HIV and AIDS prevention response has been fairly strong and effective. However the coordination of the non-health sector has been fragmented compromising the effectiveness of interventions and alignment to national priorities.

ii. Although prevention funding has increased over the years, the overall investment in prevention activities is not yet commensurate to the need, given that prevention is a national priority in the fight against HIV and AIDS.

[9] MOHSS 2008, *National Health Accounts 2001/02 to 2006/07*
[10] *Namibia's Statement to the African Leadership Forum on HIV and AIDS 2004 Addis Ababa Ethiopia*

iii. Lack of focus and targeting on key epidemic drivers and most at risk population groups such as sex workers, men who have sex with men (MSM) and prisoners. Focus has been on where funding is readily available and not necessarily on what drives the epidemic.

iv. Inadequate intensity, geographical and target group coverage of interventions.

v. Inadequate capacity at regional and community level, and among some civil society organisations to coordinate and sustain implementation of prevention activities.

vi. Fragmented coordination of prevention interventions.

vii. Inadequate quality assurance of prevention interventions.

Treatment, Care and Support

i. Pre-ART services are currently provided through different operational models with some Pre-ART clinics being a part of the ART clinic, while in other instances the Pre-ART clinic operates separately with its own human and infrastructure resources. The services that are offered at Pre-ART clinics tend to vary, with some clinics simply opening patient files, while in others health and / or socio-economic patient-support services are provided. The lack of a standard model would affect the successful provision of the comprehensive Pre-ART services recommended in the NSF. Poor nutrition has been identified as a major factor affecting effective and successful treatment of PLHIV.

ii. Health Systems: A review of the health systems indicate that current levels of human and infrastructure resources are insufficient to support the increased coverage of PLHIV, both within the Pre-ART and the ART clinics. This shortfall of resources would become even more significant if additional emphasis is to be placed on quality of service delivery to PLHIV. Opportunities for more efficient service delivery could be provided through stronger linkages with the private health sector. However the lack of an established coordination system for the two sectors has resulted in both sectors operating separately and independently of each other.

iii. The joint management of HIV, AIDS and TB (the most life-threatening opportunistic disease for PLHIV), as part of a deliberate effort to prevent and treat TB, is still in its development stages globally. The coordination, management and reporting of the two programmes is critical, however in Namibia in 2009, this was only found to happen at national level and not at implementation level where the adoption and implementation of the Three I's strategy[11] is key.

iv. Care and support: Poor coordination between health and civil society Community Home Based Care (CHBC) service providers affects the effective coverage of communities with regards to service provision and allocation of resources. It has also resulted in varying standards of CHBC service provision.

v. The socio-economic challenges that are faced amongst communities that are hardest hit by HIV and AIDS continue to affect the success rates of the CHBC interventions, making it imperative that the responses take these factors into cognisance. Poor nutrition has been particularly noted to be a major factor affecting the successful treatment of PLHIV.

[11] *The WHO-recommended "Three I's" strategy entails Intensified Case Finding (ICF), provision of Isoniazid Preventative Therapy (IPT) and TB Infection Control (IC).*

Impact Mitigation

i. While there are several interventions addressing vulnerability issues, coordination has been fragmented, necessitating the need to develop a national framework that targets vulnerable households.

ii. Existing interventions and strategies focusing on impact mitigation are fragmented, largely un-coordinated, under resourced, with a gap in capacity and technical skills. One area that is most affected is provision of services to OVC through CHBC and community based organisations.

iii. Approximately 59% of OVC does not possess all three basic needs (pair of shoes, set of clothes, and blanket)[12].

iv. There are major gaps in basic human rights, equal legal and social protection, and access to services for vulnerable groups.

v. The implementation of policies related to legal rights and protection remains inadequate due to lack of capacity to do so.

vi. Inadequate access to food production and resources by vulnerable communities and households.

Response Management

i. The coordination of the public sector multi-sectoral response to HIV and AIDS has started yielding some results. This has been coordinated by the Office of the Prime Minister. However, coordination of the broader multisectoral response involving private sector, development partners and civil society organisation has lagged behind due to lack of clarity on coordination policy guidelines, roles and responsibilities. This has also affected regions and communities. In the absence of clear policies regional and constituency level structures are struggling to find an effective niche for their meaningful contribution to the national multi-sectoral response.

ii. Inadequate capacity among the Regional and Constituency AIDS Coordinating Committees – the RACOCs and CACOCs. These committees have inadequate human resources, equipment and operational systems. Only a few of them managed to hold regular meetings during the Medium Term Plan-III (MTP-III) period.

iii. There is no defined national standard of a comprehensive workplace programme (WPP) and this is partly due to the fact that there is no national coordinating structure for workplace programme interventions. While the Ministry of Labour is well suited to facilitate monitoring of work place programmes, its role and responsibility in this context has not been clearly articulated.

iv. There is also lack of leadership support for WPPs, both within the private and public sectors. Related to this is the fact that most companies, even those that have WPPs, are not aware of their respective HIV status, yet this is necessary for the development of a relevant WPP. It is also evident that most senior and middle level managers have not prioritised WPP in their respective organisations.

[12] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*

Section 4: Strategic Orientation

4.1 NSF Strategic Orientation

The National Strategic Framework (NSF) builds upon lessons (positive and negative) learned and achievements of MTP III, while at the same time addressing the challenges and gaps encountered in the implementation of the multi-sectoral response. Successful implementation of this NSF depends on a combined lateral strategy of interventions from medical and societal to economic activities, resulting in reducing the spread and impacts of HIV and AIDS across all aspects of life.

The NSF is oriented around the following key principles:

i. A more proactive strategy that increases the level of financial investment for prevention improves implementation, coordination and the targeting of most at risk and vulnerable populations.
ii. A greater and coordinated involvement of civil society, PLHIV and communities in the response implementation, especially at regional and constituency levels.
iii. Inclusion of the private sector in a manner that capitalizes on their capacity and resources to contribute strategically towards the national response
iv. Developing responses based on empirical evidence that focus on specific results.
v. Ensuring that success and best practices achieved during MTP-III – in prevention, treatment care and support and impact mitigation – are not just maintained but expanded.
vi. Investing in sustained national capacity development and mobilisation of the required resources.
vii. Expanding the focus of Namibia's response to a multi-sectoral approach.
viii. Strengthening the coordination and management of the multi-sectoral response in the country to ensure meaningful involvement and contribution by all stakeholders and in particular communities.
ix. Improving the efficiency and effectiveness of resource mobilisation, allocation and service delivery through joint planning and effective coordination mechanisms.

The need for strategically re-positioning the coordination is to address the key challenges to the country's development goals as outlined in Vision 2030 and the NDP-III in the context of HIV and AIDS, which include, but are not limited to the following:

i. **Orphans and Vulnerable Children (OVC).** OVC are estimated at 30% of all children under the age of eighteen. They require significant social, educational and psychological support. In fifteen years the current generation of children will be those who realise Vision 2030.

ii. **Decline in Productivity**. The links between HIV and AIDS and decreased economic performance are well known. A World Health Organisation (WHO) study shows steep declines in Namibia's rural workforce as a result of the epidemic. The impacts of this decline are felt most strongly by the rural poor.

iii. **Inadequate Governance**. The MTP-III describes the processes by which the Namibian government's ability to provide for its citizens may erode as a result of the epidemic.

iv. **Threatened human resource base**. The epidemic is a threat to Namibia's efforts to build its

human resource capacity. A skilled workforce is a crucial component to Vision 2030 objectives. According to the Third National Development Plan (NDP3), "the HIV and AIDS epidemic has the potential to reverse all the gains made in the education sub-sector".[1]

v. **Poverty and severe poverty are increased by HIV**. Achieving national targets for poverty reduction becomes more difficult when the prevalence rates are high and higher numbers of people become vulnerable to the affects of the disease.

Although Namibia has done significantly well in the health response there is an immediate need to expand and strengthen the non-health response. This can only be achieved if the potential for a multi-sectoral response is realised with the involvement of all stakeholders ranging from government, private sector, civil society and traditional leaders, with development partners as necessary partners in this effort.

Despite the severity of the epidemic, Namibia has made progress throughout the course of MTP-III in addressing HIV and AIDS. The 2008 Sentinel Survey shows a further decline in prevalence rates from the 2006 survey. Another promising result from the 2008 survey is the halving of prevalence rates among young people aged 15 – 19 years. However, according to NDHS (2006/7), the age of sexual debut was found to be rising. Significant progress has been made in the provision of Anti Retroviral Therapy (ART). Yet, because the epidemic is above threshold level, the country remains amongst the most affected in the world. Given the high costs for ART, increased investment in prevention is imperative in ensuring sustainability of the national multi-sectoral response.

This progress shows a system that works. The NSF will build on that success. The core activities of MTP-III – prevention, treatment, care and support and impact mitigation – will continue. Management of these activities from within the Ministry of Health and Social Services (MOHSS) will be strengthened while also invoking national level management to strengthen the involvement of non-health sectors.

The NSF has shifted the paradigm from the previous MTP documents by adopting the Results Based Management (RBM) methodology. RBM focuses the logical chain that links programme level activities through to high level objectives. RBM relies upon measurable results throughout the chain. Activities are guided by available evidence of strategies that worked in the past and which have the potential to contribute to the desired impact and outcome level results in the future.

4.2 The Guiding Principles

The development of the NSF was guided and informed by the following principles:

a) **Evidence Based Planning**: The planning process, the selection and prioritisation of interventions and programme areas was premised on available efficacy evidence.

b) **Results Based Management**: The design of the NSF is results based with clearly defined, describable and measurable impact, outcome and output levels results.

c) **Three Ones principle**: The NSF has consolidated efforts to mainstream and operationalise the "Three Ones" principle of having one national coordinating authority, one national strategic framework and one national monitoring and evaluation framework at national, sector and regional levels of the national multi-sectoral HIV and AIDS response.

[1] NPC 2008. *Third National Development Plan (NDP3) 2007/2008 – 2011/12. page 135*

d) **Gender and Human Rights:** The NSF has and will continue to support mainstreaming of gender and human rights in all aspects of the national response. Efforts will be made to eliminate stigma and discrimination against PLHIV, and strategies to address gender based violence (GBV) will be developed and implemented. The NSF will continue to create awareness of the roles and responsibilities of "duty bearers" and "rights holders".

e) **Equity:** The NSF will ensure equal access to services for all people and in particular to disadvantaged rural communities, people with disability, people living in difficult circumstances such as refugees and internally displaced persons. In Namibia, internal displacement is often associated with natural disasters such as floods.

f) **Multi-sectoral approach:** The NSF forms the basis for the multi-sectoral response to HIV and AIDS. The design provides the opportunity for all stakeholders to identify their areas of response based on their mandate, resources, capacity and more importantly their comparative advantage.

g) **Cultural sensitivity:** While the NSF has taken cognisance of cultural sensitivity to the HIV response, the interventions will ensure that cultural norms and values that influence negative and risk behaviours such as multiple and concurrent partnerships and intergenerational sex among others are adequately addressed.

h) **Greater involvement of PLHIV:** PLHIV are part of the solution not the problem. Their meaningful involvement is critical to the success of the national response and in particular the implementation of the NSF.

i) **Community involvement**: Communities will be encouraged to drive the HIV and AIDS response at their level, through Constituency AIDS Coordinating Committees and other community based structures. They will be capacitated to plan and implement their own HIV and AIDS operational plans.

j) **Decentralised approach:** The implementation of the NSP will be decentralised, providing greater opportunities for regions, constituencies and sectors to be involved in the national response through joint planning and strengthened multi-sectoral coordination. The roles and responsibilities of the various stakeholders will be clearly defined and articulated in the National Coordination Framework. The decentralised approach will create opportunities not only for institutional involvement but also individuals including women and children in the planning and implementation of community and school based HIV and AIDS prevention, care and support and impact mitigation interventions.

4.3 Alignment of the NSF to other Policy Frameworks

HIV and AIDS remains the greatest development challenge for Namibia. Its impacts are many and complex ranging from a decline in life expectancy, productivity, investment in education, health, agriculture and human capital development. The epidemic is robbing communities of their breadwinners, leaders and the knowledge and skills necessary to sustain livelihoods. HIV is threatening the traditional community coping mechanisms (safety nets), food security[2] and long term development. It is creating a vicious circle

[2] *SADC 2006, Reviewing the Epidemic in Botswana, Lesotho, Namibia and Swaziland.*

that reduces the national capacity to absorb and utilize existing resources earmarked for socioeconomic development. This process contributes to deepening poverty and lack of national productivity. As the epidemic impacts on human capital, the cost of replacing skilled manpower has increasingly becomes expensive. The epidemic is further shrinking the pool of HIV free persons where development labour is being drawn from. In the long run, this may contribute to Namibia's dependence on imported labour.

Available evidence indicates that the epidemic is being fuelled by behavioural, structural and biological drivers. While biological drivers are easier to address, behavioural and structural drivers of the epidemic are more complex and inter-linked with socioeconomic development issues such as poverty, gender inequality, food insecurity and urban development with special emphasis on informal settlements. These complex challenges can only be adequately addressed when the national response to HIV and AIDS is properly anchored in the broader context of national socioeconomic development policy framework. Anchoring the HIV and AIDS response in the broader development framework has several advantages such as:

- Firstly, it expands the scope of the response and increases the opportunities for sectoral participation based on their institutional mandate and comparative advantage.
- Secondly, expanding the scope of participation by more stakeholders enables additional flow of resources (financial and human) that support HIV and AIDS response, contributing towards longer term sustainability.
- Thirdly, the process increases ownership, commitment and accountability.

It is on this premise that the NSF has been aligned to key national development frameworks including Vision 2030, Third National Development Plan, Poverty Reduction Strategy and Action Plan, Millennium Development Goals, the African Union Abuja and Maseru (SADC) declarations, and Universal Access. The NSF is aligned to the provisions of the Namibian National HIV and AIDS Policy and the National Health Policy respectively. It has taken cognisance of the provisions of the Namibian Constitution and other international basic human rights instruments in the context of HIV and AIDS.

The NSF national and thematic level impact results are aligned to and will contribute to the achievement of the key result areas of Vision 2030 and the goals of NDP3. Six of the eight Vision 2030 goals and six of the twenty NDP3 goals are directly linked to the NSF results framework. NSF will also contribute to the achievement of Namibia's national commitments to Millennium Development Goals, the Abuja Declaration to increase health funding to 15% of national budgets and the Maseru Declaration to accelerate Universal Access to HIV and AIDS services.

The National Poverty Reduction Strategy and Action Plan provide comprehensive sets of activities to be carried out by all government ministries to reduce poverty; strategies which are adopted into the NDP3. Action 63 of the NDP3 recognises HIV and AIDS as an activity to be mainstreamed into the previous 62 actions to be taken by government to reduce poverty. Harmonizing the NSF and NDP3 will enhance the achievements of NDP3 medium term goals and objectives. In particular a key strategy for the NSF is to improve the quality of life of PLHIV so that they can continue being economically productive and

less dependent on government handouts. Secondly the NSF aims at reducing the percentage of poor households from 28% (2008) to 20% by 2015 and strengthening the coping mechanisms of over 50% of vulnerable households.

The implementation of the NSF will be complemented by other strategic and operational plans such as the MOHSS Strategic Plan (2009-2013), the National Plan of Action for OVC (2006-2010) and the Gender Action Plan once completed. The specific areas of NSF alignment with the national strategic frameworks are articulated in the table attached as Annex 2.

4.4 The Strategic Focus of the NSF (Results Framework)

Stakeholders identified nine (9) thematic priority impact level results (Table 1) that contribute to the achievement of the national level impact result of human development articulated in the Third National Development Plan (NDP3). The lower level results in the results framework were derived based on their contribution towards achieving these ten impact level results. The lower level results are tied to specific programmes of the national HIV and AIDS response.

The M&E plan has identified core national indicators that will be used for reporting progress in the implementation of the NSF. However, other results not measured under these core indicators are catered for under programme indicators and individual programmes will be expected to track and make comprehensive reports of their implementation. The core indicators are tied to global and regional reporting such as the Millennium Development Goals, UNGASS, Universal Access, and African Union and SADC commitments. In addition, priority national level impact results identified by stakeholders will also be tracked as part of the core indicators.

Section 5: NSF Strategic Interventions

5.0 Introduction

This section provides a guide on the national response to HIV and AIDS in Namibia for the next six years from April 2010 to March 2016. The response revolves around prevention, treatment, care and support, impact mitigation, response management and coordination. The NSF will be operationalised through the national, regional (13), sector (14) operational plans and development partners' plans.

The NSF has mainstreamed cross cutting issues such as thematic area coordination, governance, capacity building with a focus on human resources, gender and human rights and therefore, these issues are integrated in the relevant sections of the documents. One of the key strategies in gender mainstreaming is to strengthen the capacity of sectors and other implementing partners to conduct programmatic and budgetary gender analysis.

The NSF has articulated the policy framework for the overall thematic and programme response, identified national priorities and results (targets) for mid and end term, operational strategies and main actions required to realise the anticipated results. In the national, regional and sector operational plans the main activities are further broken into specific and concrete sub activities to guide on-the-ground implementation.

The activities in the NSF and the operational plans have been coded using the following to enable stakeholders trace them in the various documents. "OC" is the code for outcomes and "OP" for outputs followed by numerical number i.e. OC1 or OP1. Thematic areas (e.g. prevention) are identified by a two digit code (i.e. 5.1) and programme areas (e.g. male circumcision) are assigned a three digit code (i.e. 5.1.1). The main activities in the NSF have been assigned a four digit code i.e. 5.1.1.1. The sub activities only appear in the operational plans. They are identified by a five digit code i.e. 5.1.1.1.1.

5.1 Prevention

5.1.0 Overview

Namibia has prioritised prevention as the key strategy in addressing HIV and AIDS with the aim of reducing HIV incidence rate to a threshold level where the epidemic cannot sustain itself. To achieve this aim, the NSF has articulated a strategy of combined interventions (figure 1) that will focus on the most effective biomedical and behavioural interventions, while at the same time addressing changes in underlying structural issues such as social norms. The combined intervention strategy will focus on reducing the risk of HIV transmission through changes in sexual behaviour, changes in underlying structures (e.g. social norms, poverty gender inequalities) and through biomedical interventions.

Prevention Impact level results

It is anticipated that the strategy will contribute to the realisation of the prevention impact level results stated below:

i. Annual number of new infections has reduced by 50% between FY2010/11 and FY2015/16

ii. % of pregnant women attending ANC aged 15-24 who are HIV infected reduced from 11% in 2008 to 5% by FY2015/16

iii. % of HIV infected infants born to HIV positive mothers is reduced from 12% in 2007 to 4% by 2015/16

iv. HIV prevalence among sex workers reduced from 70%[1] in 2007 to 40% by FY2015/16

Among the priority biomedical interventions included in the NSF are male circumcision (MC), prevention of mother to child transmission (PMTCT), HIV counselling and testing (HCT), increased male and female condom use and the control of sexually transmitted infections (STIs). For behavioural interventions, the NSF will focus on strategic epidemic drivers that include multiple and concurrent partnerships, inconsistent condom use, excessive alcohol use, early sexual debut, inter-generational sex, transactional sex, and mobility and migration[2]. In the case of structural drivers, the NSF will focus on addressing gender and income inequalities, gender based violence and sexual abuse, social and sexual norms and creating an enabling environment for people to access and utilise prevention services.

Up to now, there has been a "blanket approach" to prevention where responses have not been tailored to meet the needs of the different rural and urban settings; have not been sufficiently gender specific; and there has been inadequate targeting of the key epidemic drivers and MARPS. Informal settlements in urban areas are also making residents who are often the poor, vulnerable to HIV and AIDS. The informal settlements serve as the transit ground between rural and urban integration of migrants. The impacts of the epidemic drivers vary from one community to another and from one region to another.

In the past prevention interventions have focused on individuals. While NSF will continue promoting such interventions (i.e. education, skills building, HCT etc), it will also expand and intensify interventions that expand and increase coverage to couples, families, social networks, communities and community leaders. It is anticipated that once community leaders are adequately mobilised, they will initiate community based interventions that will address in particular behavioural and structural epidemic drivers. Their influence is expected to trigger a re-thinking of cultural and social practices such as MCP, inter-generational sex, alcohol abuse and gender inequalities. Attempts will be made to scale up interventions in social institutions such as workplaces, prisons, military, police, schools, and civil society organisations. This expansion strategy is intended to accelerate the outreach to large numbers of people at risk (Coates et al 2008). The NSF will inform the development of new initiatives including prevention with persons living with HIV and AIDS; integration of prevention into other health and non-health sector programmes and across other public and private sector workplace programmes.

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[1] *The 70% was calculated based on a study of sex workers in Katutura (n=1240 sex workers). it is therefore not a generalised percentage. International guidelines recommend that sentinel sites could be chosen and surveyed on an annual basis.*

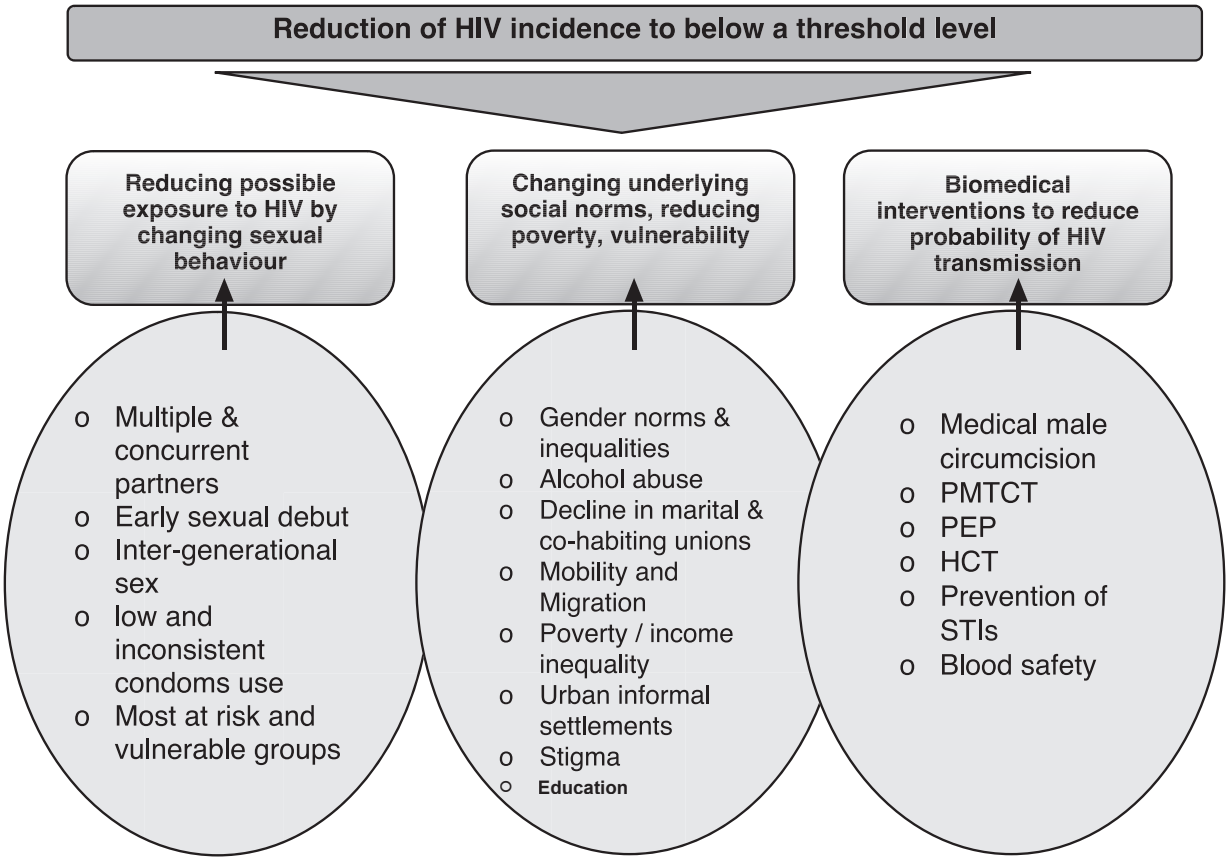
[2] De la Torre C, et al 2009, *HIV and AIDS in Namibia: Behavioural and Contextual Factors Driving the Epidemic*. MOHSS

The review of the MTP-III Status Report shows that failure to adequately address the key epidemic drivers, inadequate targeting of most at risk and vulnerable populations, and inadequate coverage and intensity of interventions has compromised prevention efforts. The planning processes for such targeted interventions have not adequately utilised available evidence, neither have they incorporated best practices. Similarly, coordination at implementation level has been fragmented and has lacked synergy. At operational level there is lack of adequate supportive supervision of implementing partners to ensure quality and comprehensiveness of interventions. Communities are in most cases inadequately mobilized and have not been sensitized on sexual behaviours, social norms, values and practices such as MCP, inter-generational sex, gender inequalities and alcohol abuse, among others, that compromise prevention efforts.

Namibia is cognizant of these challenges and is in the process of developing a comprehensive, national HIV prevention strategy to guide and inform strategic interventions. Given that some of the prevention challenges are associated with social and economic development, the NSF has linked the strategic interventions with the broad national socio-economic development framework such as Vision 2030, the Third National Development Plan (NDP3) and the Poverty Reduction Strategy.

Vision 2030 (pg 46) has called for an aggressive implementation of a national HIV reduction plan. The NDP3 and the National Policy on HIV and AIDS have further articulated strategies and policy guidelines to inform and guide HIV prevention interventions. These strategies are premised on the understanding that investing in HIV prevention has direct long term benefits for treatment, care, support and in impact mitigation.

Figure 3: Combined Prevention Strategy



The following section describes the specific prevention interventions by programme areas. The section is divided into two components. The first section articulates interventions that contribute to a change in sexual behaviour and address epidemic drivers. The second section will address biomedical programmes that contribute to the reduction in probability of HIV infection transmission.

Prevention programmes that will contribute to a change in sexual behaviour and address structural epidemic drivers

5.1.1 Social and Behaviour Change

Situation Analysis

According to the NDHS 2006/7, the level of comprehensive knowledge of HIV and AIDS in Namibia is estimated at 63% for men and 67% for women. Despite this, people have continued to engage in risky sexual behaviours that expose them to HIV or increase the opportunities for HIV transmission. This position is supported by studies by Campbell (2003)[3] and Sumartojo (2000)[4]. Campbell noted that *"The forces shaping sexual behaviour and sexual health are far more complex than individual rational decisions, based on simple factual knowledge about health risks, and the availability of medical services"*. Sumartojo notes that "*many people view behaviour as personally motivated or resulting exclusively from a person's conscious decisions. The role of the structural environment is often overlooked, and structural interventions may be perceived as going beyond the traditional role of public health"*. The analysis in a recent study in Namibia[5] indicated that the greatest challenge in social and behaviour change is associated with inadequate personal HIV risk perception and societal tolerance of practices that fuel the epidemic such as MCP, alcohol use, inter-generational and transactional sex.

This scenario illustrates the need to meaningfully integrate social and behaviour change into prevention, with interventions that are more clearly focused on specific epidemic drivers and underlying structural factors among those target groups who are most at risk or most vulnerable. The National Prevention Technical Advisory Committee has prioritised the epidemic drivers in Namibia as: multiple and concurrent partnerships, transactional and trans-generational sex, alcohol use, low levels of risk perception, low rates of male circumcision, inconsistent and incorrect use of condoms, and low levels of HIV testing. Other studies have included the underlying structural elements of gender norms and inequality, mobility and migration, income disparities and poverty, educational levels and stigma as factors contributing to new HIV infections.

During the period of MTP-III, Namibia implemented a wide range of behaviour change communicatio n (BCC) interventions. While these interventions are necessary, they have not been sufficient to have an impact on behaviour change. Available evidence suggests that BCC programmes which focused at individual level have not been successful in changing the course of the HIV epidemic and in particular in influencing adoption of key prevention behaviours.[6] Therefore, social change communication is a

[3] Cambell C, 2003, *Letting them die: why HIV/AIDS intervention programmes fail,*
[4] Sumartojo E, Laga M, 2000, *Structural factors in HIV prevention*
[5] De la Torre C, et al, 2008, *HIV and AIDS in Namibia – Behavioural and Contextual Factors Driving the Epidemic,* MOHSS
[6] FHI 2001*, HIV and AIDS Risk Assessments at Cross Border and Migrant Sites in Southern Africa*

necessity – "*there is now a growing consensus that BCC strategies must be complemented by more participatory approaches that work through and address broader underlying social and economic influences"* (Gregson et al., 2004)[7]. Focusing, intensifying and improving the quality of social and behaviour change interventions will enable Namibia to address the behavioural drivers of the epidemic more meaningfully as strategies will target both at risk individuals and the societies they live in. Social change communication also involves changing norms in society about acceptable and unacceptable sexual behaviour.

Namibia has initiated mass media campaigns around MCP and gender based violence. Such programmes have not been adequately targeted to the most at risk populations and in most cases lacked effective coordination and multi-level programming. For example, mass media programmes should have a complimentary component at the community level that supports messaging through complimentary IEC materials and interventions implemented by existing field and community workers that reinforce mass media messaging.

Namibia is experiencing a decline in prevalence rates among the young aged 15-24 years. It is acknowledged that young people are the wind of hope and have the potential to halt the spread of HIV and consequently move towards an AIDS free generation. To sustain this trend, the NSF will focus on young people and provide youth friendly HIV prevention activities ranging from life skills HIV and AIDS based education and condoms and will promote circumcision of young males. Innovative prevention interventions including HIV prevention education will be incorporated in extra curriculum youth activities and sports.

Prevention interventions have also not adequately targeted adolescents between the ages of 10 and 14 years in-spite of the fact that this is a sexually active age group. In the past, interventions for adolescents have focused more on the older and already sexually mature adolescents. Sometimes the interventions have come too late, often missing the crucial period in adopting sex appropriate behaviours i.e. between the end of childhood and the start of adolescent – 10 -14 age band. This is a critical period when children for the first time face the choices and the risks that could derail their lives. Twelve percent of men and five percent of women reported having sexual intercourse by age 15 (MOHSS 2008[8]). A key concern is also the high levels of forced sexual encounters. According to a recent study (UNICEF 2006)[9] 23% of 10-14 year olds and 18% of 15 to 24 years were reported to have had forced sexual intercourse. Many of these children are in primary and secondary schools. Focusing on young people in and out of school from an early age makes practical sense given that 94% of children in Namibia are enrolled in primary schools and about 50% of all 14 to 18 year olds are in secondary schools. The results of a study conducted by the World Health Organisation (WHO) in 53 countries indicate that good and supporting school environment, coupled with life skills-based education, helps to protective young adolescents against early sexual initiation.

Gaps and Challenges

i. Inadequate programme and intensity that focus on behaviour change and epidemic drivers;

[7] S. Gregson et al., 2004, *Sexually Transmitted. Infections*. 80, 36 (2004). (Web of Science)
[8] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*

ii. Lows levels of personal HIV risk perception;
iii. Inconsistent and incorrect use of condoms;
iv. Inadequate targeting intensity of interventions;
v. Inadequate focus on most at risk and vulnerable populations in addition to high risk areas;
vi. Inadequate programme and intensity on society norms, values and practices that influence the spread of HIV. These are closely associated with some of the epidemic drivers;
vii. There has been little or no consideration on the role of urban settlements in the spread of HIV and AIDS. Informal urban settlements are the first stop for rural-urban migrants in search of employment and are often congested. Such settlements lack basic services and the residents often constitute the urban poor. These conditions make them vulnerable to HIV infection;
viii. Inadequate use of best practices in programme and intervention design;
ix. The level of comprehensive knowledge of HIV and AIDS remains low;
x. Poor coordination of prevention activities at all levels;
xi. The design of most activities is vertical. This has compromised strengthening synergy between interventions and service providers;
xii. Inadequate coordination among implementing organisations;
xiii. Inadequate understanding of adolescent needs in the context of their sexual and reproductive health and the implications of vulnerability to HIV;
xiv. Lack of targeted young adolescent HIV prevention friendly services.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC1:	**Fewer persons have concurrent partners**: % of women and men aged 15-49 in the general population who had concurrent partnerships six months ago reduced to less than 10% by FY2012/13 and 5% for women and men in FY2015/16.
OC2:	**Fewer persons have multiple partners:** Among the women and men aged 15-49 who had sexual intercourse, the percentage who had multiple partners in the last 12 months reduced for women from 3% in 2007 to 2% in FY2012/13 1% in Y2015/16 and reduced for men from 16% in 2007 to 10% by 2012/13 and to 5% in FY2015/16.
OC3:	**More young people waited longer before having sex:** % of women and men aged 15-24 years who had sexual intercourse before age 15 reduced for women from 7% in 2007 to 6% by FY2012/13 and to 4% in FY2015/16.and reduced for men from 18% in 2007 to 14% by FY 2012/13 and to 10% in FY2015/16.
OC4:	**Fewer young women have older sexual partners:** % of women aged 15-24 who had higher-risk sex in the past 12 months with a man who was 10 or more years older than them reduced from 4% in 2007 to 3% by FY 2012/13 and to 2% in FY2015/16.

