



Republic of Namibia
Ministry of Health and Social Services

GLOBAL AIDS RESPONSE PROGRESS REPORTING 2013
Monitoring the 2011 Political Declaration on HIV/AIDS

Reporting Period: 2012 - 2013

Directorate of Special Programmes
Division Expanded National HIV/AIDS Coordination
Subdivision: Response Monitoring and Evaluation
Private Bag 13198
Windhoek, Namibia
Tel: +264-61-203-2833
Fax: +264-61-22-4155
Email: rm&e@nacop.net

PREFACE

As a country, Namibia is a signatory to many international and regional commitments; and has also ratified many international treaties and charters. Namibia therefore has a responsibility to provide periodic progress reports on its commitments. One such commitment includes that on HIV and AIDS. As a country, we need to monitor the AIDS response in line with the renewed mandates of the 2011 UN High Level Meeting.

The 2011 High Level Meeting of the United Nations General Assembly came up with a Political Declaration and commitment: by 2015 to half the transmission of HIV, eliminate mother to child transmission, increase access to ART to 15 million people and reduce TB deaths among People Living with HIV by 50%. These targets are closely aligned with the targets of the Namibia National Strategic Framework (NSF) for HIV and AIDS, which forms the basis of the national response.

As part of the process of tracking Namibia's progress, a mid-term review of the National Strategic Framework was conducted in 2013. The process looked at progress made in the implementation of the National Strategic Plan 2009/10 – 2015/16. It also led to the revision of the NSF and development of the Combination Prevention Strategy.

This progress report is an important aspect of the mutual accountability mechanism for measuring progress on the global AIDS response. The compilation of this report included consultations, interviews, data collection and validation from a wide spectrum of stakeholders including government officials, Civil Society Organisations, the UN and other development partners. The broad consultative process is important in strengthening partnerships, as well as improving transparency. Since this reporting process immediately follows the NSF midterm review, most of the data and information used are from the MTR process.

We therefore acknowledge with thank the cooperation of all the stakeholders who supported the process.

The Ministry would also like to thank the Directorates of Special Programmes for its leadership and ensuring the availability of this valuable product.



MR. A. NDISHISHI

**PERMANENT SECRETARY: MINISTRY OF HEALTH AND SOCIAL SERVICES
AND CHAIR OF THE NATIONAL AIDS EXECUTIVE COMMITTEE (NAEC)**

Contents

List of Abbreviations	5
List of Figures	7
List of Tables	7
1. Status at a glance	8
1.1 Introduction	8
1.2 Country profile.....	8
1.3 Indicator data in an overview table	10
2. Overview of the AIDS epidemic	13
3. National response to the AIDS epidemic	18
3.1 Prevention.....	18
3.1.1 Social and Behaviour Change	20
3.1.2 HIV Counselling and Testing	21
3.1.3 Condom Promotion and Distribution	22
3.1.4 Prevention of HIV among Key Populations and Vulnerable Groups	25
3.1.5 Involvement of PLHIV	27
3.1.6 Voluntary Medical Male Circumcision.....	28
3.1.7 Prevention of Mother To Child Transmission	28
3.1.8 Prevention of Sexually Transmitted Infections.....	30
3.1.9 Blood Safety.....	30
3.1.10 Universal Precaution	31
3.2 Treatment Care and Support	31
3.2.1 Pre – ART	31
3.2.2 Antiretroviral Therapy	32
3.2.3 TB/HIV Co-infection	34
3.2. 4 Care and Support.....	34
3.3 Impact Mitigation.....	35
3.3.1 Vulnerable Households and Sustainable Livelihoods.....	35
3.3.2 Care and Support for OVC.....	36
3.3.3 Legal Rights and Protection Services for Vulnerable Groups	40
3.3.4 Food security and Nutrition for Vulnerable Households and Vulnerable People	40
3.4 Response Management and Coordination.....	41

3.4.1 Institutional Arrangement, Coordination and Management.....	41
3.4.2 Enabling Policy and Legal Environment	43
3.4.3 Capacity Development.....	45
3.4.4 Resource Mobilisation	46
3.5 Monitoring and evaluation environment.....	49
4. Best practices.....	51
4.1 Political Leadership, Commitment and action	51
4.2 Supportive Policy Environment.....	51
4.3 Scale-up of effective prevention programmes	51
4.4 Scale-up of treatment, care and support.....	52
4.5 Rolling out of different models of HCT (door to door, Home based, PICT, outreach) ..	52
5. Major challenges and remedial actions.....	53
5.1 Progress made on key challenges reported 2012/13 Country Progress Report.....	53
5.2 Challenges faced throughout the reporting period (2012-2013) that hindered the national response, in general, and the progress towards achieving targets.....	54
5.3 Concrete remedial actions that are planned to ensure achievement of agreed targets.	54
6. Support from the country's development partners.....	55
USG PEPFAR	55
GFATM	55
United Nations	55
JICA.....	56
GIZ.....	57

List of Abbreviations

ABC	Abstinence, Be Faithful, Condoms
ACCSP	Advocacy, Communication and Culture Strategic Plan
AIDS	Acquired Immune Deficiency Syndrome
ALU	AIDS Law Unit
AMICAALL	Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa
ANC	Ante-natal clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BCC	Behaviour change communication
BTC	Break The Chain campaign
CACOC	Constituency AIDS Coordinating Committee
CBO	Community based Organisation
CBS	Central Bureau of Statistics
CC	Community Counsellor
CDC	Centers for Disease Control and Prevention (U.S)
CMS	Central Medical Stores
CPS	Combination Prevention Strategy
CRIS	Country Response Information System
DACOC	District AIDS Coordinating Committee
DHS	Demographic & Health Survey
DPP&HRD	Directorate: Policy, Planning and Human Resource Development
DSP	Special Programmes
ECD	Early Childhood Development
ePMS	Electronic Patient Monitoring System
ETR	Electronic TB Register
EU	European Union
FBO	Faith-based Organisation
FSW	Female Sex Worker
GAMET	Global AIDS Monitoring and Evaluation Team
GFATM	Global Fund to fight HIV/AIDS, TB and Malaria
GIPA	Greater Involvement of People Living with HIV/AIDS
GRN	Government of the Republic of Namibia
GTZ	Gesellschaft für Technische Zusammenarbeit
HAART	Highly active anti-retroviral therapy
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
IEC	Information, education, communication
KAP	Knowledge, attitudes, practices
LAC	Legal Assistance Centre
MHAI	Ministry of Home Affairs and Immigration
MCP	Mulltiple and Concurrent Partnerships
M&E	Monitoring and evaluation
MFMC	My Future My Choice
MoE	Ministry of Education
MOHSS	Ministry of Health and Social Services
MRLGHRD	Ministry of Regional and Local Government, Housing and Regional Development

MTP II	Second Medium Term Plan on HIV/AIDS
MTP III	Third Medium Term Plan on HIV/AIDS
MGECW	Ministry of Gender Equality and Child Welfare
NABCOA	Namibia Business Coalition on AIDS
NAC	National AIDS Committee
NACOP	Namibian AIDS Co-ordination Programme
NAMACOC	Namibia Multisectoral HIV/AIDS Coordinating Committee
NANASO	Namibia Network of AIDS Service Organisations
NASOMA	Namibia Social Marketing Association
NBTS	Namibian Blood Transfusion Service
NCPI	National Composite Policy Index
NGO	Non Governmental Organisation
NHIES	Namibia Household Income and Expenditure Survey
NIP	Namibia Institute of Pathology
NLT	NawaLife Trust
NPA	National Plan of Action
NPC	National Planning Commission
NPPA	Namibia Planned Parenthood Association
NRCS	Namibia Red Cross Society
NSF	National Strategic Framework for HIV and AIDS 2010/11 to 2015/16
OMAs	Government Offices, Ministries or Agencies
ORN	Out Right Namibia
OVC	Orphans and Vulnerable Children
PDNA	Post Disaster Needs Assessment
PEP	Post Exposure Prophylaxis
PEPFAR	The US President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV/AIDS
PTF	Permanent Task Force
RACOC	Regional AIDS Co-coordinating Committee
RM&E	Response Monitoring and Evaluation Subdivision
SFH	Society for Family Health
SPM	System for Program Monitoring
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organization
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UNODC	United National Organization for Drugs and Crime
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WOH	Window of Hope

List of Figures

- Figure 1: New HIV infections 15+, 2010/11 – 2019/20
- Figure 2: HIV Prevalence Adult 15+, 2010/11 – 2019/20
- Figure 3: New infections children
- Figure 4: Overall HIV prevalence rate among pregnant women attending ANC, HSS 1992-2012
- Figure 5: ANC HIV Prevalence by district in 2012
- Figure 6: AIDS Deaths Adults, 2009/10 – 2019/20
- Figure 7: Trends in HIV Counselling and Testing in Namibia 2007-2012/13
- Figure 8: Number of Orphans enrolled in school in 2012
- Figure 9: Number of Children receiving Social Welfare grant by year and Target
- Figure 10: Amount of National HIV spending and percent from domestic sources-Actual 2006/7 to 2012/12 & NSF Target projections 2011/12 to 2015/16

List of Tables

- Table 1: Namibia HIV Epidemic update for the Fiscal year 2012/13 at a glance
- Table 2: Status of the impact Result Prevention Indicators for Namibia NSF 2010/11 – 2015/16
- Table 3: Status of Condom Distribution at Mid-Term Review period
- Table 4: Prevention of Mother to Child Transmissions 2006/7- 2012/13
- Table 5: Reactive results for Transfusion Transmission Infections (TTI) per year
- Table 6: Pre-ART result during the NSF period
- Table 7: Percentage of People living with HIV on ART 2006/07 - 2012/13
- Table 8: Number of OVC receiving social Welfare grants from January 2012–March 2013
- Table 9: Status of Policies and legislation
- Table 10: Expenditure on HIV and AIDS by source 2010/11 – 2012/13 (NAD)

1. Status at a glance

1.1 Introduction

The UN General Assembly met in 2011 to review the land mark Political Declarations of the United Nations General Assembly Special Session (UNGASS) of 2001 and 2006. In 2001, the declaration was adopted unanimously by the member states. It reflected global consensus on a comprehensive framework to achieve the Millennium Development Goal 6: *halting and beginning to reverse the HIV epidemic by 2015*. The 2006 declaration recognized the urgent need to achieve universal access to HIV treatment, prevention, care and support.

The 2011 High Level Meeting came up with a renewed set of commitments through a UN Political Declaration on “Intensifying our Efforts to Eliminate HIV and AIDS” - General Assembly resolution 65/277, and the declaration mandated UNAIDS to support countries report progress on the commitments.

As indicated in the 2011 UN Political Declaration on HIV and AIDS, a successful AIDS response should be measured by the achievement of concrete, time-bound targets, and calls for careful monitoring of progress in implementing the commitments. It requires the United Nations Secretary-General to issue annual progress reports that are designed to identify challenges and constraints, and recommend action to accelerate achievement of the targets

The purpose of this report therefore is to review the progress made by Namibia toward reaching the targets agreed to in the 2011 Political Declaration on HIV/AIDS. The report is written by the Ministry of Health and Social Services with significant contribution from civil society and other development partners. The National M&E Technical Advisory Committee led the process of planning, data collection, consolidation and review of all the deliverables constituting the report. The NCPI questionnaire was administered to Government (Part A) and non-Government organisations (Part B).

1.2 Country profile

Namibia has a surface area of approximately 824,116 square kilometres. It is divided into 14 administrative regions with an estimated total population of 2,113,077 (2011)¹. The country has the second lowest population density in the world (2.6 inhabitants per km²). 37% of the population is under the age of 15 years.

The country has passed through several distinct stages from being colonised in the late nineteenth century to achieving its independence on 21 March 1990. The population of Namibia is not evenly distributed with about 60% of people living in the northern regions, while the southern and coastal areas are almost unpopulated. Namibians are diverse in ethnic origins, with Oshiwambo being the language spoken by 50% of the population. Other languages include: Kavango, Otjiherero, Nama/Damara, Afrikaans, German, English, Portuguese, Caprivi, San, and Setswana.

Being a sparsely populated country, two thirds of its population lives in rural areas and engages in subsistence farming and livestock production. The annual Gross Domestic Product

¹ Namibia 2011 Population and Housing Census Preliminary Results

(GDP) is estimated at US\$ 13.07 billion in 2012², with a per capital income of US\$5,640 (Atlas Method). The World Bank recently classified Namibia as an Upper Middle Income Country. A review of the Human Development Index in 2013 shows the Namibian index of 0.608 placing the country at number 128 out of 187. Namibia has one of the greatest income inequalities in the world, as evidenced by the Gini co-efficient of 0.64³, and 37% unemployment⁴.

Namibia's economy has a modern market sector, which supports most of the country's wealth creation, and a traditional subsistence sector. Although majority of the population engages in subsistence agriculture and herding, the country has a critical mass of skilled workers, as well as a small, well-trained professional and managerial class. The Namibian economy is closely linked to South Africa with the Namibian dollar pegged one-to-one to the South African rand. The mainstay of Namibia's economy is largely mining, fishery, large-scale farming and high-end tourism. Mining accounts for 8% of GDP, but provides more than 50% of foreign exchange earnings. This has given rise to a highly mobile population characterised by a system of circular labour migration to mines, ports, farms, urban areas and tourism nodes. Rural-urban migration is substantial and has resulted in growing informal settlements in cities, towns and smaller semi-urban localities. Socio-economic inequality is widespread and multi-dimensional and has tended to increase the likelihood of higher risk sex behaviour and vulnerability to HIV infection.

Following the end of implementation of the Third Mid Term Plan (MTP III), Namibia has been implementing the NSF 2010/11-2015/16. A mid-term review and revision of the NSF 2010/11-2015/16 was conducted in 2013 resulting to the revised NSF 2010/11-2016/17, effectively aligning the revised NSF with the implementation period of the NDP 4.

² World Bank (2012)

³ Ibid

⁴ World Bank 2008 and NPC 2008

1.3 Indicator data in an overview table

Indicator	Dis aggregation	2006/07	2009/10	2010/11	2011/12	2012/13	NSF Target 2015/16
Target 1: Reducing sexual transmission of HIV by 50 percent by 2015/16							
General population							
<i>SADC: #Annual New infections</i>		14,999	12,402	12,016	12,226	12,398	5800
Empowering young people to protect themselves from HIV							
<i>Global 1.1 & MDG</i> Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	<i>women</i>	64.9%	N/A	N/A	N/A	N/A	90%
	<i>men</i>	61.90%	N/A	N/A	N/A	N/A	90%
<i>UA & Global 1.2</i> Percent of young women and men 15-24 who had sex before the age of 15	<i>women</i>	7.4%	N/A	N/A	N/A	N/A	4%
	<i>men</i>	19.20%	N/A	N/A	N/A	N/A	10%
<i>Global 1.6 & MDG</i> Percentage of young people aged 15–24 who are living with HIV	<i>Pregnant women</i>	14.2% (2006)	10.8% (2008)	10.3% (2010)	N/A	8.9% (2012)	5%
<i>Global</i> Percentage of schools that provided life skills-based HIV education within the last academic year (primary (P) and secondary (S))	<i>primary</i>	63%	75% (2008/90)	N/A	N/A	N/A	100%
	<i>secondary</i>	70%	86% (2008/09)	N/A	N/A	N/A	100%
<i>Global 1.3</i> Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	<i>women</i>	3%	N/A	N/A	N/A	N/A	1%
	<i>men</i>	16%	N/A	N/A	N/A	N/A	5%
<i>Global 1.4 & MDG</i> Percentage of women and men aged 15-49 who had multiple partners in the past 12 months who reported the using a condom the last time they had sex	<i>women</i>	66%	N/A	N/A	N/A	N/A	85%
	<i>men</i>	74%	N/A	N/A	N/A	N/A	90%
<i>Global 1.5</i> Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	<i>women</i>	29%	N/A	N/A	N/A	N/A	50%
	<i>men</i>	18%	N/A	N/A	N/A	N/A	50%
<i>UA</i> Number of condoms distributed (male and female)	<i>male</i>	28,092,483	22,307,208	27,931,826	15,294,960	25.836,412m	33,741,172
	<i>female</i>	455,439	502,177		281,000	0.1831m	3,400,000

