



**Republic of Namibia
Ministry of Health and Social Services**

**United Nations General Assembly Special Session
(UNGASS)
Country Report**

Reporting Period April 2006 – March 2007



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List of Abbreviations

ABC	Abstinence, Be Faithful, Condoms
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
CACOC	Constituency AIDS Coordinating Committee
CBO	Community based Organisation
CBS	Central Bureau of Statistics
CDC	Centers for Disease Control and Prevention (U.S)
CMS	Central Medical Stores
CRIS	Country Response Information System
DACOC	District AIDS Coordinating Committee
DHS	Demographic & Health Survey
DPP&HRD	Directorate: Policy, Planning and Human Resource Development
DSP	Directorate: Special Programmes
ETR	Electronic TB Register
EU	European Union
FBO	Faith-based Organisation
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
M&E	Monitoring and evaluation
MoE	Ministry of Education
MoHSS	Ministry of Health and Social Services
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
NIP	Namibia Institute of Pathology
NPC	National Planning Commission
OMAs	Government Offices, Ministries or Agencies
OVC	Orphans and Vulnerable Children

PEP	Post Exposure Prophylaxis
PEPFAR	The US President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV/AIDS
RACOC	Regional AIDS Co-coordinating Committee
RM&E	Response Monitoring and Evaluation Subdivision
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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1. Status at a Glance

<i>UNGASS Indicators</i>	<i>2003</i>	<i>2005</i>	<i>2007</i>
National Commitment			
1. Domestic and international AIDS spending by financing sources			
Domestic sources (GRN, private sector, etc.)	35,000,000 [1]	38,558,000	66,300,000
External sources (Development partners)		40,564,000	64,200,000
Total		79,122,000	130,500,000
2. National Composite Policy Index		18/20	Not comparable
3. Percentage of donated blood units screened for HIV in a quality assured manner		100%	100%
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	6%	27.5%	57% adult 91% children
5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	7%	25%	49%
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV			NA
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	NA	NA	28.6% F 17.6% M (2006 DHS)
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results			NA
9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes			NA
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	NA	NA	16.5% (2006 DHS)
11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year			79%
Knowledge and Behaviour			
12. Current school attendance among double orphans and among non-orphans aged 10-14 Ratio	83% DO 90% NO 0.92 (2000 DHS)		94% DO 94% NO 1.0 (2006 DHS)
13. 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	38.9% F 50.7% M (2000 DHS)		64.9% F 61.9% M (2006 DHS)
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission			NA
15. Percentage of young women and men who have had sexual intercourse before the age of 15 among young people ages 15-24	8.8% F 27.3% M (2000 DHS)		7.0% F 18.0% M 2006 DHS
2005 UNGASS indicator Percent of adults aged 15-24 who had sex with a non-regular partner in the past 12 months	80.2% F 85.1% M (2000 DHS)		75.4% F 90.1% M 2006 DHS
16. Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months			2.5% F 16.2% M (2006 DHS)

<i>UNGASS Indicators</i>	<i>2003</i>	<i>2005</i>	<i>2007</i>
2005 UNGASS indicator Percent of adults aged 15-24 who had sex with a non-regular partner in the past 12 months who report the use of a condom at last sex	47.9% F 69.4% M (2000 DHS)		64.2% F 81.1% M (2006 DHS)
17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse			65.7% F 74.4% M (2006 DHS)
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client			NA
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner			NA
20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected			NA
21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse			NA
Impact			
22. Percentage of young women and men aged 15–24 who are HIV infected (indicator not available, used young women attending ANC) PF – Pregnant women attending ANC	18% PF	15% PF	14% PF
23. Percentage of most-at-risk populations who are HIV infected			NA
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy		91%	69% adults 82% children
25. Estimated percentage of all infants born to HIV infected mothers who are infected		28%	25%

2. Overview of the HIV Epidemic in Namibia

2.1 Introduction

In June 2001, Namibia signed the Declaration of Commitment on HIV/AIDS developed during the UN General Assembly Special Session on HIV/AIDS (UNGASS). The commitment addresses global, regional and country-level responses to prevent new HIV infections, expand health care access and mitigate the epidemic's impact. The declaration attempts to extend beyond governments to reach the private sector, labour groups, faith-based organizations, nongovernmental organizations and other civil society entities, including organizations of people living with HIV.