OC5:	**Fewer young women and men engage in transactional sex:** % of young women and men aged 15-24 who exchanged sex for gifts or favours has decreased by 20% between FY2012/13 and by 50% between FY2010/11 and FY2015/16.
OC6:	**More people have comprehensive knowledge of HIV:** % of persons aged 15-24 with comprehensive knowledge of HIV and AIDS has increased among women from 65% in 2007 to 78% by 2012/13 and to 90% by FY2015/16 and among men from 62% to 76% by 2012/13 and to 90% by 2015/16; and for 15-49 increased among women from 67% in 2007 to 80% by FY 2012/13 and to 90% by FY2015/16 and among men from 63% to 77% by FY 2012/13 and to 90% by FY2015/16
OC7:	**Fewer people have sex under conditions that could impair their judgement:** % of women and men aged 15-24, and 25 to 49 who had sex when they were drunk or when their partner was drunk reduced for women from 4% in 2007 to less than 3% in FY2012/13 and to 2% in FY2015/16 and reduced for men from 5% in 2007 to less than 3% in FY2012/13 and to 2% in FY2015/16.

Code	Output Result
	Social and Behaviour Change Programmes[10] for the youth 10-24
OP1:	% of in-school youth aged 10 – 14 years reached by skills based HIV prevention education within the regular school curriculum in the last year has increased from 45% to 60% in FY2012/13 and to 85% by FY2015/16]
OP2:	% of in-school youth aged 15-24 years reached by skills based HIV prevention education within the regular school curriculum[11] in the last year has increased from 45% to 60% in FY2012/13 and to 85% by FY2015/16]
OP3:	% of out-of-school youth aged 10 to 14 years reached with small group or individual social and behaviour change programmes since the start of FY2010/11 has increased from 0% in 2008 to 30% in FY2012/13 and to 55% n FY2015/16
OP4:	% of schools that provided life skills-based HIV education within the last academic year increased from 85% of primary schools and 50% of secondary schools in 2008/09 to 95% of primary and 90% of secondary schools in 2012/13 and 100% of primary and secondary schools by 2015/16
OP5:	% of out-of-school youth aged 15-24 reached with small group or individual social and behaviour change programmes since the start of FY2010/11 has increased from 6%[12] in 2008 to 25% in FY2012/13 and to 55% FY2015/16.
OP6:	% of CACOCs that reported MCP and other epidemic drivers reduction programmes have been implemented in their community in the last 12 months increases from 0% in 2008 to 50% in FY2012/13 and to 90% in FY2015/16.
	Social and Behaviour Change Programmes[13] for adults 25 and older[14]
OP7:	% of females aged 25 and older reached with small group[15] or individual social and behaviour change programmes since the start of FY2010/11 has increased to 20% by FY2012/13 and to 45% by FY2015/16.
OP8:	% of males aged 25 and older reached with small group[16] or individual social and behaviour change programmes since the start of FY2010/11 has increased to 20% by FY2012/13 and to 45% by FY2015/16

[9] UNICEF 2006, HIV and AIDS Knowledge, Attitudes, Practices and Behaviour (KAPB) study in Namibia.

[10] Focus of these social and behaviour change communication programmes will be to address each of the higher risk behaviours: multiple sexual partners, concurrent sexual partners, early sexual debut, large age differences between sexual partners, sex in return for money or gifts, condom education programmes, condom promotion, alcohol abuse, benefits of male circumcision, and social norms that make these relationships acceptable.

[11] Regular school curriculum here is defined as one approved by the Ministry of Education for teaching HIV/AIDS life skills based education as a regular and examinable subject

[12] The baseline is for 15 – 24 year olds only, whereas the targets are for both age groups.

[13] Focus of these social and behaviour change communication programmes will be to address each of the higher risk behaviours: multiple sexual partners, concurrent sexual partners, family strengthening and relationship strengthening skills, condom promotion (including correct and consistent condom use), alcohol abuse, benefits of male circumcision, and social norms that make these relationships acceptable.

[14] Although services will be provided to adults 25 and older, measurement of progress will mainly be carried out in the 15 to 49 year age bracket because currently DHS is restricted to this age group. However, as from the next DHS+ 2011/12, it is planned to increase the age bracket for population based surveys to 15 to 65.

[15] A 'small group' is defined as a group of 25 persons or less

[16] A 'small group' is defined as a group of 25 persons or less

OP9:	% of couples reached with small group or individual social and behaviour change programmes since the start of FY2010/11 has increased to 15% by FY2012/13 and to 45% by FY2015/16.
OP10:	% of women and men aged 15-49 years reached with S&BC interventions on the risks of alcohol abuse increased to 20% by FY2012/13 and to 45% FY2015/16
	Social norm change communication programmes for community leaders
OP11:	% of community leaders & other popular opinion leaders[17] who have been reached by programmes to address multiple and concurrent partnerships has increased from 0% by 2009 to 40% by FY 2012/2013 (8,000 out of 20,000 leaders) and to 80% by FY2015/16. (17,600 out of 22,000 leaders).

Strategies

i. To intensify implementation of quality social and behaviour change prevention interventions targeted to high risk populations that contribute to a reduction in HIV transmission through a reduction in multiple and concurrent partnerships, reduction in the practice of trans-generational sex, reduction in the practice of transactional sex, reduction in risky sex related to alcohol use, and an increase in those seeking biomedical interventions (MCP, HCT, condoms).

ii. To develop special and friendly HIV prevention programmes targeting adolescents age 10 to 14 years.

iii. To strengthen the provision of life skills-based HIV education in primary and secondary schools by establishing life skills-based HIV education as stand-alone examinable subject in schools, incorporating the subject in the core curriculum in schools and training teachers on life skills-based HIV and AIDS education.

Priority Actions

Code	Description of main activities
5.1.1.1	Strengthen integration of life skills-based HIV education in schools
5.1.1.2	Strengthen integration of life skills-based HIV education for out of schools youth
5.1.1.3	Intensify sexual and reproductive health and HIV and AIDS Education for in and out of school youth
5.1.1.4	Develop an advocacy campaign on HIV prevention behaviours
5.1.1.5	Integrate HIV and AIDS awareness and behaviour change in youth development programmes
5.1.1.6	Develop and implement community based targeted interventions to create awareness of the risks associated with MCP
5.1.1.7	Develop and implement an advocacy strategy on HIV epidemic drivers
5.1.1.8	Intensify HIV and AIDS education to people aged 10-49 years
5.1.1.9	Mobilise sectors to intensify HIV and AIDS education and awareness interventions
5.1.1.10	Develop and implement stigma reduction interventions in line with national guidelines
5.1.1.11	Create community awareness of HIV risks associated with alcohol abuse

[17] *Religious leaders, Members of Parliament, traditional leaders, members of regional councils, members of community councils, the media, and popular local celebrities (e.g. sport stars, musicians, etc.)*

5.1.2 HIV Counselling and Testing (HCT)

Situation Analysis

In generalised epidemics such as Namibia, Provider Initiated Testing and Counselling (PITC) is recommended for all patients attending health facilities regardless of their health conditions or symptoms, including for men prior to circumcision. PITC is a type of HIV Counselling and Testing (HCT) where health care providers recommend and may also provide HCT for their patients. Namibia offers provider initiated testing and counselling (PITC) and Voluntary Counselling and Testing (VCT).

PITC is provided in health facilities to increase the number of people who receive HCT, and to identify those in need of care and treatment. VCT is provided in community based stand alone sites, outreach as well as health facilities. HCT is generally offered for two purposes. First as a prevention strategy for people who want to know their HIV status and secondly as an entry point for treatment care and support. In 2005, Namibia introduced rapid HIV testing in collaboration with the Namibian Institute of Pathology (NIP). To date 26 public health facilities, 18 new start centres, 5 prison testing sites, 3 military HIV testing sites and 3 mobile vans for HIV work place programmes through NABCOA's PharmAccess partners with MOHSS, provide HCT services. All the government hospitals and health facilities, and the five mission hospitals are providing rapid HIV testing. The introduction of rapid HIV testing has reduced non-return rates (clients not returning to collect their results) from a monthly high of 13% to below 1% in the New Start Sites. In 2005 Namibia allowed task shifting of HCT from nurses to lay cadres. Task shifting of HCT included rapid HIV testing to the community counsellors. This was instrumental in integrating HCT into health care settings as it reduced the workload on already over-burdened health workers. With proper training and supervision the community counsellors have proven to be effective in delivering HCT.

The NDHS (2006/7) indicated that 32% men and 50% women have ever tested and know their status. Among young people 15-24 years, only 31.3% women and 12.9% men had tested and received results 12 months prior to the survey. Approximately 67% of pregnant women had also been counselled and tested during antenatal clinics. The analysis of available data indicates that HIV testing and counselling remains low as the data show that 65.7% men and 45.2% women had never tested.

Available data from meta-analysis of research about the effectiveness of VCT as an HIV prevention measure has shown that *"VCT recipients were significantly less likely to engage in unprotected sex when compared to behaviours before receiving VCT, or as compared to participants who had not received VCT. However VCT had no significant effect on the number of sex partners. While these findings provide only moderate evidence in support of VCT as an effective prevention strategy, neither do they negate the need to expand access to HIV testing and counselling services*" (Denison et al., 2007:363). Other studies have shown positive behavioural outcomes for HIV positive persons (Eisele et al., 2008), but negative outcomes for HIV negative persons - who either increase or maintain their high risk behaviour after testing negative (Corbett et al., 2007; Potts et al., 2008).

Namibia has held two successful HCT national testing days to date. The MOHSS coordinated events were heavily promoted by the media. The first event was held in 2008. During the three-day event, 30,000 people were tested and received their results. The second event took place in 2009 and during this five-

day event, 80,000 people were tested and received results. These have become national events that have proved to be effective in extending counselling and testing services to people throughout the country. The success of these events was partly attributed to more people feeling less stigmatised. The five day HCT event proved to be cost effective and a strategic approach that reached many people within a short period of time.

The NSF approach is to strengthen existing services and expand coverage especially in the community and the workplace. Innovative strategies will be explored including strengthening mobile HCT facilities and establishing youth friendly HCT centres that will also offer adolescent friendly sexual reproductive health services and complement counselling and testing services. PLHIV will be trained to participate in counselling and community mobilisation. HCT will be carried out in conformity with relevant international human rights standards, respective the "three Cs" of consent, counselling and confidentiality. It is anticipated that HCT will be integrated in all other health services, Multi-Purpose Youth Resource Centres and community centres. Efforts will also be made to scale up national testing days.

In strengthening the capacity for HCT at health facilities, in the community and the workplace, in-service training will be conducted for various target groups. For purposes of sustainability, training on HCT will be incorporated in the pre-service training for service providers including nurses and social workers.

The demand for HCT services is on the increase as programmes are rolled out. Several of the programmes including male circumcision, PMTCT, MARPS, blood safety, PEP and STI among others, need qualified counsellors and testers. The demand can only be met through an organised strategy of recruitment, training and retention of counsellors and testers.

It is anticipated that the training programme will be multi-pronged. Firstly, in-service training will be conducted for already serving counsellors and testers as an on-going service. Secondly, short term courses will be conducted on demand especially to meet demand from the sectors. Finally, efforts will be made to institutionalise HCT training through a public private partnership with tertiary institutions such as the University of Namibia and the Polytechnic of Namibia. Such training will be modulated and set out to create career paths in counselling.

Gaps and Challenges

i. Low levels of testing due to inadequate demand for HIV testing and counselling in some communities and among key target groups such as those most at risk of HIV infection;
ii. Inability of individuals who know their HIV status to change their risk behaviours and adopt key prevention behaviours;
iii. The linkages between client initiated testing and counselling services and treatment and care are weak;

iv. Inadequate scaling up of PITC;
v. Inadequate HCT facilities, particularly outreach/mobile and door to door testing;
vi. Fewer men are testing compared to women;
vii. Counselling and testing has focused more on individuals and less on couples testing;
viii. Inadequate accessibility to counselling and testing by MARPS (e.g. sex workers, MSM, prisoners) as well as other vulnerable populations including the urban poor.
ix. Outreach testing remains a key challenge.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC08:	**More people have tested for HIV and received their results:** % of women and men aged 15-49 ever tested for HIV and received their results increased from 51% in 2007 to 80% in 2012/13 and 90% in 2015/16 for women and from 32% in 2007 to 40% in 2012/13 and 75% in FY2015/16 for men

Code	Output Result
	HIV Counselling and Testing for all people
OP12:	Ratio of population aged 15-59 to the number of counselling and testing sites has decreased from 4250:1 in 2007 to 3900:1 in FY2012/13 and to 3000:1 in FY2015/16.
OP13:	% of women aged (15-49) who received an HIV test in the last 12 months and who know their results increased from 29% in 2007 and to 41% by FY2012/13 and 50% by FY2015/16.
OP14:	% of men aged (15-49) who received an HIV test in the last 12 months and who know their results increased from 18% in 2007 to 28% by FY2012/13 and 50% by FY2015/16.
OP15:	% of children aged 10-14 tested for HIV in the last 12 months and received their results increased to 30% in FY2012/13 and 55% in FY2015/16
OP16:	Number of couples who were counselled and tested in the last 12 months has increased from 7,129 in 2009 to 15,000 in FY2012/13 and to 35,000 in FY 2014/15

Strategies

i. To expand the opportunity for HCT so that people test, receive and know their HIV status results.
ii. To strengthen the human resources for HCT to enable the programme to meet demand by other programmes (e.g. ART and PMTCT) and by more males and the sectors.

Priority Actions

Code	Description of main activities
5.1.2.1	Expand VCT sites in the community and the workplace
5.1.2.2	Strengthen the capacity of counselling and testing services

5.1.2.3	Scale up the implementation of PITC in all health facilities both public and private
5.1.2.4	Conduct national testing day in each region annually- (Note the 5 days intensified HCT days are recommended- they are cost effective)
5.1.2.5	Update counselling materials for PITC and VCT to ensure inclusion of behaviour change prevention messages related to drivers of the epidemic

5.1.3 Condom Social Marketing and Distribution Programme

Situation Analysis

Since the introduction of condoms in the early 1980s, condoms have played a strategic role in preventing HIV transmission. In-vitro tests for virus penetration of latex (most widely used) and polyurethane condoms showed that intact condoms are essentially impenetrable to particles the size of sexually transmitted pathogens[18]. Recent studies show that when a male condom is used correctly and consistently its effectiveness can be as high as 95%[19]. Available evidence also indicates that female condoms may offer similar levels of protection against HIV[20].

The use of condoms depends on availability and the knowledge of how to use them. Namibia is the first African country to produce its own condoms. The Government provides condoms for free distribution at the workplace, community and in the health facilities by a wide range of service providers including government agencies, civil society, private sector and development partners. Namibia also has a well established condom social marketing programme that has contributed to the scaling up of condom distribution and availability countrywide. By 2007, Namibia distributed 21,332,160 male and 340,000 female condoms[21]. Despite much improvement on condom availability, distribution and education, condom use has continued to be low and inconsistent. According to the NDHS 2006/7, 41% of women, and 57% of men reported using condoms at the last sex. Similarly 62.1% women and 78.3% men aged 15-49 who had sexual intercourse in the last 12 months (prior to the NDHS 2006/7) with a non-marital, non-cohabiting partner reported using a condom. Usage was only slightly greater for higher risk sex: 64.2% women and 81% men engaged in higher risk sex reported having used a condom in the last 12 months, prior to NDHS 2006/7.

Condom use is higher in youth (15-24), which is partially attributed to the fact they are not married. However among the poor, rural and uneducated, condom use is less likely (MOHSS 2008[22]) and this makes them more vulnerable to HIV infection.

The use of male condoms depends on the willingness of men to use them. The failure of men to always want to use condoms has led to the development of the female condom which can be used by women as a physical barrier to prevent exposure to genital secretions containing HIV such as semen and vaginal fluids. The uptake for female condoms, however, has been less than ideal. This is attributed to a number of

[18] Padian N., 2008, *Biomedical interventions to prevent HIV infection: evidence, challenges and way forward,* WWW.lancet.com – published on line August 2008, DO1.1016/SO140-6736(08)60885-5
[19] *Cited just above*
[20] WHO 2008, *Priority Interventions: HIV and AIDS prevention, treatment and care in the health sector*
[21] MOHSS 2008, *Health and Social Systems Review*

factors. Some people have reported that the female condom is difficult to use while others have noted its high cost and lack of general acceptance by both men and women, despite its promising effectiveness.

Although distribution of female and male condoms has improved significantly, monitoring consistent and correct use remains a challenge. There is no empirical data on correct and consistent usage of condoms. Available information of condom usage is based on individual self reporting. The methodology has experienced challenges with data bias and inconsistency. It is also evident that the promotion of female condoms including education and awareness has lagged behind the male condoms. The NSF will support and intensifying research in the consistent and correct use of both female and male condoms, while at the same time scaling up promotion efforts of female condoms.

The MOHSS, through the DSP, and with the support of UNFPA, has embarked on a major national HIV and AIDS prevention programme, using the WHO approach called COMBI (Communication for Behavioural Impact), to encourage sexually-active men to consistently use condoms on every occasion of sexual intercourse. This approach is referred to as "COOOL" behaviour. Other reasons for consistent use of condoms are for unplanned and unwanted pregnancies especially among young and sexually active women. Condoms are also being used to prevent sexually transmitted infections such as gonorrhoea, syphilis, Chlamydia, and genital herpes. The COOOL strategy consists of a mix of communication activities ranging from door-to-door visits by volunteers called Lifestyle Ambassadors, dissemination of information sheets, community meetings, road shows, a COOOL painted vehicle with sound system travelling through each region with taped messages on COOOL behaviour, radio and television advertising, distribution of free government SMILE condoms, posters promoting the COOOL behaviour, and playing a game called the Take A Chance (TAC) Card Game which gives people a way to see what their chances are of becoming HIV infected in having sex.

The NSF strategy is to increase the availability and access of both male and female condoms at the community, workplace and institutions of higher learning. The NSF will support interventions that specifically target most at risk populations and adults as these are likely to be key sources of new infections. Efforts targeting young people in tertiary and vocational institutions of learning and out of school will be intensified. Available evidence shows a decline in prevalence among young people which is attributed to change of behaviour and adoption of key prevention strategies including condom use. As mentioned above condom use has been higher among young people aged 15-24 years.

Individual sectors will be encouraged to brand their specific condoms. This has been successfully demonstrated by the Namibian Defence Force. Branding condoms for young people is considered an attractive proposition as a condom promotion strategy.

Strategies will be put in place to monitor condom distribution, availability and consistent and correct use of condoms. Special efforts will be made to monitor and ensure condom availability to most at risk populations.

Gaps and challenges

i. Condom distribution continues to experience problems at community and work place programmes. During the consultative process, stakeholders noted that sometimes both the female and male condom dispensers remain empty for long durations of time;
ii. Low condom use;
iii. Inconsistent and correct use of condoms;
iv. There are no effective strategies for monitoring consistent and correct use of condoms. None of the current national monitoring tools measures these aspects;
v. The National HIV and AIDS Policy is silent on provision of condoms to some most at risk (prisoners) and vulnerable groups (children in primary schools who are sexually active);
vi. Awareness and knowledge regarding safe disposal of used condoms remains low and problematic especially in residential areas;
vii. Lack of prevention programmes promoting condom use that provide behaviour change communications with groups and individuals, particularly among men and general and discordant couples.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC9:	**More people consistently use condoms with casual partners:** Among women and men aged 15-49 who had higher-risk sex in the past 12 months, the % who reported consistently using a condom with the last higher-risk sex partner has increased for women from 51% in 2007 to 68% in FY 2012/13 and to 85% in FY2015/16, and increased for men from 66% in 2007 to 78% in FY2012/13 and to 90% in FY2015/16
OC10:	**More youth start their sexual lives using a condom:** Among young women and men aged 15-24 who ever had sex, the % who used a condom the first time they had sexual intercourse increased for women from 60% in 2007 to 75% in FY 2012/13 and to 90% in FY2015/16, and increased for men from 48% in 2007 to 62% in FY 2012/13 and to 75% in FY2015/16
OC11:	**More youth use condoms when they have casual partners:** Among women and men aged 15-24 who had higher-risk sex in the last 12 months, the % who reported using a condom at last higher-risk sexual intercourse has increased for women from 64% in 2007 to 77% in FY2012/13 and to 80% in FY2015/16, and increased for men from 81% in 2007 to 86% in FY 2012/13 and to 90% in FY2015/16
OC12:	**More people with MCPs use condoms:** % of women and men aged 15-49 who had multiple partners in the past 12 months who reported using a condom the last time they had sex has increased from 66% for women in 2007 to 80% in 2012/13 and to 85% in FY2015/16 and increased from 74% for men in 2007 to 85% in 2012/13 and 90% in 2015/16

Code	Output Result
	More condoms are easily accessible
OP17:	Number of male condoms distributed free per year has increased from 30.3 million in FY2008/09 to 45 million in FY2012/13 and to 52 million in FY2015/16 and by social marketing from 1.6 million in FY 2008/09 to 2.4 million in FY 2012/13 and to 3.0 million in FY 2015/16

OP18:	Number of female condoms distributed per year has increased from 1.16 million in FY2008/09 to 2 million in FY2012/13 and to 3 million in FY2015/16 and by social marketing from 157, 940 in 2007/8 to 300,000 in FY2012/13 and to 400,000 FY2015/16
OP19:	% of retail outlets and services that reported no condom stock out increased to 90% in 2012/13 and to 100% by 2015/16
	(also refer to Social & Behavioural Change output indicators)

Strategy

To increase the availability of male and female condoms and the number of prevention programmes promoting condom use so that HIV transmission may be reduced through improved and consistent use of condoms, particularly among those whose use is currently low.

Priority Actions

Code	Description of the main activities
5.1.3.1	Develop and operationalise a National Condom Policy and a Condom Management Strategy
5.1.3.2	Strengthen procurement, management and distribution of male and female condoms to all service providers.
5.1.3.3	Develop a national social marketing strategy for condom use
5.1.3.4	Review the National HIV and AIDS Policy to ensure condoms are available and accessible to most at risk populations including people with different sexual orientations.
5.1.3.5	Conduct research on correct and consistent use of female and male condoms. This information will be useful if disaggregated by age and gender, and where possible by MARPS.

5.1.4 Prevention of HIV among the Most at Risk Populations (MARPS) and Vulnerable Groups

Situation Analysis

Most at risk populations (MARPS) are groups that are often considered to be at an elevated risk of HIV infection due to their behaviours and have inadequate access to prevention, treatment care and support services. Even in the context of a generalized epidemic, some people are more at risk due to the frequency of high risk behaviours, overlapping risk behaviours, lack of access to services and are less likely to use services when available due to stigma and criminalization. In Namibia such groups include mobile and migrant populations such as long-distance truck drivers, sex workers, men who have sex with men, disciplined forces (Army, Police, and Prison officers), inmates (prisoners) and injecting drug users. Women and the girl child, OVC, PLHIV and urban poor are considered among the vulnerable groups in Namibia, given their social and economic status, coupled with cultural practices and social norms. A review[23] of the Third Medium Term Plan (MTP-III) noted that injecting drug users does not seem to be a problem in Namibia[24]. Overall in Namibia data on MARPS is limited with absence of information on the size of most of these populations and comprehensive data on HIV prevalence and risk behaviour. There

[22] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*
[23] MOHSS 2009, *MTP-III Review Status Report*
[24] MOHSS 2006, *Progress report on the Third Medium Term Plan on HIV and AIDS*

are no systematic strategies for collecting strategic information on the different categories of MARPS and hence planning for services is severely constrained. The country recognises the urgency of addressing MARPS especially in the context of prevention, treatment care and support.

Mobile and migrant populations: Mobility and migration increases the risk of HIV infection as mobile and migrant populations tend to have a higher number of multiple as well as concurrent sexual partners. While mobility and migration increases individual vulnerability, they also shape the distribution of the epidemic and the rate at which the epidemic spreads.[25] Hence, mobility and migration are both individual and structural risk factors. According to the NDHS 2006/7, men and women who spend more time away from their home are likely to have multiple partners. Four percent (4.6%) women and 22.9 % men who were away from home six times or more in the past year had multiple partners compared to 2.1% women and 11.1% men who never went away from home.

The NSF will address HIV prevention among the most at risk populations (MARPS). In Namibia and for the NSF, MARPS have been identified to include a) sex workers b) Men who have sex with men (MSM). A situation analysis of these groups is articulated below.

Sex workers: Anecdotal information indicates that sex work is well established in Namibia, yet sex work remains an illegal practice in Namibia[26] and consequently, no formal studies have been conducted. Available information on the extent of sex work, knowledge of HIV and AIDS among sex workers and their behavioural practices is limited to a few studies and reports from organisations that have conducted limited interventions. For example, in Katutura (Windhoek), one study found that out of 1,250 known sex workers only 180 regularly seek counselling and treatment for STI. The NDHS 2006/7 noted that 1.4% of men had paid for sex.

A focus on sex workers alone is not sufficient to address the HIV and AIDS challenges associated with sex work. The NSF will support interventions that target clients of sex workers with prevention messages and tools including education and supply of condoms.

Men who have sex with men (MSM): While there is very little knowledge about the group, anecdotal information indicates that MSM are starting to organise themselves in small informal groups. Available information shows that there is growing recognition that a combination of individual, socio-cultural, and biomedical factors affects HIV risk behaviour among MSM. Some of these factors have been identified as childhood sexual abuse, substance use, depression, and partner violence. Social and economic factors include poverty, alcohol abuse, homophobia, and lack of access to health care. Sexual risk factors (unprotected sex and STIs) account for most HIV infections in MSM. The stigma associated with homosexuality may inhibit some men from identifying themselves as gay or bisexual, even though they have sex with other men. Some men who have sex with men and with women don't identify themselves as gay or bisexual. There is no data showing the prevalence of HIV among MSM.

Prisoners: By 2006, Namibia had approximately 4,123 inmates (prisoners) countrywide. Seven percent were known to be HIV positive and approximately 27.5% had been enrolled on ART[27]. While there are

[25] FHI 2000, *HIV and AIDS Risk Assessment at Cross Border and Migrant Sites in Southern Africa*
[26] MOHSS 2006, *Progress report on the Third Medium Term Plan on HIV and AIDS*
[27] De la Torre C, et al 2009, *HIV and AIDS in Namibia: Behavioural and Contextual Factors Driving the Epidemic*. MOHSS

limited programmes in prisons currently, scaling up interventions in the correctional services has been limited by the lack of a clear national policy on HIV and AIDS in prisons. It is necessary to scale up the provision of specific HIV prevention interventions within prisons and the establishment of a follow up programme for inmates when they are released from prisons into the general community.

Vulnerable groups: Vulnerable populations have been defined as people who are disadvantaged by virtue of their socio-economic status. Such groups include women and girls, orphans and vulnerable children (OVC), people with disability, elderly caregivers and people who are impoverished including the urban poor. While there are programmes that address HIV and AIDS among women, girls, and OVC there are no organised programmes for people with disability. Namibia has approximately 100,000[28] people living with disability. The majority have little or no access to health care let alone access to HIV and AIDS services. According to the Rehabilitation Centre at the Evangelical Lutheran Church, some people with disability have died of AIDS related illnesses. However some limited interventions are available including Braille material, and some interpersonal communication printed materials for people with disabilities.

Others vulnerable groups who need special attention particularly in prevention or access to treatment (ART, nutrition etc) are those people being held in police custody or confined in prisons while their cases are being heard by Courts of Law. During their detention, they become vulnerable as their decision making is compromised by the circumstances. The Government, relevant sectors and the implementing partners need to develop innovative strategies, within the legal framework, on how to provide such services.

Women and Girl Child: The epidemic in Namibia like in most countries has had a gender bias. There are more women and girls living with HIV compared to their male counterparts. They are disproportionately vulnerable due to proscribed gender and cultural norms, income inequality, gender based violence and their biological make up. In most cases their basic rights are often violated making them more vulnerable and abused. With regard to care they are the majority of caregivers. Girls have increasingly become caregivers compromising their opportunity to attend school. Although Namibia has ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the empowerment of women has been slow in spite of legal reform on gender equality, prevention of sexual abuse and domestic violence. The NSF aims at reducing the vulnerability to HIV infection and mitigating the impact of HIV and AIDS on women and girls.

In addressing the prevention challenges being encountered by MARPS and other vulnerable groups, the NSF will determine the sizes of these populations and carry out second generation surveillance. NSF will also address gender and human rights issues affecting such people.

Gaps and challenges

i. The National Policy on HIV and AIDS is largely silent on the provision of services to some most at risk populations. Namibia does not have sufficient data on MARPS groups to support strategic policy formulation, programme planning and advocacy work despite the fact that the nation is

[28] Republic of Namibia 2008, *Third National Development Plan (NDP3) 2007/2008 – 2011/12*. NPC *(pg 25)*

expected to report on some of the groups under the Millennium Development Goals framework. The current HIV sentinel surveillance and the NDHS do not capture such information. Namibia has not conducted an AIDS Indicator Survey and integrated bio-behaviour surveillance surveys for MARPS.

ii. Social and behaviour change interpersonal communication materials for people with disability are limited especially for the blind and the deaf;

iii. Current social and behaviour change interpersonal communication materials for MARPS need to be updated to address the drivers of the epidemic;

iv. Implementation and enforcement of existing policies and legal instruments that protect women remain weak and inadequate. In addition there are inadequate mechanisms for monitoring the implementation;

v. Although some progress has been made towards the domestication of CEDAW, the process has been slow, compromising opportunities to empower women, raise their socio-economic status and prevent or reduce their vulnerability to HIV infection.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC13:	**More sex workers use condoms:** % of female sex workers reporting the use of a condom with their most recent client has increased 20% between FY2010/11 to 2012/13 and to 50% between FY2010/11 and FY2015/16.
OC14:	**More clients of sex workers use condoms**: % of men who reported using of a condom in their last paid sexual intercourse increased from 77% in 2007 to 84% in FY2012/13 and to 90% in FY2015/16
OC15:	**More MSM use condoms when having sex with a male partner:** % of men reporting the use of a condom the last time they had anal sex with a male partner, increases by 20% between FY2010/11 and FY2012/13 and by 50% between FY2010/11 and FY2015/16
OC16:	**More MARPS have correct prevention knowledge**: % of Most at Risk Populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission increases by 20% between FY2010/11 and FY2012/13 and by 50% between FY2010/11 and FY2015/16
	(Also refer to other prevention outcome indicators that target women and girls)

Code	Output Result
	Customised HIV prevention programmes for MARPS and Vulnerable Groups
OP20:	% of mobile populations who have received an HIV test in the last 12 months and who know their HIV results increased for mobile populations to 25% in FY2012/13 and to 45% in FY2015/16
OP21:	% of prisoners who have received an HIV test in the last 12 months and who know their HIV results increased to 50% in FY2012/13 and to 90% in FY2015/16
OP22:	% of female sex workers who received an HIV test in the last 12 months and who know their results increased to 40% by FY2012/13 and 80% by FY 2015/16
OP23:	% of MSMs who received an HIV test in the last 12 months and who know their results increased to 40% by FY2012/13 and 80% by FY2015/16
OP24:	% of sex workers reached with individual or small group HIV prevention interventions that address the drivers of the epidemic increases to 50% in FY2012/13 to 80% by FY2015/16
OP25:	% of MARP (mobile populations, migrant workers etc) who received an HIV test in the last 12 months and who know their results increased to 40% by FY2012/13 and 80% by FY2015/16
OP26:	% of MSM reached with individual or small group HIV prevention interventions that address the drivers of the epidemic increased to 50% in FY2012/13 to 80% by FY2015/16w
OP27:	% of Prisoners reached with individual or small group HIV prevention interventions that address the drivers of the epidemic is increased to 80% in 2012/13 and to 100% by 2015/16
	(Also refer to other prevention output indicators that target women and girls)

Strategies

i. To conduct a nation-wide size estimation and bio-behavioural surveillance of MARPS to inform future planning, service delivery and policy considerations.

ii. To ensure that comprehensive HIV prevention services are readily available and accessible to most at risk (MARPS) and other vulnerable populations to prevent transmission of HIV.

iii. To ensure that exposure to possible HIV infection can be reduced through behaviour change by people most at risk having comprehensive HIV and AIDS knowledge, consistently using condoms and having fewer MCPs; by more men being circumcised and through the provision of PEP services especially for rape survivors.

iv. To mobilise and educate communities on the risks of alcohol abuse as a contributing driver for HIV infections among MARPS and other vulnerable groups.