	Total	28,547,922	22,809,385	N/A`	15,575,960		37,141,172
Sex Workers							
Global 1.7 Percentage of sex workers reached with HIV prevention Programmes		N/A	N/A	N/A	N/A	N/A	80%
Global 1.8 Percentage of female and male sex workers reporting the use of a condom with their most recent client		N/A	N/A	N/A	N/A	N/A	50%
Global 1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results		N/A	N/A	N/A	N/A	N/A	80%
Global 1.10 Percentage of sex workers who are living with HIV		70% (Katutura)	N/A	N/A	N / A	N / A	40%
Men who have sex with men							
Global 1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner		N/A	N/A	N/A	N/A	N/A	Increase by 50% of baseline
Global 1.13 Percentage of men who have sex with men have received an HIV test in the past 12 months and know their results		N/A	N/A	N/A	N/A	N/A	80%
Global 1.14 Percentage of men who have sex with men who are living with HIV		N/A	N/A	12.6% (small study, 2009)	N/A	N/A	N/A
Target 3: Eliminate mother-to-child transmission of HIV by 2015/16 and substantially reduce AIDS related maternal deaths							
UA & Global 3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission ⁵		42%	77%	90%	83%	85%	95%
Global 3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth		36%	59%	60%	67%	61%	85%
Global 3.3 Percent MTCT rate (including Breastfeeding)		25%	16%	12%	14%	13%	4%
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015							

⁵ Denominator used is the medium bound estimates of PMTCT in need as obtained from Spectrum 5.03 and for in need of ART (March 2013)

UA & Global 4.1 & MDG Percentage of eligible adults and children currently receiving antiretroviral therapy	Adults	56%	88% (CD4 200)	67% (CD4 350)	87% (CD4 350)	82% (CD4 350)	95%
	Children	88%	>95% (CD4 200)	75% (CD4 350)	65%	67%	95%
Global 4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Adults	69%	80% (Jan-Dec 2010)	81.5%	86%	84%	90%
	Children	82%	82% (Jan-Dec 2010)	83.9%	87%	87%	95%
Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015/16							
National Percentage of TB patients with known HIV status		34%	74%	93%	96%	89%	95%
Global 5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV		N/A	35%	36.42	46.05	47.8	95%
Target 6: Reach 70% (US\$ 213,711,339) of annual National HIV and AIDS expenditure that is domestic by 2015/16							
Global 6.1 Domestic and international AIDS spending by categories and financing resources (% domestic)	Amount	USD 130,000,000	USD 194 000\ (20 08/9)	279.32 Million (2010/11)	N/A		USD 305,000,000
	domestic	50.80%	52%	60%	N/A		70%
Target 7: Critical Enablers and Synergies with Development sectors							
Removing punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS							
National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)		Done	Done	N/A	N/A	Done	Done
National Percent of women and men aged 15-49 expressing accepting attitudes on 4 questions about HIV	women	39%	N/A	N/A	N/A	N/A	70%
	men	36%	N/A	N/A	N/A	N/A	65%
Global 7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months		40.7% (2007/8) ⁶	N/A	N/A	N/A	N/A	N/A
Enhancing social protection for people affected by HIV							
Orphans and vulnerable children							

⁶ MGEWCW (2009) Knowledge, Attitudes and Practices Study on Factors and Traditional Practices that may Perpetuate or Protect Namibians from Gender Based Violence and Discrimination.

Global 7.3 & MDG Current school attendance among orphans and among non-orphans aged 10–14	Ratio	1	N/A	N/A	N/A	N/A	1
National Number of children receiving welfare grants	Number	65,000	113,995	124,351	135,685 (MGE CW)	145,452	160,000
Vulnerable households							
Global 7.4 Proportion of the poorest households who received external economic support in the past 3 months							

2. Overview of the AIDS epidemic

Namibia is classified as a high, generalised and mature HIV prevalence country, with HIV assumed to be primarily transmitted through heterosexual and mother-to-child transmission. The first case of HIV infection was reported in 1986. Incidence is estimated to have peaked in the late 1990s, and adult prevalence (15-49) to have peaked in 2002 at an estimated rate of 22%⁷. Since then incidence declined sharply till 2010 when a degree of levelling off occurred. Today it is estimated that over 234,508 people above the age of 15 are living with HIV⁸. This figure is estimated to increase to 238,804 by the end of the revised NSF period of 2016, and over 250,099 by 2019. However, the expected increases in the numbers of PLHIV are mainly due to the outcome of reduced AIDS death as a result of already increase coverage of ART throughout the country.

The Government of Namibia has decided to change its CD4 threshold from 350 to 500 cells/mm² for adults. In addition, all pregnant women, all children under 15 years old, all HBV/HIV co-infected patients and HIV-positive persons whose partners are HIV-negative are eligible for ART irrespective of CD4 count. This is expected to start as soon as the new guideline has been rolled out.

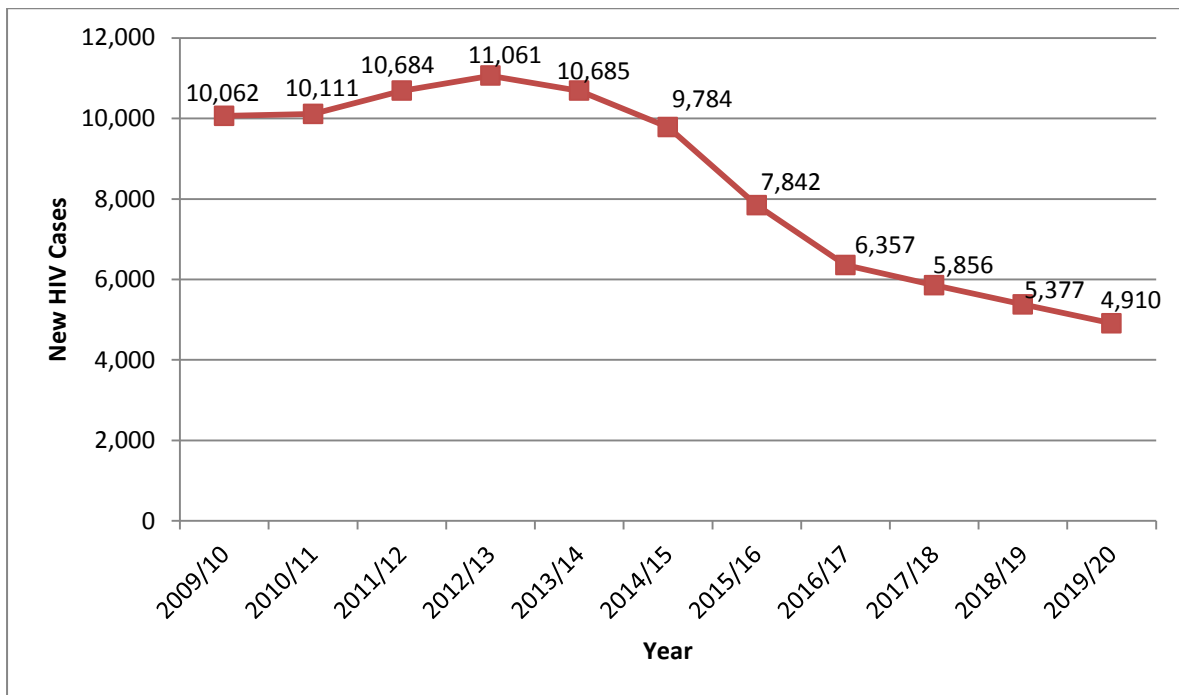
The number of new HIV infections among adults is on the decrease, which could demonstrate the impact of prevention programmes among other factors. Approximately 11,061 people were newly infected with HIV during 2012/13. The estimated number of new infections coupled with high uptake of ART, has resulted in an estimated 242,125 adults and children living with HIV (PLHIV) in Namibia in 2012/13⁹, representing an increase from 237, 267 during 2011/2012.

⁷ Annual Report April 2011 – March 2012, National AIDS and STI Control Programme, DSP, MOHSS

⁸ Spectrum GRN Guidelines 500 26 March 2014, MOHSS, 2014

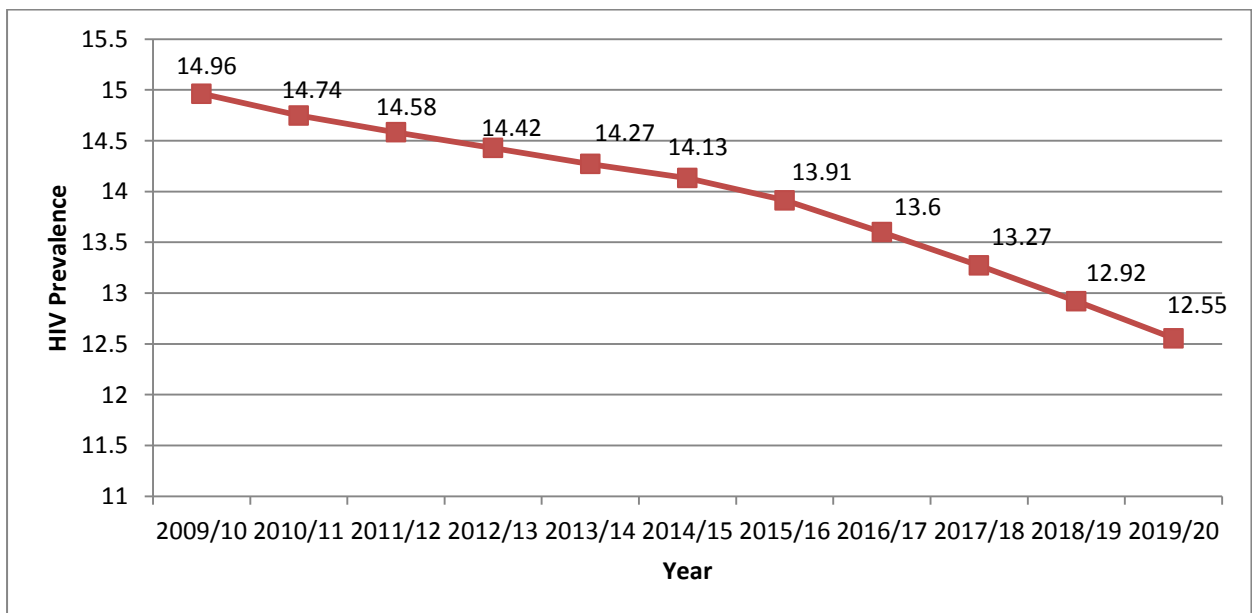
⁹ Spectrum GRN Guidelines 500 26 March 2014, MOHSS, 2014

Figure 1: New HIV infections 15+, 2009/10-2019/20



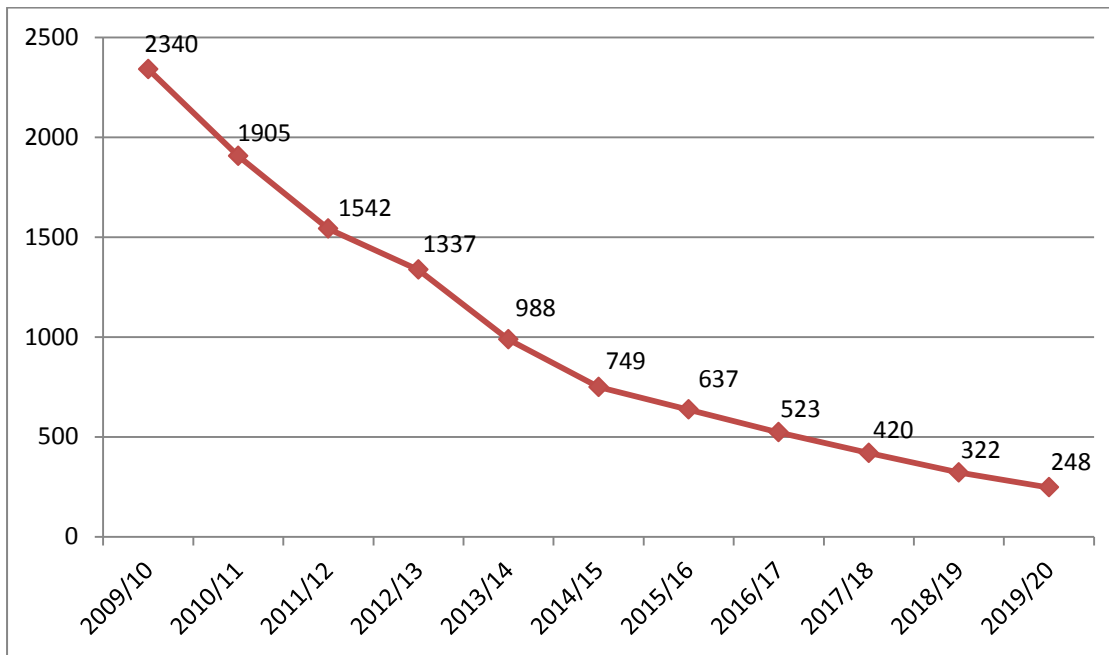
Source: Spectrum GRN Guidelines 500 26 March 2014, MOHSS, 2014

Figure 2: HIV Prevalence Adult 15+, 2009/10 – 2019/20



Source: Spectrum GRN Guidelines 500 26 March 2014, MOHSS, 2014

Figure 3: New infections – children, 2009/10-2019/20



Source: *Spectrum GRN Guidelines 500 2014*, MOHSS, 2014

In 2012/13, the total number of new infections among adults 15+ is estimated at 11,061, while the corresponding figure for children below the age of 15 is estimated at 1,337. Less than 5% of the total annual new HIV infections in 2011/12 could be attributed to Mother to Child transmission (MTCT). The modelled MTCT rate with breast-feeding in 2010/11 was estimated at approximately 5%¹⁰.

¹⁰ 2011/12 Estimates And Projections Of The Impact Of HIV And AIDS In Namibia, MOHSS, 2012 (October)

Figure 4: Overall HIV prevalence rate among pregnant women attending ANC, HSS 1992-2012

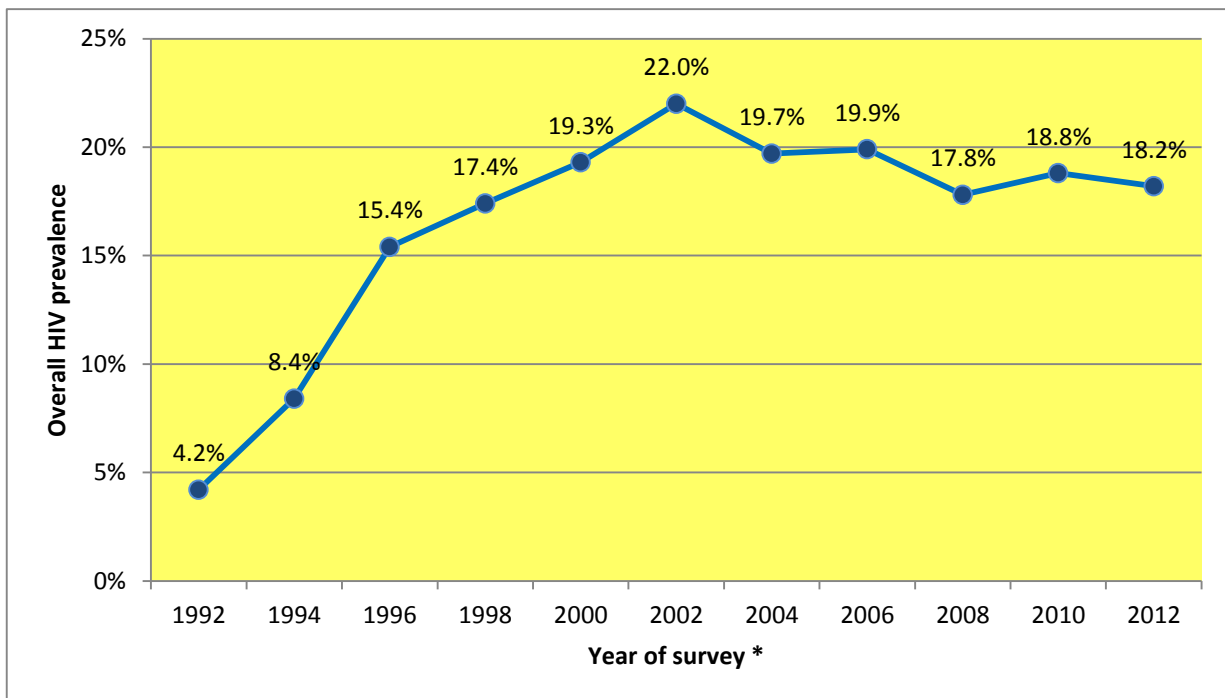
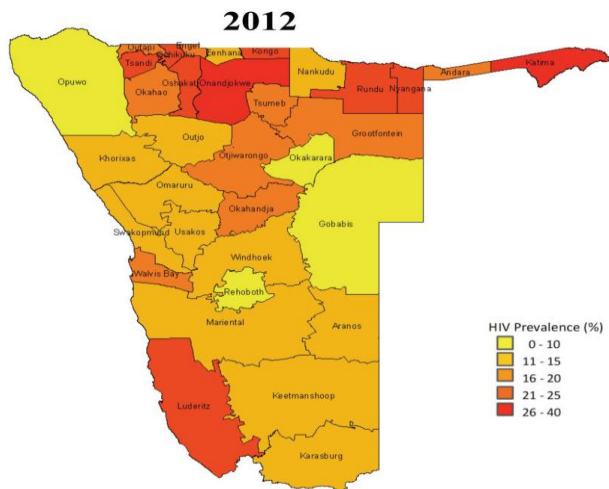


Figure 5 shows the overall HIV prevalence rate among pregnant women included in the HSS in Namibia from 1992 – 2012. The overall HIV prevalence among pregnant women attending ANC in Namibia was 18.2% in 2012, a decline since the peak in 2002, indicating an apparent stabilization of HIV prevalence among pregnant women in Namibia since 2004. However, antenatal HIV prevalence varied considerably between sites. The sites with the highest HIV prevalence rates were Katima Mulilo (37.7%), Onandjokwe (25.7%), Oshikuku (24.7%), and Rundu (24.5%). The lowest rates were recorded in Windhoek Central Hospital (9.6%), Rehoboth (9.8%), Opuwo (9.8%), Gobabis (9.9%) and Okakarara (9.9%). By age group, the HIV prevalence rate was observed to be highest among women aged 35-39 years (33.9%) and women aged 30-34 years (30.8%). The HIV prevalence rate was lowest among women aged 15-19 years (5.4%) and women aged 20-24 years (10.9%)¹¹.