Under the terms of the Declaration of Commitment on HIV/AIDS, Namibia is required to publish biennial reports on their progress toward reaching the UNGASS goals. A panel of country officers, UN agencies and other development partners has developed a list of indicators and targets against which to measure progress on the declaration of commitment. These indicators are then used by all countries to measure how they are progressing toward meeting these targets.

The purpose of this report is to review the progress made by Namibia toward reaching the goals agreed to in the UNGASS Declaration of Commitment. In addition the report describes challenges, constraints and recommended actions to achieve the UNGASS targets.

The report was written by the Ministry of Health and Social Services with significant contribution from civil society and other development partners. A technical advisory group was established consisting of key stakeholders to review the process of developing the report and reviewing the drafts. In addition a special civil society meeting was held in early December 2007 to review the results of the national composite policy index with civil society.

This report is a shortened version of the MTP Progress Report for 2006-07. Both reports cover the same topic areas, the same time period and the same indicators. Both reports use the same process of requesting significant contribution from civil society and development partners. At this point the only difference is that the MTP III Progress Report contains more details. UNAIDS has proposed that in future years countries submit their national progress reports in lieu of the UNGASS report. This will reduce any additional reporting burden. The national reports should continue to focus on meeting the national targets set by the country. Thus in future years Namibia will only need to submit their most recent MTP progress report for their UNGASS reporting requirements.

2.2 Namibian Country Profile

Namibia is located in the south-western part of Africa, hosting a population of approximately 2,000,000 (National Planning Commission, 2003). It is one of the most sparsely populated countries in Africa with an average population density of 2.5 persons per square kilometer. The country is classified as a lower-middle income country and is heavily dependent on the extraction and processing of minerals for export. Despite this good economic status the country has the highest Gini coefficient in the world at approximately 0.6 (National Planning Commission, 2006). The Gini coefficient provides a measure of income distribution across various segments of society.

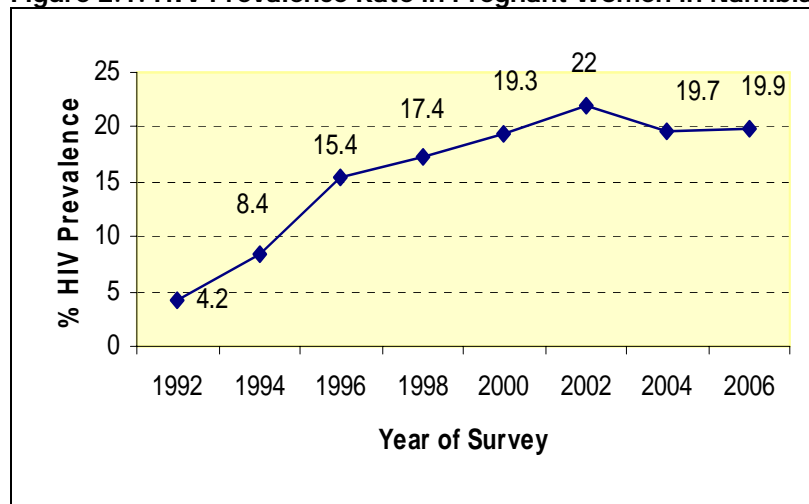
2.3 HIV/AIDS in Namibia

The first HIV infection was reported 21 years ago in 1986. The epidemic proceeded to grow rapidly until 2002 and has since show signs of stabilisation. However there are significant regional variations within the country.

The Ministry of Health and Social Services (MoHSS) conducts HIV sentinel surveys every two years using pregnant women visiting antenatal clinics (ANC). The first survey was conducted in 1992 while the latest one was conducted in 2006. HIV prevalence seems to have stabilised since 2002. It should be underlined, however, that no population-based survey has been conducted, and the actual level of national prevalence can only be estimated through models.

The most recent ANC HIV surveillance found 19.9% of women attending ANC were HIV infected (MoHSS, 2007d). There was a rapid increase in ANC HIV prevalence from 4.2% in 1992 to 22% in 2002. The apparent decrease since 2002 represents the first decrease since the start of ANC surveillance (see Figure 2.1). However, it should be noted that HIV prevalence is still on the increase in some regions and in some age groups, meaning continued high levels of prevention, care and support services are needed.