Priority Actions

Code	Description of main activities
5.1.4.1	Review the National HIV and AIDS Policy and other polices to adequately address the needs of all MARPS and other vulnerable groups, e.g. access to condoms by prisoners and school children
5.1.4.2	Develop a package of prevention interventions that specifically target each MARPS group
5.1.4.3	Enhance training and sensitisation for stigma reduction and improvement of care and support

5.1.5 Involvement of People Living with HIV in Prevention

Situation Analysis

Early HIV prevention efforts focused almost exclusively on HIV negative individuals, protecting them from becoming infected. More recent efforts have expanded to include prevention with HIV positive individuals, helping individuals to avoid spreading HIV to others. Prevention for persons living with HIV and AIDS (PLHIV) also known as "positive prevention", positive health, dignity and prevention, or prevention among PLHIV, is an essential part of a comprehensive HIV prevention strategy. The involvement and coordination of PLHIV is critical not only for prevention activities but also for the larger HIV and AIDS response.

Treatment for HIV has extended life for many PLHIV and there is a need to undertake effective HIV prevention in the area of more generalized access to ART. Most individuals will want to remain sexually active after they learn of their positive HIV status, and this desire is even more likely as ARV medicines not only extend life but also quality of life for PLHIV (Coates et al 2008). It is generally accepted that PLHIV may be best placed to prevent the virus from further spreading. Prevention for PLHIV requires engaging PLHIV in prevention efforts in a more meaningful and consistent manner. An important part of the prevention activities for PLHIV is overcoming the stigma that prevents many HIV positive people from finding out their HIV status early on, and from disclosing their status to others. In this respect, positive prevention goes hand in hand with efforts to create a supportive environment for people to come forward and to become active participants in the HIV and AIDS response, and not just passive recipients of its services. Living with HIV is an experience that enables PLHIV to add value to every aspect of the HIV prevention response ranging from awareness-raising to voluntary testing and counselling, through to the provision of ART and other related treatment.

To address the prevention needs of individuals who are HIV positive, care and treatment programmes should be multi-faceted and comprehensive, incorporating key behavioural prevention messages (e.g. partner disclosure, testing, and condom use), STI management, family planning counselling services, alcohol assessment and medication adherence counselling.

A package of clinic based HIV prevention interventions for HIV positive individuals that include behavioural and biomedical interventions has been developed and is being implemented in Namibia. The interventions and materials will be delivered in HIV care and treatment clinics by trained health care providers and lay counsellors.

In addition to clinic based interventions, prevention activities must also take place in the community setting, with clearly defined linkages between the community and health care setting activities. Community based initiatives should take place in support groups of PLHIV, home base care settings that serve PLHIV and VCT settings where HIV infected persons may be initially identified.

Gaps and Challenges

i. While the coordination of HIV and AIDS service organisations is being consolidated through NANASO, national coordination of PLHIV and their activities remains fragmented. Namibia does not have a strong and well established umbrella network of PLHIV;
ii. Lack of policy guidelines on the involvement of PLHIV not only in prevention but also in other aspects of the national multi-sectoral response;
iii. Lack of coordination between health care facilities and community based prevention with PLHIV support groups;
iv. Inevitably those with less to lose in terms of jobs, prestige and reputation are more likely to go public. This has an impact on the level of skills within the "open" PLHIV community, as very few skilled, professional people living with HIV are open about their status. Therefore the challenge is to address stigma that prevents more skilled and professional people living with HIV from being open, which would make the "body positive" more representative, not just in terms of image but also involvement in the response;
v. Lack of sustainability strategies for PLHIV interventions;
vi. Increasing number of people who know their status.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and subsequently contribute to the impact results.

Code	Outcome Result
OC17:	**More PLHIV adhere to HIV prevention behaviour:** % of PLHIV aged 15-49 years who reported having adopted and adhered to at least 2 key HIV prevention behaviours in the last 12 months increased to 40% by FY2012/13 and to 65% by FY2015/16
OC18:	**More PLHIV have disclosed their status to partners**: % of PLHIV newly tested who reported having disclosed their HIV status to their sexual partners in the last 12 months increased to 60% by FY2012/13 and to 80% by FY2015/16

Code	Output Result
	PLHIV reached by HIV prevention programmes
OP28:	Number of male and female PLHIV aged 15-49 reached with HIV prevention interventions in health facility care and treatment settings has increased by 50% by FY2012/13 and 80% by FY2015/16
OP29:	Number of male and female PLHIV aged 15-49 reached with HIV prevention interventions in community settings (e.g. PLHIV support groups, home-based care) has increased by 50% by 2012/13 and 80% by FY2015/16

Strategy

To ensure access to prevention, treatment, care and support for PLHIV to improve the quality of life and have PLHIV live longer and healthier lives. The successful implementation of this strategy will be supported and complemented by interventions identified under impact mitigation.

Priority Actions

Code	Description of main activities
5.1.5.1	Develop policy guidelines on the involvement of PLHIV in promoting and implementing universal access to HIV services
5.1.5.2	Strengthen the coordination of PLHIV structures to support the implementation of PLHIV prevention interventions
5.1.5.3	Develop social and behaviour change materials to support PLHIV prevention interventions
5.1.5.4	Strengthen health facility-based PLHIV prevention interventions
5.1.5.5	Develop and implement strategies for PLHIV involvement in community response to HIV and AIDS
5.1.5.6	Develop and implement stigma and discrimination reduction interventions

Biomedical prevention programmes that will contribute to a reduction in probability of HIV transmission

The following interventions are intended to collectively contribute to the reduction of the probability of HIV transmission where infection has occurred.

5.1.6 Medical Male Circumcision (MC)

Situation Analysis

According to the WHO[29], medical male circumcision (MC) can reduce the probability of HIV infection from HIV positive females to HIV negative males by 60%[30]. However, there is no definitive evidence showing that male circumcision reduces the risk of transmission from men to women or between men. Three randomized controlled trials were conducted in which men with a foreskin were randomly assigned to either receive circumcision or not, and then followed over time to see if one group had a higher rate of acquiring HIV. The risk reduction for circumcised men was about 60%, i.e., 6 out of 10 infections could have been prevented by circumcising men (Auvert et al, 2005; Bailey et al, 2007; Gray et al 2007).

According to the NDHS 2006/7, approximately 21% of men aged 15-49 were circumcised by 2007[31], 84% of whom were circumcised before the age 13. Of those childhood circumcisions, 70% had the operation performed by a health professional and 25% by traditional health practitioners. The available evidence does not show significant variations in the MC prevalence by age. Some regional variations were noted with estimates ranging from a low of 0.6% in Ohangwena Region to a high of 57% in Omaheke Region.

[29] WHO 2008, *Priorities Interventions – HIV prevention, treatment and care in the health sector*
[30] *(Bongaarts et al., 1989; Moses et al., 1990; Auvert et al., 2005; Drain PK et al., 2006, Bailey RC et al., 2007; Gray et al., 2007).*
[31] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*

The WHO recommends that MC be scaled up for defined geographical settings, prioritising men in areas where HIV prevalence in the general population exceeds 15%[32]. (The HIV prevalence in Namibia in the general population is estimated at 13.3% (MOHSS 2009[33]). Promoting neonatal circumcision will eliminate any back log likely to accrue from uncircumcised children.

The WHO and UNAIDS have developed guidelines to support the procedures (WHO and UNAIDS 2007). Namibia has an active male circumcision task force that has developed a MC Communication Strategy, and educational and awareness materials. However the draft male circumcision policy and action plan are yet to be finalised. In addition, Namibia has begun circumcision activities at five pilot sites and will be rolling out male circumcision activities countrywide.

In the context of the NSF, efforts will be made to scale up male circumcision throughout the country. This will involve a number of strategies. Firstly, the capacity of health facilities will be strengthened by providing the necessary equipment and supplies for male circumcision. Secondly, human resource capacity will be strengthened and expanded. Once MC is rolled out to health facilities, additional qualified doctors will be required and the government will consider task shifting to allow qualified and experienced nurses to performing MC procedures. Traditional birth attendants will also be trained in appropriate skills to support circumcision of infants. In partnership with development partners, a dedicated team of doctors for MC will be mobilised and deployed to relevant health facilities. Training, supervision and mentorship for MC service providers will be carried out as an on-going activity. Community mobilisation will be intensified through the involvement of community based organisations to generate demand for male circumcision. Finally, the MOHSS will initiate consultations with traditional health circumcisers to establish the specific roles they will play to contribute to the Outcomes.

Gaps and challenges

i. Low levels of medical male circumcision;
ii. Inadequate and qualified human and financial resources, as well as infrastructure to support MC in all health care facilities;
iii. Possible risk disinhibition[34] among men who receive MC;
iv. Inadequate numbers of trained health professionals to conduct MC procedures;
v. Existing polices preventing task shifting to nurses to perform MC activities;
vi. Inadequate national monitoring and evaluation system of MC services;
vii. Male circumcision is a newly introduced (globally) HIV prevention strategy. However, circumcision has been an on-going cultural activity conducted by traditional circumcisers. The process of engaging traditional circumcisers has been slow and inadequate given the need to ensure safety in MC;
viii. Training of community counsellors and other health care workers about MC to increase knowledge and referrals;
ix. Insufficient BCC communication and education on MC;
x. Research studies needed on risk disinhibition on men who have been circumcised.

[32] WHO 2008, *Priorities Interventions – HIV prevention, treatment and care in the health sector*
[33] MOHSS 2009, *Estimates and Projections of the Impact of HIV/AIDS in Namibia, 2008/9*
[34] Men increase their risk behaviors due to a false sense of security or protection following circumcision. It is also called risk compensation.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and subsequently will contribute to the impact results.

Code	Outcome Result
OC19:	**More men are circumcised by a health professional:** % of men aged 15-49 who reported being circumcised by a health professional increased from 15%[35] in 2007 to 30% in FY2012/13 and to 45% in FY2015/16
OC20:	**Most newborns are circumcised at a health facility just after birth:** % of newborn male infants circumcised in a health facility in the first week of life is increased to 40% in FY2012/13 and to 80% in FY2015/16.
OC21:	**Circumcised men continue to use condoms when they have sex:** Among circumcised men aged 15-49 who had higher-risk sex in the past 12 months, the % who used a condom with last non cohabiting partner has increased from 81.3% in 2007 to 86% in FY2012/13 and to 90% in FY2015/16.
OC22:	**Circumcised men have fewer sexual partners:** Among the circumcised men aged 15-49 who had sexual intercourse, the percentage who had multiple partners in the last 12 months decreased from 18.1% in 2007 to 14% in FY2012/13 10% in FY2015/16

Code	Output Result
	Comprehensive male circumcision programme for all newborns, boys and men
OP30:	450,000 men would have been circumcised as part of the minimum package of MC for HIV prevention services (approximately 50% of uncircumcised men aged 1 and older) between FY2010/11 and FY2015/16.
OP31:	% of public hospitals that provide MC surgery as part of the minimum package of MC for HIV prevention services in the last 12 months has increased from 5% in 2008 to 60% in FY2012/13 and to 90% in FY2015/16.
OP32:	167,900 male newborns have been circumcised in the first week of life (80% of newborns) between FY2010/11 and FY2015/16.
OP33:	% primary caregivers reached with male circumcision communication interventions has increased from less than 5% by 2009 to 70% by FY2012/13 and to 90% by FY2015/16
	Also see social & behavioural change and condom programmes

Strategies

i. To intensify community mobilisation targeting uncircumcised boys and men, parents of newborns, potential parents and communities in general to generate demand for circumcision through education and awareness information using inter-personal communications and community conversations.

ii. To intensify awareness creation for the need to continue using condoms for adult men who are already circumcised as a key prevention strategy.

[35]Although the NDHS 2006/7 percentage states 11%, this 11% includes those persons not circumcised at health facilities. Closer inspection and further calculations reveal that it is 15% of men who have been circumcised at a health facility, which is the baseline that the indicator definition calls for.

Priority Actions

Code	Description of main activities
5.1.6.1	Finalise and distribute the National MC Policy, MC Protocol and the Action Plan for male circumcision based on international standards set out by WHO
5.1.6.2	Strengthen the capacity of health facilities to conduct male circumcision. These will include provision of appropriate equipments and commodities for MC, additional human resources, and considerations for task shifting to qualified and competent nurses to perform MC.
5.1.6.3	Develop and implement the National Male Circumcision Communication Strategy
5.1.6.4	Provide couple counselling to parents to promote male infant circumcision
5.1.6.5	Conduct country-specific research on risk disinhibition following MC procedure
5.1.6.6	Establish M&E system for MC, aligned to the National M&E and the Health Information Systems.
5.1.6.7	Strengthen dialogue and collaboration between MOHSS and traditional circumcisers
5.1.6.8	Intensify education and awareness on consistent and correct use of condoms
5.1.6.9	Intensify education and awareness on medical male circumcision for primary care givers

5.1.7 Prevention of Mother to Child Transmission (PMTCT) of HIV Programme

Situation Analysis

According to the WHO, the risk of mother to child transmission can be reduced to less than 2% by appropriate interventions that include antiretroviral prophylaxis given to women during pregnancy and labour and to their HIV-exposed infants in the first few weeks of life, coupled with safe obstetrical interventions including elective caesarean delivery and safer infant feeding practices[36].

In March 2002, Namibia introduced PMTCT services as a pilot project at two state hospitals - Oshakati Hospital in the north and Katutura State Hospital in Windhoek. Since then services have been rolled-out to all 34 district hospitals and 206 health facilities and clinics. 256 of 335 health facilities in Namibia have ANC services; and of these 256, 189 (74%) were providing PMTCT services in 2007. This translates to, a coverage of 56% of all health facilities in Namibia. PMTCT is integrated into ante-natal care services making it possible for pregnant women attending ANC to easily access PMTCT.

Namibia has made tremendous progress in its PMTCT- Paediatrics HIV programme. Since its launch in 2002, 94% and 25% of its health facilities offer PMTCT and ART services respectively. This has enabled over 70% of the annual cohort of pregnant mothers to receive comprehensive PMTCT services and 96% (7,622) of the target children under the age of 14 years living with HIV and AIDS to be placed on treatment.

[36] WHO, UNICEF, IATT 2007, *Guidance on global scale-up of the prevention of mother to child transmission of HIV*

The "opt-out" testing strategy has facilitated the acceleration of PMTCT uptake. Between April 2007 and March 2008, the number of pregnant women who started ANC at PMTCT sites was 53,574. Out of the women who were pre-test counselled 94% had an HIV test. During January to December 2008, 7,474 (63%) of HIV positive mothers received ARVs for prevention of infections of the child[37].

As part of strengthening the PMTCT programme, Namibia introduced HIV DNA PCR in 2005 for early infant diagnosis of HIV from as early as 6 weeks. By March 2009, 202 health facilities were collecting and submitting Dried Blood Spot specimens for HIV PCR DNA test to the Namibia Institute of Pathology (NIP). A total of 13,067 babies were tested using PCR from January 2006 to March 2008[38]. The number of babies who received single dose Nevirapine was 11,116, representing 85% of all babies tested using PCR. The PCR results for 150 of the 13,067 samples processed were inconclusive. Among the remaining 12,917 samples, 11,377 (87.1%) were negative and 1,540 (11.8%) were positive. However, the repeat testing at 9 months is about half and much less at 18 months for confirmatory testing. Strategies for more complete follow-up of babies born to HIV positive mothers will be strengthened during the NSF.

This standard emphasises the importance of enrolling mothers and children in PMTCT programmes with a comprehensive continuum of care including following up HIV-exposed children until the child's HIV status has been confirmed and the child is 2 years old, or is no longer at risk. Optimising the impact of PMTCT programmes requires that:

i. Women of reproductive age, and especially pregnant women, as well as their partners receive HIV prevention services;
ii. Pregnant women and mothers living with HIV receive longitudinal care[39], treatment and support, including sexual and reproductive health care for their needs;
iii. All children born to HIV infected mothers (HIV-exposed children) receive essential postnatal care that includes early diagnosis of HIV and Cotrimoxazole prophylaxis from as early as 6 weeks of age in order to optimise their overall survival; and
iv. Children who become HIV infected despite PMTCT interventions can access care and treatment from as early after diagnosis as possible without waiting for immunological and/or clinical criteria in the first year of life.

The strategic approach under the NSF will be to ensure linkages between the acceleration of PMTCT to scaling up ART. With the revised guidelines infants will be eligible for both the prophylaxis and ART once they are diagnosed. Efforts will be made to ensure adequate linkages and collaboration between PMTCT, CHBC and support groups of PLHIV. The approach will focus primarily on strategies that promote the integration of PMTCT services in a variety of clinical settings including maternal, newborn, and child health clinics, HIV treatment centres, VCT, sexually transmitted infection clinics, and other sexual and reproductive health care including family planning clinics. The aim is to ensure delivery of a comprehensive package of essential services for quality maternal, newborn and child health care that will include routine quality antenatal care for women regardless of HIV status.

[37] UNAIDS 2008, *Namibia Universal Access Report and* MOHSS 2009 *Estimates and Projections of the Impact of HIV/AIDS in Namibia, 2008/9*
[38] MoHSS 2008, *MTP-III Annual progress report 2007/08*
[39] *Longitudinal care or continuity of care provides a wide range of HIV prevention, treatment, care and support services.*

The objective of PMTCT under the NSF is to ensure adequate and comprehensive provision of quality PMTCT services to all women of reproductive age. By offering a comprehensive PMTCT package, Namibia will eliminate paediatric HIV and ensure a free HIV generation of children. The global target for eliminating mother to child transmission is by 2015. With the adoption of the CD4 350 criteria, all HIV positive pregnant women will be on HAART starting as early as 14th week of gestation (second trimester) and will continue for the whole period of breastfeeding until a week after secession of breastfeeding. PMTCT services will include HIV counselling and testing, care, treatment and support of both HIV infected pregnant women and their HIV-exposed babies, including HIV counselling and testing for their partners and other members of their families. The PMTCT protocol has also been revised to provide for a longer treatment period for mothers and their infants. Full participation of men in PMTCT activities will be promoted.

Gaps and challenges

i. Not all health facilities are providing PMTCT. By 2007, only 56% of all health facilities (74% of ANC facilities) were offering PMTCT services countrywide. According to the Spectrum modelling (MOHSS 2009), approximately 11,600 women were in need of PMTCT in 2008/09;
ii. Lack of adequate policy guidance for HIV positive women wishing to have children. There are no specific programmes to empower pregnant women to make informed choices and decisions on sexual and reproductive rights, especially whether to have or not to have children;
iii. Only 202 health facilities out of 335 are collecting Dried Blood Spot specimens for HIV DNA PCR;
iv. Stigma continues to impact negatively on HIV and AIDS services uptake and in particular on PMTCT related services;
v. Inadequate male involvement in PMTCT;
vi. Inadequate pre-natal counselling for both partners and psychosocial support for pregnant mothers;
vii. Limited integration of sexual and reproductive health and HIV and AIDS services including PMTCT;
viii. Inadequate referral systems and linkages to other HIV-related services at community level.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC23:	**Fewer unplanned pregnancies amongst women living with HIV**: The total fertility rate has decreased from 3.6 in 2007 to 3.1 in FY2012/13 and to 2.7 in FY2015/16.
OC24:	**More HIV positive pregnant women receiving ARVs to reduce risk of transmission to child:** % of HIV infected pregnant women who received ARVs to reduce the risk of mother to child transmission increased from 70% in 2007 to 80% in FY 2012/13 and to 95% in FY2015/16.
OC25:	**More infants born from HIV-positive mothers receive ARVs:** % infants born to HIV infected women receiving antiretroviral prophylaxis to reduce the risk of MTCT in the first week of life increased from 67% in 2007 to 82% in FY2012/13 and to 95% in FY2015/16.
OC26:	**More women adopt safer breastfeeding practices:** % infants younger than 4 months who are exclusively breastfed has increased from 23% in 2007 to 34% in 2012/13 and to 45% in FY2015/16.

Code	Output Result
	Comprehensive PMTCT programme for pregnant women, their infants and their sexual partners
OP34:	% of women aged 15-49 living with HIV and accessing comprehensive family planning package increase by 20% by 2012/13 and 50% by 2015/16
OP35:	% of pregnant women who were tested for HIV and know their results increased from 71% in 2008 to 80% in FY2012/13 and to 95% in FY2015/16
OP36:	% of HIV exposed infants receiving HIV DNA PCR test at six (6) weeks of birth is increased from 20% in 2009 to 50% in FY2012/13 and to 85% in FY2015/16
OP37:	% of babies of HIV positive pregnant mothers receiving Cotrimoxazole increased to 75% by 2012/13 and to 90% by 2015/16
OP38:	% of male partners of pregnant women who know their own HIV status increases from 2% in 2008 to 21% by FY2012/13 and to 40% in FY2015/16.
OP39:	% of health facilities providing ANC services that offer both HIV testing and ARV for PMTCT on site is increased from 56% health facilities in 2008 to 90% in FY2012/13 and to 98% in FY2015/16

Strategy

To scale up the provision of comprehensive package of PMTCT services around the four prongs (prevention of unintended pregnancies, primary prevention, prevention of MTCT, and treatment of mother and child) so that services are readily available, accessible and being utilised by all people in need, and to reduce the probability of HIV transmission where exposure has occurred to newborns.

Priority Actions

Code	Description of the main activities
5.1.7.1	Institutionalise provider-initiated HIV testing and group counselling in maternal, newborn, and child health care settings
5.1.7.2	Scale up provision of comprehensive PMTCT services to all designated health facilities based on National PMTCT guidelines and aligned to international standards
5.1.7.3	Provide HAART to eligible HIV pregnant women and their HIV-exposed infants, and ARV prophylaxis to HIV infected pregnant women who are not yet eligible for ART.

5.1.7.4	Mobilise men and scale-up male involvement activities in PMTCT including support for to their HIV infected female partners. This should also include development and production of male targeted IEC materials
5.1.7.5	Provide comprehensive sexual reproductive health to HIV positive women and their spouses in the context of PMTCT
5.1.7.6	Strengthen and scale up the capacity for health facilities to collect dried blood spot specimens for HIV PCR DNA
5.1.7.7	Strengthen infant feeding including exclusive breastfeeding and nutrition counselling and support for women, their children and families.

5.1.8 Post Exposure Prophylaxis

Situation Analysis

Post Exposure Prophylaxis (PEP) is offered for both occupational and non-occupational incidents. The vast majority of incidents of occupational exposure to blood borne pathogens, including HIV, occur in health care settings. PEP for HIV consists of a comprehensive set of services to prevent infection developing in an exposed person, including: first aid care, counselling and risk assessment, HIV testing and counselling and, depending on the risk assessment, the short term (28-day) provision of ARV with support and follow up. For non-occupational PEP, the focus is preventing HIV infection among survivors of sexual abuse and in particular rape.

A national policy for PEP has been developed. Health care workers and some community groups including Namibian Men Planned Parenthood Network have been trained on PEP as master trainers for community health education. The Medical Injection Safety Programme has been scaled up, currently covering 91% (231) of all health facilities. According to the NDHS 2006/7, 18% of men and 31% women received at least 1 medical injection in the last 12 months. A policy on PEP for rape survivors has also been developed and is being used. While the policy does not include ARVs, the technical guidelines for rape management include ARVs.

Gaps and challenges

i. Data on people exposed to HIV is not adequately captured, especially data related to survivors of rape and / or general sexual abuse;
ii. Given that the management of PEP requires proper diagnosis and prescription by a qualified doctor, comprehensive provision of PEP within the country may suffer from an inadequate number of doctors;
iii. Communities are not adequately sensitised or informed about PEP services and hence access is limited. The service is under-utilised.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC27:	**More people reporting accidental exposure to HIV receive PEP services:** % of people reporting to be in need of PEP in the last 12 months and who have received PEP services as per national guidelines has increased to 80% in FY 2012/13 and to 95% in FY2015/16

Code	Output Result
	PEP service provision in all ART and PMTCT sites for all who qualify for PEP
OP40:	% health facilities with PEP services available on site and being provided according to the national guidelines has increased from 18% in 2007 to 50% in FY2012/13 and to 75% in FY2015/16 in accordance with the national guidelines
OP41:	% of people in need of PEP provided with PEP in accordance with national guidelines in the last 12 months remains at 100% in FY2012/13 and FY2015/16 (disaggregated by exposure: occupational, rape/sexual abuse, other non-occupational)
OP42:	% of rape cases reported at police stations in the last 12 months that have been referred to and screened at a health facility has increased to 60% in FY2012/13 and to 85% in FY2015/16.

Strategy

To ensure that PEP services are available and accessible so that all eligible people who have been accidentally or otherwise exposed to HIV are given drugs to reduce the risk of primary infection, and have comprehensive knowledge of HIV.

Priority Actions

Code	Description of main activities
5.1.8.1	Develop capacity for managing PEP services at health facilities, at community and organisational level
5.1.8.2	Strengthen the capacity of communities to support rape victims

5.1.9 Prevention of Sexually Transmitted Infections (STIs)

Situation Analysis

The predominant mode of transmission of HIV is sexual, which makes it a sexually transmitted infection. Epidemiological and biological studies provide evidence that other sexually transmitted infections, if present in a person, act as co-factors for HIV acquisition or transmission. The presence in a person of other STIs such as syphilis, chancroid ulcers or genital herpes simplex virus infection greatly increases the risk of acquiring or transmitting HIV. New research suggests an especially potent interaction between very early HIV infection and other STIs. This interaction could account for 40% or more of HIV transmissions.

Despite this evidence, efforts to control the spread of STIs have lost momentum in the past five years as the focus has shifted to HIV therapies.[40]

Herpes simplex virus type 2 plays an important role in the transmission of HIV. A study in Mwanza[41], Tanzania showed that 74% of HIV infections in men and 22% in women could be attributed to the presence of herpes simplex virus type 2. Recent evidence indicates that genital herpes may be responsible for fuelling a large proportion of new infections[42] and suppressive treatment of herpes simplex virus type 2 infection reduces genital shedding of HIV in women. Genital ulcers or a history of such disease have been estimated to increase the risk of transmission of HIV 50-300 fold per episode of unprotected sexual intercourse[43]. HIV shedding in semen increased six fold in men with gonococcus arthritis in Malawi. Following treatment for urethritis, the seminal viral load was reduced to levels similar to those of HIV infected men without urethritis.

HIV shedding in semen increased six fold in men with gonococcus urethritis in Malawi. Following treatment for urethritis, the seminal viral load was reduced to levels similar to those of HIV infected men without urethritis. A recent study in the United States of 52 HIV infected men with primary or secondary syphilis, 58% of whom were receiving ART, showed that syphilis is associated with increases in plasma viral load and significant decreases in the CD4+ cell count. Syphilis treatment restored immunity to pre-infection levels.[44]

The burden of STIs in Namibia is extremely high. In 2006, 69,414 STIs (other than HIV) cases were reported accounting for 2.9% of all out patient consultations. During the reporting period (April 07-March 08) there was an increase of STI cases from 69,414 in 2006 to 73,552 representing a 5.96% increase. Given social demographic and migratory trends, the population at risk for sexually transmitted infections will continue to grow dramatically.

Common STIs in Namibia include gonorrhoea, syphilis, vaginal discharge, herpes, bubo and genital warts. By March 2007, the majority (94%) of the STI cases were reported from among persons aged 18 and above. 5% of STI cases were reported from clients aged 5-14 years. This finding indicates the need to address sexual and reproductive health needs of adolescents to prevent and control STIs[45] and potentially reduce the risk of HIV infection.

Namibia has adopted syndromic management of STIs. Treatment of viral STIs still remains a challenge. During the 2008 Sentinel Surveillance, syphilis prevalence was found to be above 2.1% across all ages with the highest prevalence found in age group 40-44 years (2.9%) and 45-49 years (3.4%).[46] These findings underscore the importance of preventing and promptly treating syphilis in HIV infected individuals both as a prevention strategy and to improve the quality of care for persons living with HIV. This strategy also calls for increased efforts to strengthen partner tracing to ensure comprehensive

[40] WHO 2007, *Global Strategy for the Prevention of and Control of Sexually Transmitted Infections: 2006 -2015*
[41] Pujades Rodrgues M et al. 2002, *Herpes Simplex Virus Type 2 infection increases HIV incidence: a prospective study in Rural Tanzania,* AIDS 2002, 16:451-462
[42] Wald A, Link K 2000, *Risk of HIV infection in herpes simplex virus type 2. Seropositive persons : metal-analysis,* Journal of Infectious Diseases 2000 185: 45-52
[43] Hayes Rj, Schulz KF, Plummer FA 1995, *The co-factor effect of genital ulcers in the per-exposure risk of HIV transmission in Sub Saharan Africa*. Journal of Tropical Medicine and Hygiene, 1995 98:1-8
[44] *Cited just above*
[45] MOHSS 2007, *Progress Report on the Third Medium Term Plan on HIV and AIDS 2006-2007*
[46] MOHSS 2008, *Report on the 2008 National HIV Sentinel Survey*

treatment. Linking HIV prevention to a broader sexual reproductive health programme has merit. Such a programme would include: (a) a person learning about their HIV status and accessing relevant services; (b) promotion of safer and healthier sex; (c) optimising the connection between HIV and AIDS and STIs; and (d) integrating HIV with maternal and infant health programmes (UNFPA, WHO, UNAIDS and IPPF 2008[47]).

Challenges and Gaps

i. Inadequate coverage of STI treatment and contact tracing;
ii. Insufficient community education on STIs;
iii. Inadequate treatment of viral STIs;
iv. Stigma and prejudice associated with STI infection;
v. Reluctance of patients to seek early treatment;
vi. Lack of policy guidelines on partner tracing limits comprehensive treatment;
vii. Limited integration between STI and sexual reproductive health;
viii. Difficulties in notifying and treating infections in sexual partners.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC28:	**Fewer men and women have STIs:** % of women and men who reported having a genital sore/ ulcer in the past 12 months reduced for women from 2.9% in 2007 to 2% in FY2012/13 and to1.5% in FY2015/16 and for men from 1.8% 2007 to 1% in FY2015/16.
Code	**Output Result**
	Expanded coverage and integration of STI services for those in need
OP43:	% of facilities offering care and support services that have at least one medication for treating Herpes increased from 15% in 2009 to 25% in 2012/13 and to 50% in 2015/16
OP44:	Number of clients treated for urethra discharge syndrome in public sector hospitals has decreased from approximately 17,000 in 2007 to 9,750 in FY2012/13 and to 7,000 in FY2015/16

Strategies

i. To increase the number of facilities that can provide syndromic treatment for STIs.
ii. To strengthen the integration of STI prevention and control with sexual and reproductive health services and other HIV prevention and treatment services.
iii. To destigmatise STIs and increase community awareness about the importance of early STI treatment and partner tracing.

[47] UNFPA, WHO, UNAIDS and IPPF, 2008, *Linking Sexual and reproductive Health and HIV/AIDS, Gateways to integration: A case study from Haiti.*

Priority Actions

Code	Description of main activities
5.1.9.1	Develop a National Policy for STI management.
5.1.9.2	Develop a National Social and Behaviour Change Strategy on STIs focused on the relationship between STIs and HIV infection to promote early treatment-seeking behaviours and reduce risky sexual behavioural practices.
5.1.9.3	Develop a public education campaign focused on STI and HIV infection to promote early treatment seeking behaviours by the general population and especially of the MARPS
	Strengthen health systems to provide comprehensive STI services.