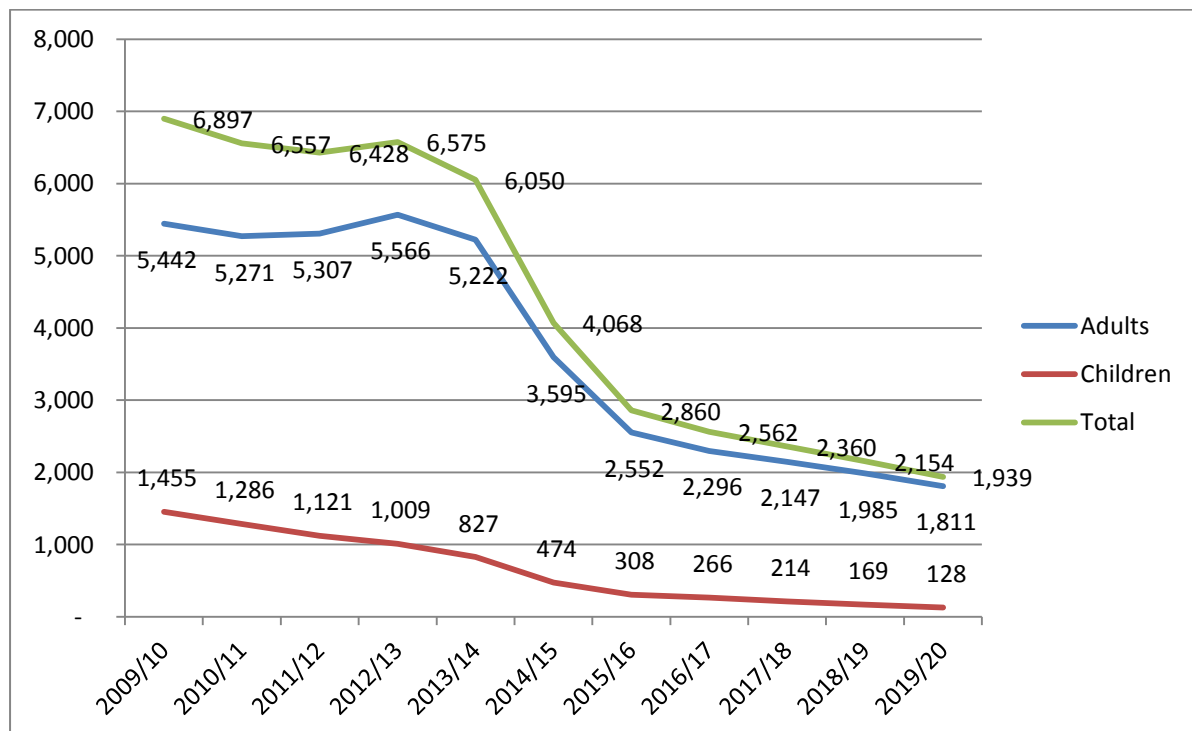
¹¹ Namibia MOHSS 2012 HIV Sentinel Surveillance Report

Figure 5: ANC HIV Prevalence by district in 2012



The introduction of the new WHO Treatment Guidelines in 2014 is expected to have a dramatic impact on the trajectory of mortality caused by AIDS. Thus, while the annual number of AIDS deaths amongst adults 15+ stood at over 5,270 at the beginning of the NSF period (2010/11), this figure is expected to drop dramatically by the end of the NSF period.

Figure 6: AIDS Deaths Adults, 2009/10 – 2019/20



Source: *Spectrum GRN Guidelines 500* 26 March 2014

Table 1: Namibia HIV Epidemic update (Median Bound Estimates) for the Calendar Years year 2013, 2014 and 2015 at a glance

Epidemic Variables	2013	2014	2015
HIV Adults + Children	245,351	250,942	255,894
HIV Adults 15+	222,352	228,763	234,508
HIV 15+ female	131,018	135,437	139,175
HIV population- children	22,999	22,179	21,386
Prevalence Adult	14.3	14.18	14.18
Prevalence- Males aged 15 to 24	2.68	2.75	2.76
Prevalence- Females aged 15 to 24	4.8	4.8	4.68
HIV Prevalence- Children	2.58	2.48	2.37
New HIV infections- Adult	10,820	10,281	8,294
New HIV infections- Children	1,058	777	666
Annual AIDS deaths	6,585	4,443	2,942
Annual AIDS deaths- Adult	5,657	3,918	2,625
Annual AIDS deaths- Children	927	526	317
Need for ART- Adult (Dec 31) (15+)	143,766	211,860	220,317
Need for ART- Children (Dec 31)	19,134	21,918	20,881
Mothers needing PMTCT	10,414	10,209	9,940
AIDS orphans	95,811	93,226	86,253
HIV population (15-49)	190,281	193,281	195,260
Number of new HIV infections	11,878	11,057	8,960
Incidence Adults 15-49	0.91	0.84	0.66
Annual AIDS deaths- Children (1-4)	267	110	57
HIV+ pregnant women with CD4 counts < 350	6,711	7,518	7,852
New HIV infections - Males aged 15 to 24	1,406	1,318	1,047
New HIV infections - Females aged 15 to 24	2,454	2,300	1,828
Annual AIDS deaths - Adults (15-24)	325	304	259

SOURCE: Spectrum Policy Modelling System, Version 5.03 (2014); Namibia model 26 March 2014

3. National response to the AIDS epidemic

3.1 Prevention

The decline in HIV incidence since its peak in the late 1990s suggests that HIV prevention efforts in Namibia have been at least partly effective. However, the rate of decline in incidence is levelling off, and it needs to accelerate to reach the critical non-replacement threshold to turn back the epidemic. The motivation for this is two-fold: better quality of life for Namibians, and an investment bonus. Prioritised prevention expenditure today is highly cost effective later on in time. This needs to be achieved with greater efficiencies, greater

reliance on high impact interventions, and a prioritised, costed combination prevention strategy. Synergies are needed between biomedical and behavioural interventions, with close links with treatment and wider sexual and reproductive and other health services. These must be backed by distal enabling factors in the social environment, and integrated programmatic strategies.

Table 2 below shows that there has been some continued reduction in new adult infections over the past two years and a substantial reduction in new infant infections, in both cases meeting and surpassing the NSF mid-term targets. There are various hot spots, according to antenatal sero-surveillance, and particularly in border towns and transport corridors.

Table 2: Status of the impact Result Prevention Indicators for Namibia NSF 2010/11 – 2015/16

Indicator number	Indicator description	Baseline	Mid-Term Target	2011/12	March 2013	Status	End-Term Target
<i>NSF Result: Fewer adults become infected with HIV</i>							
IR 1	Annual number of new infections	10,542 est. (2008/09)	Reduced by 20%	8177 (22%)	6738 (36%)	Achieved	Reduced by 50%
<i>Result: Fewer young people are HIV positive</i>							
IR 2	% Of young women and men aged 15-24 years who are HIV infected	11% (ANC survey 2008)	7%	10%	8.9%	Not on target	5%
<i>NSF Result: Fewer most at risk populations are HIV positive</i>							
IR 3	% Of MARPs who are HIV infected (MSM, SWs, prisoners)	70% (CSWs Katatura 2007)	55% SWs		N/A	No data	40% CSWs
<i>Result: Fewer infants become infected with HIV</i>							
IR 4	% Of HIV infected infants born to HIV positive mothers	12% (2007)	8%	5%	4%	Achieved	4%

Source: Report of the MTR of the Namibia NSF 2010/11-2015/16 (DSP, MOHSS)

Findings from the Mid Term Review of the Namibia NSF 2010/11-2015/16 indicate that investment in prevention over the past few years have been on the decrease. This is evidenced in the partial NASA conducted for the fiscal years 2008/9, 2009/10 and 2010/11. The study found out that total prevention spending declined by 47% from N\$ 535.4 million in 2008/9 to N\$ 281.8 million in 2009/10, and by a further 24.1% to N\$ 213.9 million in 2010/2011. From 2009/2010, international investment for prevention declined from N\$ N\$253.1 million to N\$ 157.8 million in 2010/2011 and, although domestic investment increased by over 50% during this time period (from N\$ 30.2 million to N\$ 46.8 million), the net result was a substantial drop in total investment in prevention. This creates serious concerns about sustainability of the prevention response in, particularly by civil society which relies primarily on international investment.

3.1.1 Social and Behaviour Change

The aim of the NSF 2010/11 – 2015/16 is to reduce risky sexual partnership and behavioural norms and practices that increase the risk of HIV transmission. Although challenging, but it's an essential part of the HIV prevention response, requiring complementary, intensive and sustained efforts. It also complement and promote the effectiveness of biomedical gains through male circumcision, treatment access and adherence, and pre-exposure prophylaxis and microbicides as these become available. Community mobilisation and social norm change are also required to create an enabling environment with greater gender equality and reduced gender violence; to reduce stigma and discrimination, and to ensure that PLHIV, key and vulnerable groups enjoy full human rights and equitable access to services. By far the most important players are diverse civil society organisations that need government recognition and domestic support to reduce their dependence on dwindling external funding. The private sector also has a significant and increasing role to play, particularly to reach men.

Achievements:

- i. Many NGOs and CBOs and private sector organisations are involved in social and behaviour change programming, community mobilisation and awareness and demand creation, as well as government initiatives in schools and with young people. Although the specific contribution of these programmes to HIV prevention is difficult to quantify, they have undoubtedly contributed to the effectiveness of biomedical prevention services through increasing uptake, and raising awareness of risky behaviours¹².
- ii. Networks such as Prevention Alliance Namibia, PAN, coordinate efforts of several NGOs (Nawalife for sub-granting, Catholic AIDS Action, Society for Family Health, Positive Vibes, and Lifeline Childline) in extensive social and behaviour change work that reaches into all regions. Another example is a new alliance, Mutual Action in Development, MAD, that links seven NGOs in integrated action. The Coalition on Responsible Drinking (CORD) is coordinating efforts to tackle alcohol abuse, including by children and young people. The Namibian Business Coalition on AIDS, NABCOA, coordinates private sector initiatives.

Gaps and challenges:

- i. Imminent reduced in external funding for the civil society response is a major concern and is already leading to organisational closures and downsizing. It is unclear whether GRN will sufficiently fill the funding gap, and whether there will be a drop in efficiency and effectiveness of SBCC programmes as a result.
- ii. Lack of a national strategy for social and behaviour change has contributed to poor synchronisation and targeting of programmes, and a divided response not closely aligned to NSF indicators and targets.
- iii. Gender differences in needs, risks and opportunities are not always sufficiently recognised and incorporated.
- iv. Widespread alcohol use and abuse has not been sufficiently addressed, although alcohol and other substance use are associated with risky sexual behaviour.

Opportunities:

- i. The extensive civil society involvement in the response can be harnessed to support a coordinated response for HIV prevention, treatment, care and impact mitigation, and wider SRH needs.

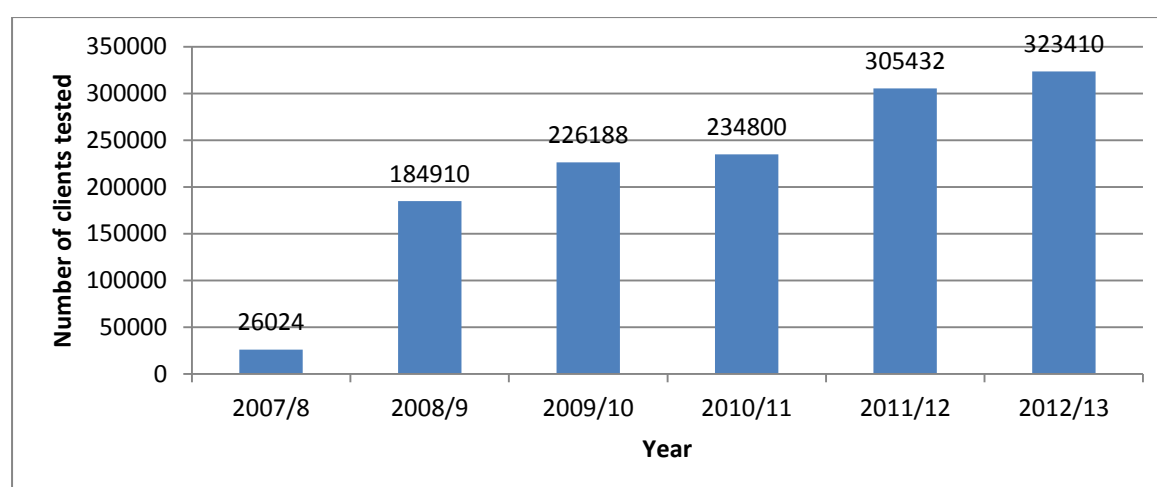
¹² NSF Progress Report, 2011/2012, DSP, MOHSS

- ii. The many models of civil society engagement provide an opportunity for review and strategic comparisons..
- iii. Strong RBM and M&E frameworks are essential and can be built utilising examples from other experienced partners. Where data gathering is weak and not strategic, guidance and support should be provided, with lessons learned from within Namibia and internationally.
- iv. There is potential for increasing private sector involvement financially and programmatically.
- v. Wellness programmes in public sector organisations provide an opportunity for strengthened, HIV prevention integrated with SRH and PHC.
- vi. The health extension worker programme, recruiting over 4,200 health extension workers, can, if managed effectively, be a positive community development to increase prevention service and treatment access and adherence.

3.1.2 HIV Counselling and Testing

A key entry point for treatment, treatment as prevention and PMTCT has always been HIV counselling and testing (HCT). Mixed methods of HCT delivery are being investigated and implemented, ranging from facility based HCT at all levels, provider initiated counselling and testing (PICT), mobile outreach, standalone centres, workplace HCT integrated into Wellness programmes, door-to-door HCT and self-test kits.

Figure 7: Trends in HIV Counselling and Testing in Namibia 2007-2012/13



Source: MOHSS, HCT Programme

Achievements:

- i. By March 2013, 384,970 adults 15-49 had been tested for HIV and knew their results¹³, (over twice as many women as men), compared with 289,921 by March 2012. Roughly three-quarters of HCT took place in public health facilities.
- ii. In 2011 the MOHSS developed comprehensive and progressive national guidelines for HCT covering mixed methods for diverse service settings and population groups, standards, roles and responsibilities, operational requirements and M&E. An HCT strategy and action plan has just been finalised¹⁴.

¹³ DSP, MOHSS

¹⁴ National Strategy and Action Plan for HIV Counseling and Testing, 2013/14 – 2016/17; MOHSS September 2013

- iii. Mobile outreach services are available and expanding in a number of regions, as integrated PHC or as HCT services linked with strong referral for prevention and treatment and SRH. A recent pilot for home-based HCT (HBHCT) in Kavango and Oshana regions¹⁵ found very few testing refusals, and report achieving over 90% referral of those testing positive to care and treatment facilities. As with rural mobile outreach, they also had higher rates of couples counselling.

Gaps and challenges:

- i. Logistical challenges arose for HBHCT that could be resolved. In remote areas, mobile outreach and HBHCT referrals may be compromised by the lack of nearby health facilities.
- ii. Despite progress, the coverage of couples, men, and key and vulnerable populations remains insufficient. Stigma remains a major deterrent to HCT uptake.
- iii. Mass testing days have not managed to track linkage to HIV prevention, care and treatment services.
- iv. Health facilities appear to concentrate far more on treatment access than in depth sexual risk reduction counselling, condom distribution, or referral for male circumcision. For mobile populations, follow up is particularly challenging.