Figure 2.1: HIV Prevalence Rate in Pregnant Women in Namibia, 1992 - 2006

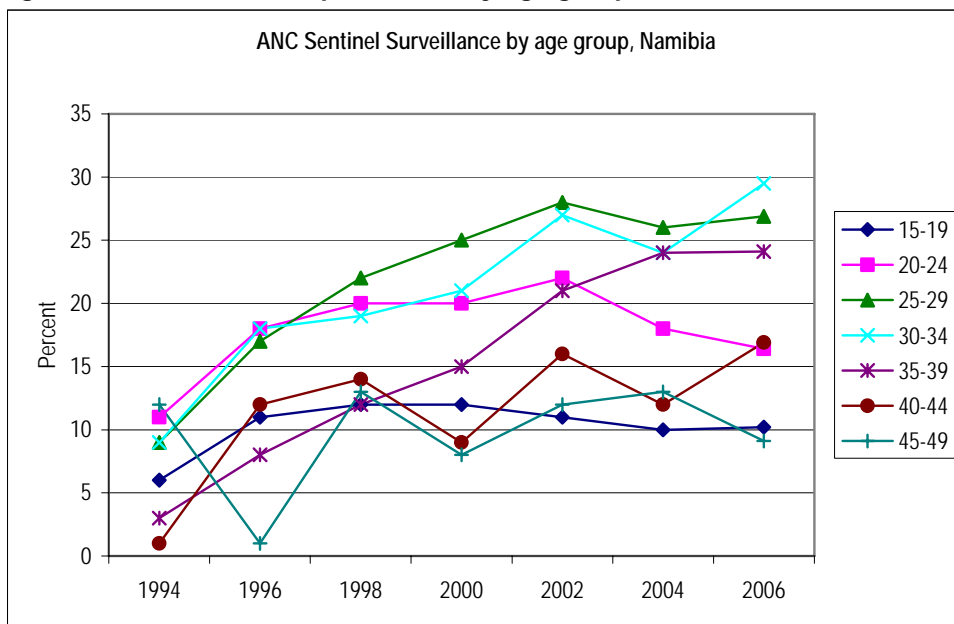


Source: MOHSS, 2007d.

The highest ANC HIV prevalence was reported in Katima Mulilo at 39.4%, while the lowest was reported in Opuwo and Gobabis at 7.9%. This dramatic variation between the regions signifies quite different epidemics throughout the country.

HIV prevalence among young women 15-24 is often used as a proxy for new infections or HIV incidence. Women in this age group are just starting to be sexually active and are thus likely to have recently been infected. Among young women ages 15-24 there has been a slight decline in HIV prevalence from 17.9 in 2002 to 15.2 in 2004, to 14.2 percent in 2006 (see Figure 2.2). It is important to note however that the sites where ANC prevalence has been measured have varied between 2002, 2004 and 2006. These changes were to improve the overall coverage of ANC surveillance which ultimately improves our understanding of the epidemic. However, a more accurate analysis of trends in prevalence among the 15-24 age group should be done using only those sites that were consistent over the three surveys. This analysis has been done but is not yet published.

Figure 2.2: Trends in HIV prevalence by age group



Source: MoHSS, 2007d.

<i>UNGASS Indicator</i>		<i>2003</i>	<i>2005</i>	<i>2007</i>
22. Percentage of young women and men aged 15–24 who are HIV infected – indicator is not available	15-24	17.9	15.2	14.2
Proxy: Percentage of young women attending ANC aged 15-24 who are HIV infected	15-19	10.7	9.9	10.2
	20-24	12.7 (2002 HSS)	18.2 (2004 HSS)	16.4 (2006 HSS)

A thorough analysis of what is driving the HIV epidemic in Namibia has not yet been conducted. Such an analysis is planned for 2008 to inform the next national strategic plan.

Despite strides in improving the lives and well-being of Namibia’s citizens, many of these gains have already been undermined by HIV infection and AIDS related illnesses and death, and this is likely to worsen over the next decade. In recent years, deaths have accelerated in the most productive age group, 15-49, while child mortality rates have stopped decreasing (the preliminary DHS results show an increase from 18 to 24 deaths per 1,000 children over the past five years – MoHSS and Macro International, 2007). The estimated number of people living with HIV in 2007 was 200,000, 14,000 of which were children (MoHSS, Forthcoming[a], using Spectrum 3.13).

AIDS has taken a large toll on children in Namibia. According to the Demographic and Health Surveys, between 1992 and 2006 the percent of children under age 15 who had lost both parents increased from 0.4 percent to 2.5 percent (MoHSS and Macro International, 1993 and MoHSS and Macro International, 2007). Currently among children under the age of 18, 4.6 percent lost their mother (father still alive) and 10 percent lost their father (mother still alive). It is likely that up to one-third of Namibia’s children are living in difficult circumstances (MoHSS and Macro International 2007, preliminary NDHS tables 2006).