5.1.10 Blood Safety

Situation Analysis

The safety of Namibia's national blood supply is assured by the Blood Transfusion Service of Namibia (NAMBTS). NAMBTS policies and procedures for collecting, screening and distributing blood are based on international quality assurance standards. Quality-assured laboratory screening of all donated blood is complemented by a policy of collecting blood exclusively from voluntary, non-remunerated blood donors. The recruitment and retention of these donors ensures that blood is collected from individuals with a low behavioural risk for HIV or other transfusion-transmissible infections (TTI).

Namibia tests 100% of all donated blood for HIV, Hepatitis B, Hepatitis C, and syphilis. All testing is performed by the South African National Blood Service laboratories through an innovative contractual agreement with NAMBTS. This contractual agreement is reviewed for cost effectiveness every two years. To date, this external testing strategy has been deemed a sustainable alternative to building TTI testing capacity in Namibia. A lack of trained laboratory technologists is a primary barrier to the expansion of blood testing in Namibia. This policy will continue to be reviewed for sustainability and appropriateness, especially as more trained laboratory technologists graduate from the Polytechnic of Namibia.

NAMBTS staff is trained in quality assurance of blood bank management, including cold chain, as well as quality aspects associated with the production of blood products (e.g. packed red cells, platelets, plasma). Blood donor activities focus on the recruitment and retention of voluntary, non-remunerated donors. HIV prevention messages, as well as the promotion of healthy lifestyles, are a cornerstone of the blood donor recruitment and retention strategy. In this way, blood safety contributes to national objectives to raise awareness about healthy lifestyle choices and HIV prevention. The overall prevalence of HIV and other TTIs among blood donors has remained low due to this recruitment policy which includes the use of a stringent pre-donation behavioural questionnaire and physical examination.

Table 2: 2009 prevalence of HIV and other Transfusion-Transmissible Infections among NAMBTS blood donations

TTI	2009
Syphilis	0.24%
Hepatitis C	0.09%
Hepatitis B	0.84%
HIV	0.49%

Blood donors with reactive test results for any TTI are notified and counselled by NAMBTS and referred for further counselling and testing. NAMBTS is also another entry point through which infected Namibians may, through referrals, access care and treatment services. With the expansion of high school-based health education programmes linked to the blood donor recruitment strategy, NAMBTS activities also contribute to national objectives to raise awareness about HIV and healthy lifestyles among Namibian youth.

Challenges and Gaps

i. Inadequate cold chain storage and facilities for blood compatibility testing at health facilities;
ii. Low participation of youth as blood donors and an aging pool of regular donors;
iii. Lack of linkages between electronic data systems at NAMBTS, hospital clinical services, and other laboratories e.g. National Institute of Pathology (NIP). This weakness prevents the analysis of data to track and monitor blood utilization trends and conduct effective haemovigilance;
iv. Despite the availability of procedures and guidelines most hospitals still do not have functional transfusion committees;
v. A revised national blood bill is pending, and the delays in its completion and passage have stalled the creation of a National Blood Authority.

Outcome and Output level results

The implementation of the priority actions at national, sectoral and regional levels through the operational plans aims to achieve the following **outcome** and **output** level results. These results in turn contribute to the attainment of the thematic and national level impact results.

Code	Outcome Result
OC29:	**Safe blood products maintained:** Blood units are safe for usage: % of donated blood units that have been screened for HIV through national testing guidelines is maintained at 100% by FY2012/13 and by FY 2015/16

Code	Output Result
	100% Safe blood products maintained for all who need it

OP45:	% of safe blood units supplied in the last 12 months has remained at 100% in FY2012/13 and FY2015/16.
OP46:	Number of blood units donated in the last 12 months that have been screened for HIV through national testing guidelines increases from 21,000 in 2008 to 24,225 in 2012/13 and in 2015/16

Strategy To reduce the probability of HIV transmission through contaminated blood and blood products.

Priority Actions

Code	Description of main activities
5.1.10.1	Conduct social mobilization activities for the recruitment and retention of voluntary, non-remunerated blood donors from low risk populations.
5.1.10.2	Use stringent donor selection procedures, including pre- and post-donation counselling, a medical exam, and a behavioural risk questionnaire to screen out potentially high risk donors and refer them to other counselling and testing services.
5.1.10.3	Sustain and expand blood collection activities through support for mobile and fixed site blood donor clinics, the procurement of consumable supplies and capital equipment for blood collection, and the appropriate management of medical risk waste generated by these activities.
5.1.10.4	Ensure uninterrupted quality-assured testing for HIV and other TTIs through an existing contract with the South African National Blood Service and plan for the potential return of TTI screening to the NAMBTS laboratory in Windhoek.
5.1.10.5	Sustain and expand NAMBTS capacity to produce blood products and ensure uninterrupted blood group serology testing at NAMBTS and NIP laboratories nationwide.
5.1.10.6	Ensure the recruitment and retention of qualified technical, medical and administrative staff; implement strategies for human capacity development, with a special emphasis on promoting Namibians; manage the payment of staff salaries and benefits; and ensure NAMBTS employees have access to a defined career path.
5.1.10.7	Provide evidence-based training to medical, technical and administrative staff within NAMBTS, and expand blood transfusion training programmes for laboratory personnel and clinical staff at NIP, the MOHSS, and private sector healthcare facilities.

5.1.11 Universal Precautions

Situation Analysis

Universal precautions is a set of practices to be applied to all patient care settings to reduce the spread of blood borne pathogens. It assumes that all blood and potentially infectious fluids materials can transmit disease. Similarly, all instruments, surfaces and other equipment that have come into contact with patients are assumed to be carrying potentially infectious pathogens and thus must be cleaned, sterilized, disinfected or discarded in a manner that does not increase the risk of disease.

The NSF promotes the use of universal precautions to ensure that the accidental exposure of patients, health care workers or any other person (including cleaners, waste collectors, general public) to potentially infectious blood is reduced or eliminated. The implementation of national guidelines and

procedures for universal precautions is on-going in Namibia. With substantial donor support over the last decade, injection safety has been integrated into the national HIV prevention strategy. National Infection Control Guidelines were finalized in 2009 and dissemination was planned for 2010. Healthcare workers have been trained using a medical injection safety and waste management modules.

Oversight of technical policies and activities has been assured in recent years by a National Injection Safety Working Group. This group, and others charged with infection prevention and control, will continue providing technical assistance to line ministries and health facilities on the implementation of strategies and activities described below. Institutionalizing training into pre-service training, improving on the job supervision of staff and monitoring of infection control processes will be essential to ensure guidelines, policies and standard operating procedures are observed and practiced by all clinical and other frontline health care staff.

The NSF will promote and support the implementation of measures to prevent healthcare acquired infection related to HIV counselling and testing, blood safety, injection safety, male circumcision, and laboratory and ART services. Other infection prevention and control measures are described in the chapter on post-exposure prophylaxis (5.1.8).

Reprocessing of instruments is also important to prevent healthcare associated transmission. Regarding re-usable instruments, NSF will encourage monitored and supervised sterilization to should be performed between every use. Surfaces contaminated by blood and body fluids should be cleaned of all visible dirt and wiped with disinfectant.

Waste management

The NSF will support a broad range of measure in waste management, including waste segregation; handling, storage and transportation of waste; personal protective equipment for persons handling waste; the treatment of infectious waste by incineration and/or removal to an approved landfill. The NSF will encourage segregation and safe disposal of lancets, syringes, needles, sharps and blood bags. Safe disposal implies the disposal of sharps into leak proof puncture proof containers at the point of use, which can reduce the risk that of re-use of contaminated instruments.

Training in infection prevention and control will be provided to healthcare workers, and, where appropriate, to members of the public. These training courses will be integrated into pre-service and in-service programmes. Environmental impact studies will be conducted on existing and new waste management facilities to protect public health from unhealthy emissions or other exposures from incinerated or buried waste.

Challenges and Gaps

i. Not all health care workers have received training on infection prevention and control, and waste management. Policies and guidelines on these topics are being disseminated but are not yet fully implemented as part of routine service delivery;

ii. Infection control practices and guidelines, developed for the HIV and AIDS response, that target blood borne pathogens such as HIV, HBV, and HCV need to be broadened to protect against the organisms most commonly spread in health care facilities, including those spread by contact and airborne or droplet transmission;

iii. National monitoring and evaluation systems for infection control, use of universal precautions and waste management remain under development;

iv. National standards for the management and disposal of medical risk waste are yet to be finalised. Facilities currently rely on regional standards and/or existing local laws and policies, e.g., draft waste management guidelines;

v. Sustainability and ownership problems with current efforts in infection prevention and control that includes injection safety and waste management;

vi. Waste segregation and disposal in the private sector is yet to be fully tackled.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following outcome and output results and subsequent contribute to the impact level results.

Code	Outcome Result
OC 30:	**Greater medical injection safety reported**: % of men and women receiving medical injection in the last 12 months who said that the last injection the syringe and needle were taken from a new / unopened package increased from 95% for men and 97% for women in 2007 to 100% and maintained at that level for both men and women by 2015/16.

Code	Output Result
	Health workers strictly adhere to IPC guidelines
OP 47:	% of health facilities with observed guidelines for infection prevention and control, and waste management at site increased by 20% in 2012/13 and by 50% by 2015/16.

Strategy

To reduce the probability of HIV transmission through work-place exposure to contaminated blood and blood products, other biological material, or instruments or equipment that have been contaminated with potentially infectious materials.

Priority Actions

Code	Description of main activities
5.1.11.1	Train service providers on infection prevention and control, and waste management. Specifically design and conduct training for members of the Central Sterilization Services Department
5.1.11.2	Development of an implementation strategy and plan for infection prevention and control including waste disposal in public and private institutions
5.1.11.3	Strengthen Quality Assurance Division through provision of technical assistance until its fully functional

5.1.11.4	Support resource mobilization efforts of the Quality Assurance Division both from the Ministry of Health and Social Services and partners to ensure implementation of Infection Control Plans activities
5.1.11.5	Support collaboration between the Quality Assurance Division and the Directorate of Special Programmes (meetings, joint planning, supervision)
5.1.11.6	Provide support for quarterly meetings of the National Injection Safety Group.
5.1.11.7	Provide technical and financial support to procure new incinerators, maintain existing ones and explore alternative safe and environmentally friendly technologies for waste treatment.
5.1.11.8	Strengthen district and facility infection control committees to implement effective infection control measures (district infection control plans, training, meetings, and supportive supervision).
5.1.11.9	Support the review and update of existing policies and guidelines, and monitor the implementation of infection prevention and control measures.
5.1.11.10	Print and distribute policies and guidelines (waste management policy and guidelines, infection prevention and control guidelines).
5.1.11.11	Develop and distribute materials on infection prevention and control (IPC).
5.1.11.12	Ensure the continuous availability of supplies and equipment for patient care management (injection safety boxes, disinfectants, Personal Protective equipments).
5.1.11.13	Technical assistance and financial support for the implementation of a nationwide immunization of healthcare workers against hepatitis B and/or tetanus early in their career.
5.1.11.14	Strengthen existing monitoring and evaluation to develop a national infection prevention and control system.
5.1.11.15	Health system strengthening through infrastructure modification to allow isolation, and other areas like wash basins, tap, transportation, and waste storage places.
5.1.11.16	Establish a survey system to identify risk situations and procedures and modify them wherever possible.

5.2 Treatment Care and Support

5.2.0 Overview

Universal access to care and treatment for HIV positive people remains a major component of the national response to HIV and AIDS. However, following the country's successful roll-out of ART to approximately 81% of the people in need of treatment[48], the challenge now is to ensure patients receive quality care and that morbidity and mortality rates are minimised, whilst increasing coverage.

Increased demand for ART services is anticipated in line with the strengthening of the HCT activities, particularly with the introduction of Provider Initiated Counselling and Testing (PITC). The shift from CD4 200 to CD4 350 and the provision of ART to people with HIV/Hepatitis B co-infection will increase the demand for ART. Additional demand will from come from PMTCT and PEP. As coverage for ART increases, there will be increased need for support services, particularly with regards to the continuum of care outside the health setting. This is important for purposes of adherence to treatment schedules and generally ensuring psycho-social needs are met in the home and community setting. Easing of pain and suffering of PLHIV is another consideration to be addressed by offering palliative care. The provision of Community Home Based Care (CHBC) therefore becomes an integral part of the ART programme that has to be addressed as part of the treatment package and in particular with reference to palliative care.

[48] *The actual number of people on ART as of 31 March 2009 was 64,637, while the* MOHSS 2008, *Estimates and Projections of the Impact of HIV/AIDS in Namibia report placed total number of people in need of ART at 76,727 resulting in the 84% coverage*

Providing treatment to HIV positive people is not limited to ART delivery alone. Additional challenges are faced by the presence of other Opportunistic Infections (OI) typically associated with HIV. STIs in particular need to be treated since their presence increases HIV transmission significantly, and it is imperative that these diseases are managed as part of the HIV treatment package. TB remains the leading OI, with co-infection rates standing at 60%. Enhanced interventions are therefore required for the effective joint-management of the two diseases.

As the up-take increases, additional pressure is placed on ART clinics resulting in more waiting time and rushed patient-doctor consultations. The Pre-ART clinics are seen as an important strategy to facilitate de-congesting ART clinics.

The above areas represent the components to be addressed when developing the treatment, care and support strategy under this NSF. Although the components are presented in this document by service delivery area, emphasis should be placed on the provision of all these services as a comprehensive package in order to provide quality ART services.

This NSF's strategic orientation for Treatment, Care and Support therefore builds on the MTP-III's treatment strategy that emphasised the rolling-out and scaling-up of the ART programme. However this time, greater emphasis is being placed on offering a more comprehensive, quality-oriented, service provision that commences before ART and extends beyond the health setting.

Treatment Care and Support Impact level results

It is anticipated that the implementation of the NSF treatment, care and support initiatives will contribute to the following impact results:

i. *Life expectancy has increased from 51.6 years in 2008 to 55 years in FY2015/16.*

ii. *% of people reported dying from AIDS has decreased from 23% in 2008 to 18% in FY2015/16.*

5.2.1 Pre-Antiretroviral Therapy

Situation Analysis

The Pre-ART programme aims to provide necessary services to HIV positive people who are not yet on ART. Services that are provided include OI screening, prophylaxis and treatment, monitoring of viral loads, nutritional support, treatment literacy in preparation for ART, the avoidance of re-infection, counselling and psycho-social support amongst others.

The main benefit of Pre-ART is that a patient who is not yet needing ART is still able to receive the necessary attention for his/her other ailments and needs, without having to compete for the same resources as an ART patient. Facilities that do not offer separate Pre-ART services result in long waiting times for non-ART patients at the clinics, as well as possible patient deterioration while waiting to commence ART. Pre-ART can therefore also be used as a strategy to keep HIV positive people that are not yet on ART in a state of health that postpones commencement on ARVs. This ultimately reduces the pressure on health facilities and reduces HIV morbidity and mortality rates over the longer term.

Pre-ART is however still yet to be standardised across health facilities in Namibia, both in terms of the services that are offered and the operational model. Services that are offered are varied, ranging from the simple opening of a file, commencement on Cotrimoxazole Preventative Therapy (CPT) and TB Isoniazid Preventative Therapy (IPT) to offering a comprehensive set of services as mentioned above. Operationally, there are two models in place – the first entails offering of an integrated service with the Pre-ART and ART clinics running concurrently as is the case in most health facilities offering ART, while the second model is a stand-alone Pre-ART clinic that services HIV positive people not yet on ART, using separate facilities and staff[49]. The introduction of the Pre-ART clinic model at Oshakati Hospital, which has the only known stand-alone Pre-ART facility in Namibia, was deemed necessary to improve the quality of care for both sets of patients since the separation enabled a more focussed and less pressurised environment to attend to each patient[50].

The incorporation of Pre-ART as a key component of the Treatment, Care and Support strategy therefore contributes towards the element of quality care for PLHIV not yet on ART, and improves the attainment of reduced morbidity and mortality rates amongst the same group of people. The intention is to offer key health care support to the patient within the facility, whilst taking advantage of the care and support services offered by civil society organisations for instance under the CHBC and HIV and AIDS support group programmes (see section 5.2.4).

Gaps and challenges

i. Lack of a definitive Pre-ART model that clarifies what a Pre-ART clinic entails, including the human resource and infrastructure requirements;
ii. Limited availability of human resources to support Pre-ART clinics, particularly if a stand-alone model is adopted;
iii. There are already infrastructure limitations (buildings and equipment) at periphery level clinics to provide ART and other health services. The Pre-ART clinics would have to fit within the existing infrastructure if costs are to be minimised and services sustained;
iv. Currently, there is limited attention paid to a patient's socio-economic conditions under current ART programmes. The adoption of the Pre-ART clinics would facilitate the earlier assessment of a patient's health and socio-economic status which could lead to an improved quality of life and better responses to treatment;
v. Inadequate retention of PLHIV in the pre-ART programme.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and subsequently will contribute to the impact results.

Code	Outcome Result
OC31:	**More PLHIV have improved quality of care before starting on ART:** % of PLHIV retained on pre-ART programme until they graduate to ART has increased to 80% by FY2012/13 and to 90% by FY2015/16

[49] *At Oshakati Hospital, the Pre-ART staff are the same resources that work in the ART clinic, who work on a rotational basis at the Pre-ART clinic*
[50] I-TECH 2008, *Clinical Mentoring in Namibia, Clinical Mentoring Toolkit*

Code	Output Result
	PRE-ART for all PLHIV, immediately after testing HIV positive
OP48:	% of female PLHIV not on ART who are enrolled in pre-ART programme in the past 12 months has increased from 60% in 2009 to 80% in FY2012/13 and to 95% in FY2015/16
OP49:	% of male PLHIV not on ART who are enrolled in pre-ART programme in the past 12 months has increased from 38% in 2009 to 55% in FY2012/13 and to 80% in FY2015/16.
OP50:	% children enrolled in HIV care and eligible for Cotrimoxazole (CTX) prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis remains at 100% up to FY2015/16
OP51:	% adults enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis remains at 100% up to FY2015/16

Strategy

To enhance quality of care by scaling-up the Pre-ART programme.

Priority Actions

Code	Description of main activities
5.2.1.1	Refine the model for the Pre-ART
5.2.1.2	Scale-up the Pre-ART programme to cover wider patient populations, and increase geographic coverage
5.2.1.3	Provide treatment for OIs including TB and Hepatitis B HIV co-infection
5.2.1.4	Strengthen clinical quality assurance and improvement programmes in order to ensure national guidelines are being implemented, both within private and public health facilities

5.2.2 TB/HIV Co-Infection

Situation Analysis

The TB burden in Namibia has increased notably over the last two decades, from 9,625 patients in 1996 to 12,698 patients in 2002[51]. TB is believed to have a direct co-relation to the HIV epidemic since HIV is the major known individual risk factor for the development of TB[52]. Approximately 59% of people with TB in Namibia are co-infected with HIV[53] which is a major threat to PLHIV and has the capacity to negatively impact the success of ART scale-up[54]. According to the WHO, TB is the most life threatening opportunistic disease, even in those receiving ARVs, and it has been shown to be a leading cause of death[55].

[51] *The country has one of the highest TB case-notification rates (CNR) in the world, MOHSS 2004, The National Strategic Plan on TB, MTP I, 2004-9*
[52] MOHSS 2004, *The National Strategic Plan on TB, MTP-I, 2004-9, page 9*
[53] MOHSS 2009, *National TB and Leprosy Control Programme 2008/2009 Annual Report, page 14*
[54] *WHO Three "I's meeting April 2008: Intensified Case Finding, Isoniazid Preventative Therapy and TB Infection Control for people living with HIV*
[55] *Cited just above*

The emergence of Multi-Drug Resistant TB (MDR-TB) and Extensively Drug Resistant TB (XDR-TB) over the last few years further exacerbates the situation since these forms of TB are also more commonly found amongst HIV positive people. It is also notable that the treatment for these drug resistant TB strains can compromise the effectiveness of ARVs, further affecting the potential success of the ART programme.

It is therefore imperative that more concerted efforts are undertaken to prevent and treat TB in PLHIV. One such strategy is the WHO-recommended "Three I's" strategy that entails **I**ntensified Case Finding (ICF), provision of **I**soniazid Preventative Therapy (IPT) and TB **I**nfection Control (IC). Namibia has begun to adopt measures aligned with the Three I's strategy, for instance, establishing a national coordination body to manage TB/HIV collaborative activities and scaling up HIV surveillance amongst TB patients[56]. However, there are still several aspects that need to be addressed, particularly with regards to IPT provision and Intensified case finding.

The joint management of TB and HIV is considered an important component of the Treatment, Care and Support strategy since TB is the most prevalent of the OIs to affect PLHIV. Without effective management, TB prevalence can affect the success of the ART programme. This NSF therefore emphasises the holistic adoption of the Three I's strategy to minimise TB prevalence and to contain its effects on PLHIV.

Gaps and challenges

i. Higher TB incidence amongst HIV positive people which complicates patient management;
ii. The joint TB/HIV Plan is still in its infancy, with few activities being implemented;
iii. Lack of a national strategy on TB/HIV co-infection which has led to issues such as poor coordination between TB and HIV clinics at facility and decentralised administrative levels;
iv. There is no joint TB/HIV M&E Plan that would strengthen monitoring activities and provide clarity on reporting responsibilities for the TB/HIV collaborative indicators (e.g. PLHIV provided with IPT which is provided at the case management clinics);
v. Limited implementation of intensified TB case finding;
vi. Limited implementation and monitoring of IPT provision.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and subsequently will contribute to the impact results.

Code	Outcome Result
OC 32:	**More PLHIV with TB co-infection are successfully treated:** % of PLHIV with new smear-positive TB who have been successfully treated has increased from 73% in 2007 to 80% in FY2012/13 and to 85% in FY2015/16

[56] *In 2008, the National TB Control Programme reported that 66.9% of TB patients had been tested for HIV.*

Code	Output Result
	Management of TB/HIV co-infection for all PLHIV
OP52:	% of HIV positive TB cases that received treatment for TB and HIV has increased from 74% in 2008 to 85% by FY2012/13 and to 95% by FY2015/16.
OP53:	% of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit has increased to 80% in FY2012/13 and to 95% in FY2015/16.
OP54:	% of TB patients who had an HIV test result recorded in the TB register increased from 54% in 2007 to 70% in FY2012/13 and to 95% in FY2015/16
OP55:	Number of adults and children newly-enrolled in HIV care in the past 12 months who start (given at least one dose) treatment of latent TB infection (IPT) increased from 1,495 in 2007 to 1,800 annually in FY2012/13 and to 2800 in FY2015/16
OP56:	% of HIV-positive TB patients who are started on ART increased to 50% in FY2012/13 and to 75% in FY2015/16.

Strategies

i. To strengthen coordination between HIV and TB so that more PLHIV with TB are successfully treated
ii. To scale up implementation of the Three I's strategy

Priority Actions

Code	Description of main activities
5.2.2.1	Strengthen the capacity of HIV/TB services delivery
5.2.2.2	Scale up TB/HIV collaborative initiatives
5.2.2.3	Scale up IPT to minimise the incidence of TB among HIV patients.
5.2.2.4	Enhance collaboration of TB and HIV activities in community-level interventions to track defaulters

5.2.3 Anti-Retroviral Therapy (ART)

Situation Analysis

As indicated above, Namibia has made significant strides in the provision of ART since the introduction of the programme in 2003 in the public health sector when the coverage was 3%. To date Namibia offers ART services at 141 facilities and outreach clinics. As of 31 March 2009, 64,637 people were on ART[57] with current coverage levels at 84% (based on CD4 200) and 67% (based on CD4 350). Of the people that were actively receiving ARVs, 57% were adult females, 31% were adult males and 12% were children (0 – 14 years). Coverage for children is nearly 100%, from a baseline of zero in 2003. However these statistics do not include private sector information because no proper systems are in place to regularly capture that sector's data.

[57] *e-PMS results for people on active ART as of March 2009 provide numerator data, while denominator data is provided by the Spectrum estimates in* MOHSS 2009, *Estimates and Projections of the Impact of HIV/AIDS in Namibia, 2008/9*

In terms of PLHIV that are identified and initiated on treatment, MOHSS statistics show that 39% of children 0 to 14 years, and 44% of people 15 years and above, commenced treatment at stage 3 or 4. The majority in both age groups (above 50%) started at earlier stages implying higher chances of treatment success rates.

The NSF plans to increase the coverage of ART for adults from 67% in 2008/09 to over 83% by 2013 and to 95% by 2015/16. Namibia has adjusted the CD4 200 criteria to CD4 350 beginning 2010 in line with the WHO global recommendation. The progress made scaling up ART service provision has to a large extent been facilitated by the mobilisation of resources from international partners such as the GFATM and PEPFAR. The Government of Namibia also increased budgetary allocations for HIV and AIDS and the ART programme in particular.

The country has also noted strengthened partnerships between Government and non-government implementing partners. Whereas treatment is provided within the public health system, home based care and support and issues pertaining to adherence and tracking of defaulters are typically covered by civil society, capitalising on the respective strengths of the different implementing institutions.

The private sector has seen the introduction of new health insurance options. Facilities such as the Health-is-Vital Risk Equalisation Fund and the Namibia Health Plan's Blue Diamond were established to equalise risk amongst medical schemes and to establish schemes for lower income beneficiaries. These schemes offer day-to-day medical aid benefits for the employed yet uninsured workforce, and include out-patient care and hospitalisation services for HIV and AIDS.

The challenge with human resources capacity can be alleviated by allowing task shifting with nurses taking on more responsibilities from the doctors such as screening, diagnosis and prescribing medications to clients**.** Given the increased work load as a result of scale up, there will be need for additional human resources at different levels to provide different services not only for ART but also for associated services. In 2005 the MOHSS adopted the WHO Integrated Management of Adolescent and Adult Illness (IMAI) strategy that enabled nurses to expand their service provision to HIV patients (screening, counselling, and treatment of OIs and, to an extent, managing ART medication for stable patients). Another innovative approach that has been adopted is the clinical mentoring programme amongst doctors whereby experienced clinicians in HIV are assigned to support three to four districts in the provision of care and treatment for HIV. The experienced clinicians occasionally work together with Government HIV clinicians attending to patients, monitoring operations to provide feedback on how operations at clinics may be improved, and also providing long-distance support by discussing client cases[58].

The provision of quality ART in the face of growing patient loads is expected to continue to be a challenge. Some patient groups, for instance adolescents, have unique needs that will have to be addressed. The increasing demand for ART services shall place more pressure on the available human and infrastructure resources in the public sector and greater involvement of the private sector shall be crucial.

[58] I-TECH 2008, *Clinical Mentoring in Namibia, Clinical Mentoring Toolkit*

Early Warning Indicators (EWIs) data abstraction was successfully carried out in 2009 and a comprehensive report was produced. According to the report existing pharmacy and medical records allowed for the collection of two EWIs: ART prescribing practices and loss to follow-up at 12 months. ART prescribing practices followed national and international guidelines for first-line regimens. Loss to follow-up at 12 months met the international suggested target of ≤20% at all but one site. The existing pharmacy and medical record database did not allow for accurate collection of retention on first-line ART at 12 months, on-time ARV medicine pick-up, or ARV medicine-supply continuity. Results generated a national dialogue which resulted in modifications and strengthening of existing national record-keeping systems which will permit analysis of all five selected EWIs in subsequent years. In the future, as the HIV drug-resistance (HIV-DR) evidence base grows and is augmented by data from population-based surveys of transmitted and acquired HIV-DR, care of HIV-infected patients in the country is expected to be further optimized and the emergence of preventable HIV-DR minimized. Currently, monitoring survey for emergence of HIV-DR during ART treatment is being carried out in three sentinel sites. Transmitted HIV-DR survey using the specimen collected during antenatal sero-surveillance is being planned.

The ART strategy therefore entails continued scale-up of the treatment programme in line with the Universal Access goal, while emphasising quality and holistic care for ART patients. With the shift from CD4 200 to 350, the number of people in need of ART will inevitably increase. In addition all TB cases with HIV will be treated with ARVs, while people with HIV/Hepatitis B co-infection will also be eligible for ART in accordance with the WHO guidelines. The NSF also proposes to provide nutrition for adults and children on ART who are malnourished. This will require a policy shift and capacity building for health facilities to provide nutrition. The involvement of PLHIV as expert clients is strategic in scaling up universal access not only to ART but also to prevention involving PLHIV.

The NSF will also explore innovative and sustainable strategies for providing nutrition for adults and children on ART, who are likely to malnourished. Considerations could be given to provide nutrition as part of the prescription and administered in the context of home based care.

Gaps and challenges

i. Currently, about 95% of ART is first line treatment. However, as the numbers of people on ART increase, it is expected that the number of people on second and third line drugs will increase due to treatment failure.

ii. There is an imbalance in terms of men and women accessing ART – of the 64,637 people on ART in public health facilities by 31st March 2009, women comprise 57% are adult females, 31% are adult men and 12% are children (0-14)[59].

iii. Drug resistance – Although the Report of the 2006 Namibia Drug Sensitivity Survey concluded that prevalence of transmitted HIV drug resistance was low in the study group[60], continued efforts are needed to prevent the emergence of drug resistance.

[59] ePMS – *Ministry of Health and Social Services*

[60] MOHSS 2006, *Report of the 2006 Namibia Drug Sensitivity Survey: Although the population study group (young women attending ANC services) was limited to Windhoek, the two hospitals typically record the highest numbers of births per year*

iv. Limited access to private sector information, including numbers of people on ART, treatment regimens, etc - this poses a challenge for patients crossing over from private to public health systems if drug regimens are different. Not all private sector institutions providing ART follow the national guidelines. Additional challenges exist from the national management point of view since the public sector has to eventually absorb patients that crossing over from the private sector. The risk of this happening in tough economic times is even higher as business operations close down and employees are laid off.

v. Namibia is challenged with a capacity short-fall across all cadres of health staff. In the context of ART, shortage of medical officers, laboratory technicians, pharmacists and registered nurses is major concern as the country plans the ART roll-out.

vi. The ART programme faces several operational challenges that include:

- Congested ART clinics that are overwhelmed with patient numbers;
- The above situation affects ability to provide quality services; and
- Delays in commencement of treatment is an issue, with some patients having to wait months before they can start by which time patients may have deteriorated.

vii. Patients' socio-economic needs are not always addressed which could affect the success of the ART programme. In some instances, even when it is identified, the issue is not adequately handled; for instance nutrition is normally addressed as an issue of food insecurity which disregards the clinical aspects of under- and over-nutrition[61]. Nutrition was also identified as a major gap in the Status Report on the MTP-III.

viii. Infrastructure shortfalls: ART clinics require physical space and support services such as pharmacies and laboratories which are not always able to service the patient populations.

ix. Central Medical Stores (CMS) currently faces various operational challenges regarding procurement, storage and distribution of essential medicines and products that are necessary for the ART programme, that includes amongst other issues:

- Insufficient storage capacity – ARVs currently occupy more than a third of storage space at CMS and health facilities;
- Shortages of suitably qualified and skilled pharmaceutical, procurement and other key personnel at all operational levels; and
- Inadequate infrastructure for effective quality surveillance.

x. Issues of adolescents (10 to 19 year olds) living with HIV and AIDS are not adequately addressed, particularly with regards to disclosure, adherence, psycho-social support, and sexual and reproductive health needs.

xi. There is a need to intensify the early identification of infants and children that are exposed to or have HIV, particularly in terms of:

- Accessing children when parents / caregivers are in denial; and
- Managing related complications – OVC, poor nutrition, poor economic circumstances, etc.

xii. Stigma, issues around confidentiality and adequate diagnosis and treatment of opportunistic infections including TB also remain critical challenges.

xiii. M&E: The country is only reporting on ART interventions in the public sector. There are no reporting systems for private sector data for ART, despite the fact that ART has been available through private providers since 1997.

xiv. The need to strengthen research initiatives for ART

xv. Limited availability of human resources (at health facilities and community levels) to support comprehensive ART services may compromise uptake and adherence.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC33:	**More PLHIV survive longer on ART:** % of adults and children (0-14) with HIV still alive at 12 months after the initiation of ART increased for adults from 69% in 2007 to 86% in 2012/13 and to 90% in FY2015/16, and increased for children from 82% in 2007 to 93% in 2012/13 and to 95% by FY2015/16.