Opportunities

- i. Namibia is moving towards more integrated strategies for HCT so that referral to both prevention and treatment services can be strengthened and quantified.
- ii. The mixed methods for HCT are providing examples of good practice that can be closely assessed to guide scale up to reach different key and vulnerable population and the hard-to-reach.
- iii. Self-testing is a new approach to HCT on which a report is about to be released.
- iv. The HBHCT pilot suggests the value of this outreach approach to make linkages, and also to extend coverage to hard-to-reach populations geographically as well as to clients who rarely seek HCT, notably men and couples.

3.1.3 Condom Promotion and Distribution

Increase in condom distribution and use has been a key objective of the NSF, and both male and female condoms have proved to be effective in preventing HIV, STI and unwanted pregnancy. Both male and female condoms have therefore been distributed for free through the public sector, and by social marketing. Targeting of condoms may be more effective when directed at discordant couples and for casual or transactional sex and sex work. Table 4 indicates the NSF targets set for overall male and female condom distribution and the extent to which they were achieved.

DHS statistics show that condom use among adolescents and young adults (15-25 years old) appears to have increased substantially over the years. However studies also show that consistent use of condoms remains generally low, and this constitutes a major challenge. The main reported barriers to condom use include: lack of access, unequal gender relations, and alcohol and drug abuse. Shyness amongst youth and concerns about being seen to be 'promiscuous' by virtue of carrying a condom, particularly amongst young women, have also been highlighted as important barriers to condom use in studies conducted by UNICEF in 2008 and 2011. The 2008 UNICEF study found that 25% of boys and girls in the sample did not know how to use a condom and/or were too embarrassed to put a condom on. A

¹⁵ Home-Based HIV Counselling and Testing (HBHCT) in Namibia, Report on Evaluation of a Pilot Project, August 2013, MOHSS, PEPFAR, CDC, DAPP.

subsequent study undertaken in 2009 among schoolgirls reported that girls who carried condoms were labelled as ‘sex addicts’, and, as a result, only 40% of the sexually active girls carried condoms when they planned to have sex¹⁶ (ETC Crystal, 2012).

¹⁶ Risks and Vulnerabilities Among Young People in Namibia: A Study of Possible Behavioural and Contextual Factors Driving the HIV epidemic in Namibia among young people. ETC Crystal, 2012

Table 3: Status of Condom Distribution at Mid-Term Review period

Indicator number	Indicator description	Baseline (in millions)	Mid-Term Target 2012/13	2011/12	March 2013	Status	End-Term Target
Result: Risk of infection reduced by using condoms							
OP 17	Number of condoms distributed free by year	Male: 30.3 m Female: 1.16 m (2008/09)	Male: 45 m Female: 2 m	Male: Female: 0.281 m	Male: 25.836,41 2m Female: 0.1831 m	Not on target Not on target	Male: 33,741,17 2 Female: 3,400,000
OP 18	Number of condoms distributed by social marketing by year	Male: 1.6 m Female: 0.157,94 m (2007/08)	Male: 1.6 m Female: 0.3 m	Male: 2.509,608 m In 2011, NaSoMa sold 2.4 million male condoms and 12,000 female condoms	N/A	N/A	Male: 3 m Female: 0.4 m

Source: 2013 MTR Report

Achievements:

- i. Despite periods of reduced condom distribution, supplies of both male and female condoms have recently increased and particularly male condoms have wide distribution through multiple outlets – community sites, workplaces and others beyond health facilities.
- ii. A Draft National Condom Strategy has been developed and will be updated and operational plan. This will help to maximise synergies between condom programming and other prevention programmes, and address the supply chain, demand creation and other specific challenges facing the condom programme.
- iii. The disciplined forces have strong awareness programmes backed by their own branded condoms.

Gaps and challenges:

- i. Public sector free male and female condom distribution and uptake are not on track, and updated social marketing figures will indicate progress through this strategy.
- ii. Consistent correct condom use is difficult to measure. High teen pregnancies, such as documented in Kavango Region, indicate that condoms are not sufficiently used by this sexually active cohort.

Opportunities:

- iii. The impending finalisation of the condom strategy as part of the combination prevention strategy (CPS) will provide important new directions.
- iv. As a result of an MOHSS National Quantification Exercise in 2012/13, the GRN is now in a position to undertake procurement and distribution of male and female condoms.

3.1.4 Prevention of HIV among Key Populations and Vulnerable Groups

a) Key populations

In the NSF the key populations are defined as men having sex with men (MSM), sex workers (SW) and their clients who are often mobile and migrant populations of various types; inmates (prisoners) and people who inject drugs.

Systematic data on HIV prevalence rates and risk behaviours amongst key populations and vulnerable populations at higher risk is not currently available in Namibia, and incidence by modes of transmission is unknown. However, one limited independent study undertaken in 2008 found a prevalence of 12.4% amongst men-who-have sex with men (MSM)¹⁷; and a 2012 rapid assessment using focus groups established that children as young as 10 years old are involved in sex work in Namibia¹⁸.

To address the important data gaps regarding key populations and the dynamics of sexual transmission, a number of major studies are planned and/or are underway. CDC is currently undertaking an Integrated Bio-Behavioural Survey (IBBS), which will seek to provide size estimates and behavioural characteristics of MSM and female sex workers in selected sites around the country. Results are expected in 2014. More systematic data on key populations and sexual transmission will be provided by the DHS+ and Modes of Transmission (MoT) study which will both be undertaken in 2014/15.

Achievements:

- I. Several civil society organisations provide support for key populations, including mobile outreach to hot spots, advocacy and community sensitisation. SFH report¹⁹ increasing reach to multiple key populations with SBCC, and on SRH referrals.
- II. In late 2011 SFH²⁰ with UN support conducted a rapid assessment of sex workers in five high prevalence towns that made clear recommendations for strengthening sex worker organisation and for awareness rising.
- III. Information on prison settings was increased by a UNODC-supported survey of the 13 prisons in Namibia in 2011²¹ highlighting HIV prevalence in both prison inmates and officers and making recommendations for scale up of prevention services and treatment in prison settings.

Challenges:

- I. Data are scarce on key populations, making size estimates problematic, and HIV prevalence difficult to measure, as well as the measurement of impact of prevention interventions.

¹⁷ Global AIDS Response Progress Reporting 2012: Monitoring The 2011 Political Declaration On HIV/AIDS. Reporting Period 2010 And 2011. MOHSS, 2012.

¹⁸ Review and Analysis of The National HIV Prevention Response For Young People In Namibia. Population Council, 2012

¹⁹ MTR of the Namibia NSF 2010/11-2015/16

²⁰ Sex Work and HIV in Namibia series, UNFPA, 2011

²¹ Namibia Correctional Service Assessment Report: HIV and Related Communicable Diseases, 2011/2012

- II. Widespread stigma and discrimination, gender violence and legal barriers continue to impede the realisation of human rights and HIV prevention and health care access of key populations, notably MSM and SW, thus exacerbating their already high risk for HIV, and that of clients.
- III. Civil society coordination for the response is insufficient, partly hampered by the lack of guidelines, and declining civil society funding could diminish their scope.

Opportunities:

- i. An Integrated size estimation and Bio-Behavioural Survey (IBBS) in eight sites among MSM, female sex workers has been conducted, and result are being processed.
- ii. Namibia could investigate the potential for adopting a pre-exposure prophylactic (PREP) programme for key populations such as sex workers and MSM.
- iii. The UN Special Rapporteur on Extreme Poverty and Human Rights²² made strong and substantive recommendations in relation to MSM and SW in Namibia for the Human Rights Council 23rd Session, that were presented to the relevant Namibia Parliament Standing Committee on 17th September 2013 and could form the basis for serious reform of the policy and legal environment for key populations. Parliamentarians are seeking proposals for law reform on MSM and sex work.

b) Vulnerable groups

Vulnerable groups are women and girls, OVC, PLHIV, people with disabilities, elderly caregivers, youth, the urban poor, and disciplined forces amongst others. The degree of vulnerability varies across these groups, and obviously the extent of targeting for HIV prevention services. According to UNAIDS²³, about 285 informal settlements exist in Namibia, home to 25% of the population²⁴ and housing an estimated 35-50% of people living with HIV²⁵ and for whom HIV prevention, treatment and other health services are an urgent priority.

Achievements:

- i. Secondary schools have an institutionalised HIV life skills education programme, and a sexuality education programme with UNESCO guidance run by the HIV and AIDS Management Unit (HAMU) in the Ministry of Education, Sports and Culture (MOESC).
- ii. The recent “Know your epidemic, Know your response”, (KYE/KYR) exercise in Windhoek (City of Windhoek, CoW, study), currently being replicated in Katima Mulilo, highlighted both gaps and opportunities for strengthening the urban response by understanding better the dynamics of the epidemic and mapping current efforts with respect to coverage, quality and effectiveness.
- iii. Several CSOs, through public private funding partnerships, operate mobile clinics for PHC, HCT and SRH services with outreach to remote rural populations and other hard-to-reach populations such as sex workers in known hot spots.
- iv. Women and Child Protection Units have been established and are functioning in 15 district hospitals to assist in cases of sexual violence.

²² UN Special Rapporteur on Extreme Poverty and Human Rights, Magdalena Sepúlveda Carmona Visit to Namibia 1-8 October 2012

²³ The Capacity of Cities to respond to HIV, UNAIDS Presentation to AMICALL Annual Partners' Conference, 12 September 2013, Swakopmund

²⁴ Report by MOLRG and Shackdwellers, 2010

²⁵ UNAIDS, personal communication 30 Sept 2013

- v. The army has well developed HIV and AIDS programming, the Military Action and Prevention Programme (MAPP) dating from before the NSF, and the police have their own programme, PolAction, also reported to be extensive.

Gaps and challenges:

- i. Interventions are not at scale and are uncoordinated.
- ii. Youth friendly SRH and HIV services are not well developed, and negative health worker attitudes towards young people and other key populations sexual and reproductive health needs impede service uptake.
- iii. Poor urban populations, particularly those in informal settlements, are not yet being effectively reached despite the resources that could be brought to bear for them and their substantial share of HIV infections.
- iv. There is no national programming in place to reach people with disabilities, although small initiatives exist in some regions.

Opportunities:

- i. The opportunity is there to utilise the city of Windhoek KYE/KYR²⁶ and HBHCT lessons to reach people in informal settlements and urban hot spots with integrated SRH, TB and HIV prevention, treatment, care and support.

3.1.5 Involvement of PLHIV

Meaningful involvement of PLHIV is globally acknowledged as essential, yet it tends to be a relatively neglected area for many reasons. One is that PLHIV with higher education and skills tend not to want to engage openly in the response, so that the public face of PLHIV is often predominantly one of the poor, needy and less educated.

Achievements:

- i. Efforts to involve PLHIV have increased through the efforts of several PLHIV support organisations and through adoption of Positive Health, Dignity and Prevention (PHDP). For young people, Adolescents Living with HIV (ALHIV) is being rolled out.
- ii. Several PLHIV organisations exist, including Positive Vibes that operates through volunteers in all regions, and has a strong advocacy voice.

Challenges

- i. Continued stigma and discrimination against PLHIV remains a challenge, with insufficient community mobilisation and engagement, the lack of a representative network.
- ii. Numerous small support groups exist, estimated at over 250, but their capacity is low and they are uncoordinated.
- iii. The PHDP approach is not yet at sufficient scale to have much impact.

²⁶ Towards Strategic Investments in HIV and AIDS at City Level: Lessons learned from the Know Your Epidemic, Know your Response exercise in Windhoek, Namibia, UNAIDS

3.1.6 Voluntary Medical Male Circumcision

As a proven efficient and cost-effective high impact intervention for prevention in high prevalence epidemic settings such as in Namibia, VMMC has been a priority for the NSF.

Achievements:

- i. The MOHSS developed a VMMC policy in 2010, and considerable funding was made available by PEPFAR to develop the infrastructure and skills for VMMC, with all district hospitals and some health clinics now equipped to provide the service. By March 2013 MOHSS reported that close to 10,000 men aged 15-49 had been medically circumcised, although the numbers for 2012-2013 (3889) were substantially lower than for 2011-2012 (6082)²⁷.
- ii. Namibia has adopted the WHO target of 80% coverage and estimates it needs to reach a target of 309,376 male circumcisions for men aged 15-49.
- iii. In September 2012, the MOHSS developed a strategy and implementation plan²⁸ for VMMC scale up that was finalised in September 2013.
- iv. With renewed funding from PEPFAR, VMMC is set to be scaled up through a two-year pilot in two regions, Oshana and Zambezi, with high prevalence and low male circumcision, with an ambitious coverage target.

Gaps and Challenges:

- i. The VMMC programme in Namibia has not met its mid-term target of 30% coverage for adults or 40% for infants.
- ii. Neonatal male circumcision is not part of the initial MC strategy, a potentially missed opportunity for future cost savings in HIV prevention, but it is scheduled to start later.

Opportunities:

- i. The launching of the VMMC strategy should assist continuation of VMMC in all regions.
- ii. Expanded training of qualified nurses supervised by medical officers is enabling task shifting from clinicians to increase the efficiency, cost effectiveness and scaling up of service provision.
- iii. Many civil society SBCC efforts include VMMC, contributing to demand

3.1.7 Prevention of Mother To Child Transmission

The UN 2011 HLM Political Declaration on HIV/AIDS commits signatory countries to eliminate mother to child HIV transmission by 2015 – an aspirational goal, and to reduce substantially maternal deaths. Currently 50% of maternal mortality is due to AIDS/TB.

Achievements:

- i. Aligned to the Global Plan, the Ministry of Health and Social Services has developed a costed National Strategy and Action Plan for the Elimination of New Paediatric Infections and Keeping their Mothers Alive 2012/2013 – 2015/2016.
- ii. The PMTCT roll out prior to and during the NSF is impressive, with 94% of health facilities providing HIV testing and ART by March 2013 (against a mid-term target of 90%).

²⁷ DSP, MOHSS

²⁸ Strategy and Implementation Plan for Voluntary Medical Male Circumcision Scale Up in Namibia, September 2012, MOHSS

Table 4: Prevention of Mother to Child Transmissions 2006/7- 2012/13

Target 3: Eliminate mother-to-child transmission of HIV by 2015/16 and substantially reduce AIDS related maternal deaths	2006/07	2009/10	2010/11	2011/12	2012/13	NSF Target 2015/16
UA & Global 3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission ³⁰	42%	77%	90%	83%	85%	95%
Global 3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	36%	59%	60%	67%	61%	85%
Global 3.3 Percent MTCT rate	25%	16%	12%	14%	13%	4%

- iii. During the NSF GRN has adopted Option B+29 of the WHO recommendations, and roll out of this approach will add further to PMTCT results.
- iv. Administering of ART by nurses (Nurse Initiated and Managed ART, NIMART) is a new approach being piloted in six districts with the intention of scaling up.

Gaps and challenges:

- i. Gaps and challenges remain around Prongs 1 and 2 (HIV prevention in women and men of reproductive age and the prevention of unintended pregnancies), neither of which has been extensively achieved.
- ii. The involvement of men in PMTCT lags seriously behind for multiple reasons including culture, access, facilities and attitudes of health workers.
- iii. Couple testing rarely occurs, although about 10% discordancy has been documented. Thus an important opportunity for improved services is lost.

Opportunities:

- i. PMTCT can progress further towards the elimination target and reducing maternal deaths through the full roll out nationwide of Option B+.
- ii. Prongs 1 and 2 need strengthening through couples HCT, extended provider initiated counselling and testing (PICT), and stronger PMTCT integration with wider sexual and reproductive health services and PHC.
- iii. Current initiatives by civil society to increase male involvement also need to be scaled up and assessed.
- iv. The roll out of health extension workers will strengthen community linkages and SBCC to ensure adherence to treatment, male involvement and links with other services.

²⁹ Option B+ means putting all HIV-positive antenatal mothers on ART for life, thereby protecting current and future pregnancies and breastfeeding, and reducing maternal deaths

³⁰ Denominator used is the medium bound estimates of PMTCT in need as obtained from Spectrum 5.03 (March 2014)

3.1.8 Prevention of Sexually Transmitted Infections

STI treatment remains a priority. Reported STIs are increasing in Namibia, which is a cause for concern, particularly if there are rises in viral STIs such as genital herpes (HSV-2). STI syndromic management is essential but has not demonstrated strong impact on HIV reduction in mature epidemics like in Namibia.