3. Overview of Progress Made in the National Response

Namibia's Vision 2030 regards HIV as one of the most serious threats facing the country, and it highlights the need to mainstream HIV programmes to effectively meet the resultant development challenges. Consistent with the goals of Vision 2030, the country's response to the epidemic has intensified considerably in recent years. The Government of Namibia is fully committed to tackling the epidemic in a multi-sectoral manner. This is reflected in the Medium-Term Plan III (MTP III) for the period 2004-2009, which places particular emphasis on the importance of effective monitoring and evaluation of the epidemic. The national goal of MTP III is the reduction in incidence of HIV infection. To realize this goal, five key strategic results have been articulated:

Component 1: Enabling Environment -- People infected and affected with HIV/AIDS enjoy equal rights in a culture of acceptance, openness and compassion

Component 2: Prevention -- Reduced new infections of HIV and other STIs

Component 3: Access to treatment, care and Support Services -- Access to cost effective and high quality treatment, care and support services for all people living with or affected by HIV/AIDS.

Component 4: Impact Mitigation Services -- Strengthen and expanded capacity for local responses to mitigate socio-economic impacts of HIV/AIDS

Component 5: Integrated and Co-ordinated Programme Management at all levels -- Effective management structures and systems, optimal capacity and skills, and high quality programme implementation at national, sectoral, regional and local levels

The first HIV/AIDS Medium Term Plan was launched in 1992 with the implementation of a Short Term Plan. To coordinate implementation of this plan, the country established the National AIDS Control Programme housed within the Ministry of Health and Social Services (MOHSS). In March 1999, Dr Sam Nujoma, the former President of the Republic of Namibia launched the Second National Strategic Plan for HIV/AIDS (Medium Term Plan II).

To facilitate and coordinate implantation of MTP II, the National AIDS Co-ordination Programme (NACOP) was established in 1999, replacing the National AIDS Control Programme. This structure was designed to oversee the different sectors responding to HIV. In 2002, the Directorate of Special Programmes was established where NACOP is housed. Additionally, a specific subdivision under DSP, "Response Monitoring and Evaluation" (RM&E) was established with the primary mandate of monitoring and evaluating the implementation of HIV/AIDS response strategies at national and regional levels.

MTP II strengthened support to HIV/AIDS prevention and control efforts and focused on mobilising all partners to reduce HIV incidence. It also addressed increased stigma and discrimination and access to quality health services to those living with the disease. The Third Medium Term Plan (MTP III) went a step further to consolidate access to treatment with anti-retroviral medicines and ensuring the mainstreaming of HIV programmes in all sectors. It further pulls together efforts from all Government Officers, Ministries/Agencies, Regions, Non-governmental Organisations, Faith Based organisations, and Community Based Organisations, the Private Sector and various development partners to play a distinct role addressing the causes and reducing the burden of HIV/AIDS.

In June 2007 there was a mid-term review of the MTP III. The draft report of this review has been shared with partners; however, the results have not formally been presented to the government or published. These results are likely to influence the formulation of MTP IV.

3.1. Creating an Enabling Environment

Laws, financing and political commitment (or leadership) are necessary to ensure the rights of individuals infected and affected by HIV. Policies and laws are necessary to guide the response to HIV/AIDS and to ensure a legal and organizational framework on which to base actions and activities. Policies define the responsibilities and set standards for what services should be provided. Laws are necessary to enforce the policies and also to ensure that the rights of individuals affected and infected by HIV are protected.

The national response to HIV requires a large financial commitment by the government and the development partners. This commitment needs to be sustained over time; even if all new infections were averted the cost of supporting and caring for those currently infected or affected by HIV is significant.

Finally we need the commitment of our leaders to show through their words and actions the critical importance of responding to HIV. A coordinated, government led response is the only way to ensure a healthy and productive population.

3.1.1 HIV/AIDS Policies

The National Policy on HIV/AIDS was approved in March 2007. The goal of this policy is to guide current and future health and multi-sectoral responses to HIV/AIDS in Namibia, to encourage all Namibian institutions to fulfil their obligations for responding to HIV/AIDS and to serve as a guiding frame for a coherent and sustained approach enhancing political commitment and participation of civil society at all levels.