Code	Output Result
	ART accessible for eligible PLHIV with CD4 count less than 350
OP57:	% of women eligible for ART who receive ART is increased from 73% in 2009 to 87% in FY2012/13 and to 95% in FY2015/16
OP58:	% of men eligible for ART who receive ART is increased from 55% in 2009 to 83% in FY2012/13 and to 95% in FY2015/16.
OP59:	% of children (age 0-14) eligible for HIV receiving ART is increased from 78% in 2008/09 to 86% in FY 2012/13 and to 95% in FY 2015/16.
OP60:	% of health facilities that offer ART has increased from 17% of facilities and outreach clinics in 2008, to 30% in FY2012/13 and 45% in FY2015/16.
OP61:	% of health facilities dispensing ARVs for ART that experienced a stock-out of at least 1 ARV in the last 12 months has decreased from 14% in 2008 to 6% in FY2012/13 and to 3% in FY2015/16.

Strategies

i. To improve ART coverage as well as the service provision environment including human resource and infrastructure capacities

ii. To encourage adherence to treatment schedules to minimise defaulters and drug resistance over time

iii. To enhance quality of care by managing treatment standards

iv. To strengthen linkages across key response areas for treatment care and support, particularly referral to the ART programme and the management of OIs

v. To develop more reliable monitoring and tracking systems for ART patient management

vi. To strengthen the pharmaceutical supply system throughout all the levels of the supply chain.

Priority Actions

Code	Description of main activities
	To improve ART coverage as well as the service provision environment
5.2.3.1	Strengthen and improve human resource capacity in ART service delivery
5.2.3.2	Scale up provision of ART to remaining health facilities
5.2.3.3	Strengthen provision of paediatric ART
	To encourage adherence to schedules to minimise defaulters and drug resistance
5.2.3.4	Implement ART treatment literacy activities
5.2.3.5	Adopt a cohort system within ART clinics
5.2.3.6	Strengthen monitoring of HIV Drug Resistance in accordance with WHO recommendations
	To enhance quality of care by managing treatment standards
5.2.3.7	Ensure compliance of quality of care standards as provided in ART national guidelines, for instance by establishing clinical quality improvement programmes at all health facilities offering HIV care
5.2.3.8	Standardise and offer a comprehensive care package to ART patients including children
	To strengthen linkages across key response areas
5.2.3.9	Develop a collaboration framework with private sector and civil society organisations to provide the necessary support services
	To develop more reliable monitoring and tracking systems for ART patient management
5.2.3.10	Strengthen a comprehensive ART monitoring system
	To strengthen the pharmaceutical supply system throughout all the levels of the supply chain
5.2.3.11	Upgrade CMS infrastructure and health facilities' pharmaceutical stores in response to the increased coverage of ART service provision
5.2.3.12	Strengthen ART procurement and supply management chain

5.2.4 Care and Support

Situation Analysis

A key component of Community Based Health Care is the provision of Community Home Based Care (CHBC) which is offered as part of a continuum of care for chronically and terminally ill clients and their families, and includes people infected and affected by HIV and AIDS. The provision of care and support is in alignment with the National HIV Policy which requires that all patients be provided with adequate and effective palliative care at all times. CHBC entails the provision of care and support, in collaboration with CHBC providers, at the client's home and includes the family's involvement as a component of care. The CHBC package encompasses clinical care, nursing care, counselling and psycho-spiritual care and social support.

The nature of community CHBC service provision has evolved to match the changing needs of patients, particularly in terms of HIV and AIDS. The considerable scale-up of the ART programme has resulted in the requirement for new and additional forms of support from CHBC providers, for instance, support

with respect to HIV prevention, adherence and treatment literacy, as opposed to predominantly requiring palliative and traditional CHBC. The adoption of comprehensive health service delivery strategies at community level (for instance, offering reproductive health services that target a common age group and client profile) have also led to more services being included under the CHBC service package.

These developments are recognised and reflected in the CHBC Policy and National Community Home-Based Care Standards which comprise four key aspects: Preventative Care and Health Promotion; Home Nursing and Treatment Adherence; Emotional, Psychological and Spiritual Care; and Social Legal and Household Livelihood Support. Specific services that are provided as part of CHBC include the following: palliative care, nursing care, clinical care, counselling and psycho-social support. Components of CHBC that specifically relate to HIV and AIDS include treatment adherence and treatment literacy for people on ART, reproductive health as part of the double intervention strategy, nutritional support for people on treatment, and referrals to VCT, TB and ART service providers, amongst others.

CHBC in Namibia is provided by various institutions that include MOHSS, Faith-Based Organisations (FBOs), NGOs and CBOs. The services range from coordination, capacity enhancement, implementation of specific activities to monitoring and evaluation. The potential for civil society organisations to provide comprehensive home based care and support has been compromised by lack of capacity and resources. Many of them have no basic training in health care or social work. Extensive training will be required for CHBC service providers coupled with regular supervision by qualified health workers such as community health nurses or social workers. CHBC outreach services by MOHSS have been compromised by inadequate human resources.

As of 2006, CHBC providers had reached 39,330 PLHIV, reportedly covering 69% of the people eligible for ART and other terminal ill patients. The provision of CHBC services has however not been provided in a standardised manner due to the various training programmes offered by different implementers, and in some instances, due to the lack of funding to train new CHBC providers as well as incentive packages. However, efforts are underway to standardise CHBC training.

Support groups for PLHIV have also proved to be an effective strategy for enhanced care and support. According to a recent survey on HIV and AIDS and treatment literacy[62], members of support groups are generally better informed on HIV and AIDS and are better at adhering to ART, as well as following other positive living strategies. HIV and AIDS support groups are self-help groups that provide emotional, psychological, and even physical support to one another. Current training that is offered for HIV and AIDS support group members includes positive living (addressing dietary and safe health practices that improve quality of life including exercising, psychological wellbeing, effects of alcohol and smoking), nutrition, human rights, income generation and positive speaking amongst others. The coverage of support groups is however not equitably spread across the country which limits the positive effects on the ART programme. The NSF will support strengthening collaboration and building linkages between support groups with CHBC.

[61] MOHSS 2008, *Nutrition in HIV Care in Namibia: A Needs Assessment*
[62] Steinitz L, van Zyl D, Goercke B. & Wolmarans L, 2009, *HIV and AIDS Treatment Literacy Survey 2008: Main Report*. Windhoek: Positive Vibes, p.4

The Care and Support intervention in this NSF therefore aims to scale up the provision of quality care and support services in support of the Pre-ART and ART programmes, and in a manner that is equitable across all regions of the country. The National Policy on Community-Based Health Care is only referred to for guidance and therefore CHBC interventions are to include interventions within and beyond the health system. In keeping with the National HIV and AIDS Policy, palliative care shall continue to be emphasised, particularly with regards to pain management, as well as clinical, psychological, spiritual, social and prevention services. Nutritional support for clinically malnourished PLHIV and other eligible clients (for example PMTCT mothers and OVC) shall also be prioritised in recognition of the economic challenges faced in several areas where HIV is also prevalent.

Gaps and Challenges

i. Poor coordination between health facilities and civil society organisations providing CHBC – while the National CHBC Standards states that "*it shall be the responsibility of the MOHSS at all levels to register and coordinate the activities of all organisations providing community CHBC services in the country*"[63], there are no clear operational modalities that define how the non-health stakeholders are to interact with the Ministry. The involvement of civil society organisations (who comprise a significant percentage of CHBC service providers) at national level in coordination and advocacy is limited.

ii. Uncoordinated allocation of CHBC providers: CHBC services are not equitably provided across the country's different geographical areas due to inadequate mapping of CHBC services and service providers.

iii. Inadequately skilled and experienced human resources in civil society organisations and MOHSS providing CHBC.

iv. Inadequate quality assurance in CHBC: CHBC services are currently provided by both "trained and untrained providers"[64] which can compromise the quality of service delivery. Some service providers such as National Red Cross Society have noted that as few as 20% of the CHBC volunteers providing CHBC and working with OVC have had quality assured training[65].

v. Non-standardisation of monetary incentives for CHBC providers among implementing organisations: In the recent past, CHBC services have been provided by both paid and unpaid (volunteers). The provision of CHBC services without compensation needs to be addressed as this has the tendency to impact on the quality of service delivery. However, even where CHBC providers are paid, the payment packages are inconsistent. This has led to CHBC providers dropping-out or moving to other NGOs[66] and that has further contributed towards the "service gaps" in some geographic areas where payments and incentives are low.

vi. Inadequate management and monitoring of the CHBC kits. Some services providers have experienced stock-outs, and in some instances some contents were found to have expired.

[63] MOHSS 2008, *National Policy on Community Based Health Care, p.23*
[64] MOHSS final draft 2008, *National Community Home Based Care Standards, p.1 and 11*
[65] Ashby A., 2008, *Namibia Red Cross Society: Mid-term Evaluation of Community Based Health and Care Programme*
[66] Ashby A., 2008, *Catholic AIDS Action: Mid Term Evaluation of the CAA Programmes in Community and Home Based Care, Orphans and Vulnerable Children, Youth, Education and Prevention*

vii. Social and economic challenges that affect the success of HIV and AIDS interventions, particularly those relating to stigma and nutrition. High poverty levels affect the personal circumstances of PLHIV including their ability to access the necessary nutrition required to keep a person healthy, particularly those on ART.

viii. Some NGOs and CBOs operate independently and do not conform to regional structures, and in some regions CHBC Forums are inactive or non-operational.

ix. Poor collaboration between regional health directorates and their respective regional councils at regional level with regards to coordination of CHBC services.

x. A functioning referral system.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC34:	**More PLHIV are cared for in their communities:** % of households with terminally ill / life limiting (vulnerable persons) and their families, who have reported that they have received CHBC services in the past 12 months increased by 20% in FY2012/13 and by 50% in FY2015/16

Code	Output Result
	CHBC for all PLHIV households
OP62:	% of male and female adult PLHIV who are clinically malnourished and who received therapeutic or supplementary food increased from 25% in 2008 to 40% in FY2012/13 to 55% in FY2015/16.
OP63:	% men and women 18-59 yrs, who have been either very sick or who died within the past 12 months after being very sick, whose households received at least one type of free basic external support in the past 30 days increased from 16% in 2007 to 30% in FY2012/13 and to 55% in FY2015/16.
OP64:	% of PLHIV with known status enrolled in PLHIV support groups in the last 12 months has increased to 50% in FY2012/13 and to 61% in FY2015/16.
OP65:	Ratio of number of vulnerable households to number of active CHBC volunteers has decreased from 15:1 in 2007 (9,615 volunteers) to 13:1 in FY2012/13 (10,235 volunteers) and to 10:1 in FY2015/16. (11,835 volunteers).

Strategy

To improve coordination and harmonisation of the service delivery of Community Home Based / Palliative Care.

Priority Actions

Code	Description of main activities
5.2.4.1	Strengthen CHBC operations at community level
5.2.4.2	Finalise and implement the Community Home Based Care (CHBC) Standards. *[e.g. coordination, M&E, human resource capacity, CHBC supplies etc]*
5.2.4.3	Standardise training for CHBC providers
5.2.4.4	Strengthen the capacity for providing quality palliative care interventions
5.2.4.5	Strengthen community capacity for monitoring and reporting on CHBC activities as per National CHBC Standards

5.3 HIV Impact Mitigation

5.3.0 Overview

The priority and strategic focus of impact mitigation response is two-fold. Firstly, ***to reduce the number of vulnerable households*** and secondly, where vulnerability exists ***to strengthen and improve the coping mechanisms for individuals and households affected by the*** impacts of HIV and AIDS. To achieve these, the NSF has aligned its impact mitigation strategies and results to key strategic frameworks including NDP3, Poverty Reduction Strategy, National HIV and AIDS Policy and with specific programme frameworks such as the National OVC policy (2004), National Plan of Action for OVC 2006-2010, and the Education Sector Policy for OVC (2008).

These will be achieved through the implementation of the following priority programmes:

i. Vulnerable Households and Sustainable Livelihoods
ii. Care and Support for OVC
iii. Legal Rights and Protection Services for Vulnerable Persons. These will include interventions that address gender based violence, succession issues, and child protection.
iv. Food Security and Nutrition for Households with Vulnerable Persons

The programmes will be implemented within the context of a Social Protection Framework which aims to reduce the vulnerability and risks faced by poor people and disadvantaged social groups who are unable to earn their own livelihoods, through both economic and non-economic approaches. Social protection measures can include income transfers, school feeding programmes, vocational skills training, livelihoods training, early childhood development interventions and micro credit to name a few[67]. These strategies are potentially overlapping, and allow for interaction.

Programmatic responses within this framework enhance social transformation and equity, and address empowerment and economic, social and cultural rights, discrimination and exclusion among the most vulnerable groups. Thus social protection is about limiting fluctuations in welfare, mitigating the impact on HIV and AIDS, and addressing structural 'stresses' that are associated with chronic poverty.

[67] UNICEF 2008, *Social Protection in Eastern and Southern Africa: A Framework and Strategy for UNICEF*

Applied to a Namibian context, a Social Protection Framework would facilitate the achievement of cross-sectoral social development outcomes by providing the high level strategic coordination framework necessary to respond to overlapping impact mitigation strategies and responses. The Ministry of Gender Equality and Child Welfare (MGECW) may play a critical role in coordinating the OVC response and in meeting the social welfare rights of vulnerable children, but the framework would facilitate achievement of overlapping and cross-sectoral accountabilities. For example the overlapping efforts of the MGECW and the Ministry of Education to ensure all children attend school, and the overlapping efforts of the MGECW and the MOHSS in ensuring all children access critical health care would be coordinated through a social protection framework, versus a vertical social welfare response.

The most affected people by HIV and AIDS are women and children and the poor who live among the vulnerable households. They are often considered to be in the lowest wealth quintile. According to the NDHS 2006/7, 33% of the population are in this category. Gender inequality is among the contributing factors to vulnerability associated with HIV and AIDS. The root cause of gender inequality is predominantly due to women's low status in society. At the household level, the UN Common Country Assessment identified cultural perceptions regarding the role and status of women and cultural and traditional practices that result in their impoverishment and economic dependency[68]. Also violence and the threat of violence can increase vulnerability to HIV by making it difficult or impossible to set the terms of sexual relationships on the part of women.[69] Gender based violence discourages women getting tested for HIV, from publically sharing their HIV status, following preventive measures, and receiving treatment, care, and support services.

The implementation of impact mitigation interventions will require well coordinated multisectoral strategies involving all stakeholders at all levels of the response. This is necessary to ensure adequate and equitable coverage of services. Effective coordination will also ensure gender and human rights mainstreaming in the response. Gender related interventions will be guided by the National Gender Policy and aligned to National Gender Plan of Action. The Plan of Action will articulate strategic interventions to address gender based violence.

PLHIV, OVC, the elderly, women and girls, and the urban poor are among the main vulnerable groups. By 2008/9, Namibia had approximately 174,000 PLHIV[70]. Most are afraid of disclosing their HIV status due to fear of being stigmatised and discriminated or of gender based violence. The latest estimate of the number of OVC is approximately 250,000[71] as a result of a variety of causes including AIDS. OVCs are entitled to their basic rights and protection including education, health and social care and support, protection from abuse and neglect and nutrition. There are approximately 108,819 elderly people over the age of 60[72]. The elderly have increasingly taken over the burden of providing care and support to OVC as their parents succumb to AIDS, or AIDS related deaths. The burden of care place on them is enormous with increasing financial pressure on the old age grants, access to pension (where applicable), psychological trauma, emotional stress, and worsening health conditions.

[68] UN Namibia 2004, *Common Country Assessment – the Situational Analysis*
[69] UNFPA Project Namibia*: Gender Based Violence and HIV*
[70] MOHSS 2009, *Estimates and Projections of the Impact of HIV/AIDS in Namibia, 2008/9*
[71] MGECW 2008, *National Plan of Action 2006 to 2010 for OVC: Annual Progress Report 2007/8*
[72] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*

The increase in households that are affected by HIV and AIDS, poverty, lack of livelihoods and gender inequality has destabilised traditional livelihood systems and stretched community safety nets. Thirty five percent (35%) of the population in Namibia live on US$1 per day while only 56% have US$2 to spend every day[73]. The care of OVC and PLHIV remain the greatest challenge for vulnerable households as they struggle to obtain basic needs including food, shelter, education, clothing, social-protection, access to health care, and sanitation. Furthermore, households have to deal with psychological and mental trauma with issues such as loss of loved ones, gender based violence, and physical, emotional, and sexual abuse.

Impact Mitigation Impact level results

The priority programmes should achieve the following impact level results:

i. % of poor households has decreased from 28% in 2003/4 to 20% in FY 2015/ 2016

ii. % of households with vulnerable individual/s[74] that are able to cope with the impact of HIV[75] has increased to 50% by FY2015/16[76].

5.3.1 Vulnerable Households and Sustainable Livelihoods

Situation Analysis

The NSF's strategic approach to vulnerability is to focus on vulnerable ***households*** rather than the individual persons. This approach has several advantages. Firstly, in most cases, vulnerable individuals live in vulnerable households and hence addressing the needs of an individual does not solve the bigger problem of collective vulnerability within the household. Secondly, it enables the response to remove labels that are seen to be discriminatory and inappropriate such as OVC. OVC themselves do not like to be referred to as "OVC" but would rather be known as children.

The key social-economic drivers that cause households to be vulnerable are poverty, lack of food and nutrition, low levels of education, inequality in households and the presence of OVCs, PLHIV and other chronically ill patients. The World Food Programme Community Household Surveillance monitoring system in six (6) SADC countries indicated that the presence of orphans was a common trait of vulnerability followed by asset poor and female-headed households[77].

Poverty is identified as the over-arching cause of vulnerability as found in the NPC review[78]. Firstly, there is a consumption expenditure that is positively correlated with the education level of households. The higher the level of education, the higher the levels of consumption expenditure and the more likely

[73] *Cited just above*
[74] *These individuals include OVC, PLHIV, and the elderly*
[75] *"able to cope" is defined by a composite measure asked in a survey, where vulnerable persons are asked about a number of aspects of their lives to determine whether they can cope with the impact of HIV*
[76] *The number of households, calculated from: CBS/NPC 2008 Review of poverty and inequality in Namibia*
[77] SADC 2006*, State of Food Insecurity and Vulnerability in South Africa*
[78] CBS/NPC 2008*, Review of Poverty and Inequality in Namibia*

the household is to be classified as a non poor household, holding other factors constant. Two poverty lines are established for "poor" and "severely poor" where household consumption levels per adult equivalent are lower than N$262.45 (27.6% of households) and N$184.56, (13.8% of households) respectively. Among those with no formal education, 50% are poor and 26.7% are severely poor. On average, these households have total consumption expenditure levels that are 17.2% below the national threshold for poor households. Next, poverty affects the purchasing power to buy the necessary food and nutrition required for the household. Among the 20% of households with the lowest consumption expenditure (quintile I), 56.7% of total expenditure is devoted to food compared to just 13.2% in the 20% of households with the highest consumption expenditure (quintile V). Also, the incidence of poverty among households where there is at least one orphan is 41.8% which is well above the national average of 27.6%, and 9.4% in households without any children aged 0-17. Lastly, poverty provides constraints to manage HIV and AIDS including the ability to afford treatment, adhere to treatment, and avoid risky behaviour such as transactional sex. Disasters or emergency situations increase the vulnerability of the poor, overstretching their coping capacities, deepening their poverty and preventing them from taking advantage of economic opportunities.[79]

The NDHS 2006/7 reported that female-headed households increased from 31% in 1992 to 44% in 2006/7. Gender inequality and patriarchy creates major disadvantages for female-headed households that include gender-based violence, women's lack of access to social and economic resources, and poverty. For example, income levels of female headed households in rural areas are only half of their male counterparts.[80] In addition, fewer women are found in industries such as construction (which comprises only 7% of women) and transport, storage, and communication which make up merely 20% of women in the workforce[81]. An area of concern is the emerging child-headed households. However there is limited empirical data on the current number and status of child-headed households.

As the epidemic unfolds, more people succumb to AIDS, and more often than not they have lost their ability to earn a decent living. It is evident that HIV and AIDS have largely contributed to the deterioration of human development as mirrored in a worsening human poverty in Namibia[82]. By 2005, the Namibian Human Poverty Index stood at 26.5%. The index measures deprivations in the three basic dimensions captured in the human development index (i.e. a long a healthy life as measured in life expectancy, knowledge as measured in adult literacy and a decent standard of living[83]). Improvements in these areas constitute the core strategy for developing sustainable alternative livelihoods which many of the households lack.

Over the years, the response to most vulnerable households and in particular those affected by HIV and AIDS has been a welfare approach that has sustained dependency on external basic support. Such support has targeted individuals for support, primarily PLHIV and OVC, rather than the entire affected household. The strategy has not been able to effectively transform the lives of the people affected. Consequently, the key shift in the NSF strategy is the need to move beyond welfare material and cash handouts, and to

[79] GRN 2009, *Namibia National Disaster Risk Management Policy*
[80] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*
[81] GRN 2009, *Namibia National Disaster Risk Management Policy*
[82] UNDP 2007, *Trends in Human Development and Human Poverty in Namibia: background paper to the Namibian Human Development Report, 2007*
[83] UNDP 2008, *Human Development Report (Global) 2007/08*

empower households to better cope with impacts of HIV and AIDS as opposed to only supporting the vulnerable individual. Empowering vulnerable households to move towards self-reliance is also a priority strategy for Namibia Poverty Reduction Strategy and Action Plan.

Livelihoods improvement projects that have worked elsewhere include organised community revolving micro credit schemes, backyard and community gardens, small livestock and poultry initiatives and other income generating activities. These activities can be carried out both at household or community level. They are complemented by broader interventions that include improved community sanitation, access to clean and safe water, and legal and social protection. Furthermore, there is a greater need to increase the number and coverage of individuals and communities trained in agricultural techniques and accessing labour saving devices that contribute to greater self reliance and sustainability.

Gaps and Challenges

i. Lack of a common vulnerability framework focusing on household level;
ii. Existing interventions are fragmented, largely un-coordinated, and under resourced;
iii. The focus of interventions is more on key vulnerable individuals such as OVC or PLHIV rather than the "vulnerable households";
iv. Lack of coordination and collaboration among service providers who provide sustainable livelihood initiatives;
v. Inadequate technical expertise and business management skills to effectively implement sustainable livelihood programmes;
vi. Ineffective and unsustainable income generating programmes;
vii. Inadequate coverage and reach of sustainable livelihood programmes in rural areas.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and subsequently will contribute to the impact results.

Code	Outcome Result
OC35:	**More vulnerable[84] households can economically cope with the impact of HIV**: % of persons living below the poverty datum line reduced from 35% in 2003/4 to 28% by FY2012/13 and to 20% by FY2015/16.

[84] 'Vulnerable households' defined as households with the elderly, OVC and PLHIV

Code	Output Result
	Support for vulnerable households and sustainable livelihoods
OP66:	% of vulnerable households reached with sustained support programmes in the past 12 months has increased to 45% in FY2012/13 and to 65% in FY2015/16. [disaggregate data by type of vulnerable household, including child headed households]
OP67:	% of vulnerable households trained in self sufficiency and livelihood techniques has increased to 20% in FY2012/13 and to 45% in FY2015/16.
OP68:	% of women aged 60+ who have received an old age grant in the past 12 months has increased to 70% in FY2012/13 and 80% in FY2015/16.
OP69:	% of men aged 60+ who have received an old age grant in the past 12 months has increased to 70% in FY2012/13 and 80% in FY2015/16.

Strategies

i. To strengthen the capacity of members of vulnerable households so that they are able to cope with the impacts of HIV and AIDS.

ii. To reduce household level poverty and increase household income so that more households can better cope with the impact of HIV.

Priority Actions

Code	Description of main activities
5.3.1.1	Develop a national framework for vulnerability reduction. [*Framework to include factors that also contribute to vulnerability, take into account gender dimensions of vulnerability in particular in child and women headed households*].
5.3.1.2	Establish a national mechanism for monitoring and coordinating responses related or contribute to HIV and AIDS Impact mitigation interventions
5.3.1.3	Strengthen the capacity for vulnerable households to cope with the impacts of HIV and AIDS
5.3.1.4	Strengthen community capacity to plan, implement and monitor sustainable livelihoods
5.3.1.5	Provide elderly grants
5.3.1.6	Strengthen national capacity for coordination and implementation of sustainable livelihood programmes

5.3.2 Care and Support for OVC

Situation Analysis

Orphans and vulnerable children (OVC) are the most visible impact of HIV and AIDS. Approximately 250,000 children under the age of 18 are considered OVC representing 28.2% of all children in Namibia. 155,000 are orphans and 95,000 are vulnerable children[85]. The proportion of OVC increases with age from 15% among children 2 years to 40% of children aged 15-17 years. The proportion of OVC is highest (34%) in the poorest wealth quintile. 54.6% of the OVC do not live with all their siblings as they

[85] MGECW 2008, *National Plan of Action 2006 to 2010 for OVC: Annual Progress Report 2007/08*

are separated to distribute the burden of care when a head of household dies. OVC may experience serial bereavements and multiple movement from household to household that increases their vulnerability and emotional stress.

Approximately 1,008 children are placed in child care facilities because they need a place of safety and for alternative care. The mushrooming of residential child care facilities that are not registered with the Ministry of Gender Equality and Child Welfare (MGECW) is a matter of concern. In some instances the quality of care has been compromised and abuse of vulnerable children cannot be effectively monitored and controlled.

According to the 2001 Census, only 32% of children between the ages of 3 and 6 were enrolled in some form of Early Childhood Development (ECD) programme. ECD provides strong foundations and basic skills in literacy and numeracy, reduces the drop out and repetition rates in schools, and creates a nurturing and supportive environment for young OVC. OVC are at greater risk of dropping out of school for many reasons including inability to pay school fees (although the policy exempt OVC from paying school fees), the need to help with household work or to provide care to sick parents or relatives, among others. 94.6% of OVC were attending primary schools compared to 93.2% of non-OVC (MOHSS 2008[86]). In the 2007 Education Management Information System (EMIS) data, there is a significant school drop-out at secondary school level. Secondary school enrolment is only 52.6% for OVCs for ages between 15-19, 25,880 female and 25,401 male OVC enrolled to school.[87] It will need a renewed focus to ensure that OVC are retained in, and complete their secondary education. The National Plan of Action for OVC should put in place strategies that ensure that OVC have priority access to child-friendly hostels regardless of their ability to pay hostel fees. The hostels should become places of security for OVC manned by trained staff who understand and address OVC needs.

With 47.4%[88] of OVC not enrolled at secondary school, there is a gap to provide economic and social support to empower out-of-school OVC. Anecdotal evidence suggests very few interventions or programmes are targeted for out-of-school OVC. HIV based life skill programmes should expand and reach out to out-of-school youths and OVC. The establishments of "community youth clubs" is an effective medium to bring out-of-school OVC together to sensitise and inform youths about HIV. In addition, out-of-school trainers need to be mobilised and capacitated to work with out of school youth to implement these specific programmes. Out-of-school youth should also be supported to start their own income generating activities and be given scholarship to pursue further skills or academic training. Life skills-based HIV education should also be extended to out of school youth.

Some evidence has shown that increasing the years of education for children, especially girls, will provide a stronger coping mechanism against the impact of HIV and AIDS. Research shows that increased years of education results in the delayed sexual debut for girls and increased use of condoms by boys. Studies from 51 countries show that each year of schooling increases wages by 9.7% on average[89]. However,

[86] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*
[87] EMIS, Ministry of Education, *2007 Education Statistics*
[88] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*
[89] Adato M, Bassett l., 2008, *What is the potential of Cash Transfer to strengthen Families Affected by HIV and AIDS: A review of evidence on impact of key Policy debates*.

school enrolment is not in itself sufficient to mitigate the short and medium term impacts. Significant results can only be achieved if children are retained in schools for the duration of their primary and secondary education. In addition to education, OVC are also empowered through life skills-based HIV education, provision of psychosocial support, legal and social protection especially from sexual abuse and economic exploitation.

Given their social and economic status, teenage OVCs tend to be at greater risk of early sexual debut than non OVC partly due to lack of parental guidance. 10% of OVC reported having had sex before the age of 15 (NDHS 2006/7) compared to 7.1% of non OVC. These statistics illustrate the need for effective family care of OVC. Children and guardians need to have greater awareness of health care practices and HIV and AIDS and be equipped with skills to make informed decision about their sexuality.

Women and children, particularly OVC, are more vulnerable to abuse and violence compared to their male counterparts. More than 1,100 rapes and attempted rapes are reported to the Namibian police each year and more than 1/3 of those rape victims are children under the age of 18 years[90]. Even with these high statistics, evidence suggests that child rape is rarely reported due to children fearing blame and guilt for the situation. One study found that 25% of respondents aged between 10 and 14 years, and 15% aged 10 and 15 years experienced different forms of sexual abuse[91].

The "sugar daddy" phenomenon, where older men have relations with young girls including school girls in return for material favours, is well known in Namibia.[92] This mentality attributes to transactional sex which is an epidemic driver of HIV. A study on the economics of sex work[93] shows that most sex workers interviewed entered into this trade before the age of 16 years and others began sex work when they became orphans.

Emerging evidence provides that forms of exploitative child labour are becoming a concern. Children are working illegally in unsuitable conditions but it is quite challenging to identify appropriate and inappropriate work especially in households that require income generation. There is also indication that small numbers of children are being trafficked within Namibia, and into Namibia from Angola, Zambia, for domestic work, child mining, and agricultural work, charcoal production, and in rare cases commercial sex work.[94]

The link of poverty, violence and abuse are factors that cause children to end up on the streets. Most of these children are involved in criminal activities and end up in the criminal justice system[95] being treated as adults in the absence of a law that can deal with them proportionally. They are also stigmatised as criminals and some service providers do not realize their vulnerability as they are also in need of care. Some of these service providers also have a retributive mind-set and do not value re-integration and diversion options. Most crimes committed by juveniles are economic related. Some of the children are coerced into crime by older children or adults.

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[90] MGECW 2008, *National Plan of Action 2006 to 2010 for OVC: Annual Progress Report 2007/08*
[91] UNICEF 2006, *HIV and AIDS Knowledge, Attitudes, Practices and Behaviour (KAPB) study in Namibia*
[92] Iipinge E., & LeBeau D., 2005, *Beyond Inequalities 2005: Women in Namibia*
[93] LeBeau D., 2007, *Economics of Sex work : Implications for sex workers HIV risk taking and legal alternatives for Namibia, in Unravelling Taboos: Gender and Sexuality in Namibia, 2007, LAC*
[94] MGECW 2006, *National Plan of Action 2006 to 2010 for OVC*
[95] *Information is based on interviews with officials working with OVC from MGECW*

To provide quality and comprehensive care, families taking care of OVC need external support in terms of economic, material and psychosocial support, in addition to provisions for education and medical care. OVC and their caregivers have access to assistance in the form of welfare grants. In 2006, 16.5% of OVC households received at least one type of support (medical, emotional, social / material, and school related support)[96]. 11.4% of the OVC received social/material support and 4.1% received education related assistance[97]. Namibia is among the few countries in the region that provide OVC grants. The grants are used to support OVC to meet their basic needs in addition to education support. In 2009, cash transfers were made to provide financial support for 104,438 OVC[98].

Forty one percent (41%) of OVC were reported to have three basic needs met (shoes, clothes, and a blanket)[99]. According to the NDHS 2006/7, 33% of children are not registered at birth which denies children access to child welfare grants, medical services, and other exemptions. The registration of a parent's death is important as well for eligibility of benefits and services to OVC. OVC face tremendous stress and trauma from parental illnesses and death, feeling of helplessness to economically support the household, continuous movements to different households, child abuse, stigma and discrimination and other factors with being affected and/or infected by HIV and AIDS. Psychosocial services must be scaled up so that all children have support and guidance in meeting their social, spiritual, and emotional needs to ensure their holistic development.

Namibia is making significant progress towards addressing OVC's needs and challenges. The response is guided and informed by the National Plan of Action 2006-2010. The multi-sectoral OVC Permanent Task Force was established by Cabinet in May 2001, has advised, co-ordinated, and monitored the implementation of the National Plan of Action with the MGECW being the lead agency. The plan has identified the following five priority areas for action:

- Rights and protection
- Education
- Care and support
- Health and nutrition
- Management and networking.