Achievements:

- i. Strategic information is available to HIS from all regions on STI cases and rates per 100,000 population; trend data on different STI syndromes since 2007 and on partner tracing is available and coordinating structures are in place.
- ii. Between 2007 and 2011, the reported number of partners treated steadily increased (from 649 to 8783).

Gaps and challenges:

- i. STI prevention is not on track to meet the NSF target of 7000 new infections in 2015/16, down from 17,000 at the baseline in 2007. On the contrary, the incidence is increasing with 18,966 reported cases at March 2013.
- ii. Partner contact tracing remains weak, despite showing some improvement.

3.1.9 Blood Safety

The Blood Transfusion Service of Namibia (NAMBTS) follows international quality assurance standards for collecting, screening and distributing blood and blood products. Quality-assured laboratory screening has been undertaken in South Africa because of a shortage of facilities and trained personnel in Namibia, and this policy is under regular review for cost effectiveness, sustainability and appropriateness and for gradual transfer to Namibia.

Table 5: Reactive results for Transfusion Transmission Infections (TTI) per year

Marker	2006	2007	2008	2009	2010	August 31, 2011	August 31, 2012
Syphilis	0.21%	0.30%	0.38%	0.20%	0.50%	0.2%	0.3%
Hepatitis C	0.12%	0.17%	0.16%	0.10%	0.80%	0.1%	0.1%
Hepatitis B	0.92%	1.47%	0.90%	0.80%	0.10%	1.2%	0.8%
HIV	0.45%	0.59%	0.38%	0.60%	0.13%	0.8%	0.4%

Source: NAMBTS quarterly report

Achievements:

- i. Namibia has achieved very high standards of blood safety, meeting targets. At baseline, 100% of donated blood units were reported to be screened and to be safe, and Namibia has developed guidelines and procedures to ensure blood safety. The % of donated blood units that have been screened for HIV through national testing guidelines was 100% as of March 2013.
- ii. Blood donation is voluntary with stringent donor screening in place, and retention of donors is encouraged by the provision of additional services such as HIV education and the promotion of healthy life styles.

Challenges:

- i. Cold chain storage and blood compatibility testing at health facilities; low recruitment of donors among youth; and unlinked electronic data systems between NBTS and other tracking systems.

3.1.10 Universal Precaution

Universal precautions are a general requirement of quality health service provision to minimise the spread of all blood borne pathogens, of which HIV is but one. National guidelines and procedures are in place and increasingly implemented, although hard data are not available to show whether the strategy is fully on track.

Achievements:

- i. The existence of national guidelines and procedures is important
- ii. Injection safety is clearly high. The only indicator with a baseline, from 2009, showed that 95% of men and 97% of women reported that their last injection was from a new/unopened package, close to the target of 100%.

Challenges:

- i. The lack of strategic information on universal precautions is cause for concern.
- ii. Sixteen priority actions are cited for universal precautions in the NSF but it was not possible to ascertain how far they are on track.

3.2 Treatment Care and Support

Reduction of HIV related death and improvement in the quality of PLHIV is the main goal for the treatment, care and support program. The NSF strategic objective in treatment, care and support is to increase access to cost effective and high quality treatment, care and support services for all people living with and affected by HIV and AIDS. By the end of the NSF period, it is expected that 95% of people who need ART will be receiving high quality services in health facilities as well as through home and community-based services that support HIV and AIDS treatment.

3.2.1 Pre – ART

Pre-ART is a very important component of the continuum of care in HIV-related ill health. The NSF pre-ART programme aimed at providing necessary services to PLHIV who were not yet enrolled on ART. Such services were identified to include opportunistic infection screening, provision of prophylaxis, clinical monitoring including monitoring the viral loads and psychosocial support. The model that is being used in Namibia is to provide both pre-

ART and ART services in the place and services being offered by the same team of health workers.

Table 6: Pre-ART result during the NSF period

Indicator description	Baseline	Mid-Term Target 2012/13	Status at mid-term 2012/13	End-Term Target
% of adults enrolled in HIV care and eligible for CTX prophylaxis who are receiving CTX prophylaxis remains at 100% up to FY2015/16	100%	100%	100%	100%

Achievements

- i. Access to pre-ART services has increased as the number of ART sites has increased and all of them offering both pre-ART and ART services.
- ii. Availability of Rapid Tests has made it possible for newly diagnosed persons with HIV to get counselling and treatment immediately.

Challenges

- i. Health workers at ART sites reported that, some patients diagnosed at free-standing HCT sites and home based counselling may find it difficult to get go to ART sites to get enrolled onto pre-ART because of transport problems and long distances.
- ii. Lost-to-follow-up is a major problem during the Pre-ART period. An estimated 17% of patients newly enrolled on the pre-ART program are lost to follow-up in the first year following diagnosis.

3.2.2 Antiretroviral Therapy

On the CD4 350 eligibility criteria, the GRN since March 2009 have been committed to increase ART coverage for adults from 67% baseline to over 83% by 2013 – midterm for the NSF. The Government also planned to expand access to ART services and address the unique needs of adolescents on ART.

Scaling up of ART services has been compromised by lack of adequate competent human resources equipped with the right knowledge and skills to manage ART. Government has adopted task shifting allowing trained nurses to initiate ART; including plans to recruit and train Health Extension Workers (HEW) and post them to health facilities. HEW would serve as the link between health facilities and communities. Government is also absorbing health professionals previously paid for by development partners.

Table 7: Percentage of People living with HIV on ART 2006/07 - 2012/13

Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015	Dis aggregation	2006/07	2009/10	2010/11	2011/12	2012/13	NSF Target 2015/16
UA & Global 4.1 & MDG Percentage of eligible adults and children currently receiving antiretroviral therapy	Adults	56%	88% (CD4 200)	67% (CD4 350)	87% (CD4 350)	87%	95%
	Children	88%	>95% (CD4 200)	75% (CD4 350)	65%	70%	95%
Global 4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Adults	69%	80% (Jan-Dec 2010)	81.5%	86%	84%	90%
	Children	82%	82% (Jan-Dec 2010)	83.9%	87%	(87%)	95%

Achievements

- i. The number of public sector health facilities offering ART has increased from 141 in 2009 to 221 sites by March 2012. This number includes main ART sites, IMAI sites and outreach sites.
- ii. The MOHSS Training Network (TN) supported by development partners has expanded the number of training courses for HIV and AIDS prevention, treatment care and support.
- iii. The training of Health Extension Workers (HEW) is now being implemented. The first group of 26 HEW has already been deployed to pilot sites.
- iv. MOHSS piloted the task-shifting model in 9 public Health facilities to assess the capacity of nurses to initiate ART. The pilot concluded that nurses are capable of successfully initiating ART and MOHSS has approved the initiation of ART by nurses under the supervision and mentoring by doctors.
- v. The number of PLHIV on ART has increased from 75,681 (March 2010) to 113,486 (March 2013) representing 90% coverage of people needing ART.
- vi. Quality of care improvement (HIVQUAL) –The HIVQUAL program has been introduced and is being implemented in 37 facilities across all the 34 districts.
- vii. MOHSS has established an ART Monthly Reporting system that uses an electronic dispensing tool (EDT) as well as the electronic patient monitoring system from which information on number of patients on various ART regimens, stock levels and ART retention rates can be generated.
- viii. The GRN through the National Institute of Pathology has established a network of 40 laboratories that offer the full range of lab test needed alongside the continuum of care.

Challenges

- i. Shortage of skilled and experienced health workers. Attrition is equally high. The increase in demand for ART will also exacerbate the manpower shortage.
- ii. Inadequate storage space at some of the small ART sites.
- iii. HIV Viral load testing is only available in Windhoek and transporting specimens across long distances poses challenges. Long-distances from laboratories also cause delays in getting results.

- iv. Point of Care (POC) still not available in all ART sites

3.2.3 TB/HIV Co-infection

Namibia has a high burden of tuberculosis (TB). In 2012 the case notification rate was 529/100,000 population, making Namibia one of the worst affected countries in the world. Coupled with a high prevalence of HIV infection, TB/HIV co-infection is a major public health problem. In 2012, 47% of TB patients were co infected with HIV. The high TB burden in Namibia is further compounded by an increasing numbers of cases of multi-drug resistant (MDR) TB and extensively drug resistant (XDR) TB. The strategy of the MOHSS to tackle the problem of TB/HIV co-infection is to strengthen coordination between HIV and TB programmes so that more people living with HIV are screened for TB and all TB patients are tested for HIV and put on ART if found to be HIV infected. In addition the NSF includes strategies to scale up implementation of the Three I's strategy which entails (a) Intensified case finding, (b) provision of Isoniazid Preventive Therapy (IPT), (c) TB Infection Control.

Achievements

- i. The percentage of TB patients with known HIV status increased up to 89% in 2012.
- ii. % of PLHIV with new smear-positive TB who have been successfully treated was at 81% by March 2013 with the mid-term target (2012/13) of 80% and the end term target (2015/16) of 85%
- iii. 87% of HIV positive persons were screened for TB at their most recent visit.
- iv. The number of HIV infected persons who are getting Isoniazid Preventive Therapy (IPT) is increasing in most regions but the percentages are still low at some sites
- v. The National Tuberculosis and Leprosy Programme (NTLP) has initiated the use of Gene Xpert diagnostic technology to improve case finding
- vi. TB management and coordination structures within the health sector have been established with roles and responsibilities for the different levels and individuals clearly spelt out. The roles of community level structures and those of other sectors have been well articulated.

Challenges

- i. Despite all efforts to prevent new TB/HIV co-infections, the TB/HIV co-infection rate remains high, which suggests that interventions have not reached the desired level of effectiveness.
- ii. It is also evident that the focus has concentrated on addressing the clinical management of the TB and TB/HIV co-infection. Strategies have not adequately addressed critical social enablers such as food security, adequate housing, general hygiene and sanitation.

3.2. 4 Care and Support

The care and support intervention are essential components of the pre-ART and ART programmes. Nutrition is particularly important given its critical role in enhancing retention and adherence in ART. In addition, unlike, other illnesses, AIDS is a very social condition that requires much support from family, friends, community and other societal institutions that PLHIV interact with on a day-to-day basis and hence the importance of community-

based ART care and support services. Most of the community based care and support services are being provided by civil society organisations.

On its part private sector are also supporting the implementation of selected interventions mainly with the context of the SHOPPS project. Through the project a mapping of the Private Health Sector in Namibia has been completed. Findings from the mapping revealed that the private sector contribute to the national response to HIV in a variety of ways that include: (a) dialogue with government to create the necessary policies and guidelines for a partnership beneficial to the people of Namibia; (b) Financing – through establishing health insurance schemes that target low income groups or workers in the informal sector; (c) Health workforce; (d) service delivery; (e) Medical products (f) information.

As the nation moves into the second phase of the NSF implementation against a background of decreasing international donor support and an increase demand for services, mobilising domestic resources through private sector is essential. By doing so, Namibia has the potential to address some of the manpower, technological, financial challenges, through innovative practices such as the health insurance schemes, support to CBOs, FBOs and NGOs that offer community services to facilitate ART

3.3 Impact Mitigation

Two objectives have been highlighted in the NSF on Impact Mitigation: i) a reduction of vulnerable households and ii) strengthening of coping mechanisms of individuals and households affected by HIV and AIDS. It was envisaged that the NSF programmes would be implemented through a social protection framework including such interventions as income transfers, school feeding programmes, vocational skills training, livelihoods training, early childhood development interventions and micro credit among others. The social protection approach is further articulated in the National Agenda of Children 2012 – 2016 that prioritises the expanding social assistance grants and expansion of early childhood Development (ECD) to poor communities.

3.3.1 Vulnerable Households and Sustainable Livelihoods

The overall aim of Impact Mitigation is to reduce household poverty and increase household income, enabling vulnerable households to cope with the socioeconomic impacts of the epidemic. It is also the core objective of NDP4 that outlines strategies to reduce poverty and income inequality and to promote growth areas and efficiencies

Achievements

- i. The increase in number of old-age pensions to 142,806 (over 91% coverage) and the increase in the monthly amount have a substantial and positive effect on poverty.
- ii. The restructuring of the MGECW included a Directorate of Community Empowerment. In addition new guidelines for community development and economic strengthening have been developed. The MGECW has drafted guidelines for managing and facilitating sub-contracting mechanisms with CSOs.

Challenges

- i. Poverty has a gender, an age and a geographic profile. Households in rural areas are twice as likely to be poor than those in urban areas, and a higher percentage of female-headed households.
- ii. The resources available, including staff and financial resources are limited and scattered. Various sectors offer income generating grants or grants for community development projects but often without a clear well informed, evidence based and economically sustainable strategy.
- iii. Access to formal and non-formal skills training remains difficult for the vulnerable.

3.3.2 Care and Support for OVC

The promotion and provision of comprehensive and quality care and support for OVC, and in particular ensuring equitable access to emotional, social/material, and school related support is the main aim of the NSP. The 2011 Annual Census reports that 124,320 (13%) children have lost one parent and 6269 have lost both parents (2, 7%), giving a total of 130,589 OVCs.

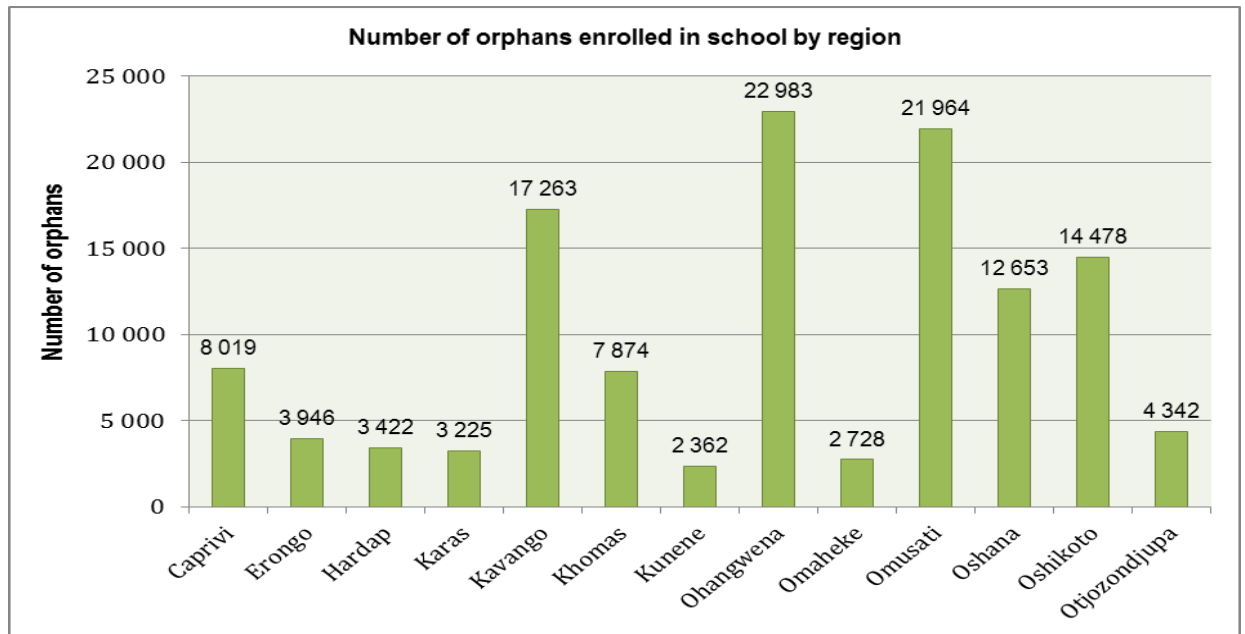
Achievements

- i. In total as of August 2013, 88,409 caregivers were receiving a grant to care for a child (information provided by MGECW and OPM) one of the most important support mechanisms. A study on the use of grants found that this grant was used for educational, medical and material needs for the child³¹.
- ii. The MGECW and its sectoral partners developed the National Agenda for Children (2012-2015) with health and nutrition; education; HIV prevention, treatment and care; legal rights and standard of living; and protection from abuse as the priority results for children.
- iii. Between 2008 to 2011, the Ministry of Home Affairs and Immigration (MHAI) established 21 hospital-based offices in high volume hospitals as well as 26 sub-regional offices across the country. More than a 100 000 babies have been registered in a hospital-based facility. According to information received from the MHAI, in 2012, 37,053 children were registered before they turned 1 year, and 28,898 of these were at hospital-based facilities
- iv. Support to Early Childhood Development (ECD) facilities expanded through the introduction of subsidies to ECD caregivers following a Cabinet directive (4th/27.03.12/006) to MGECW. From January – June 2013, 276 ECD caregivers (17 male; 259 female) from 264 ECD centres located in poor communities received an allowance through the Regional Councils for the first time. The budget for ECD programming in MGECW rose from N\$5 million in 2011/12 to N\$15 million in 2013/14. (Medium Term Expenditure Framework)
- v. Ministry of Education abolished the school development fund, making primary education more accessible to all children. The 2012 Education Management Information System (EMIS) reported 125,250 orphans and 106,914 vulnerable

³¹ How effective is the social protection system in reducing child poverty, MGECW and NPC, 2013.

children enrolled in school. The numbers of orphans attending school by region can be seen in the table below.