Since the implementation of MTP III there has been increased attention to the development of sectoral policies for HIV that address both workplace related issues as well as mainstreaming aspects of HIV.

3.1.2 Stigma and Discrimination

The AIDS Law Unit (ALU) engages in advocacy and lobbying for law reform and successfully lobbied parliament to include HIV as a prohibited ground for discrimination in the Labour Bill. In spite of the effort by ALU and other agencies, capacity for policy development in many sectors is still limited and requires increased attention. It is necessary to ensure that social assistance policies and procedures are more responsive to the needs of PLWHA and children affected by HIV/AIDS.

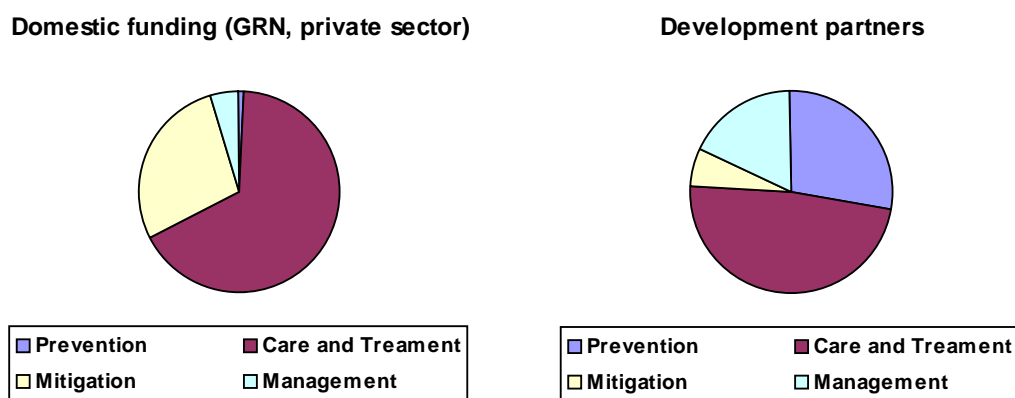
Preliminary data from the 2006 Demographic and Health Survey suggest that the discrimination against people living with HIV is improving. In the 2000 NDHS survey only 45 percent of women said they would buy food from a person living with HIV, while in 2006 75 percent of women said they would buy food from a person living with HIV (MoHSS and Macro International, 2002 and MoHSS and Macro International 2007). Similar results were found for men. This could also reflect a better understanding of transmission routes and not necessarily changes in stigma associated with HIV.

3.1.3 Domestic and International AIDS Spending

<i>UNGASS Indicator</i>	<i>2003</i>	<i>2005</i>	<i>2007</i>
National Commitment			
1. Domestic and international AIDS spending by categories and financing sources (US\$)			
Domestic sources (GRN, private sector, etc.)	35,000,000	38,558,000	66,300,000
External sources (Development partners)		40,564,000	64,200,000
Total		79,122,000	130,500,000

Spending on HIV has increased over the past two years from US\$35 million in 2003 to almost US\$80 million on 2005 to US\$130 million in financial year 2006. Funding from domestic sources, primarily the government and private sector, accounted for approximately half of the spending while the remainder came from external sources such as development partners. Figure 3.1 shows that almost two thirds of the government spending went to care and treatment – primarily ARVs – while a little less than half of development partner funds went toward ARVs. Also important to note is the very small proportion of domestic funding that goes toward prevention efforts.

Figure 3.1 Breakdown of spending by area and type of funding, 2006/07



Source: Directorate of Special Programmes: Resource Mobilization Sub-Division

3.1.4 National Composite Policy Index

The national composite policy index provides a summary measure of the progress toward developing policies and strategies to address HIV. The following section describes the process for assessing the policy index and the results from the national policy index interviews. The information for the NCPI was collected from nine informants; six members of civil society organizations and three government officials.

Civil Society Responses

The civil society informants were individually interviewed while the government informants indicated that due to their busy schedules at the end of the year, they preferred to answer the questionnaire independently. All the civil society participants were invited to a meeting in order to review and discuss findings. Although the turnout for the meeting was poor, this meeting was very useful insofar as the participants candidly discussed the findings and came to consensus on the few issues where there was not immediately obvious agreement.