The Ministry of Education has introduced the Education Sector Policy for Orphans and Vulnerable Children and collects information and data for OVC through its Education Management Information System (EMIS). Fifteen (50) Women and Child Protection Units have been established country wide[100]. Traditional leaders and communities have been sensitised on children protection issues, and the Child Care and Protection bill has been updated but is yet to be adopted. Between October 2007 and March 2008, over 1,879 children benefited from protection services provided by a wide range of stakeholders. The OVC Policy and Planning Efforts Index improved from 73 in 2004 to 76 in 2007, indicating the effectiveness of the programme.

[96] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*
[97] *Cited just above*
[98] MGECW *Datawarehouse 2009*
[99] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*
[100] MGECW 2008, *National Plan of Action Annual Progress Report and Monitoring Report 1st 2007/08*

Gaps and Challenges for OVC

i. Approximately 59% of OVC do not possess all three basic needs (pair of shoes, set of clothes, and blanket)[101].
ii. 83.5% of OVC households were not receiving free basic external support for caring for a child[102].
iii. Accessing services such as child protection, protection of basic rights and social welfare services remain problematic.
iv. Not all schools have the capacity to provide life skills-based HIV education. Life skills-based HIV education is currently not an examinable subject.
v. Limited psychosocial support for OVC. Few schools have psychologists or adequately trained counsellors to provide psychosocial support.
vi. Lack of interventions and programmes targeting out-of-school OVC.
vii. Not all OVC have been identified and issued with a birth registration certificate to access and utilise available services.
viii. Limited understanding and awareness of the obligations of community based service providers, line ministries and NGOs to provide services.
ix. Limited capacity in terms of staffing, skills and resources in providing OVC services.
x. Limited awareness of OVC and their caregivers, as rights holders, to demand and access services.
xi. Inadequate monitoring and evaluation systems for OVC interventions.
xii. Inadequate reporting by services providers on services being provided to OVC.
xiii. Lack of succession planning by PLHIV and elderly foster parents and guardians.
xiv. The Education Act does not provide for exemption of school development funds and hostel fees for children unable to pay including OVC. Harmonisation of the Education Act and the Education Sector Policy for OVC will be necessary.
xv. Inadequate scholarships for OVC in secondary and vocational training institutions.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

[101] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*
[102] *Cited just above*

Code	Outcome Result
OC36:	**More OVC receive free external basic support:** % of OVC aged 0-17 whose households received any free external support (medical, education, emotional, social and materials) in the past 12 months to care for the child increased from 16% in 2007 to 30% in FY2012/13 and to 45 % in FY2015/16.
OC37:	**More OVC possess basic needs**: % of OVC aged 5-17 possessing three minimum basic material needs increased from 41% in 2008 to 60% in FY2012/13 and to 75% in FY2015/16
OC38:	**More women have made succession plans for their children to be cared for if they are unable to do so**: % of women who have made succession plans has increased from 48% in 2007 to 65% in 2012/13 and to 75% in 2015/16
OC39:	**OVC Programme increases in effectiveness:** OVC Policy and Planning Efforts Index increased from 76 in 2007 to 86 FY2012/13 and to 89 in FY2015/1

Code	Output Result
	Comprehensive care and support for OVC
OP70:	% of health facilities (hospitals) offering birth registration services has increased from 0% in 2004 to 40% in FY2012/13 and 80% in FY2015/16
OP71:	% of children under five who had a birth certificate has increased from 60% in 2007 to 75% in FY2012/13 and to 85% in FY2015/16
OP72:	Number of OVC receiving psychosocial support services, economic strengthening, shelter, care and support increased to 20% of registered OVC by FY2012/13 and to 55% in FY2015/16
OP73:	Number of children receiving social welfare grants increased from 41,000 in 2006 to 131,000 in FY2012/13 and to 160,000 in FY2015/16
OP74:	% of OVC aged 10-14 attending school increased from 94.6% in 2007 to 100% in FY2012/13 and maintained at 100% in FY2015/16
OP75:	% of OVC completed grade 10 and grade 12 maintained at the rate of non-orphans in 2012/13 and in FY2015/16
OP76:	% of children attending ECD programme increased from 32% in 2001 to 50% in 2012/13 and by 75% in 2015/16
OP77:	% of annual planned activities in the National Plan of Action 2011 to 2015/16 for OVC implemented and reports submitted to MGECW
OP78:	Number of policies and bills drafted, promulgated, enacted, and implemented related to the protection of OVC

Strategy: To provide comprehensive and quality care and support for OVC and in particular ensuring equitable access to emotional, social/material, and school related support.

Priority Actions

Code	Description of main activities
5.3.2.1	Review and develop a successor for the National Plan of Action for OVC to run up to 2015/16
5.3.2.2	Mainstream gender in out-of-school OVC programme planning
5.3.2.3	Accelerate the registration of births and deaths for OVC
5.3.2.4	Ensure that OVC and their caregivers can obtain national documents to facilitate access to state assistance in a timely manner

5.3.2.5	Update and decentralise the national OVC database
5.3.2.6	Identify and assess basic material needs for OVC
5.3.2.7	Strengthen coordination and management of OVC and social welfare grants
5.3.2.8	Ensure OVC attend school
5.3.2.9	Accelerate the enactment, promulgation and implementation of the Child Care and Protection (CCP) Bill and the Child Justice Bill
5.3.2.10	Advocate for the acceleration for the domestication of the CRC and CEDAW
5.3.2.11	Expand and increase the capacity of Early Childhood Development (ECD) programmes
5.3.2.12	Identify and assess OVC who require external support
5.3.2.13	Capacitate women and men in succession planning
5.3.2.14	Develop a comprehensive social protection system
5.3.2.16	Mobilise and engage local authorities and elected leaders to play a greater role in the care and support of OVC at community levels
5.3.2.17	Strengthen human resources (adequacy and competencies) to support comprehensive OVC services provision
5.3.2.18	Develop and implement a Vocational Training Programme for out of school OVC
5.3.2.19	Strengthen the capacity of shelters and community hostels to cater for more OVC in need of care and support
	Strengthen the capacity of OVC care facilities

5.3.3 Legal Rights and Protection Services for Vulnerable Persons

Situation Analysis

The Constitution of Namibia guarantees basic human rights including equal legal and protection services for all people including those infected and affected by the epidemic, vulnerable and marginalised groups. The enjoyment of the basic rights by "rights holders" is dependent on the existence of an enabling legal and policy environment that enables "duty bearers" to provide the appropriate services. It is also dependent on awareness of basic rights and how to access them.

The government has initiated a number of strategies to ensure that all people enjoy basic human rights including not being stigmatised or discriminated due to HIV and AIDS. The strategies include developing an enabling legal, ethical, and social environment and creating multi-sectoral polices for HIV and AIDS such as the 2007 National HIV and AIDS Policy. Efforts to achieve the enabling environment have included policy formulation, legislation and creating broad public awareness of HIV and AIDS. Once an enabling environment is fully functional, communities, households and individuals can effectively address the challenges to protect PLHIV, OVC, poor people, MSM, prisoners, sex workers and other marginalised groups from discrimination, stigmatization, and gender based violence. A priority for the NSF is to ensure fulfilment of the rights of women and children as they are disproportionately affected not only by HIV and AIDS but also by the other factors discussed above.

The UN General Assembly noted that the realisation of human rights and fundamental freedoms for all is essential to reduce the vulnerability to HIV and AIDS.[103] The Convention of the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) emphasize basic human rights especially for vulnerable groups including OVC, women and girls and to some extent to PLHIV, sex workers, and MSM.

Namibia has passed several laws and policies in respect to gender equality and gender based violence such as the National Gender Policy (2007), Combating of Rape Act (No.8 of 2000) and Marriage Person's Equality Act (No.1 of 1996). The development of 15 Women and Child Protections Units (WACPU) in all 13 regions to respond to incidents of abuse and provide a safe haven for women and children has been instrumental as part of an inter-agency and coordinated effort. Plans are underway to convert these units into One Stop Centres[104]. The creation of support groups that reach to community members with prevention messages on violence against women and children has also played an important role.

With the ratification of the Convention on the Right of the Child, Namibia committed itself to fulfil all the rights of children which are also reflected in the Constitution. Laws such as the Combating of Rape Act 2000, Combating of Domestic Violence Act of 2003 and the Maintenance Act of 2003 have improved the protection of children. However, there needs to be additional law reforms dealing with family issues such as distribution of family resources, removal of existing discrimination in women's rights, and children's ability to inherit property.

Anecdotal evidence shows that the capacity of social welfare and child protection systems, law enforcement agencies and key service providers are not fully resourced or capacitated to provide adequate care, support and protection services for women, children, and vulnerable groups. One challenge is the reach and coverage of protection services cover abuse and violence cases, especially to remote communities and villages. There are specific skills required when dealing with children and women who have been sexually abused or are victims of gender based violence. These include the skills related to being sensitive towards gender and sex, knowledge in PEP, interpersonal communication skills and basic counselling. This calls for the need to strengthen and build capacity for duty bearers (service providers) to be able to provide comprehensive protection and curative services.

There is a continuous need to strengthen awareness of people's basic rights especially those affected and or infected by HIV. Key activities to reinforce the awareness of people's rights include education and awareness programmes that include age-appropriate information on HIV, life skills, reproductive health, gender equality, non-violence against women and girls, HIV-related tolerance and non-discrimination and empowering children against exploitation[105]. The awareness of people's rights such as health, education, freedom of expression, security and privacy, support and protection, sexual and economic exploitation and discrimination are necessary to protect vulnerable households especially children and women. Protecting the human rights of vulnerable households reduces the probability of infection and re-enforces the ability to live positively if affected or infected by HIV.

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[103] GRN 2007, National HIV and AIDS Policy

[104] *One Stop Centre is when all the service providers are accommodated in one building for e.g. police, social workers, magistrate, prosecutor and doctor who will deal with protection services. Shelters will also be available on the same premises*

[105] UNAIDS *Briefing Note: HIV and Children's Rights*

Respect for the rights of people living with HIV and AIDS is an essential and central component of an effective response. Discrimination against people living with HIV and AIDS violates their rights and is counterproductive to an effective response to HIV and AIDS. Discrimination constitutes a significant disincentive for voluntary counselling and testing, threatens voluntary disclosure of HIV status and increases vulnerability to HIV infection, thereby undermining the response[106].

Gaps and Challenges

i. There are major gaps in basic human rights, equal legal and social protection, and access to services for vulnerable groups
ii. Lack of evidence based and empirical data on certain vulnerable groups such as MSM, sex workers, and prisoners that limit the ability to provide appropriate services
iii. Poor mainstreaming of HIV and AIDS in policy documents due to lack of understanding of the impacts and inherent risk factors by sectors.
iv. The implementation of policies of legal rights and protection are weak and inadequate due to lack of buy-in, capacity, monitoring and evaluation and political sponsorship
v. Although the Child Care and Protection Bill has been updated, it is yet to be promulgated and enacted
vi. Despite the importance of the CRC for children and in particular for OVC, the convention is still yet to be adopted into law in Namibia
vii. Lack of capacity and resources for social welfare and child protection systems, law enforcement agencies and key service providers

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC40:	**Vulnerable people are empowered:** Vulnerable people (including OVC, PLHIV, women, and girl child) understand their human and legal rights and are empowered to access services
OC41:	**Protection systems provide essential care, support and protection**: Social welfare and child protection systems strengthened to ensure provision of essential care, support and protection services

Code	Output Result
	Legal rights and protection services for vulnerable persons
OP79:	% of vulnerable households reached with messages on legal rights and protection services for vulnerable persons has increased to 25% in FY2012/13 and to 55% in FY2015/16.
OP80:	Number of service providers trained on referral system for existing legal rights, and protection services has increased from a cumulative total of 500 to 1000 annually

[106] MOHSS 2007 *National HIV and AIDS Policy*

Strategy

To reduce stigma and discrimination against vulnerable households and reduce gender based violence.

Priority Actions

Code	Description of main activities
5.3.3.1	Review existing policies, bills, and laws to mainstream responses to vulnerability affecting OVC
5.3.3.2	Conduct a baseline survey on individual knowledge and awareness of human and legal rights related to HIV and AIDS
5.3.3.3	Strengthen the capacity of individuals to address gaps in human and legal rights
5.3.3.4	Develop opportunities and mechanisms for OVC involvement in planning and implementation of programmes
5.3.3.5	Strengthen the capacity of Women and Child Protection Units (WACPU)

5.3.4 Food Security and Nutrition Support Programmes for Vulnerable Households

Situation Analysis

Food insecurity and malnutrition remain daunting challenges for Namibia. The poor, food insecure and nutritionally disadvantaged populations tend to be highly dependent on subsistence farming, have low income from remittances by relatives, and are more dependent on pensions than the average Namibian[107]. Forty percent (40%) of Namibians are living below the poverty datum line[108]. Thirty five percent (35%) live on one dollar a day, while 56% live on two dollars a day[109]. Twenty four percent (24%)[110] of the total population was malnourished in 2004, and 24.2% of all the children under five were malnourished in 2008[111]. With a Gini co-efficiency of 0.6[112], the majority of the poor have neither adequate access nor the money to purchase safe and nutritious food. Most households in rural areas spend up to 60% of their income on food[113].

The key shift in the NSF strategy is to ensure that households are capacitated to become self reliant and reduce their dependence on food relief programmes. It also promotes sustainable food production and accessibility to food. The Ministry of Agriculture provides training to strengthen the capacity of individuals, particularly women subsistence farmers, on food production and agriculture techniques, effective strategies to raise livestock, and to utilize labour saving devices. The NSF supports strategies that adopt and customise food security interventions based on the needs of each community, bearing in mind factors such as climate, geography, socio-economic systems and political structures.

[107] Isaacson B., 1995, *Namibia Food Security and Nutrition Assessment Report*. Prepared for the National Food Security and Nutrition Technical Committee (NFSNTC), Windhoek
[108] *Cited just above*
[109] NFSNTC / FAO 2008, *National Food Security and Nutrition Assessment Report, GRN*
[110] UNDP 2008, *Human Development Report (Global) 2007/08*
[111] NPC 2009, *Second Millennium Development Goals Report: Namibia 2008*
[112] NPC 2007, *Analysis of the Social Economic Challenges of Namibia and How the Donors Community should Assist*

Anecdotal data suggests that food insecurity can fuel the spread of HIV. Food and nutritional insecurity increases the mobility and migration patterns of individuals seeking food. Mobility and migration place people in risky situations and behaviours. The lack of food in households greatly affects the women and children. This can lead women to seek food in other ways such as getting involved in transactional or commercial sex. Socially marginalised and economically disadvantaged women also tend to stay in sexually abusive and violent relationships.

Food security and adequate nutrition is especially important to PLHIV and OVCs when weight loss and malnutrition are likely to accelerate disease progression and the likelihood for increased mortality[114]. In the case of women, the NDHS 2006/7 noted that 16% were chronically malnourished with a body-mass-index of less than 18.5[115] indicating a chronic energy deficiency[116]. The malnutrition–infection complex which is an outcome of HIV and AIDS is a significant factor among adults, but more severe among children[117]. Twenty two percent (22%) of children are underweight. Twenty seven percent (27%) of OVC are likely to be underweight compared to non-OVC (21%). Furthermore, poor nutrition in children is associated with risk of faltered growth, impaired mental development and even death. The NDHS (2006/7) observed that 10% of children under five were stunted, with 33% of all children stunted being severely stunted. Eight percent (8%) of children were wasted, while 17% were underweight. These indicators on malnutrition were higher for children not living in the same households with mothers, illustrating the increased vulnerability of OVC[118].

HIV exacerbates under-nutrition through lack of food intake, increased energy needs and reduced absorption of nutrients. Under-nutrition in turn can hasten the progression of HIV and worsen its impact by weakening the immune system, increasing susceptibility to OIs, and reducing the effectiveness of treatment[119]. Survey results in 2008 showed that 20.1% of ART patients were undernourished; including 2.5% who were severely malnourished and 17.6% were moderately or mildly malnourished[120]. Adherence to ART and its efficacy has a direct correlation to adequate nutrition and diet. Emerging evidence shows that people on ART receiving food supplementation recover much faster. To mitigate these challenges the MOHSS provides food by prescription. This intervention will require scaling up and consolidation. Working with other sectors such as agriculture will alleviate the burden on MOHSS. The NSF will also support nutrition supplementation as a priority intervention for adults and children who are particularly malnourished. Better food and nutrition makes ART more effective and has a cost-saving effect, not only for households and dependants, but also for the national economy[121].

HIV and AIDS have a direct impact on food security and nutrition in Namibia. The reduction in land under cultivation has been partly attributed to the death of men and women due to AIDS, who traditionally till the land, provide cash incomes and secure food for vulnerable households[122]. With a HIV prevalence of 17.8%[123], managing HIV and AIDS including nutrition is crucial to food security. Attempts to address

[113] NFSNTC / FAO 2008, *National Food Security and Nutrition Assessment Report, GRN*
[114] W-C Hsu J., et al 2005, *Macronutrients and HIV and AIDS: A Review of Current Evidence. Consultation on Nutrition and HIV and AIDS in Africa: Evidence, Lessons an Recommendations for Africa*
[115] MOHSS 2008, Namibia Demographic and Health Survey *2006-07*
[116] NFSNTC / FAO 2008, *National Food Security and Nutrition Assessment Report GRN*
[117] NFSNTC / FAO 2008, *National Food Security and Nutrition Assessment Report, GRN*
[118] MGECW 2006, *National Plan of Action 2006 to 2010 for OVC*
[119] MOHSS 2008, *Nutrition in HIV Care in Namibia: Needs Assessment Report*
[120] *Cited just above*
[121] Sadler K., 2006, *Food, Nutrition and HIV/AIDS: What next?* ODI Briefing Paper 7; http://www.odi.org.uk/resources/download/399.pdf
[122] Dlamini A. 2008, *Formative research for Undertaking Quality, Relevance and Comprehensiveness of Impact Services Survey (QUIMS) in Swaziland*
[123] MOHSS 2008, *Report on the 2008 National HIV Sentinel Survey*

food insecurity and malnutrition should focus on improving the socio-economic welfare and household income, particularly of subsistence farmers, wage earners and those who primarily depend on pensions.

Gaps and Challenges

i. Inadequate access to food production and resources by vulnerable communities and households
ii. Lack of nutritionists which impedes the implementation of an effective nutrition care programme
iii. Lack of human resource skills and capacity for food production and agriculture methods
iv. Lack of access to productive resources such as land and water where vulnerable households could farm and raise livestock as part of income generation especially for women and children
v. High dependence on food relief programmes from the government and other development agencies
vi. Inadequate farming and agriculture options in an environment where rainfall is erratic.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC42:	**Fewer OVC are underweight:** % of children and OVC younger than 5 who are underweight has decreased from 27% in 2007 to 20% in FY2012/13 and to 15% in FY2015/16
OC43:	**Fewer PLHIV are malnourished:** % of the PLHIV malnourished reduced by 20% by 2012/13 and by 50% by FY2015/16

Code	Output Result
	Food Security Programme for vulnerable households
OP81:	% of OVC aged 0-17 who received food support in the last 12 months has remained stable at 36% up to FY2015/16
OP82:	% of households with vulnerable adults aged 18 and older who receive food support has increased from 63% in 2008 to 75% in FY2012/13 and to 85% in FY2015/16
OP83:	% of facilities offering HIV and AIDS Care and Support Services that have fortified protein supplement increased from 21% in 2009 to 35% by 2012/13 and 50% by 2015/16
OP84:	% of vulnerable households trained in food production techniques has increased to 20% in FY2012/13 and to 50% in FY2015/16

Strategy

To improve household level food security and access to basic food items

Priority Actions

Code	Description of main activities
5.3.4.1	Expand the coverage of OVC feeding programmes for those in need
5.3.4.2	Develop a National Plan for strengthening household food security for vulnerable households
5.3.4.3	Develop a training programme for vulnerable households in sustainable food production techniques

5.4 Response Management

5.4.0 Overview

The NSF's strategy in management and coordination of the national multi-sectoral HIV and AIDS response is to improve the efficiency and effectiveness of the governance and coordination structures, leadership, social and resource accountability. This can only be achieved if adequate and appropriate policy guidelines and sufficient resources are available complemented with a strong political commitment. Strengthening the social and legal enabling environment is necessary for an expanded and decentralised multi-sectoral response.

As the epidemic has unfolded in Namibia, coordination and management has become complex with increasing number of stakeholders participating in the planning and implementation of the response, the expansion of services coverage, the diversity of programmes in place and substantial increases in financial resources to support the response.

Effective and efficient coordination of the response requires clearly defined and decentralised multi-sectoral structures. Available evidence indicates that such institutions are characterised by well articulated mandates, roles and responsibilities, a functional joint programme review, planning and development process and a strong monitoring and evaluation system. The strategic roles of communities, civil society, PLHIV and the private sector is not only recognised but also mainstreamed. Without a strong and sustained political commitment and leadership, availability of adequate resources and appropriate policies, effective coordination of a multi-sectoral HIV and AIDS response cannot be realised.

During the implementation of the MTP-III, Namibia made significant progress in establishing and resourcing the coordination mechanism within the context of the Three Ones principle of one national coordinating authority, one national strategic framework, and one national M&E framework.

In strengthening its coordination mechanism, Namibia has aimed to:

i. Improve the effectiveness and efficiency of the coordination mechanism
ii. Ensure equitable distribution and delivery of services countrywide
iii. Harmonise and align development partners' programmes and support with national systems and policy frameworks
iv. Strengthen partnerships and strategic alliances with development partners and civil society organisations.

Response Management Impact Results

It is anticipated that efficient and effective coordination and management of the national multi-sectoral response will contribute to the achievement of the following results by 2015/16:

Effective and efficient management of the response and service delivery for those infected and affected by HIV and AIDS (NDP3 Goal 14 Programme 1 outcome):

i. *% of NSF service coverage targets (output level results) that have been met in the areas of HIV prevention, treatment care and support and impact mitigation has increased from 0% in 2009 to 60% in FY 2012/13 and to 90% in FY 2015/16*

ii *% of stakeholders that have expressed satisfaction with the level and type of services provided by HIV coordination structures[124] has increased from 60%[125] in 2009 to 80% in FY 2015/16*

The NSF specific strategies and activities for coordination and management are presented in the following seven complementary and inter-linked programme areas:

i. Institutional Arrangement, Coordination and Management
ii. Enabling Policy and Legal Environment
iii. Capacity Development
iv. Community systems strengthening
v. Mainstreaming, Policy and Advocacy
vi. Resource Mobilisation and Management
vii. Monitoring and Evaluation, and HIV Research.

5.4.1 Institutional Arrangement, Coordination and Management

Situation Analysis

The coordination of the Namibia HIV and AIDS response takes place at national, sector, regional and community levels. During the MTP-III period the Government of Namibia in collaboration with other stakeholders established the following institutions to coordinate the multisectoral response:

The **National AIDS Committee (NAC)** is the highest policy making body on HIV and AIDS related issues in Namibia. Its membership comprise of Ministers and Regional Governors. NAC is responsible for ensuring that policies are adhered to and the response is adequately resourced.

The **National Multi-sectoral AIDS Coordination Committee (NAMACOC)** was comprised of Permanent Secretaries, and equivalent representatives from the regions, private sector and civil society organisations. It was charged with the responsibility of providing adequate and sustained leadership. NAMACOC had the mandate to review progress of the multi-sectoral response implementation, adopt strategic and annual plans, and budgets.

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[124] For the response management, outcome level results will be assessed through the DSP client satisfaction survey, a qualitative assessment of the extent to which each result has been achieved, case studies vignettes that show how the HIV response has been managed in the regions, sectors, communities, and at a national level. This baseline is based on MOHSS statistics as per MOHSS strategic plan. MOHSS has been designated the coordinating body of national HIV and AIDS multi-sectoral response.

[125] This baseline is for the MOHSS only, as per MOHSS Strategic Plan.

The **National AIDS Executive Committee (NAEC)** provides the technical leadership, management oversight and in particular coordinates the planning, development, implementation, monitoring and evaluation of national multisectoral response. Its membership is drawn from key stakeholders including government, development partners, civil society, private sector and comprises of people who are directly involved in the planning and implementation of the response.

The **Sector Steering Committees** oversee the HIV and AIDS response in the various development sectors such as agriculture, mining, education and transport.

The **Regional AIDS Coordinating Committees (RACOCs**) coordinate the regional multi-sectoral HIV and AIDS response in their respective regions. They also provide financial and technical support to CACOCs.

The **Constituency AIDS Coordinating Committees (CACOCs)** are community based and are responsible for facilitating meaningful community planning and participation in the implementation of the multi-sectoral response.

The NAC, NAMACOC and NAEC operate under the auspices of the Ministry of Health and Social Services, while the RACOCs and CACOCs are under the Ministry of Regional and Local Government, Housing and Rural Development. The Directorate of Special Programmes within MOHSS provides the secretariat for NAC, NAMACOC and NAEC. The Ministry is also responsible for the day to day coordination and management of the national response including HIV and AIDS donor coordination.

Gap Analysis and Challenges

Under MTP-III, coordination of public sectors was the responsibility of government line ministries. The coordination of private sector and civil society was the responsibility of NABCOA and NANASO respectively in collaboration with the appropriate government line ministry. Trade unions participated through the public and private sectors institutions.

The MTP-III Review[126] noted that the effectiveness of these institutions was compromised and identified the following gaps and challenges:

i. **Lack of clarity of roles and responsibilities:** The MTP-III review noted lack of clarity on the mandate, roles and responsibilities of national and decentralised coordinating structures. The membership of the existing committees was not adequately oriented on their roles and responsibilities.
ii. **Inadequate coordination at national level:** Although NAC, NAMACOC, NAEC, Sector Steering Committees were formally established under MTP-III, only NAEC held regular meetings. Others committee meetings were ad hoc and often there was no follow up action that compromised their effectiveness. NAC and Sector Steering Committees never met during the MTP-III period.

[126] MOHSS 2009, *MTP-III Review Status Report*

iii. **The Authority of the NAC**: Although it is generally accepted that the MOHSS through the NAC and its subsidiary organs is the national coordinator of the multi-sectoral response, this mandate is not fully understood or appreciated by most stakeholders.

iv. **Inadequate capacity**: The capacity of the Directorate of Special Programmes to facilitate the national multi-sectoral coordination of the response was compromised by inadequate human and financial resources. Some stakeholders have indicated lack of clarity on the Directorate's mandate and role in the overall coordination of the multi-sectoral response.

v. **Inadequate resources:** Inadequate resources also affected the performance of the RACOCs and CACOCs. In the case of CACOCs they did not have full time coordinators or specific operational budgets to support their work.

vi. **Mainstreaming HIV and AIDS in corporate and sector operations**: Although some public sectors have been oriented and supported to mainstream HIV and AIDS in their sectoral operations, mainstreaming has remained a challenge. Not all sectors have developed HIV and AIDS policies, budgets, workplace programmes or have made plans for mainstreaming HIV in their development programmes.

The NSF addresses these coordination and management challenges in different ways ranging from the development of the National Coordination Framework, clarifying mandates, roles and responsibilities, to strengthening the institutional capacity development of the coordinating structures. To increase efficiency and effectiveness, some of the coordination structures have been merged reducing the number of the structures. The membership has been articulated and specific terms of reference (TOR) developed for each of the coordinating structures. The TORs have further outlined the lines of reporting and accountability.

The restructured coordinating structures

1. <u>National AIDS Council (NAC)</u>

The National AIDS Council remains the highest policy making body on HIV and AIDS in Namibia. Its membership comprises of Ministers and Regional Governors. The core business of the NAC will be to provide leadership, policy guidance, resource mobilisation, ensure political commitment, review progress reports, and approve strategic plans and policy documents on HIV and AIDS. A key function of NAC is to review and approval the National HIV and AIDS Strategic Framework, the national, regional and sectoral operational Plans, the M&E plan and the National HIV and AIDS Policy.

2. **<u>National AIDS Executive Committee</u>**

NAEC will continue to providing technical leadership, facilitating programme development and planning, coordination of capacity development, partnership strengthening and management of strategic information among other functions.

NAEC will be expanded to incorporate the NAMACOC and the National Partnership Forum. In this case the membership of NAEC will be expanded to include Permanent Secretaries, the membership of Partnership Forum, and the usual members of NAEC draw from among Government, development partners, civil society and private sector. Given the expansion, the business agenda will also be reviewed

to include programme coordination, policy discussions, resource mobilisation and development partner coordination. This is necessary given that the membership is primary people involved directly with programme planning and implementation.

NAEC will also work through technical advisory committees, sector steering committees, programme and specialised steering committees that may be established by NAC, NAEC or other government institutions such as Cabinet, and whose mandate impact directly or indirectly on the national HIV and AIDS response.

3. Regional AIDS Coordinating Committees (RACOCs)

The RACOCs will continue to coordinate the regional multi-sectoral HIV and AIDS response. Their institutional management will be through the Ministry of Regional and Local Government, Housing and Rural Development. Their particular responsibility is to ensure meaningful involvement and participation of all stakeholders in the implementation of the Regional Operational Plans. Their roles will include planning, coordination, monitoring and evaluation of the multi-sectoral regional response.

4. Constituency AIDS Coordinating Committees (CACOCs)

The CACOCs will be strengthened to coordinate the community based response, led by the communities themselves. Communities will be encouraged to plan and implement community specific interventions. Support will be provided to establish a coordinating office with staff, human and financial resources.

5. Sector Steering Committees

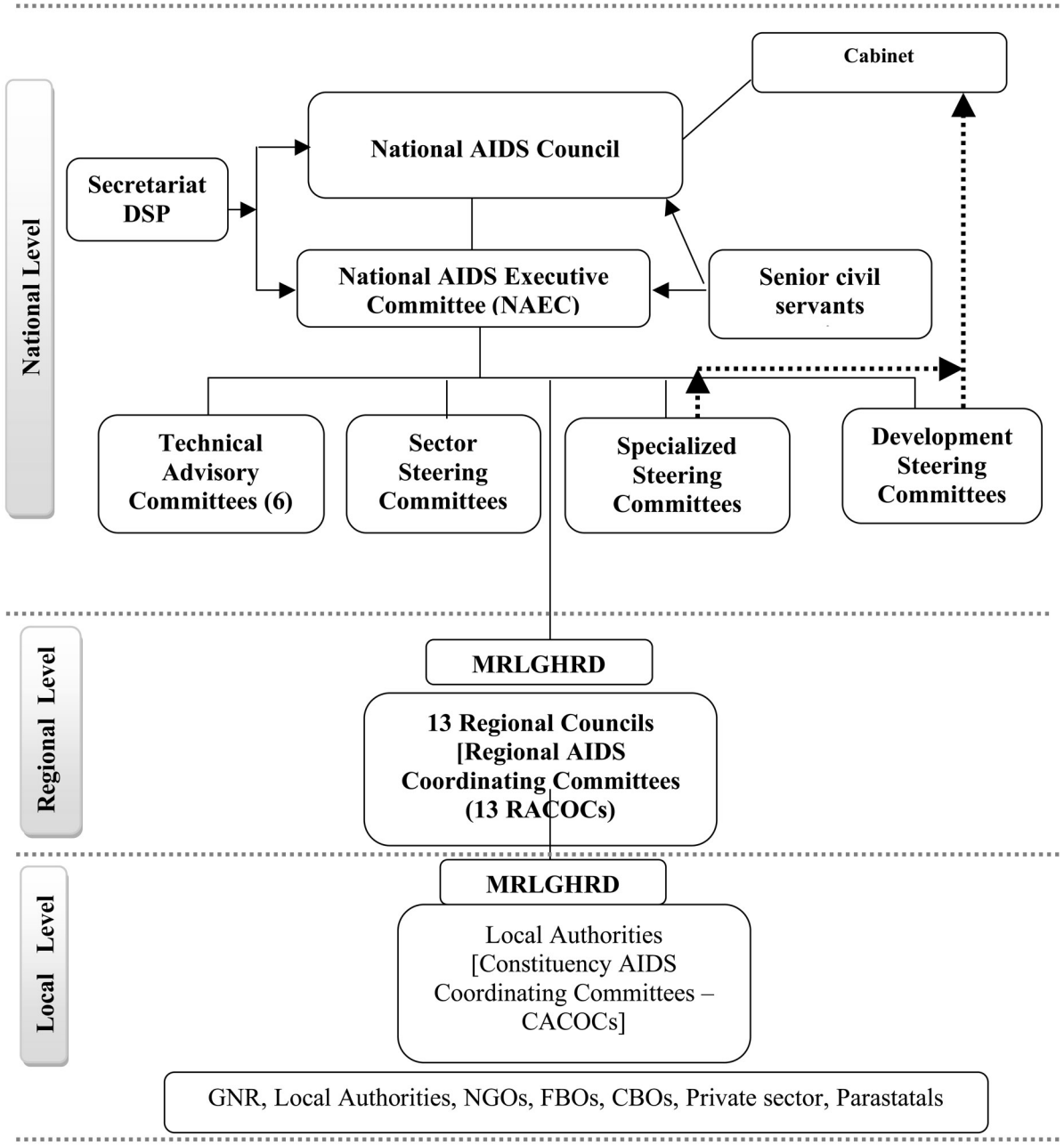
Sector Steering Committees are responsible for facilitating development and coordination of the sector response in terms of workplace programmes and mainstreaming HIV and AIDS in sector development programmes. Annex 4 lists the 14 sectors. Sectors are comprised of public and private institutions and enterprises, civil society and development partners.