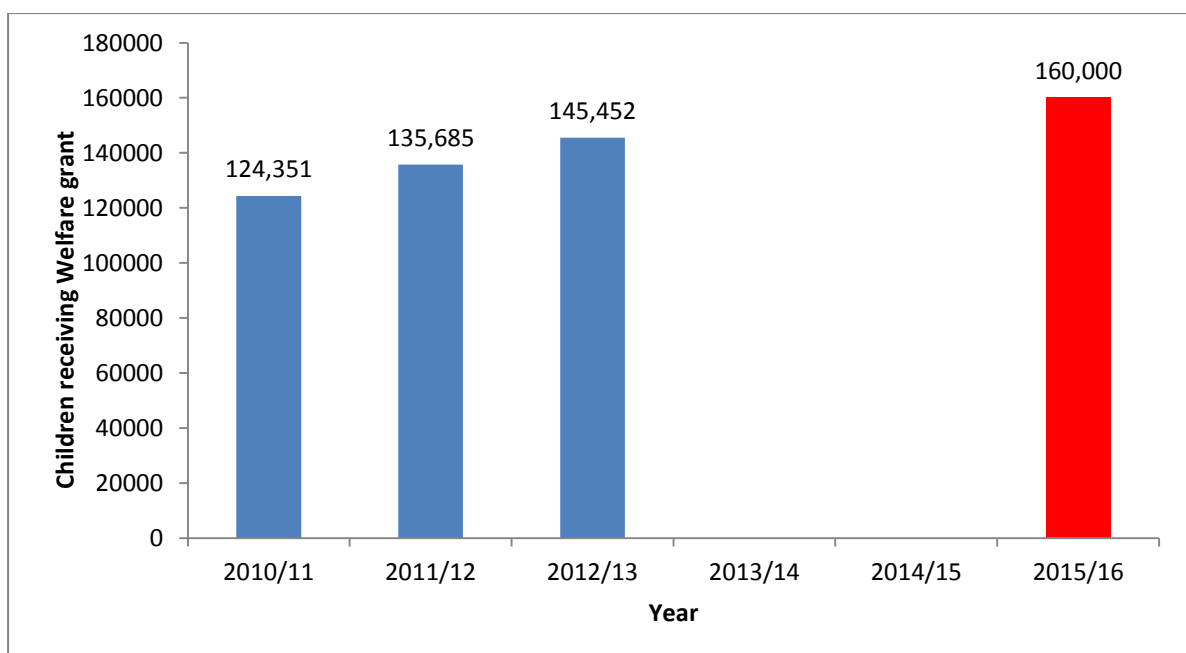
Figure 8: Number of Orphans enrolled in school in 2012



Source: EMIS (MOE 2012)

- vi. The number of OVCs receiving social grants continue to expand with 145, 452 children receiving social welfare grant by March 2013.

Figure 9: Number of Children receiving Social Welfare grant by year and Target



- vii. Standards have been developed for Residential Child Care Facilities (RCCFs) and Foster Care. Registration of RCCFs with MGECW has increased from 16 facilities on record in 2008 (the first year that data are available) to 27 facilities in 2013. The increase in subsidized facilities has been more dramatic, from two in 2008 to 22 in 2013³².
- viii. The Child Care and Protection Bill has been discussed in a comprehensive consultative process involving children and communities nation-wide.

³² MGECW (draft Annual Report 2012/13)

Table 8: Number of OVC receiving social Welfare grants from January 2012–March 2013

REGION	January 2012			February 2012			March 2012			March 2013		
	M	F	Tot	M	F	Tot	M	F	Tot	M	F	Tot
	Caprivi	2979	3163	6142	2991	3176	6167	3006	3191	6197	3624	3710
Erongo	1770	2101	3871	1773	2105	3878	1759	2088	3847	1888	2240	4128
Hardap	2236	2559	4795	2299	2632	4931	2302	2634	4936	2178	2691	4869
Karas	1430	1612	3042	1429	1611	3040	1427	1608	3035	1479	1836	3315
Kavango	6171	6561	12732	6190	6581	12771	6247	6642	12889	7366	7680	15046
Khomas	4115	4570	8685	4129	4584	8713	4122	4578	8700	4347	4682	9029
Kunene	4606	5085	9691	4646	5129	9775	4727	5220	9947	5551	6265	11816
Ohangwena	10515	11766	22281	10503	11752	22255	10511	11761	22272	10862	12658	23520
Omaheke	2007	2072	4079	2021	2088	4109	2044	2112	4156	1963	2529	4492
Omusati	9709	10553	20262	9715	10559	20274	9704	10546	20250	10023	10698	20721
Oshana	8195	8979	17174	8190	8972	17162	8156	8935	17091	8279	9472	17751
Oshikoto	7391	8384	15775	7388	8380	15768	7353	8341	15694	7301	8984	16285
Otjozondjupa	3119	3504	6623	3129	3516	6645	3141	3530	6671	3099	4047	7146
Total	64220	70932	135152	64380	71108	135488	64473	71212	135685	67960	77492	145452

Challenges

- i. Accurate figures on how many children are vulnerable is not available and the variance in the way vulnerability is defined will continue to obscure the number of children in need of care and their specific forms of vulnerability, the real cost of supporting them, and the effectiveness of that support³³.
- ii. The continued shortage of trained social workers, heavy workloads for those in place and time-consuming administrative tasks impact on the effectiveness and quality of services provided to orphans and vulnerable children³⁴.
- iii. The delay in enacting the Child Care and Protection Bill means that the regulations to guide social workers is not up to date and that vulnerable children, especially the ones from poor households with parents alive do not qualify to access social welfare grants.

³³Namibia Research Situation Analysis on Orphans and Other Vulnerable Children Country Brief, Boston University Centre for Global Health and Development & PharmAccess Foundation, Namibia August 2009

³⁴ MGECW Annual Report 2011/12

3.3.3 Legal Rights and Protection Services for Vulnerable Groups

Women's lower economic status and lack of economic autonomy create relationships of dependence and increase vulnerability to abusive relationships, poverty, social exclusion and disempowerment. Gender based violence including child abuse and domestic violence is prevalent in Namibia. High rates of adolescent pregnancies (15 per cent of women aged 15-19) and forced sex remain key protection issues.

Achievements

- i. The Ministry of Education launched its progressive policy on pregnancy among learners in school. The National Gender Policy adopted by Parliament in March 2010 was launched in March 2012 by the President. A plan of action for the policy is being developed. A National Plan of Action on Gender-based Violence 2012-2016 was also developed.
- ii. Community Child Care and Protection Forum Guidelines were developed and distributed to constituencies. One hundred and fifty (150) Child Care and Protection Forum members were trained on child protection³⁵.
- iii. There are now 15 Women and Child Protection Units (WACPU) intended as specialized units, which can provide child and gender sensitive responses to victims of gender-based violence and child abuse.
- iv. The MGECW with its CSO partners developed and published a National Protection Referral Network and flow chart for explaining the avenues for reporting and dealing with issues of child abuse. A Child Rights Network has been established among CSOs³⁶.

Challenges

- i. There is no standard operational manual for the Woman and Child Protection Units (WACPU) as an integrated service, weakening organisational efficiencies.
- ii. Child abuse and neglect are prevalent with 1,710 children provided with a protection services in terms of neglect, abandoned, sexually and physically abused in the past year. The vast majority of those experiencing sexual abuse were girls (MGECW 2012/2013 Annual Report).
- iii. The legal environment for Key Populations in Namibia remains prohibitive with sodomy and sex work punishable under the common law statutes of the country.

3.3.4 Food security and Nutrition for Vulnerable Households and Vulnerable People

Namibian experienced a drought in the 2012/2013 season and nutrition issues are likely to become more pressing. Food is recognized as a barrier to the efficacy of ART and treatment of opportunistic infections, with people living with HIV requiring between 10 and 30% more caloric intake. Child malnutrition is very common, with about 30% of children estimated to

³⁵ Ibid

³⁶ Lifeline/Children Progress Report on the National Agenda For children (NAC) 2012-2016 Reporting Period: 1.4.2012-31.3.2013

be short for their age, making it unlikely that the midterm target of 20% malnourished children in 2012/13 is met³⁷.

Achievements

- i. High-level commitment and leadership characterize the nutrition sector. The Namibian Alliance for Improved Nutrition (NAFIN), chaired by the Prime Minister, developed a multi-sectoral plan (2012-2015) that was launched in March 2013.
- ii. The School Feeding Programme has expanded and now reaches approximately 320,000 children, half of all children at school, up from 200,000 in 2012.

Challenges

- i. The NDP4 and the National Agenda for Children all recommend providing school feeding to ECD centres, but this has yet to be implemented, threatening the efficacy of ECD, as it has been shown in many countries that offering feeding at ECD centres improves attendance³⁸.
- ii. Nutrition is included in some pre-service curricula for nurses and teachers at University of Namibia (UNAM) and at the Polytechnic in Food Hygiene and Epidemiology of Namibia; however, the Nutrition Landscape Assessment Survey (2012) identified the need to harmonize the nutrition messages.

3.4 Response Management and Coordination

3.4.1 Institutional Arrangement, Coordination and Management

National Coordination

The national coordination comprises of the NAC, the highest policy body, and the National AIDS Executive Committee (NAEC), which provides technical leadership and coordinates the National Strategic Framework (NSF) implementation. The Directorate of Special Programmes serves as the secretariat of the NAC and NAEC. The NAEC works through thematic Technical Advisory Committees (TACs) and specialized steering committees that facilitate specific programme initiatives and partnerships, such as the Permanent Task Force (PTF) on Orphans and Vulnerable Children (OVC) and the Namibian Coordinating Committee for HIV and AIDS, Tuberculosis and Malaria (NaCCATuM).

In September 2010 the GRN and USG signed a five year HIV and AIDS Partnership Framework that is lined with the NSF. The Framework guides a shift in investments to further strengthen Namibian capacity and ownership, especially in the areas of human resources, and enhance the operation of national health-care systems. Implementation of the Partnership Framework is overseen by a multi-sectoral steering committee chaired by representatives of the GRN and USG governments.

³⁷ Children and Adolescents in Namibia 2010: A Situation Analysis, UNICEF and Namibia National Planning Commission, (Windhoek, Namibia, 2010)

³⁸ The Cost of Inaction, Case Studies from Rwanda and Angola. S. Anand, C. Desmond, N. Marques, H. Fuje, Harvard University Press, Cambridge MA. USA 2012

The Joint UN Team on HIV and AIDS, comprised of UN technical staff responsible for HIV and chaired by the UNAIDS Country Coordinator, meets on a monthly basis. It seeks to consolidate UN support to the national programme, in the context of the United Nations Partnership Framework (UNPAF). Private sector coordination is served by the NABCOA. Two umbrella organizations (NANGOF and NANASO) support civil society coordination.

Regional Coordination

Regional structures are placed under the management authority of the MRLGHRD. A regional AIDS Coordinating Committee (RACOC) coordinates the multi-sectoral HIV and AIDS response in each region, and Constituency AIDS Coordinating Committees (CACOCs) coordinate the community-based response in their constituencies.

Achievements

- i. Annual Strategic Review and planning meetings have been held, in 2011, 2012 and 2013, with USAID support. The meetings bring together representatives from all RACOCs with the National HIV and AIDS Management Unit of the MRLGHRD, and also the DSP/MOHSS.

Challenges

- i. Only 7 out of the 13 RACOCs met at least 3 times in the last year (they are expected to meet quarterly). The functions of the RACOCs are not fully understood by all stakeholders and many key actors remain unclear about their roles and responsibilities.
- ii. Many regions, with some notable exceptions, face challenges in getting line ministries and government agencies to participate in RACOC activities. RACOC meetings seem to serve primarily as information-sharing fora among technical/programmatic actors.
- iii. Availability and use of data at regional level have suffered from the high staff turnover among M&E officers in Regional Councils.
- iv. Only 35 CACOCs held at least 3 meetings in the past year (the NSP mid-term target was 60).

Sector Coordination

The NSF identified fourteen sectors and provided a preliminary list of potential sector membership. The NSF also anticipated that individual sectors would establish Sector Steering Committees to guide and oversee the sectoral HIV and AIDS response. Lead agencies were expected to provide a functional coordinating unit for the sector and to mobilize the necessary resources for mainstreaming activities.

Achievements

- i. Most sectors have established Sector Steering Committees. Six sectors have appointed full time Sector HIV and AIDS Coordinators, while others have appointed a focal point persons.
- ii. Most sectors have developed approaches to mainstream HIV and AIDS throughout the sector.

Challenges

- i. Mainstreaming of HIV and AIDS into sectoral development programmes, with the full participation of identified partners and institutions, remains a challenge:
 - Few Sector Steering Committees are active.
 - Few sectors have developed HIV and AIDS policies, work plans and budgets to address priority issues faced in the sector, or even workplace programmes for their own
 - Most have not identified dedicated focal points at a sufficiently senior level to make a difference.
- ii. A major gap for advocacy and planning remains the lack of data about the risk of HIV and AIDS in different sub-sectors and sectors and access to services among those concerned

3.4.2 Enabling Policy and Legal Environment

Creating and sustaining an enabling policy and legal environment

The Constitution of Namibia and the National HIV and AIDS policy among other policy documents emphasise the need to protect, respect and fulfil human rights of people living and affected by HIV and AIDS. To operationalise these constitutional provisions, Namibia has reviewed a number of policies and legislations to mainstream HIV and AIDS dimensions in terms of human rights, and accessing and utilisation of services.

Civil Society organisations have continued to play important advocacy role in critical areas, including gender-based violence, sexual abuse of women and girls, marginalisation of key populations and equitable distribution of affordable HIV services.

Achievements

Some policies relevant to the HIV response were developed prior to the NSF, while others have been developed thereafter. The following table presents some of the policies and legislation accessed and reviewed.

Table 9: Status of Policies and legislation

Pre-NSF Policies	Post NSF policies	Legislation
National Policy on HIV and AIDS (2007)	National Health Promotion policy 2012	The Combating of Domestic violence Act (#3 of 2003)
VMMC policy 2010	HTC draft policy (2013)	Married persons Act (#1, 1996)
National Health Policy Framework 2010-2020 – (2010)		Medicines and related substances Control Act (# 13, 2003)
National Blood Policy (2007)		Married Persons Equality Act (#1 of 1996)
Food and Nutrition Policy for Namibia (1995)		Combating of Rape Act (#8 of 2000)
CSO Partnership Policy (2005) ³⁹		Immoral Practices Amendments Act (#7, of 2000)

³⁹ NANGOF Trust, UNAIDS (2013) Investing in Communities, The role of small granting in scaling and sustaining community responses to HIV and AIDS In Namibia, Workshop report

It is important to note that several other policies and legislations do exist that are likely to be relevant to the national response. Other programme specific operational guidelines also continue to support an enabling environment. The most significant in this context are guidelines related to HTC, and voluntary male circumcision.

NANGOF has continued to implement the 2005 (launched in 2006) Civil Organisations Partnership Policy (COPP) that aim at strengthening civic participation in national initiatives including the HIV and AIDS response.

A public private partnership has been developed to improve partnerships and collaboration with the private sector including in critical areas of HIV and AIDS service delivery.

Addressing Stigma and Discrimination

Stigma and discrimination remains the single most important barrier to services uptake and adherence. Consultations with organisations of PLHIV reveal that self and expressed stigma is prevalent despite the concerted efforts by stakeholders to eliminate or reduce stigma. Literature review shows that Namibia has embraced the concept and goal of working towards “zero discrimination” – of the three zero global agenda.

Namibia has established, consolidated and is continually strengthening the foundations for a non-discriminatory and stigmatising environment by reviewing existing policies and legislation, developing capacity of service providers to respond effectively, and strengthening systems to support stigma and discrimination interventions at community and work place. Several public and private sector institutions have developed and are implementing HIV and AIDS workplace policies.

Although Namibia has not conducted a Stigma Index Survey, information available from various service provider reports indicate that communities are increasingly expressing accepting attitudes towards people living with HIV and AIDS. Analysis of the information also show mixed feelings with regard to men who have sex with men and sex workers.

There is strong political will to address issues of stigma and discrimination as demonstrated in policy and legislation reviews.