The scale of the HIV/AIDS epidemic in Namibia, coupled with slow and/or partial implementation of certain elements of the national response and structural limitations of the public health and welfare systems, has contributed to the growing pressure on NGOs, CBOs, FBOs, and private sector to respond to various aspects of the epidemic. This includes the visible and growing need to support and care for PLWHA and others who are affected by the epidemic, particularly OVC, as well as engagement with prevention, treatment, and rights-related activities.

Part B (Civil Society) of the NCPI questionnaire addresses four areas: human rights, civil society involvement, prevention, and treatment, care and support in relation to the national response to HIV/AIDS epidemic.

Human Rights

There are sufficient laws and regulations which protect people living with HIV against discrimination. Indeed, Namibia has excellent laws, although the implementation of these laws sometimes falls short. However, the Constitution as well as the HIV/AIDS Policy is silent on MSM and IDU, condoms are not distributed in prisons, sex work is illegal, sodomy is illegal, and thus prevention is difficult for many of the most at-risk populations. There are channels in place to address discrimination, such as Ombudsman, and the AIDS Unit of the Legal Assistance Centre, but the capacity of these organizations is limited.

PLWHA are represented in almost all levels of government forums, but their impact may be minimal. PLWHA and at-risk populations are involved in policy design, but again, the implementation of the policies is neither uniform nor consistent.

Although HIV services (prevention, care and treatment) are intended to be provided free of charge, hospitals often charge fees to individuals seeking treatment and care and support are provided by the community organisations rather than by government. Access to prevention, treatment, care and support for some of the most at-risk populations (MSM, IDU, sex workers) is limited; prisoners are denied condoms, and sex work, sex between men and injecting drug use are illegal.

There are well-received programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance, in particular those in the schools (Window of Hope, My Future is My Choice).

While the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS have improved from 2005 to 2007, the 2007 policy still ignores some vulnerable groups. The effort to enforce the existing policies, laws and regulations also has improved from 2005 to 2007, but there remains a lack of effective enforcement. The barriers are lack of human resources in MoHSS and MGECW as well as consistent policy implementation due to de-centralization. Also cited was lack of policy ownership and political will.

Civil Society Participation

Civil society has been involved in all levels of policy formulation. However, money is not allocated in the national budget for civil society activities (HIV prevention, treatment, care and support). There is neither adequate financial nor technical support of civil society to implement its HIV activities. Nevertheless, efforts to increase civil society participation in 2007 have improved from 2005. There has been involvement of PLWHA in all 13 regions, NANASO has been revived, and multi-sectoral responses are more common.

Prevention

The national prevention approach is a “blanket approach,” where local responses are weak. It is well known that there is higher HIV and AIDS prevalence in some regions, but prevention approaches are not adapted accordingly. Involvement with civil society in the area of prevention is increasing, but there is little that goes beyond “ABC” at the mainstream level. This may be due to constraints placed by some donors on additional prevention approaches other than “ABC”.

Treatment, Care and Support

The approach to treatment, care and support is national and is too dependent on human and other resources. Specific districts are identified but responses may not be adequate. People who want treatment are sometimes 100km from a hospital and have no means to obtain the treatment which they want and need. Treatment roll-out is scaling up but still not accessible to all in need. There is currently no extra effort being made by GRN to improve service delivery.

Civil society provides the majority (over 50%) of all HIV programmes or services with the exception of clinical services (counselling, testing, ART). Programmes for OVC and youth, as well as home-based care are largely the domain of civil society.

Issues Arising from Civil Society Interviews

The over-arching issue is that civil society on its own has inadequate resources. Institutional support is needed to deliver services. There is lack of information about the financial support for civil society in the national budget, and it appears that government does not recognize the budgetary need to support civil society efforts.

Many services for PLWHA and OVC are provided primarily by civil society organizations. There are insufficient members of NGOs and CBOs to provide material, financial and technical assistance for local responses, including nutritional support, psycho-social support, establishment of income generating activities (IGAs) and economic skills empowerment for PLWHA, OVC, and their caregivers. Additionally, there is insufficient geographic coverage of comprehensive OVC services.

In prevention efforts, some segments of the population are neglected, such as IDU, MSM, sex workers and criminalisation is a major concern. The official bodies in place to oversee law enforcement and investigate cases of discrimination, such as office of the Ombudsman and Legal Assistance Centre-Aids Legal Unit (LAC-ALU) have limited capacity to take up these issues. Prevention approaches are not adapted accordingly in most districts and treatment roll-out is not accessible to all in need because of geographic and financial constraints.