It is anticipated that each sector will nominate one institution to coordinate the activities of the sector. The respective sectors will also nominate a small effective and efficient "Sector Steering Committee" to facilitate and oversee sectoral coordination. For the time being while the sectors are consolidating themselves and refining their sectoral operational plans, respective government line ministries will serve as the sector coordinators and will provide for a sector secretariat and appoint a sector coordinator at management level.

The Sector Steering Committees will work in collaboration with established umbrella networks and other established organisations with a mandate to coordinate some sector or sub-sector initiatives. Such organisations include NGO networks (NANASO and NANGOF), Namibian Business Coalition on HIV and AIDS (NABCOA), the Office of the Prime Minister (OPM) and the UN Joint Team on HIV and AIDS among others. The NSF will encourage collaboration and coordination between Sector Steering Committees and such organisations to avoid confusion and duplication of efforts.

The following diagram illustrates the suggested coordination institutions and mechanisms during the implementation of the NSF.

Figure 4: Coordination of the National Multi-sectoral HIV and AIDS response – Organogram



Outcome and Output level results

Efficient and effective coordination and management of the national multi-sectoral response will result in the following **outcome** and **output** level results.

Code	**Outcome Result**
OC44:	**Effective and efficient HIV and AIDS response management:** All regions, sectors, partners and communities work together effectively and efficiently by FY2015/16

Code	Output Result
	Institutional Arrangement, Coordination and Management
OP85:	Coordinating structures capacitated with clearly defined roles and responsibilities to provide leadership and governance by FY2015/16
OP86:	All development partners' coordination systems are harmonised and aligned with the NSF strategies by FY2012/13 and remain that way by FY2015/16
OP87:	% of strategic sectors that have reviewed their policies and programmes and integrated HIV and AIDS activities in their development programmes in line with NSF services has increased to 50% in FY2012/13 and to 80% in FY 2015/16

Strategies

i. To articulate and clarify the mandate, roles and responsibilities of the various coordinating structures. The National Coordination Framework will largely contribute to the success of this strategy.
ii. Strengthen the capacity for coordination and management of the response at national, sector, and regional levels

Priority Actions

Code	Description of the main activities
5.4.1.1	Develop a National Coordination Framework that clarifies the mandates, roles and responsibilities of coordinating structures at all levels.
5.4.1.2	Strengthen capacity for the effective coordination of the implementation of the NSF
5.4.1.2	Facilitate the institutionalisation of the Three – One Principles in sectors and regions.

5.4.2 Enabling Policy and Legal Environment

Overview

The National Policy on HIV and AIDS requires an enabling social and legal environment that is characterised by being free of stigma and discrimination. These can be achieved through the implementation of sound policies which are driven by strong institutional leadership coupled with comprehensive awareness and understanding of the implications of stigma and discrimination on people affected. The importance of on-going advocacy by all political, traditional and religious leaders, PLHIV, NGO or private sector leaders, is critical to the success of the entire expanded response to HIV and AIDS epidemic. The leaders will be required to be adequately informed about HIV and AIDS and be able to communicate effectively to their constituencies. Through effective communication and dialogue the leaders will be able to provide leadership, and guide and promote initiatives that strengthen the enabling environment.

The strategic orientation for the enabling environment is to:

i. Ensure adequacy of policies that provide space for effective and efficient implementation for the HIV and AIDS response

ii. Ensure human rights are adequately addressed to reduce stigma and discrimination, and to promote the dignity of PLHIV and MARPS and
iii. Address gender inequality.

The activities presented in this section are interlinked. While human rights are enshrined and protected, the special circumstances of PLHIV and groups made vulnerable by the epidemic require specific recognition. Stigmatization and discrimination exist at multiple levels within the society. In turn they create barriers for PLHIV to participate in the development of programmes and to access and utilise appropriate services.

5.4.2.1 Creating and sustaining an enabling policy and legal environment

Situation Analysis

Namibia has established strong foundations for an enabling environment. The Constitution of Namibia provides a wide range of protections to all residents of Namibia and it further articulates the roles and obligations of duty-bearers in protecting those rights. The rights of Namibians affected by HIV and AIDS are protected by the courts and the Office of the Ombudsman. In addition, Namibia has ratified the major human rights protocols and international instruments.

PLHIV, OVC and others affected by the epidemic still require further policy and legal protection. As the epidemic matures, the challenges and needs of the vulnerable groups will expand; PLHIV on ART will live longer and will remain productive. Issues such as access to credit, social services and other forms of stigmatisation will emerge and the country will need to develop policies and perhaps legislation to address future issues.

Sustained national debate is needed to turn policies into laws and programmes that empower those affected by the epidemic. There is a common perception that PLHIV and OVC face discrimination. Anecdotal evidence indicates discrimination ranging from social interactions in local communities to the financial sector where access to certain investments may be hindered by HIV status. Yet, despite popular perception, very little data on the extent and impact of that discrimination exists. The introduction of ART in the response means that a person who is HIV positive can live productively for many years. As the epidemic unfolds PLHIV will be found throughout all sectors of the society. The need to effectively address their rights as put forward in the National Policy on HIV and AIDS will only grow. This growing need provides another reason to approach the epidemic from a holistic view. The fact that such information is missing indicates an absence of a national consciousness on the situation of PLHIV. To address the challenges, it will require the involvement of all people from the Presidency to the ordinary citizen at community level.

Both Vision 2030 and NDP3 call for the mainstreaming of HIV and AIDS into sectoral policies and programmes. HIV and AIDS policies have been developed in many organisations within both government and the private sector. However, guidelines on how to link these policies to the National Policy do not exist. Currently there is no central repository of existing policies. Neither is there an office which monitors and evaluates the implementation and or effectiveness of these polices. Within government, the

Office of the Prime Minister has attempted to collect policies, however the extent to which this exercise has been successful is not clear. A parallel vacuum exists for sectors outside government. A number of large businesses have instituted workplace policies; some have implemented workplace programmes. The responsibility for the monitoring and evaluation of existing workplace programmes is not clearly defined as also indicated in the coordination and management of the response section.

Gaps and Challenges

The following are the key challenges associated with creating and sustaining a policy and legal environment for HIV and AIDS:

i. Weak capacity and strategies for advocacy to sustained political commitment to support an enabling policy and legal environment for HIV and AIDS implementation.
ii. Inadequate monitoring of the policy environment to ensure that people are not discriminated or stigmatised.
iii. Inadequate forums to support public debate on the wider social issues brought about by HIV and AIDS and in particular as their affect vulnerable groups. The National Policy on HIV and AIDS identifies twelve groups vulnerable to the epidemic including MARPS. Each faces unique problems that require policy and perhaps legal tools. Furthermore, as impacts from the epidemic move throughout Namibian society, new groups of vulnerable Namibians may emerge. These groups, if they do appear, will require identification and the development of approaches that suit their own unique needs.
iv. Inadequate monitoring and evaluation of stakeholders' performance in implementing appropriate policies and legislation.
v. Research on the extent and impact of stigma (self and expressed) and discrimination is lacking and hence policies are not driven by evidence.

Strategy

To ensure that Namibia has effective policies and legislation in place that promotes and sustains an enabling policy and legal environment. The strategy will also promote and facilitate public debate on policy and human rights issues associated with the HIV and AIDS, including issues of stigma and discrimination.

Priority Actions

Code	Description of main activities
5.4.2.1	Review existing policies and legal instruments to mainstream HIV and AIDS responses in all sector and corporate functions

5.4.2.2 Strengthening Leadership Commitment

Situation Analysis

Vision 2030 and NDP3 call for sustained commitment of political leaders to the national response. The National Policy on HIV and AIDS focuses on the need for leadership commitment at all levels to ensure an effective multi-sectoral response. Although there is a sense of political commitment, this has not adequately translated into practical terms. At an operational level, the planning processes have not been mainstreamed into the roles of the leaders. Leadership is not simply an obligation of politicians, but also of all leaders in the sectors, religious organisations and communities. Effective leadership leverages the overall response management.

Gaps and Challenges

i. Lack of adequate and sustained leadership
ii. Lack of effective leadership models with regards to HIV and AIDS especially at community level
iii. National, regional and local structures do not provide a platform for the involvement of leadership on HIV and AIDS issues
iv. There are no standards to measure accountability on HIV and AIDS leadership performance.

Strategy

To strengthen the capacity and participation of all leaders in the design and implementation of the national multi-sectoral response at appropriate levels of the leadership.

Priority Actions

Code	Description of main activity
5.4.2.2	Mobilise and engage political and community leaders in the implementation of HIV and AIDS related activities

5.4.2.3 Greater Involvement of People Living With HIV

Situation Analysis

The success of any multi-sectoral response to HIV and AIDS is dependent on meaningful participation and involvement of PLHIV. Over the years stakeholders have attempted to address critical issues that create barriers for PLHIV participation in the national response. In most cases, the environment in which PLHIV are expected to meaningfully participate, is characterised by denial, fear, stigmatisation and discrimination. On the other hand, even when the political, social and legal environment is conducive, the participation of PLHIV is rarely reflected in the formulation of policies and programmes. In most cases they are seen as mere beneficiaries of services and not as key stakeholders.

It is increasingly evident that PLHIV are part of the solution and not the problem and hence their participation and involvement in the national response is not only their right but strategic to the achievement of the intended results especially in preventing new infections. In this regard the NSF will support effective strategies, and strategic alliances that will scale up the involvement of PLHIV in the national response to HIV and AIDS. Existing networks and support groups will be capacitated to support scaling up of such initiatives.

Gap and Challenges

i. Existing PLHIV support groups lack capacity and resources to be effective spokespersons.
ii. PLHIV, especially those in rural settings lack the skills and the experience to engage institutions and government in policy dialogue.
iii. Namibia lacks a strong, unified national voice for advocacy for PLHIV
iv. There is inadequate resource allocation for PLHIV groups to achieve their potential in the national response.
v. There is no defined framework of partnership between government development partners and PLHIV.

Strategy

To strengthen strategies that expand opportunities for PLHIV engagement and involvement in the national multi-sectoral response to HIV and AIDS.

Priority actions

Code	Description of main activities
5.4.2.3	Develop policies and regulations that prevent stigma and discrimination
5.4.2.4	Develop a community-focused advocacy strategy to reduce stigma and discrimination
5.4.2.5	Strengthen the capacity of support groups to promote the rights of PLHIV
5.4.2.6	Improve the coordination and quality of counselling and support services for PLHIV
5.4.2.7	Strengthen the capacity of PLHIV support to provide community based support to other PLHIV

Outcome and Output level results: Enabling environment

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC45:	**Protective laws are in place:** Qualitative assessment of the extent to which national policies and legal instruments incorporate human and legal rights that prevent vulnerable people from all forms of discrimination and stigmatisation at all levels of society

OC46:	**More people express accepting attitudes towards PLHIV:** % of women and men aged 15 – 49 expressing accepting attitudes towards people living with HIV has increased for women from 39% in 2007 to 55% in FY 2012/13 and to 70% in FY2015/16, and increased for men from 36% in 2007 to 50% in FY2012/13 and to 65% in FY2015/16
OC47:	**Fewer PLHIV experience workplace discrimination:** % of self-identifying PLHIV that are formally-employed (in government and other sectors) that report stigma and discrimination as per the HASI index[127] has reduced to less than 15% by 2012/13 and to less than 10% by FY2015/16
	(See also OC40: Vulnerable people are empowered)

Code	Output Result
	Enabling environment strengthened so human rights are honoured
OP88:	% of political and community leaders trained in providing sustained leadership in community planning and implementation of HIV and AIDS related activities has increased to 50% by FY2012/13 and 70% by FY2015/16
OP89:	% of individuals that have been reached with stigma and discrimination reduction messages has increased to 20% by FY2012/13 and to 30% in FY2015/16
OP90:	% of OMAs that address stigma and discrimination in their workplace policies has increased from 32 (9 out of 28 OMAs) in 2008 to 50% (14 out of 28 OMAs) in FY2012/13 and to 86% (24 out of 28 OMAs) in FY2015/16
OP91:	Number of support groups capacitated to address legal and basic human rights increased from 0 in 2009 to 50 in 2012/13 and to 85 by 2015/16
OP92:	% of vulnerable people reached with human and legal rights education and information messages increased from 0% in 2009 to 75% in 2015/16

5.4.3 Capacity Development

Overview

The implementation of the NSF depends on both existing capacities as well as capacity that need to be developed during the next five years. Capacity development is a long term, continuous process that must take cognisance of future requirements beyond the term of this NSF. The NSF capacity development will focus on a) developing human resources capacity; b) retaining the enhanced human resources; c) systems strengthening; d) development of infrastructure; and e) availability of appropriate technology and strategic information. The development of capacity in these areas will be a pre-requisite for the implementation of the NSF and the operational plans. A comprehensive national capacity assessment of public, private sectors and civil society organisations will be followed by a capacity development plan that will be operationalised.

In the past, the Government of Namibia in collaboration with different stakeholders has developed capacities in some critical areas of health and non-health service delivery. These efforts addressed capacity needs ranging from basic operation skills to more complex and technical skills depending on the nature of the intervention or service. A key focus by development partners has been strengthening health and community systems. These have been core areas of support by the GFATM and PEPFAR.

[127] The *People Living with HIV Stigma Index* provides a tool that will measure and detect changing trends in relation to stigma and discrimination experienced by people living with HIV.

Gaps and Challenges

i. **Inadequate human resources**: Namibia has not conducted a comprehensive capacity assessment of its HIV and AIDS response to establish the critical capacity gaps among all the implementing partners including civil society and private sector. Capacity gaps being addressed are primarily identified at programme or service delivery level. Consequently, there is no systematic and comprehensive strategy that cuts across interventions for capacity development in the context of HIV and AIDS responses. This is important to capitalise on synergies and to create investment efficiencies.

ii. Areas that require capacity development include human resources (adequacy, skills and competencies) organisational capacity (operational systems, financial resources and technology) and availability of strategic information[128] (empirical data / evidence) to inform choices and decision making for the national HIV and AIDS response. These needs apply across government, non-governmental sectors and the regions.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC48:	**Service providers have capacity to implement the NSF:** 80% of all HIV implementers at national, sectors and regions are able to implement the NSF by FY2015/16

Code	Output Result
	Capacity of service providers is developed
OP93:	% of sectors, regions and communities for which HIV implementation capacity has been developed has increased from 0% in 2009 to 100% in FY2012/13 and remains at this level by FY2015/16
OP94:	% of established posts of key professionals in the MOHSS in the last 12 months that have been filled has increased from 75% in 2009 to 85% in FY2012/13, and to 90% in FY2015/16

Strategy

To strengthen the capacity of sectors to absorb resources earmarked for HIV and AIDS programmes and effectively and efficiently implement prioritized programmes at all levels**.**

[128] *UNDP /and the UN African Capacity Building Initiative 2006, Joint Review of the Regional Support Programme for HIV and AIDS, UNOPS*

Priority Actions

Code	Description of main activities
5.4.3.1	Conduct a comprehensive National Capacity Assessment at all levels covering all stakeholders and sectors. [*Subsequent to the capacity assessment, develop a national framework that will institutionalise capacity building and strengthen efforts. This will allow a systematic approach in the development and standardization of capacity development. The framework will also identify areas of possible public private partnership cooperation*].
5.4.3.2	Provide technical assistance to sectors and regions in the development of sector or institutional strategic plans for HIV and AIDS
5.4.3.3	Review the human resource needs of the MOHSS necessary to support the implementation of the health sector response to HIV and AIDS. [*The review would focus on the adequacy of human resources and availability of technical skills and appropriate competencies, as well as their retention*]

5.4.4 Community Systems Strengthening

Situation analysis

Communities are both beneficiaries and implementers of HIV and AIDS programmes. Available evidence indicates that community involvement has greatly contributed to ownership and constitutes a critical element for sustainability and service uptake. Communities in all the regions are mobilising and organising themselves in community action groups, support groups of people living with HIV and in other forms of community based organisations (CBOs). The Namibian Government realises the potential for community participation and involvement in scaling up the national response. A number of initiatives have been started to support and strengthen community efforts. These efforts have parallel advantages because they recruit and empower women into the broader development process. Through these interventions, community groups continue to receive financial and technical support. The government and civil society organisations in collaboration with development partners continue to strengthen the capacity of community groups. Capacity building of local leadership and sub-national structures as well as a strong mechanism to ensure accountability to the NSF is vital for sustained interventions. At the community level, CACOCs have been established to facilitate community (constituency) interventions. However not all constituencies have functional CACOCs. All CACOCs will need institutional and capacity development, in addition to operational systems strengthening.

Gaps and challenges

In most constituencies, communities are struggling to respond effectively to the challenges of HIV and AIDS due to the following challenges:

i. Inadequate management and implementation framework. Currently CACOCs are coordinated by volunteers and have no resources to support their operations
ii. Inadequate coordination framework. Currently CACOCs are coordinated by volunteers, and have no resources to support their operations.
iii. Inadequate capacity for planning, management and service delivery.

iv. Inadequate financial and human resources.
v. Weak and fragmented community systems exist. In most cases community interventions are said to operate in isolation of each other and hence lack synergy and complementarity.
vi. Lack of focus on causes of vulnerability to HIV and AIDS.
vii. Lack of a comprehensive approach to the response on impact mitigation.
viii. The principle of "the Three-Ones" has not taken root at community level.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC49:	**Community systems are strengthened:** Communities lead efforts to coordinate their local HIV responses by FY2015/16

Code	Output Result
	Community Services are well coordinated through CACOCs and RACOCs
OP95:	All RACOCs that have met at least 3 times a year in the past 12 months has increased to 13 regions by FY2012/13 and remained at this level by FY2015/16
OP96:	Number of CACOCs that have met at least 3 times a year in the past GRN financial year has increased to 60 CACOCs by FY2012/13 and to 80 CACOCs by FY2015/16

Strategy

To strengthen the capacity of communities in planning, coordination and management

Priority Actions

Code	Description of main activities
5.4.4.1	Strengthen the capacity of RACOCs and CACOCs in planning and managing community based HIV and AIDS projects
5.4.4.2	Strengthen the capacity of CACOCs to effectively coordinate the implementation of the community based activities
5.4.4.3	Strengthen community leadership through leadership for transformation training

5.4.5 HIV Mainstreaming, Policy and Advocacy

Situation Analysis

The complex linkages between HIV and AIDS and socioeconomic development indicate that the negative impacts of HIV are reversing the socio-economic development benefit that have accrued since 1990, while at the same time creating major obstacles to achieving the goals of Vision 2030 and NDP3. It is evident from the various studies including the Human Development Reports, the Demographic and

Health Surveys, poverty studies, and HIV and AIDS impact studies that the epidemic spreads along the fault lines of development – poverty, gender inequality, poor and or inadequate social services.

While HIV prevention work is necessary to inform and motivate people to protect themselves, it cannot overcome deeply-rooted societal and socio-economic causes of susceptibility. Similarly, treatment, care and support programmes can reduce the impact of AIDS on affected individuals and households but cannot address the underlying reasons for their vulnerability. Many of these factors can only be addressed through mainstreaming HIV and AIDS into the socio-economic development process, complemented with interventions around basic human rights.

Mainstreaming HIV and AIDS takes place in both internal and external environments. The internal HIV and AIDS response deals mainly with the development of HIV and AIDS workplace policies and programmes for the workers in the individual sectors. The external response deals with aligning HIV and AIDS response to the core mandate, policies and strategies of the sector or organisation. Development and poverty reduction are natural starting points for mainstreaming HIV and AIDS – particularly when an identified development priority will also contribute to HIV prevention and HIV and AIDS impact mitigation targets.

5.4.5.1 HIV and AIDS Workplace Programmes

The response to HIV and AIDS in the workplace is a critical intervention that focuses on the productive sector of the national economy. This response aims to minimize risks that would adversely affect productivity, human capital investments and bottom-line profitability, upon which the country's economic security is hinged. The management of HIV and AIDS with respect to employees is critical in Namibia, given the country's limited population and human resource base.

The National Policy on HIV and AIDS requires public and private workplaces to implement HIV and AIDS workplace programmes (WPPs) as a way to reduce and manage the impact of HIV and AIDS in the workplace. In addition other legislation and policies complement the National HIV and AIDS Policy requirements for workplace programmes development, implementation and monitoring. Such legislations, policies and guidelines include the Labour Act N0. 11 of 21st December 2007 which integrates HIV and AIDS protection in the workplace; The Public Service Workplace Policy on HIV and AIDS (OPM 2009); Workplace HIV and AIDS Policy for the Education Sector; Guide to HIV and AIDS workplace programmes (2007); Guide to HIV and AIDS mainstreaming (2008); Plan for National Multi-sectoral Monitoring and Evaluation of HIV and AIDS (2006/7 – 2008/09); and National HIV and TB Targets (MOHSS 2008).

In Namibia, the response to HIV and AIDS in the workplace has been driven by various institutions that include the Office of the Prime Minister for the public sector, AMICAALL for Local Authorities, the Namibia Business Coalition on AIDS (NABCOA) for the private sector and the Walvis Bay Corridor Group (WBCG) for the transport sector. The National Union of Namibian Workers (NUNW) and Trade Union Congress of Namibia (TUCNA) together target employees (union members) from various sectors. NUNW represents approximately 70,000 workers in 9 affiliated trade unions while TUCNA represents over 40,000 members in 15 affiliated trade unions. Several of these organisations interact with each other

and are co-implementers, depending on their respective competencies and capacities. They aim to assist member organisations to mainstream HIV and AIDS in the workplace by developing comprehensive HIV and AIDS workplace programmes.

Whilst progress has been made with regards to WPPs, activities to increase efficiency across labour, business and the public sector remains a challenge. Of further concern is the fact that there is no definitive national standard / minimum package for a comprehensive HIV and AIDS workplace programme. The description of the components of workplace programmes as articulated in the National Policy on HIV and AIDS is broad, referring to aspects of prevention, care and support and treatment, and further includes aspects of TB management (diagnosis, treatment and sensitisation). However, the National Policy provides more details on the protection of the employee and issues of non-discrimination in the workplace than it does with respect to actual interventions.

Some progress has been made with regards to the adoption of workplace programmes over the last few years. The interventions that have been more widely adopted mainly relate to development and adoption of workplace HIV and AIDS policies, capacity building and prevention interventions (IEC, condoms distribution and to some extent testing and counselling). These are services that are typically provided freely by Government and development partners while the proactive interventions that require some form of investments (in terms of finance, time, and human resources etc) have tended to lag behind.

The Public service sector workplace programmes

The development of HIV and AIDS workplace programmes in the public sector started in 2004, as part of the Government's efforts to adopt a multi-sectoral response to epidemic. The Office of the Prime Minister (OPM) was mandated to take leadership in both the development and coordination of the programme in Government Offices, Ministries and Agencies (OMA). In 2008, the positions of HIV and AIDS Focal Point Persons were established to support the programme.

A recent review of the Government's multi-sectoral response showed that 11 out of 28 Government institutions that were assessed had no workplace programmes, while 13 had prevention activities, 3 had prevention and care and support for family members, and only 1 had prevention, care and support and mitigation activities. Only 8 institutions had Focal Point Persons, while 24 had workplace programme committees[129].

AMICAALL also registered progress with 30 Municipalities out of 51 Local Authorities having developed workplace programmes and appointed focal point persons[130].

Private sector and parastatal companies

According to NABCOA, there are 104 companies that have workplace programmes that reach approximately 37,742 employees[131]. The response is however biased towards certain company profiles.

[129] *NDP3 Progress Report for 2006/2008: Governance of the Multi-sectoral response*
[130] MOHSS 2006, *Progress report on the Third Medium Term Plan on HIV and AIDS, page 24*
[131] *This number relates to companies that are either members of NABCOA, or non-member companies that NABCOA has supported in their development of their WPPs. It is acknowledged that this number could be higher.*

A 2007 Private sector HIV and AIDS survey that covered 43 private sector and parastatal companies showed that while 72% of the companies surveyed had workplace programmes, this was predominantly amongst the medium (between 100 to 500 employees) to large (over 500 employees) type companies, and predominantly the multi-national companies.[132] It was also noted that workplace programmes were not always fully implemented, with only 67% of the respondents confirming that they had allocations for HIV and AIDS in their company budgets. A subsequent study conducted by NABCOA in 2008 also arrived at similar conclusions - that it was mainly the large companies that had well-established WPPs since these companies could afford to establish workplace policies and appoint coordinators within the corporate structure to coordinate the development and implementation of WPP activities[133].

From the trade union perspective, the National Union of Namibia Workers (NUNW) targets nine (9) affiliated unions with a membership of approximately 70,000 people. The union has a well established HIV and AIDS workplace programme that addresses four components – training and capacity development; advocacy lobbying and communication; leadership and institutional development; and establishment of a resource centre on HIV and AIDS.

Similarly TUCNA targets approximately 40,000 people in 15 affiliated trade unions. TUCNA's HIV and AIDS programme was established in 2009 with a focus on strengthening institutional programmes through training. Shop Stewards drive the programmes at company level.

The role of trade unions in the development and implementation of workplace programmes is critical to the successful scaling up of service uptake in the private sector institutions. To consolidate these efforts a HIV and AIDS tripartite agreement between NUNW, Ministry of Labour and Social Welfare and Namibia Employers Federation was developed. TUCNA has recently joint the tripartite group. The tripartite agreement is intended to accelerate the expansion and scaling up of comprehensive HIV and AIDS wellness and workplace programmes in the public and private sectors. The agreement is aligned to NSF priorities and results.

The WBCG, which addresses the high-risk transport sector, has developed a standard group WPP and facilitated interventions such as testing and counselling, and management training and sensitisation for its members. Currently there are 16 transport companies that are members and operate at the port of Walvis Bay and along Namibia's major transport routes. It has also developed sector-specific tools, for instance an information toolkit for drivers and peer educator manuals for transport-sector employees, and has started setting up Roadside Wellness centres that target mobile workers in high-risk areas.

The strategy for the NSF is to promote a Minimum Internal Package for HIV and AIDS workplace programmes. The contents of the MIP will depend on the sector or individual companies' capacity, resources, political will and commitment. The following is suggested as the Minimum Internal Package:

i. Peer HIV and AIDS education including awareness creation on epidemic drivers.
ii. HIV and AIDS Counselling and Testing (HCT)

[132] NABCOA and PricewaterhouseCoopers 2007, *Business Decision makers' survey*
[133] NABCOA 2008, *HIV and AIDS prevention strategies in the private sector*

iii. Condoms distribution and education
iv. Provision of Post Exposure Prophylaxis (PEP)
v. Prevention of STI
vi. Policies and strategies to reduce stigma and discrimination
vii. Establishment of an effective referral system to other HIV and AIDS related services such as ART, PMTCT, male circumcision, care and support for OVC, and TB/HIV
viii. Strategies for involving people living with HIV and AIDS
ix. Support for support groups within the organisation or company
x. Adequate policy guidelines, human and financial resources to support the operationalisation of the Minimum Internal Package.

Gaps and Challenges

i. Limited coordination of WPP interventions – there are several coordinating entities engaged in WPPs that cover various sectors, however the relationship structures amongst these organisations is unclear, neither is it clear who is ultimately responsible for settings standards with respect to WPPs in Namibia.
ii. Lack of a clear definition of a "comprehensive workplace programme" - failure to define a minimum intervention package has resulted in inconsistent implementation, and in some instances resulted in emphasis being placed on activities that have minimal impact.
iii. Few organisations have undertaken HIV prevalence surveys to establish their HIV workplace "status" which is necessary to develop relevant and appropriate WPPs.
iv. There are still only a limited number of workplaces with WPPs, and even fewer that have dedicated human resources to drive WPP implementation activities.
v. Inconsistent implementation of WPPs across sectors – some sectors such as transport have made significant progress while others are still yet to start.
vi. Workplaces are still characterized by stigma, fear and silence.
vii. Additional challenges within the public sector include the following: the absence of a performance appraisal system within the public sector, the lack of investment in human capital for aligning the WPP planning and implementation processes to be part of the broader sectors' planning and implementation cycles, and the absence of data/information within the public sector for evidence based WPP programming.
viii. Low coverage of small and medium enterprises in WPP interventions.
ix. Limited access to data / information on WPPs – there are no established data collection mechanisms and processes. In other instances, companies are unwilling to provide information.
x. Focal point people typically have other responsibilities in addition to managing the HIV and AIDS programmes. This situation prevails in both the private and public sector.
xi. Lack of leadership and management commitment to address HIV and AIDS in the workplace.
xii. Inadequate HIV and AIDS programmes for the small and medium size and informal business sectors.
xiii. Low percentage of low income employees on medical aid in both the public and private sector which affects access to ART.

5.4.5.2 Mainstreaming HIV and AIDS in Development Programmes

Mainstreaming HIV and AIDS in sector policies and integrating HIV and AIDS interventions into their development programmes creates a framework within which development practitioners are obligated to provide services to mitigate the impacts of HIV and AIDS among the beneficiaries of development programmes. In this context, the identification of duty bearers (service providers), and the extent of their accountability[134] is crucial to the implementation of the NSF and in particular the scaling up of essential services. Successful mainstreaming of HIV and AIDS largely depends on how individual organisations and/or sectors address the following questions:

- What is the Risk Factor to the organisation or how is the epidemic likely to affect the goals, objectives and programmes of the organisation or sector?
- How the spread of HIV is caused or contributed to by the organisation or sector through the implementation of their development programmes?
- Where does the comparative advantage of the organisation lie in responding to those causes and effects?

The following table illustrates the various levels of mainstreaming HIV and AIDS.

Table 3: Instruments to be used to mainstream HIV and AIDS in development work

Level for mainstreaming	Suggested Instruments for Mainstreaming
National	• National Strategic Visions (documents) • National Development Plans • Poverty Reduction Strategy • Medium Term Expenditure Frameworks • National Human Resources Development Strategies
Sectoral	• Sectoral mandates, policies and budgets • Human Resources Development Plans • Sector-wide approaches • Sector specific development programmes plans
Sub-National	• Regional and community development projects • Local community development responses

In 2001, the UN General Assembly Special Session (UNGASS) Declaration of Commitment on HIV and AIDS required countries to integrate their HIV and AIDS response into the national development process, including poverty reduction strategies, budgeting, human resources and in sectoral programmes

Gaps and Challenges in Mainstreaming HIV and AIDS in Development Programmes

i. A lack of consensus on the meaning and importance of mainstreaming in development work remains a challenge. This gap is particularly due to a failure to appreciate the risk factors posed by HIV and AIDS on different sectors, including their human resources.

ii. Most experiences to date are of insufficient scale to achieve the multi-sectoral effects required to produce a sustained impact on causes and consequences of HIV and AIDS.

Through mainstreaming, the process helps to institutionalise national HIV and AIDS response within the development instruments and processes. This process ultimately will ensure sustainability of HIV and AIDS programmes and strengthen the national coping capacity.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and subsequently contribute to the impact results

Code	Outcome Result
OC50:	**HIV and AIDS is mainstreamed:** % of regions and sectors that have mainstreamed HIV, planned and implemented their HIV response every year in a collaborative manner by FY2015/16

Code	Output Result
	Sectors and Regions have mainstreamed HIV and AIDS
OP97:	% of sectors that have reviewed their policies and programmes and integrated HIV and AIDS activities in their development programmes and are implementing them in line with the NSF services has increased to 50% in FY2012/13 and to 80% in FY2015/16.
OC98:	Number of small, medium and large enterprises implementing a comprehensive HIV and AIDS workplace programme with a budget is increased from 50 in 2007 to 150 in FY2012/13 and to 200 in FY2015/16
OP99:	% of the public sector, civil society and private sector work force accessing quality and comprehensive HIV and AIDS services through workplace programmes is increased from 6%[135] in 2008 to 25% in FY2012/13 and to 45% in FY2015/16

Strategies

i. To strengthen the national capacity to develop, implement, coordinate and monitor workplace programmes at sector and institutional levels.
ii. To strengthen the capacity of the various sectors to evaluate, understand and respond to the critical HIV risk factors to the organisation and at the same time address cause and consequences of their work in fuelling the spread of AIDS. The sectors will be encouraged to institute impact mitigation interventions where necessary.