Achievements

- i. All forms of discrimination or stigmatisation is outlawed,
- ii. There are improvements in accepting attitudes towards people living with HIV and AIDS.
- iii. Public and private sectors institutions have developed policies to support a non-discriminatory and stigmatising environment

Challenges

- i. Namibia currently does not have empirical evidence on the extent of stigma and or discrimination.
- ii. Lack of effective enforcement and monitoring of policies aimed at stigma and discrimination reduction

Gender inequalities

Analysis of the information presented in the “Report on Rapid Needs Assessment on Linkages and Integration of HIV and Sexual and Reproductive Health” (2011), reveals that gender inequalities are often rooted in cultural and economic practices and tend to increase the risk and vulnerability of women and men to HIV infection. These are associated with the low social status of women and girls, poverty and income inequality. These factors have pushed women in particular to engage in risk sexual behaviours including transactional and commercial sex. Increased incidents of gender-based violence and sexual abuse are clear symptoms of gender inequality in Namibia.

Achievements

- i. The National Gender Policy (2010 – 2020) was revised in 2012 and a National Action Plan developed.
- ii. The National Gender –Based Violence (GBV) Action Plan was finalised in 2012
- iii. The MGECW rolled out offices to support increased access to Women and Child protection Units (WACPUS). WACPU’s have been established in all the 13 regions.
- iv. A Gender Committee has been established in Parliament⁴⁰
- v. The Legal Centre continue to provide training and advocacy, including development of gender related materials awareness and educational materials⁴¹

Challenges

- i. Inadequate implementation and monitoring of national strategies that address gender inequality, such as policies, laws and action plans
- ii. Despite the formation of WACPUs, reporting of GBV incidents remains low.

3.4.3 Capacity Development

Capacity development for the national HIV and AIDS response is premised on health and community systems strengthening approach. A review of available reports indicates that capacity has been strengthened across all the six health systems strengthening blocks in varying degrees.

The Namibian health care system is organised in a three (3)-tier structure with operations at central, regional and district levels. The central level has devolved authority to 14 regional MOHSS regional directorates and 34 districts. The 2013 MTR noted that the public sector is the major financier of the health system contributing 54% of the total health expenditure (THE) followed by development (22%), private companies and households (12.3%)⁴².

Service delivery is premised on the primary health care (PHC) approach. This approach has shown its value as the key principle in the health system. It is people centred (service delivery reform); focused on health equity, solidarity and social inclusion (universal coverage reforms), and health authorities that can be relied on and communities where health is promoted and protected (public policy reform).

⁴⁰ SADC PF, 2013, SADC Council of Ministers Briefing Note

⁴¹ Update from the Legal Assistance Centre,

⁴² WHO Namibia (2011): Annual Report

While the system is established, service delivery remains weak largely due to lack of adequate human resources capacity. It is estimated that on average three (3) health workers service approximately 1000 population. Majority of the health work force is within the private sector⁴³.

The critical areas in the health system that require accelerated capacity development include human resources (adequacy, skills and competencies) organizational capacity (operational systems, financial resources and technology) and availability of strategic information (empirical data / evidence) to inform choices and decision making for the national HIV and AIDS response. Strengthening a national capacity for resource mobilisation is critical given that Namibia is no longer eligible for many concessional grants and loans. The categorisation of Namibia as a higher level middle-income country by the World Bank has changed the donor landscape resulting in donor withdrawal or scaling down of their support. This has serious implications on health systems and in particular in service delivery as Namibia is not in a position to absorb all the activities and programmes currently funded by donors.

Achievements

- i. Namibia has conducted human resources for health Situation Analysis and is committed to develop and implement a human resource development strategic plan to ensure availability of sufficient health workers.
- ii. Bursaries have been provided (by Global Fund and CDC). The programme has provided bursaries to 37 students studying medicine (15), nursing (6), social-work (6), pharmacy (6) and 4 laboratory technicians. Over 600 HIV counsellors have been trained and certified by MOHSS. 30 health workers from 10 hospital blood banks have been trained on group serology and oriented on NAMBITS Standard Operating Procedures⁴⁴. The policy on task shifting has been initiated and currently some nurses have been trained to initiate ART. University of Namibia and the Polytechnic are also training doctors and bio-medical scientists.
- iii. Domestic funding has increased from 50% in 2008/2009 to approximately 60% in 2011/12.
- iv. Global Fund has approved the RCC application for funding. PEPFAR continue to provide financial support through the PEPFAR Partnership agreement with the Government of Namibia. Currently the government is funding 100% condom procurement and close to 80% of ART⁴⁵.

Challenges

- i. Inadequate human resources for the health sector and the HIV and AIDS response couples with a lack of retention strategy and incentives for qualified and experienced Namibian health professionals in the public service

3.4.4 Resource Mobilisation

In the wake of the reclassification of Namibia as an upper middle-income country, the goal of the Government is to ensure that the national multi-sectoral response for HIV and AIDS is adequately funded and funding sustained mainly from domestic resources with additional support from development partners.

⁴³ Ibid

⁴⁴ WHO (2012): Annual Report

⁴⁵ 2013 HLM MTR of the 10 targets and elimination commitments

Namibia, like many other countries, is faced with the challenge of finding adequate resources to finance their health system and provide a basic package of health services. During the period under review, efforts have been made to develop resource mobilisation and financial sustainability strategies. This has occurred against a backdrop of a global economy struggling to shake off the effects of the 2008 global economic crisis. The country faces increasingly urgent demands on resource mobilisation as it has been registering impressive economic growth. Consequently, during the period under review, it has had its status of lower middle-income country elevated to upper middle income country. This has resulted in a decrease in the amount of donor funding available to the country, and calls for more efforts to be made domestically to increase fiscal space through increased domestic funding, alternative funding strategies and increased efficiencies in the use of available resources.

A proposal on suitable options to consider in achieving sustainable financing for HIV/AIDS in Namibia as prepared and published in September 2012⁴⁶.

The sustainability study explored alternative sources of funding to bridge the expected financing gap. These focussed on increasing contributions from public sector mainstreaming, the private sector, an airline levy and private health insurance. The study estimated that additional revenues could be generated from these sources, beginning with about N\$81 million in 2012/13 and increasing to N\$731 million by 2020/21. This would not fully close the financing gap, which would be reduced from 0.6% to 0.35 of GDP in 2020/21.

The study also concluded that Namibia could make considerable efficiency gains in drug efficiency due to a high median cost of ART drugs⁸⁷. This analysis was based on 2008 figures. Based on this, the estimate made by the study was that Namibia would not have a financing gap if efficiencies were achieved. This proposition needs to be re-considered carefully; the median cost for First Line drugs in 2012 had dropped to US\$57.4188 compared to US\$87.84 in 2008. This in turn would lower the annual treatment cost per person.

PEPFAR

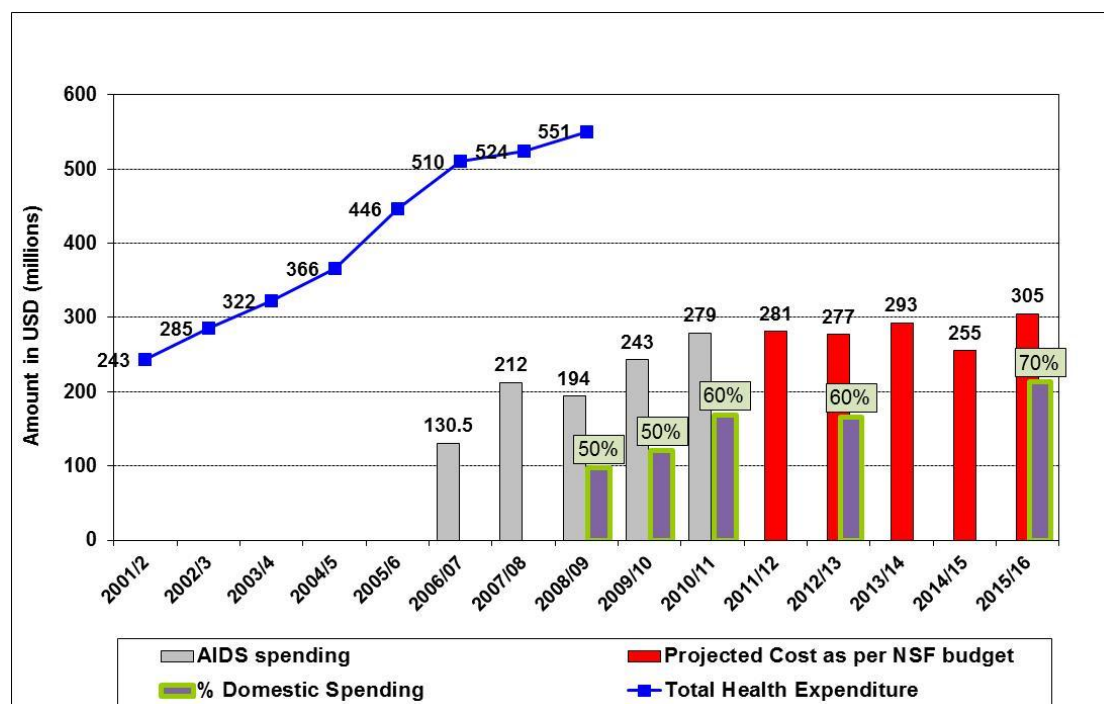
The Republic of Namibia continues to receive significant support for its National AIDS Response from the United States Government through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The planned funding during the fiscal year 2012 (covering the time period of January 2013 - December 2013) was \$88,776,117.

Namibia is one of the three Southern African countries slated for transition as a direct implementation program to that of a technical assistance program. The transition in Namibia is guided by the Blue Print to Achieve an AIDS Free Generation, our Partnership Framework (PF) signed in August 2010 and the Global Health Initiative (GHI) strategy, approved in May 2012. The PEPFAR Namibia transition goal is to position Namibia to assume full responsibility for the management of its HIV program. USG resources during the transition period are focused on ensuring that Namibia will have the body of country specific data, technical capacity, human resources, and coordinating mechanisms required to direct and execute an HIV program that reflects the nation's priorities, consistent with reduced donor funding. Transition in Namibia is built upon a strong partnership with the Ministry of Health and Social Services and the Namibian government's strong commitment to the success of the

⁴⁶ Ministry of Health and Social Services, Namibia. Sustainable Financing for HIV/AIDS in Namibia: Managing the Transition towards a new AIDS Financing Strategy. September 2012

National HIV Response. The high percentage of Namibians covered by the HIV Treatment and PMTCT programs, and HIV counseling and testing among women, is a testament to this partnership.

Figure 10: Amount of National HIV spending and percent from domestic sources-Actual 2006/7 to 2012/13 & NSF Target projections 2011/12 to 2015/16



Source: MOHSS (2013) 2011 mid-term review of the 10 targets and Elimination, commitments, Namibia country report.

The demonstrated commitment by Government to increase its budget contribution towards national AIDS spending through payment of human resources and procurement of HIV commodities is an important step towards sustainability of the response. It is acknowledged that there is potential for significant private sector contribution and that the resource gap can be significantly reduced through efficiency gains.

Table 10: Expenditure on HIV and AIDS by source 2010/11 – 2012/13 (NAD)

Source	2010/11 ⁴⁷	2011/12 ⁴⁸	2012/13	2013/4
Government	1,214.1m	1,432.7m	N/A	N/A
Global Fund	67.1m	164.8m	N/A	N/A
PEPFAR	665.1m	861.7m	N/A	N/A
UN	56.5m	72.7m	N/A	N/A
GIZ & Other International	4.0m	20.7m	N/A	N/A
Other (including Private Sector)	2.3m	4.7m	N/A	N/A
TOTAL	2,009.1m	2,557.3m		

⁴⁷ Ministry of Health and Social Services, Namibia. National AIDS Spending Assessment (NASA) 2009/10 & 2010/11. September 2012

⁴⁸ Namibia Global Fund RCC Renewal Gap Analysis

Achievements

- i. Namibia's application for the Global Fund HIV RCC II was successful (USD98.4 million).
- ii. The country continued to receive assistance from development partners including PEPFAR, UN agencies and GIZ. EU,
- iii. Government has continued to disburse increased funding to health and HIV, evidenced by its continued commitment in funding recurrent expenditure and the absorption of expenditure items such as human resources and drugs, which previously funded by development partners.
- iv. The GRN in partnership with development partners have initiated the development of an Investment Case for Namibia, which will require undertaken extensive resource re-modelling. The Investment Case will seeks to:
 - Optimise the AIDS Response to be effective and efficient;
 - Estimate the impact of the Response; and Map resource requirements and pursue financial sustainability

Challenges

- i. No linkages exist between programmatic results and financial resources utilised in achieving those results.
- ii. Reporting on revenue and expenditure remains a challenge. The last full National AIDS Spending Assessment (NASA) conducted was for the years 2007/08 and 2008/09, and a mini-NASA was conducted for the years 2009/10 and 2010/11.
- iii. Reduced funding from donors implies that renewed and continuous efforts for identifying alternative financing sources have to be made. A sustainable financing strategy for HIV still has to be finalised and operationalized.

3.5 Monitoring and evaluation environment

Overview of the current monitoring and evaluation (M&E) system

Monitoring and Evaluation of the HIV response is guided by the National multi-sectoral Monitoring and Evaluation (M&E) Plan and a prioritised Research Agenda. Progress is measured by a set of indicators compiled in the result framework. The principle upon which the evaluation of the RM&E component of the NSF is based is the extent to which RM&E supports the effectiveness of the national response to the epidemic at policy and programme levels.

At the highest level the M&E system for the national response consists of multiple data sets from multiple data systems within the broader Health Information System (HIS). These data sets converge at the M&E unit in the Directorate of Special Programmes (DSP), they are used to generate information products that support strengthening the national response. Most of the programme specific data pertinent to monitoring the national response - including Pre-ART, ART, VMMC and HCT data -flows from facility level, through district and regional health offices, to DSP. The exception is PMTCT data, the custodian of which is the Primary Health Care Directorate at MOHSS. All of these data sets are in discrete data systems.

Data from non-health facility based programmes, implemented by the private sector, civil society or government organisations, ministries and agencies (OMAs), are reported into the System for Programme Monitoring (SPM). The process requires programme implementers operating in regions to submit data to Regional AIDS Coordinating Councils (RACOCs), where an M&E officer captures the data into SPM.

The two critical institutions in the system are DSP and the RACOCs, which in addition to collecting, collating and reporting data should be feeding analysis back to implementers and other institutions, in order to improve planning and programme implementation.

Development partners play an important role as information consumers, and providers of technical support and funding for systems capacity development. Although they are also data custodians, most of their programme data would have entered the system through SPM submitted by the implementers that they fund, or through the HIS from facility level programming their funding supports.

Achievements

- i. M&E of the NSF is adequately aligned with Namibia's international commitments. Data is available to report against key obligations, including the United Nations General Assembly Special Session on HIV and AIDS (UNGASS), the Millennium Development Goals (MDGs), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and Southern African Development Community (SADC) epidemic updates.
- ii. In terms of collecting relevant data the M&E system is also aligned to the NDP4, being in a position to report on indicators of interest to the NPC
- iii. Through the SPM, guidance, including tools for data collation and submission, has been produced and disseminated, and the RACOCs are producing reports on regional programme activities regularly.
- iv. Efforts to resolve the fragmentation of data systems is supported by evidence provided in a comprehensive assessment of the HIS in Namibia, supported by USAID and concluded in 2012. The approach has been to integrate programme data from the programmatic data sets in a common data warehouse, while maintaining the existing data systems to record the data.
- v. DSP in collaboration with development partners invests substantial resources in the training of M&E personnel. In appointing senior data clerks it was intended that a need for complementary supervision and mentoring of the M&E function as far as facility level would be met.
- vi. Key population surveys are underway, including NDHS+, BSS in data analysis and AIS under development.

Challenges

- i. Data collected from the SPM system have not been optimally utilised to realised it strategic relevance. SPM data have not used adequately by community programs that provide linkages to priority high impact interventions in treatment and care, PMTCT, male circumcision and key populations.
- ii. In some regions reporting into SPM has been dormant for months at a time due to high staff turnover among M&E officers. Civil society reports more frequently, followed by OMAs at regional level, with the private sector reporting very rarely. RACOCs are producing reports regularly and it is apparent that SPM has the potential to be effective.
- iii. Other factors that have undermined the optimal utilisation of the SPM are lack of M&E skills serving the system.
- iv. HIS data appears to be strategically under-utilised
- v. The current organizational support structure for the National HIV/AIDS research agenda does not provide sufficient political and organizational leadership to ensure the effective management and use of research and evaluation resources to support the National Strategic Framework for HIV/AIDS.

4. Best practices

4.1 Political Leadership, Commitment and action

Male involvement in maternal child issues is a challenge. As a result, the first lady Madam Penhupifo Pohamba actively participates in national campaigns for male involvement. In addition, Namibia has reviewed the High level Meeting Targets and came up with recommendations on how to improve on the targets that are lagging behind.

4.2 Supportive Policy Environment

The National Strategic Framework for HIV and AIDS 2010/11 to 2015/16 was reviewed during the year of reporting. The Government and other partners have committed sufficient resources to this exercise. In addition, political leaders actively participated in this exercise by providing their views during the consultation processes.

4.3 Scale-up of effective prevention programmes

HIV prevention in Namibia has been partly effective as evidenced by the rate of decline in new infections. The decline seems to have levelled off, thus the need for innovative prevention approaches to reach the critical tipping point that turns back the epidemic.

The PMTCT programme has registered tremendous successes over the period under review, with development partners providing technical assistance towards the implementation of the National Elimination Plan 2012 – 16, including the monitoring and evaluation components, integration of SRH in to eMTCT, condom and male circumcision strategies. PMTCT has been scaled up across all 14 regions and 35 districts, now reaching 336 health facilities (94%). The national consultation on prongs 1 and 2 of PMTCT for WLHIV informed the final eMTCT plan. The UN Joint Team support in 2012 has guided planning for the roll-out

of point-of-care CD4 count machines for Option B+ treatment and highly active ART for people living with HIV (PLHIV).

A new development is the country's agenda to strengthen integration of SRH and HIV services. Through the EU funded SRH-HIV linkages project, Namibia embarked in 2013 on a service delivery pilot in 7 clinics across the country, whereby the preliminary results from the baseline assessment already indicate tremendous potential efficiency gains. An innovative approach to the HIV prevention response is further evidenced by the initiation of mobile service delivery in the capital city of Windhoek. Informed by the findings of the UNAIDS and UNDP supported KYE/KYR study in Windhoek, the MOHSS has joined the City of Windhoek and PharmAccess Foundation to provide HIV prevention and primary health care services to previously under-served informal settlements in the city.

In 2012 and 2013 concerted efforts were made to support the scale up of prevention efforts for young people and key populations, notably sex workers, and promote enhanced participation and inclusion of these populations in programming. Training of 137 Life Skills teachers was conducted to deliver comprehensive sex education in secondary schools.

As part of the revision of NSF and associated documents, the country is also in the process of finalising the combination prevention strategy

4.4 Scale-up of treatment, care and support

The Namibia ART programme have been the flagship of Namibia's AIDS response, with the country reaching its 2010 Universal Access target for ART already in 2009. Since then it has continued to register remarkable achievements – with the number of PLHIV on ART increasing from 75,681 in March 2010 to 113,486 in March 2013; and increased capacity development targeting nurses and extension workers to assist in ART administration particularly in remote settings.

Namibia has been in the forefront for implementing the WHO treatment guidelines including the previous threshold of 350 CD4 counts, which had a huge effect on increasing coverage to over 84% of those eligible on ART by 2012. Namibia has again revised its ART guidelines based on the 2013 WHO criteria; and the Government has taken a decision to implement the new guidelines starting 2014. The CD4 cut-off for eligibility has increased from 350 to 500 cells/mm² for adults. In addition, all pregnant women, all children under 15 years old, all HBV/HIV co-infected patients and HIV-positive persons whose partners are HIV-negative are eligible for ART irrespective of CD4 count. The obvious implication, although with accompanying high costs, is a dramatic increase in coverage of ART among those in need. The MOHSS in collaboration the development partners are currently working on a framework for the implementation of the revised Namibia 2013 Treatment Guidelines.

4.5 Rolling out of different models of HCT (door to door, Home based, PICT, outreach)

As a matter of increasing HCT, the ministry is implementing different models of testing. This is also expected to increase the uptake of new testers. The models are inclusive recently piloted home-based testing, door to door testing and provider initiative Counselling and Testing (PICT). With the implementation of rural mobile outreach services, there is expected to be a high rate of couple testing.

5. Major challenges and remedial actions

5.1 Progress made on key challenges reported 2012/13 Country Progress Report

- i. Namibia's reclassification as an upper middle income country and the implications of potential reduction in donor funds has been a key challenge that the country has been grappling with since 2012. This prompted the country to undertake a study on Sustainable Financing for HIV/AIDS in Namibia. The study provided a strategic insight into how Namibia could manage the transition towards financing its AIDS response. The study explored alternative sources of funding to address the expected financing gap. It focussed primarily on increasing contributions from the public sector through mainstreaming, the private sector, an airline levy and private health insurance. The forecast is estimated that additional revenues could be generated from these sources, beginning with about N\$81 million in 2012/13 and increasing to N\$731 million by 2020/21. This would not fully close the financing gap, but it would be reduced from 0.6% to 0.35 of GDP in 2020/21.

Further to the sustainable financing study, the Government in partnership with development partners have made commitment to develop an investment case for Namibia, which would optimise the AIDS Response to be effective and efficient; map out resource requirements and pursue financial sustainability.

- ii. Limited capacity of domestic human resources both in terms of numbers and critical expertise has been a huge challenge to the AIDS response and other sectors in Namibia. The country has therefore depended substantially on external funding and technical assistance to support core functions, processes and services for HIV and AIDS.

To address this challenge, the GRN is still committed to developing and implementing a human resource development strategic plan based on the situation analysis on human resources for health conducted in 2010. The strategic plan would provide a blue print for ensuring a sustained availability of sufficient health workers.

Government has continued to disburse increased funding to health and HIV, evidenced by its continued commitment in funding recurrent expenditure and absorption of expenditure items such as human resources and drugs, which previously funded by development partners.

A five year HIV and AIDS partnership framework signed in 2010 by the GRN and the USG that is aligned to the NSF guides a shift in investment for strengthening Namibian capacity and ownership particularly in the areas of human resources and implementation of the national plans. Implementation of the framework is on-going with oversight by a multi-sectoral steering committee chaired by representatives of the GRN and USG governments

- iii. Stigma and discrimination remains a crucial barrier to services uptake and adherence. Namibia continually keeps strengthening the foundations for having a non-discriminatory and stigmatising environment by reviewing existing policies and legislation, developing capacity of service providers to respond effectively, and

strengthening systems that support stigma and discrimination interventions at community and work place.

There has been a strong demonstration of political will to address all forms of stigma and discrimination as demonstrated in on-going policy and legislation reviews. All forms of discrimination or stigmatisation has been outlawed, and public and private sectors institutions have developed policies to support a non-discriminatory and stigmatising environment at the workplace

5.2 Challenges faced throughout the reporting period (2012-2013) that hindered the national response, in general, and the progress towards achieving targets

- i. The downwards trend of investments in prevention over the past few years have consistently shown a worrying trend
- ii. Some FBOs and churches are still opposed to condoms, and condom distribution in prisons been banned.
- iii. Limited capacity of domestic human resources both in terms of numbers and critical expertise is still a huge challenge to the AIDS response.
- iv. Data on size estimates, HIV prevalence, behavioural and social issues for key populations is scarce.
- v. Widespread stigma and discrimination, gender violence and legal barriers continue to impede the realisation of human rights, HIV prevention and health care access by key populations, - notably MSM, SW and their clients

5.3 Concrete remedial actions that are planned to ensure achievement of agreed targets.

- a) Accelerate the scale up implementation of the combination prevention strategy (CPS) as part of operationalizing the NSF
- b) 2014 and 2015 presents an opportunity to accelerate planning and implementation of targeted strategies for key populations (e.g. MSM, sex workers, mobile populations), particularly in epidemic hot spots and for identified vulnerable groups, including young women and men, among whom estimated incidence is highest
- c) With the reviewed NSF aligned with the “Investment Approach”, the focus will be to develop the Invest Case for Namibia to accelerate advocacy and resource mobilisation, and to support the rollout of efficient and cost-effective high impact interventions necessary to stop new HIV infections and reduce AIDS related deaths in adults and children
- d) In line with current commitment from the Namibia government, implement the WHO 2013 treatment guidelines - in particular adopt the CD4 500 eligibility criteria
- e) Intensify health and community systems strengthening, with a key focus on human resource, technologies, procurement and supply chain, HIV financing and strategic information management. Short and long-term human resources
- f) The Joint Team and the entire UN system to continue providing assistance to civil society in planning and implementation of interventions that generate strategic information, address legislative reforms, and focus on key populations including women and youth

6. Support from the country's development partners

USG PEPFAR

The planned funding during the fiscal year 2012 (covering the time period of January 2013 - December 2013) was \$88,776,117. Of this, \$15,583,605 was allocated to adult care and treatment, \$4,998,789 for biomedical prevention including voluntary medical male circumcision, \$5,996,697 for counseling and testing, \$8,306,997 for health systems strengthening, \$1,820,531 for laboratory infrastructure, \$6,008,645 for orphans and vulnerable children, \$4,146,558 for pediatric care and treatment, \$4,196,874 for prevention of mother-to-child transmission, \$7,062,445 other for sexual prevention, \$6,106,882 for strategic information and \$3,684,411 for TB/HIV co-infection. This support is expected to shift from funding of direct program implementation to a technical assistance framework.

PEPFAR, through CDC, has funded the Integrated Bio-Behavioural Surveillance Survey which is targeting the Female Sex Workers as well as Men having Sex with Men. The survey will provide us with information on the risks behaviour among this population as well as the prevalence. In addition, a PMTCT impact evaluation is planned for the year 2014. A Sentinel Incidence Survey to evaluate the response will also be carried out in Zambezi region. This study is important as it will provide Namibia with information on incidence.

GFATM

The Global Fund to Fight AIDS, Tuberculosis and Malaria in 2013 is an approved and signed agreements with Namibia for US\$110.6 million to further support the national HIV response programmes.

The programmes focus on high impact interventions including treatment, care and support, Prevention of Mother to Child Transmission of HIV, scaling-up of voluntary male medical circumcision, basic prevention for men who have sex with men and sex workers; and cross-cutting activities such as strategic and targeted behavioural change communication, HIV counselling and testing and condom promotion and distribution. These programmes are being implemented jointly by the Ministry of Health of Namibia and Network of AIDS Service Organisations (NANASO) under the RCC Phase II grants.

United Nations

The Joint United Nations Team on AIDS (JUTA) has provided technical and financial support in a range of areas over 2012 -2013. Examples include the provision of technical assistance (TA) towards the National Elimination Plan of MTCT 2012–16, including the monitoring and evaluation components, and integrating SRH in the eMTCT, condom and male circumcision strategies. The national consultation on prongs 1 and 2 of PMTCT for WLHIV, civil society and community organizations informed the final eMTCT plan, while UN advocacy fuelled dialogue on the 'treatment as prevention' strategy. In 2012, UNICEF, UNFPA, WHO and UNAIDS also guided planning for roll-out of point-of-care CD4 count machines for Option B+ treatment and highly active ART for people living with HIV (PLHIV). The UN supported the 2013 Mid-Term Review of the National Strategic

Framework which was informed by the investment approach and led to a revision of the NSF to ensure a stronger focus on high impact interventions and efficiencies. UNFPA and UNAIDS have been supporting the EU and SIDA funded SRH-HIV linkages project, which aims to strengthen policy, system and service delivery linkages and has led to a service delivery pilot in 7 clinics across the country, whereby the preliminary results from the baseline assessment already indicate tremendous potential efficiency gains. Namibia's innovative approach to its HIV response is further evidenced by the initiation of mobile service delivery in the capital city Windhoek. Informed by the findings of the UNAIDS and UNDP supported KYE/KYR study in Windhoek, the MOHSS has joined the City of Windhoek and PharmAccess Foundation to provide HIV prevention and primary health care services to previously under-served informal settlements in the city. During 2012-2013 concerted efforts were made by the UN to support efforts to scale up prevention efforts for young people and key populations, notably sex workers, and promote enhanced participation and inclusion of these populations in programming. UNESCO helped train 137 Life Skills teachers to deliver comprehensive sex education. UNAIDS, UNFPA and UNICEF supported the strengthening of the AfriYan Namibia network and the capacity building of youth leaders on HIV and SRH resulting in a Call for Action by Namibian young people. UNFPA and UNAIDS supported the formation and capacity building of Namibia's African Sex Worker Alliance and have disseminated strategic information to reflect how criminalizing laws are hindering this population from accessing HIV related services. Together with civil society and MOHSS, the UN has supported sex worker led to advocate for their rights and sensitize key parliamentarian leaders on the need to remove punitive laws against sex work and sodomy. Meanwhile, support was provided to the Namibia Planned Parenthood Association to reach out to sex workers and provide accessible HIV and SRH services. UNAIDS and cosponsors took action to promote the capacity building and participation of PLHIV in the national response through the UNESCO led positive speaking programme for Young PLHIV, and through national consultations.

The UN has also supported increased awareness and understanding of the linkages between HIV and GBV and advocated for stronger linkages and sustainability with the civil society response to HIV.

JICA

In 2007, JICA assistance to the AIDS response spans to as far back as 2007 with the Ministry of Health and Social Services, which came up with a HIV/AIDS M&E Capacity building proposal. The aim of the proposal was to strengthen the non-health facility based M&E system called the System for Programme Monitoring (SPM) which was non-existent or not well developed. In addition, the proposal was also developed to strengthen the community based M&E as there was a lack of understanding on the benefits of M&E amongst HIV/AIDS stakeholders at all levels in the country especially the non-health facility based M&E implementers.

The Non-health facility based response system, the System for Programme Monitoring (SPM) now constitute an integral part of the national HIV M&E system and has in place data

collection tools which enables the MOHSS, the Regional Councils and its partners to collect, analyze, report and use routine data generated during the provision of HIV and AIDS services by implementers at venues other than health facilities. During the implementation of the proposal, staff from the ministry of Health and Social Services, civil society organisation (NANASO), private sector (NABCOA), AMICAALL, the Regional Council and staff from the University of Namibia have been trained annually in Monitoring and evaluation through the University of Pretoria, South Africa. The trainings includes a three days manager's course and a five days technocrat's course. The project strengthened the use of data especially at the regional council as they are able to know who is doing what in their region, discuss data in the Regional AIDS coordinating committees and use data for planning purposes.

In 2012, Regional Seminar to strengthen M&E for HIV Programmes in Southern Africa was held from 13-15 Feb 2012 in Johannesburg. Five (5) Namibian participants from the Regional Councils, Civil Society (NANASO), National M&E Office from Ministry of Health and Social Services participated were supported to attend the seminar. A data management workshop attended by Regional M&E officers and Community Liaison officers based in the regional council as well as officers from the Office of the Prime Minister (OPM), NANASO, Council of churches in Namibia (CCN) was held from 6-8 February 2012 in Windhoek. This training aimed at introducing the participants to the software (DHIS2) tool that is used to capture SPM data at the regional councils.

During the implementation of phase I proposal, a generic M&E curriculum was developed which countries can use. Staff from UNAM, Ministry of Regional Local Government Housing and Rural Development (MRLGHRD), and NANASO were trained as TOT in the use of this curriculum.

In 2013, 9 Regional implementer's trainings were conducted country wide. The remaining 4 regions (Erongo, Oshikoto, Omaheke and Oshana) will be trained this year before the end of February 2014.

GIZ

The Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH on behalf of the German Federal Ministry of Economic Cooperation and Development (BMZ) has been supporting Namibia's response to HIV and AIDS through technical cooperation since 2005. The current development programme 'Multisectoral HIV and AIDS response Programme in Namibia' started in July 2011 and is to date in the process of being extended until June 2016. The programme is planned and implemented in line with the National Strategic Framework for HIV and AIDS Response in Namibia for the period 2010/11 – 2015/16 (NSF).

The Custodian and Implementing Partner of the programme is the Ministry of Health and Social Services (MOHSS) and the value of the current commission for July 2011 until June 2014 of the Federal Ministry for Economic Development and Cooperation (BMZ) is EUR 5.54 Million. Upon request of the Ministry of Health and Social Services end of 2012, the BMZ agreed in Namibian-German bilateral Government Negotiations held in November 2013 to extend the programme until June 2016 with an additional value of 3 Mill EUR.

The Multisectoral HIV and AIDS response Programme in Namibia works to support public, private and civil society partners from a Central level and in the Ohangwena and Oshana regions. From 2011 – 2014, the programme has focused to date on three components:

- HIV and AIDS in the World of Work
- Strengthening of Regional and Local Responses to HIV and AIDS
- HIV and AIDS Mainstreaming

As of June 2014 with an extension until June 2016, the programme will implement a slightly changed concept that will focus on three relevant target groups

- Formal sector employees through HIV workplace programmes in the private sector and MWT and MAWF as public sector partners
- Youth aged 15-24 in Ohangwena region
- People living with HIV in Ohangwena and Oshana region