Priority Actions

HIV and AIDS mainstreaming will take place at national, sectoral and regional levels. The NSF has suggested some instruments that will be used to mainstream HIV and AIDS in development work as shown in the table below. The following specific priority actions will be undertaken:

[134] HACI / UNICEF 2004, *Guidelines for HIV and AIDS programming for OVC interventions in post conflict environments*
[135] Vulnerable Households defined as those households with elderly, OVC and PLHIV

Code	Description of main activities
5.4.5.1	Review sector policies and mainstream HIV and AIDS in development programmes
5.4.5.2	Strengthen sector capacity for mainstreaming HIV and AIDS, and gender in development / capital projects
5.4.5.3	Accelerate the application and use of national guidelines on HIV and AIDS mainstreaming, planning and budgeting in all corporate functions
5.4.5.4	Provide technical assistance to all sectors to establish HIV and AIDS workplace programmes
5.4.5.5	Strengthen capacity of sectors to conduct their own sectoral analysis of the impacts of HIV and AIDS
5.4.5.6	Strengthen the coordination of workplace and wellness programmes

5.4.6 Resource Mobilisation and Management

Situation Analysis

The implementation of the NSF will require adequate financial, human and material resources. The management of these resources is equally important in-order to ensure equity in services distribution, provision and sustainability of operations.

Financial Resources

The financing of HIV and AIDS in Namibia is largely dependent on domestic and international funding. Over the years, the Government of Namibia has increased its funding for HIV and AIDS significantly. Fifty percent (50%) of the funding comes from domestic resources, mainly from the Government of Namibia while the remaining 50% comes from external resources. Among the key development partners funding the Namibia response include Global Fund to Fight AIDS, TB and Malaria (GFATM), Presidents Emergency Plan for AIDS Relief (PEPFAR), GTZ, United Nations Agencies and private donors. The private sector tends to mobilise their own resources to support private sector workplace HIV and AIDS programmes. A minimal but critical contribution comes from communities both in cash and material support.

The review of MTP-III[136] indicated that available resources are insufficient to fully fund the national multi-sectoral response. A key constraint in resource mobilisation has been the lack of adequate capacity, especially among civil society and the private sector institutions. Fundraising has also been largely uncoordinated and fragmented.

Given the importance of HIV prevention in the overall response, the funding for prevention has been inadequate. However, the Government acknowledges that investing in prevention has long term collateral benefits in reducing the burden in treatment, care and support and addressing impact mitigation.

The Public Private Partnership for HIV and AIDS has not been systematically developed in Namibia. This has an impact on resource mobilisation and flows especially from the private sector to the national multi-sectoral response. This is partly due to lack of a conducive and attractive environment for private sector

investment in the response. To a large extent this has compromised the potential to leverage resources through the private public partnerships (PPP).

Other Resources

In addition to financial resources, HIV and AIDS response face major challenges in terms of availability of adequate skilled and experienced human resources across all sectors and regions. While Namibia has done well in developing its human resources the epidemic has negatively impacted on these resources as some people succumb to AIDS and become less productive or have died. This trend may contribute to Namibia being dependent on imported labour. The shortage of skilled manpower may also become a barrier in the utilisation of existing resources earmarked for HIV and AIDS response, not to mention the overall socio-economic development.

However, Namibia is scaling up its efforts to improve the quality of life of PLHIV and ensure that they remain productive through comprehensive treatment, care and support programmes.

With regard to skills development, Namibia in collaboration with development partners has initiated several programmes for internal and external training of required human resources. Namibia has also established its School of Medicine at the University of Namibia. The National Polytechnic also continues to train other cadres required for HIV and AIDS and the health service.

The country's infrastructure that supports the provision of health and HIV and AIDS related services is fairly well established. However given the need to scale up some of the key interventions such as ART, PMTCT, HCT, male circumcision, condom distribution, OVC care and support, among others, there is urgent need to renovate existing structures, expand availability of space and increase outreach coverage of services through mobile units.

Gaps and challenges

i. No national sustainability funding plan;
ii. Inadequate investment in prevention as a proportion of total AIDS expenditure;
iii. Inadequate funding availability to support the response by civil society;
iv. Private public partnership arrangements are limited;
v. Limited allocation of funding to the local level;
vi. Inadequate human capacity to absorb available funds earmarked for HIV and AIDS;
vii. The disbursement and monitoring of funds to community based organisation have been identified to be weak;
viii. Recent reviews show that civil society organisations are under-resourced. The potential for civil society had not been realised due to lack of resources and inadequate capacity for resource mobilisation.
ix. Resource tracking from both the supply and demand ends has been inadequate. Accountability is often compromised given that no one system is tracking where the money is coming from, where it is going and how the money is being used. In the absence of the National AIDS Spending Assessment it is difficult to objectively establish resource gaps by programmes or by implementing partners.

x. Limited diversification of funding of the national AIDS response. A mapping of the current funding sources indicates that Namibia is dependent largely on a handful of donors. In the long term this will be a risk factor in the event that one of the key donors withdraws or substantially reduce its funding. Currently Namibia has only received funding from the GFATM for one round - Round 2 - which comes to an end in December 2009. GFATM has approved the Rolling Continuous Channel application for HIV and AIDS for the next six years.

xi. Delayed disbursement of available funding. The general perception is that disbursement of available funding is not made in time from national level structures to lower level structures.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC51:	**Well managed financial resources:** 100% of the NSF financial resources are mobilised and efficiently used by FY2015/16

Code	Output Result
	Resources for the national response are available and well managed
OP100:	% public sectors and regions with annual costed HIV action plans that are harmonised with the GRN financial year have increased to 50% in FY2012/13 and to 100% by FY2015/16.
OP101:	% of government funding spent on health has increased from 11% in 2003 to 14% in FY2012/13 and to 15% in FY2015/16.
OP102:	Amount of domestic (government, private sector and other national sources) and international AIDS spending by categories and financing has increased 80% by 2012/13 and 100% by 2015/16
OP103:	% of National HIV and AIDS expenditure that is domestic increased from 50% in 2007 to 60% by 2012/13 and 70% by 2015/16

Strategy

To develop a capacity for resource mobilisation, tracking and sustainability

Priority Actions

Code	Activity description:
5.4.6.1	Train sector planning and budget officers on HIV and AIDS planning using evidence and results based management approaches
5.4.6.2	Develop and operationalise a resource mobilisation strategy
5.4.6.3	Strengthen donor coordination mechanisms
5.4.6.4	Develop financial sustainability strategies

5.4.7 Monitoring and Evaluation, and HIV Research

Situation Analysis

Namibia adopted a multi-sectoral approach for the implementation of the national HIV and AIDS response during the Medium Term Plans II and III. The country also adopted and institutionalised the Three Ones principle, one of which is one national multisectoral framework for HIV and AIDS. In September 2006, Namibia launched the first costed national multi-sectoral HIV and AIDS plan that was used for monitoring and evaluating the progress and achievements of MTP-III.

The monitoring and evaluation of health facility based responses is coordinated and managed by the MOHSS in collaboration with private sector institutions and civil society organisations that run health facilities. Data is reported through the Health Information System. The monitoring of non-health facility based services is conducted by a wide range of stakeholders primarily from communities. Namibia has developed a non-health monitoring system known as Systems for Programme Monitoring (SPM).

The current M&E plan comes to an end by March 2010 and a new plan is being developed that is aligned to the NSF. The new plan is expected to ensure effective and efficient monitoring and evaluation of the NSF based on the agreed national priority impact, outcome and output results. These results are articulated in the NSF Results Framework. The plan will also be used to guide, track and monitor Namibia's performance towards achieving its international commitments including Millennium Development Goals, UNGASS, the Abuja and other Southern African Development Community and African Union commitments.

The Ministry has established and staffed a unit in the Directorate of Special Programmes (DSP) to facilitate the multi-sectoral M&E. Other stakeholders have also established similar institutional based M&E units and have assigned staff to manage the M&E system. At the regional level, RACOCs have M&E desks and health facilities have M&E staff positions established. In most health facilities, data clerks have been recruited. An M&E Technical Working Group has been established to provide technical support to stakeholders in M&E. NAC and NAEC have the overall policy oversight on M&E.

Skilled and experienced human resources are primary requirements for a functional M&E system. However, M&E human resources remain a critical challenge for the monitoring of the multi-sectoral response. In most cases people serving as M&E officers as not necessarily M&E specialists but are persons who have been assigned to the job; however, some have gained a wealth of experience on M&E systems.

Strategic partnerships and alliances have been formed with development partners and various stakeholders to support multi-sectoral planning, coordination and management of the HIV M&E system. Some key areas where partnerships have added value include the development of the national costed M&E plan, data collection, analysis, triangulation and quality control, and in human resources development through recruitment of new staff and training.

Namibia has continued to conduct HIV and AIDS related surveys and surveillance to generate the evidence necessary for policy planning and HIV and AIDS programming. Biological HIV routine surveillance is conducted every two years amongst women attending antenatal clinics. The DHS and the Household Income and Expenditure Survey are conducted every five years. During the implementation of the MTP-III, Namibia also conducted several other biological and behavioural surveys and studies including KAPBs, a study on epidemic drivers, and micro-biological surveillance for sexually transmitted infections (2007) among others.

Namibia does not have a single multi-sectoral HIV and AIDS database. However, a number of programmes have functional related databases that collect both medical/clinical and non-medical data. The HIS database is maintained by MOHSS. The District Health Information System is also in place. Currently the Ministry is in the process of developing a national multi-sectoral HIV and AIDS database. It is also planning to roll out and mainstream the UNAIDS Country Response Information Systems (CRIS) in the regions to enhance monitoring and reporting of non health facility-based HIV and AIDS services.

In order to improve on data quality, data auditing and supervision is done routinely. The MOHSS is responsible for supervising and auditing health facility-based data. However, there are no guidelines for supervising data collectors for non health facility-based services or for quality assurance.

While Namibia has conducted a number of HIV research studies, the institutional arrangement for HIV and AIDS research remains underdeveloped. A national Ethical and Research Committee has been established. Its capacity will need strengthening to ensure efficiency and effectiveness.

Namibia has developed an HIV Research and Evaluation Agenda as part of the NSF development process. The agenda will be reviewed and updated every two years. The NSF will support the implementation of the research agenda and strengthen the Ethical and Research Committee. A number of surveys and studies are planned to be conducted during the period of the NSF (Annex 5). In strengthening the coordination capacity for research, the focus will be to ensure that all identified and prioritised studies have been conducted. The NSF will promote strategies that will reduce the number of research undertaken without the approval of the Ethical and Research Committee.

Dissemination and use of M&E and research data has remained weak. The dissemination of data has been limited and consequently has compromised the use of such data and information in decision making, policy formulation and programme planning. A key challenge is in the absence of a national multi-sectoral database, information is fragmented and difficult to access.

Gaps and Challenges

The following are the strategic gaps that need to be addressed during the implementation of the NSF:

i. Not all stakeholders have aligned or harmonised their M&E systems with the national M&E system;
ii. Lack of skilled and experienced M&E staff at all levels;
iii. Monitoring and evaluation of the non-health facility-based services remains weak and largely uncoordinated. The Systems for Programme Monitoring has not taken root fully especially

outside of the government system and a few development partners;

iv. Data quality assurance systems are under developed;

v. Use of M&E and research information and data remains inadequate in policy formulation, decision making, and in programme planning;

vi. Namibia has not developed a research agenda;

vii. Namibia does not have a national repository for HIV and AIDS research;

viii. Channels for disseminating M&E and research information is weak and inadequate;

ix. Where data is available it is not readily accessible in a user friendly manner;

x. HIV research and M&E are under-funded;

xi. Capacity for research is inadequate and under-developed;

xii. The role and terms of reference for the M&E Technical Working Group are not clearly understood by many people. The composition is not based on any technical criteria;

xiii. Programme level databases are operating on a vertical basis and largely remain isolated from each other. Hence the synergy between different systems such as electronic Patient Monitoring System (e-PMS), Electronic Dispensing Tool (EDT) system, and System for Programme Monitoring (SPM) have not been adequately developed.

Outcome and Output level results

The implementation of the priority actions will result in the achievement of the following **outcome** and **output** level results and will subsequently contribute to the impact results.

Code	Outcome Result
OC52:	**National M&E system tracks NSF progress:** The country's functional M&E system provides indicator values for 70% of the NSF results framework indicators by FY2012/13, and for 90% by FY2015/16.

Code	Output Result
	All stakeholders are aligned or harmonised with the national M&E system
OP104:	Joint AIDS Annual Reviews of the NSF have been held annually by 2015/16, with a Mid-term review in 2012/13 and end evaluation in 2015/16
OP105:	National M&E plan and HIV targets have been revised in 2012/13 and in 2015/16
OP106:	80% of the implementers are using standardised M&E tools by 2012/13 increasing to 95% by 2015/16
	HIV Research results informs response management
OP107:	NDHS+, BSS and QUIMs surveys for understanding the epidemic have been completed by 2012/13, and AIS has been conducted and used to inform end evaluation of current NSF and planning for the next NSF by 2015/16
OP108:	HIV research agenda has been updated at least once in the last 24 months.

Strategy

All stakeholders to have aligned or harmonised their M&E systems with the national M&E system.

Priority Actions

The following priority actions will be undertaken to ensure that a functional M&E system is developed and in place.

Code	Description of main activities
5.4.7.1	Operationalise the National M&E plan and Work plan
5.4.7.2	Strengthen the capacity of stakeholders to generate data necessary for validating the NSF results
5.4.7.3	Conduct quarterly M&E supervision missions
5.4.7.4	Strengthen national capacity to conduct HIV research

5.4.8 Costing of the National Strategic Framework

Overview

The costing of the National Strategic Framework was carried out according to a results based framework by developing a Resource Needs Model (RNM) tailored to the Namibian situation. The model provides a tool to estimate the resources required to respond to various HIV and AIDS interventions and programmes. It uses three basic criteria to achieve this: the size of the population targeted by the intervention or programme, the coverage or access targets of that target population and the unit cost of reaching each person targeted.

Demographic and epidemiological estimates were adopted by the country from the Spectrum modelling (MOHSS 2009[137]) during the preparation of the NSF, as well as from other relevant sources such as the NDHS 2006/7, the NPC's population projections based on the 2001 census[138] and the Sentinel Survey 2008. These were used to determine population targets.

Target setting and coverage rates were decided upon by programme experts by using current coverage and the anticipated rate of roll out of each programme or intervention. Unit costs were estimated through consultations with experts and other relevant players and verified through multiple sources. Although the Spectrum model allows for three levels of estimates (low, medium and high scenarios), the costing was carried out at one level only as the approved estimates were a combination of the different scenarios.

In order to facilitate budgeting at regional, sectoral and national levels, a more detailed costing exercise was carried out using an activity based approach. Under this approach, all activities required to implement the NSF, together with their related sub-activities, were identified and costed in detail by determining expected target levels for each activity and applying the estimated unit costs.

[136] MOHSS 2009, *MTP-III Review Status Report*
[137] MOHSS 2009, *Estimates and Projections of the Impact of HIV/AIDS in Namibia, 2008/9*
[138] National Planning Commission (NPC) 2003, *2001 Population and Housing Census. National Report. Basic Analysis with Highlights.*

Resource Needs Estimates

The total resource needs for the NSF was generated using the Resource Needs Model. The need for the next six years is estimated to be N$ 12,497,978,552. The need for the first three years i.e. FY2010/11 to FY2012/13 is estimated at N$ 5 672 586 352. A detailed summary of the NSF resource needs, costed by thematic and programme areas, is presented in Annex 3.

5.4.9 Sustainability of the National Response

The Namibian Government has continued to strengthen the national response to HIV and AIDS by developing appropriate policies, legal instruments and by providing financial, human and material resources. The infrastructure, especially in the context of the health sector, is fairly developed. Decentralised service delivery systems are continually being strengthened. As the epidemic unfolds and more services are made available, the demand for resources will increase. A key example is the increased number of people now eligible for ART. The demand for complementary services will also increase.

To move towards sustainability Government funding for HIV and AIDS must be increased to a sustainability threshold of more than two thirds (66%) of the total funding. Currently government funding is approximately 50% of the total resource needs for HIV and AIDS. Most of the external resources also come from two main development partners i.e. GFATM and PEPFAR. Dependence on a few funding agencies poses a serious risk in the event that one of the partners had to stop or reduce its funding significantly. This calls for a comprehensive sustainability strategy.

The challenge for sustained and increased funding is further compounded by the recent global financial crisis. Namibia is likely to experience deficits in its external trade earning as result of the economic down turn. A clear example is the decline in income from Southern African Customs Union (SACU) which makes up to 40% of government funds. The trickle-down effect means that funding for HIV and AIDS will also be affected as competition for resources increases. Similarly international development partner resources are likely to scale-back because of economic conditions and likely changes in developing partner priorities. Key challenges to sustainability are human resource capacity, coupled with high levels of poverty, income disparities and inadequate infrastructure. Meeting these challenges will require long term efforts by a number of sectors. In addressing the challenges of sustainability, Namibia will consider a number of options including:

i. Increasing government funding
ii. Establishing alternative sources of funds such as introduction of a HIV levy, endowment fund, tax exemptions on funds providing to support HIV and AIDS interventions
iii. Expanding the donor base
iv. Strengthening public private partnerships

In the context of other aspects of the response sustainability Namibia will:

i. Invest in human resources including, the establishment of a Medical School at UNAM
ii. Improve and expand the existing infrastructure
iii. Strengthen partnerships with civil society organisations in a more meaningful manner so that further aspects of the response are decentralised to them for implementation.

Overall coordination of the response will be improved to be more efficient and effective at all levels of the response.

Annexes

Annex 1: Glossary of Terms used in the NSF

Terminology	Definition
Three Ones principle	Three Ones principle means a country having one national coordinating authority, one national strategic framework and one national M&E framework.
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
Epidemic threshold	The level at which the epidemic cannot sustain itself and stops growing.
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.
Impact result	Long term positive changes in the lives of people, condition or organisation arising from an intervention.
Impact Mitigation	A strategy used to alleviate social and economic negative forces on the lives of people and society and contributes to lessening the burden of HIV and AIDS, poverty and income inequalities.
Input	Pre-requisite resources (human, information, finance) required to support activity implementation to produce outputs.
Multiple and concurrent sexual partners	This is a composite term, made up of those with multiple sexual partners and those with concurrent sexual partners. The term '**multiple sexual partners'** refers to when a person has sex with more than one person over a period of time. These partnerships could be overlapping or not. The prevalence of the population with multiple sexual partners is referred to as 'multiple partner prevalence'. The term '**concurrent sexual partners'** refers to when a person has "overlapping sexual partnerships where sexual intercourse with one partner occurs between two acts of intercourse with another partner" (UNAIDS Reference Group on Estimates, Modelling, and Projections, 2009).
Outcome	A change in behaviour (values, attitudes, practices etc) of, or the use of new capacities (laws, policies etc) by target group (people and institutions).
Output	Operational changes or new capacities (knowledge, skills and equipment, products and services) which result from the completion of activities within a specified intervention in a given time.
Region	An administrative geographical area with clearly defined boundaries. Namibia has 13 administrative regions.
Regional Coordination	A decentralised arrangement for a multi-sectoral coordination of HIV and AIDS activities in a particular administrative region
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 Management	A Planning and management strategy that focuses on the achievement of results (impact, outcome and output) at all levels through a systematic and evidence-based strategic and results-based planning.

Results based planning	Part of the results-based management approach: it involves using evidence to understand the current situation and weaknesses, and then to plan based on the current situation and other evidence of what is most cost effective to address the weaknesses in the program.
Results Framework	A diagrammatic illustration of the logical chain of results that will lead to strategic objectives being achieved.
Sector	A section of society that has common characteristics or interests. The mandates of sectors differ depending on the nature of their core business. The categorisation of the sectors is provided in Annex 4
Vulnerable households	'Vulnerable households' are defined as households with the elderly, OVC and PLHIV

Annex 2: Summary of the relationship between NSF and other policy frameworks

National Policy Framework	What does the framework intended to do / achieve	How will NSF contribute or complement to its realisation
Vision 2030	Improved quality of Life (life expectancy is 68 years for males and 70 years for females	The NSF will contribute to improve quality of life through a reduction in mortality and morbidity associated with HIV and AIDS. The impact level result for treatment care and support is to increase life expectancy from 51.6 years in 2008 to 55 years by 2015. Vulnerable households will also be strengthened to cope with the impacts of HIV and AIDS. New HIV infections will be reduced by 50% by 2015
	Implement aggressively the HIV and AIDS reduction plan	The NSF has consolidated the multi-sectoral approach and planning by providing opportunities for all stakeholders' participation in the implementation of the HIV and AIDS reduction plan. Regions and sectors for the first time developed their own HIV and AIDS operational plans aligned to NSF
Third National Development Plan	**Human Resources**: ***NDP3 Goal (8):*** *Adequate supply of qualified, productive and competitive labour force* • "The country is fully cognisant of the threat to human resources. posed by HIV and AIDS pandemic" • "Improve system response to the impact of HIV and AIDS"	The NSF will: • Initiate programmes that reduce mortality and morbidity through treatment, care and support and allow people to continue being economically productive and competitive in the labour market • Expand the scope and ownership of the national multi-sectoral response through regional and sector operational plans that are aligned to the National Operational plan and NSF priority results. • Prevent new HIV infections thereby ensuring a HIV free generation pool of human resources
	Quality of life: ***NDP3 Goal (10)****: Affordable and quality health care*. • Prioritise improved access to health care, health facilities • Provide affordable and accessible quality health and social services	• Capacity of service providers will be strengthened to ensure availability of services country wide • Services will be scaled up / rolled out to all health facilities, through CHBC and through mobile outreach services to previously under-served regions • Communities will be mobilised and sensitised on the availability of HIV and AIDS and other related services

	Quality of life ***NDP3 Goal(11):*** *Reduced spread of HIV and AIDS and its effects*	The NSF will contribute to this goal through the implementation of the intensified, coordinated and targeted prevention activities. The focus will be on the behavioural, structural and biomedical epidemic drivers. This will also address other factors such as gender and income inequality
	Equality and Social Welfare: ***NDP3 Goal(13):*** *Reduced inequality and social welfare* • *"Create and maintain a conducive policy, legal and regulatory framework and environment where all social welfare issues could be played out securing equity, affordability, and equal access to such services for all"* •	• The NSF will advocate for review of existing policies and legislation, and the creation of new ones to facilitate, strengthen and consolidate the enabling environment • Duty bearers and rights holders will be sensitised and mobilised to objectively exercise their roles and responsibilities in the delivery and access to services • The coordination of impact mitigation services will be strengthened including strengthening community systems to effectively and efficiently deliver appropriate services
Third National Development Plan	**Equality and Social Welfare:** ***NDP3 Goal(14)****: A society imbued with culture, tradition and morality* • *"encourage the private sector to engage more actively in youth development through partnerships, exposure and job attachment"* • *"develop cultural response to HIV and AIDS* • *"engage faith based organisations to promote moral values"*	• A key tenet of the NSF is equity in health, social and welfare services provision including to most at risk and vulnerable populations. • The NSF promotes public private partnerships (PPP) that will address youth development needs and mitigate the impacts of HIV including keeping young people out of transactional sex • Under HIV Prevention- the NSF supports interventions that promote change in social norms, values and practices that fuel the spread of HIV. The role of traditional leaders has been identified as one of the success factors in this endeavour. • The NSF will not only consolidate the existing partnerships with civil society organisations including faith based organisation but will also establish strategic alliances with such organisations in its implementation.
	Equality and Social Welfare ***NDP3 Goal(15)****: Gender equality* This section states that the consequences of gender inequality and patriarchy, such as gender based violence, poverty and lack of access to social and economic resources place women at a particular risk of HIV. The goal has called for all national strategies on HIV and AIDS to mainstream gender issues.	• Gender mainstreaming is one of the guiding principles that have guided the development of the NSF. Gender dimensions have been incorporated in operational strategies and in the anticipated impact, outcome and output results.

Poverty Reduction Strategy for Namibia	The strategy has stated that some of its aims are to: • reduce the level national levels of poverty • promote equitable and efficient delivery of public services • strengthen food security	• The NSF impact level result for impact mitigation programmes aims at reducing the percentage of poor households from 28% (2008) to 20% by 2015. In addition vulnerable households will be capacitated to cope with the impact of HIV and AIDS including deepening levels of poverty. • The NSF has suggested a framework for effectively and efficiently coordinating the delivery of services targeted for vulnerable households including those with OVC and PLHIV. • NSF has articulated strategies for strengthening household and community food security and in particular enabling them to move towards self-reliance.
National HIV and AIDS Policy	**Policy objective 1**: "Support the strengthening of a multi-sectoral and multi-disciplinary institutional framework for coordination and implementation of the HIV and AIDS programmes"	• NSF has articulated strategies for strengthening the coordination mechanism for the multi-sectoral response. • The development of regional and sector operational plans for the NSF has expanded the scope of the multi-sectoral involvement and participation • The identification of national results that all stakeholders subscribe to creates a harmonised multi-sectoral approach to addressing national priorities
	Thematic Programme Focus	The NSF prioritised programme areas are aligned to those identified in the National policy.

Annnex 3: NSF resource needs: National Operational Plan

NSF Programme Area	Estimated Cost (US$)		Percentage
	Mid-term	Five year	
1. Social and Behaviour Change	111,712,433	244,897,035	15.7
2. HIV Counselling and Testing	104,905,017	243,370,834	15.6
3. Condom Social Marketing and Distribution	21,189,460	46,017,407	2.9
4. Prevention of HIV among the Most at Risk	5,503,500	10,078,500	0.6
5. Involvement of People Living with HIV	12,808,190	17,168,394	1.1
6. Medical Male Circumcision	46,581,894	83,997,257	5.4
7. Prevention of Mother to Child Transmission	13,140,720	27,617,395	1.8
8. Post Exposure Prophylaxis	16,549,829	40,856,831	2.6
9. Prevention of Sexually Transmitted Infections	1,218,548	2,017,680	0.1
10. Blood Safety and Universal Precautions	14,483,472	33,733,989	2.2
11. Universal Precautions	917,850	1,151,850	0.1
1. Pre-Anti Retroviral Therapy	11,770,141	21,958,432	1.4
2. TB/HIV Co-infection	13,011,042	24,205,146	1.5
3. Anti Retroviral Therapy	169,411,499	343,855,529	22
4. Care and Support	30,641,499	64,113,784	4.1

1. Vulnerable Households and Sustainable Livelihoods	30,100,531	127,629,031	8.2
2. Care and Support for OVC	27,599,298	61,330,859	3.9
3. Legal Rights and Protection Services for Vulnerable Persons	3,210,845	7,188,108	0.5
4. Food Security and Nutrition Support Programmes for Vulnerable Households	38,560,711	90,996,820	5.8
1. Institutional Arrangement, Coordination and Management	3,628,019	8,322,644	0.5
2. Enabling Policy and Legal Environment	4,723,111	9,569,359	0.6
3. Capacity Development	815,806	815,806	0.1
4. Community Systems Strengthening	17,126,500	33,312,250	2.1
5. HIV Mainstreaming, Policy and Advocacy	2,129,750	4,554,000	0.3
6. Resource Mobilisation and Management	282,500	407,250	0
7. Monitoring and Evaluation	7,051,129	13,081,129	0.8
TOTAL RESOURCES NEEDED US$	**709,073,294**	**1,562,247,319**	**100**
N$	**5,672,586,352**	**12,497,978,552**	

Calculated at exchange rate US$: N$ = 1:8

Annex 4: Sector categorisation

The following is a revised list of sector classification for purposes of planning the sector plans for the National Strategic Framework for HIV and AIDS 2010/11 to 2015/16.

1. Agriculture Water and Forestry
2. Education
3. Environment and Tourism
4. Finance
5. Fisheries and Marine Resources
6. Governance and Leadership
7. Health
8. Information and communication
9. Labour
10. Mining and Energy
11. Social Protection and Gender
12. Trade and Commerce
13. Transport and Works
14. Uniform Services

Annex 5: Inventory of prioritised planned HIV and AIDS research and evaluation studies and surveys

Strengthen the capacity of stakeholders to generate data necessary for validating the NSF results	
PREVENTION	**When**
AIDS Indicator Survey (AIS)	2014/15
Prevention with Positives (PWP) study	2012/13
Mode of Transmission (MOT) study	2013/14
Namibia Demographic and Health Survey plus (NDHS+)	2011/12
Study on changing gender norms that support HIV risk behaviours among young men in Namibia	2012/13
Study on condom needs assessment including condom availability and quality assessment in Namibia	2011/12
STI aetiological study to determine the aetiologies of the three common syndromes	2012/13
Aetiological survey for genital infections among HIV-infected adults entering HIV care	2011/12
Counselling intervention behaviour change study (Men's Study)	2012/13
Counselling intervention trial to reduce alcohol-related HIV risks in Namibia	2011/12
Exploratory investigation of drinking and sex contexts among women (Women's Study)	2011/12
Shebeen demonstration project (study on alcohol consumption and HIV risk reduction)	2010/11
Exploratory study among vulnerable young women (Women's Study)	2011/12
Formative assessment with recently released inmates in Namibia	2011/12
HIV prevalence survey in Namibian corrections facilities	2011/12
HIV Sentinel surveillance in ANC clinics	2010/11, 2012/13, 2014/15
MSM Size Estimation and Integrated Bio-Behavioural Study (IBBS)	2010/11
CSW Size Estimation and Integrated Bio-Behavioural Study (IBBS)	2010/11
Shebeen demonstration project (study on alcohol consumption and HIV risk reduction)	2010/11
Study on reaching vulnerable target groups with sexual reproductive health/STI services	2011/12
Study to strengthen the BCC outreach programme	2011/12
Study on Infant and young child feeding in PMTCT	2011/12
Multiple and concurrent partnerships (MCP) evaluation study	2010/11
Process and outcome evaluation of the Windows of Hope Life Skills Prevention Programme	2012/13
Study of Health Behaviours After Male Circumcision	2012/13
Effectiveness of a Community Level Intervention on Individual Behaviour Change	2011/12
Evaluation of the Communication for Behavioural Impact (COMBI) project	2010/11

CARE AND TREATMENT	When
Study on compliance to guidelines and evaluation of medicines prescription including ARVs	2012/13
Impact of ART adherence interventions study	2012/13
Carry out Public Health evaluation for Palliative Care in Namibia	2012/13
Study on AZT/Anaemia	2010/11
Evaluation of an Intervention Toolkit for HIV Care and Treatment Settings	2012/13
Study on improving clinical outcomes through patient education (ART literacy)	2012/13
Nutrition study among people living with HIV	2010/11
TB MDR Survey	Every 2 years
ART Drug resistance monitoring	Annual
IMPACT MITIGATION	
HIV and AIDS Stigma Instrument (HASI) Index determination	2012/13
Operational Research on Adolescent Girls	2011/12
Risks and Vulnerability to HIV of Adolescents	2011/12
Service coverage of PLHIV in support groups	Every 2 years
Quality of Impact Mitigation Services (QUIMS) survey including OVC policy index determination	2011/12
Study on understanding and reducing sexual vulnerability of adolescent OVC (multi-country Population Health and Environment (PHE)	2011/12
RESPONSE MANAGEMENT	
Mid-term Review of NSF	2012/13
End Term review of the NSF	2015/16
Qualitative assessment of the extent to which national policies and legal instruments incorporate human and legal rights	2011/12
Survey of workplace programmes in Namibia in the public sector	2011/12, 2013/14, 2015/16
Survey of workplace programmes in Namibia in the private sector	2011/12, 2013/14, 2015/16
National Composite Policy Index (NCPI) determination	Every 2 years
National AIDS Spending Assessment (NASA)	Every 2 years
HIV and AIDS Data triangulation	Every 2 years