Government Perspectives on NCPI Questionnaire

This section details the responses of the government to the items in the NCPI questionnaire. Part A (government officials) of the NCPI questionnaire addresses five areas: strategic plan, political support, prevention, treatment, care and support, and monitoring and evaluation. The responses to items in each of the five areas are presented below.

Strategic Plan

Namibia has had a multi-sectoral strategy for 15 years, with specific target populations being women, children, defence force, police, and health workers.

The country has ensured "full involvement and participation of civil society" in the development of the multi-sectoral strategy. Civil society is involved in service delivery at the community level, such as prevention activities, home based care, community mobilization, care and support for orphans and vulnerable children and coordination of activities.

Namibia has integrated HIV and AIDS into its general development plans:

"The government of Namibia is firmly committed to accord the highest priority to the prevention of HIV/AIDS as a critical strategy for the alleviation of poverty. This is reflected in the Poverty Reduction Strategy of MTP III 2004-2009. The National Policy on HIV/AIDS of March 2007 has stipulated that HIV/AIDS should be accorded priority and especially prevention among youth, vulnerable groups and general population."

There is a strategy/action framework for addressing HIV and AIDS issues among the national uniformed services such as military, police, peacekeepers, prison staff, etc. The implementation of behavioural change communication, condom provision, HIV testing and counselling, STI services, treatment care and support are provided. Additionally, HIV testing is mandatory of armed forces personnel, while it is voluntary for the general public.

The country has developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs, but not much improvement was noted from 2005 to 2007.

Political Support

The Minister of Health and Social Services, who is a political appointee, is the chairperson of the national multi-sectoral AIDS management/coordination body, which was created in 1998. The main achievements of this coordination body were cited as: better understanding by PLWHA of governments' efforts; development of an M & E plan for HIV/AIDS at national level; supervisory support visits to regional levels. The challenges identified by government respondents were: lack of financial and human resources; too many meetings on HIV/AIDS related issues - some of the sectors have too few staff members to attend every meeting; leadership at higher levels not active; at lower levels it is often difficult to get multi-sectoral cooperation.

In response to the question, "What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?", one respondent said, "no idea" while another said, "difficult to quantify." These responses fit with those of civil society, wherein it was stated that the national budget does not promote activities of civil society sector. Good progress has been made in terms of planning at the national level; however, DSP should scale up efforts to coordinate HIV/AIDS activities at both regional and district levels.

Prevention

There was significant improvement noted in policy efforts in support of HIV prevention in 2007 from 2005. However, it appears that the government officials who responded to the questionnaires had little knowledge of the on-the-ground implementation of these policies. Indeed, many of the prevention activities are carried out by civil society. In addition no national HIV prevention strategy exists.

Treatment, Care and Support

As indicated above, Namibia has strong policies and strategies in place which address the needs of PLWHA for comprehensive HIV treatment, care and support (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and

home and community-based care). It is the implementation of these policies that continues to present difficulties.

Regarding an estimate of OVC being reached by existing interventions, the respondents suggested that 50% are being reached, which is a perceived improvement from 2005. It was stated that an M&E plan for OVCs for 2006- 2010 has been developed, the number of OVCs who received social welfare grants increased from 7,000 to 40,685 from 2003-2006. Social workers have been appointed at regional and national levels to address the plight of OVCs. However, there is still insufficient geographic coverage of comprehensive OVC services. Quality assurance, supervision, and M&E of OVC programmes remain critical gap areas.

Monitoring and Evaluation

Implementation partners are not yet reporting on the required indicators to their co-ordinating body and to MoHSS/DSP. NANASO is the civil society co-ordinating body and NABCOA is the private sector co-ordinating body. However, the M&E Subdivision needs restructuring to allow for improved national M&E and human resource capacity building to better take up its role to bring together data from different information sources, so that national indicators can be reported on a regular basis.

Areas that need strengthening include: surveillance and research, monitoring, evaluation, informatics, health sector and multi-sectoral support and secretarial support. M&E structures need to be established at the regional levels in the MoHSS (M&E offices in each region) in order to support the health sector response M&E at their levels. Sectors need to be strengthened in terms of M&E capacity; officers have been recruited for crucial sectors/umbrella organisations e.g. NANASO, NABCOA, MoRLGHRD, OPM. Additional human resources are needed for MoE, MGECW, NPC, and Lironga Eparu.

There is lack of capacity in MoHSS; high turnover of field people trained in PMTCT/ART/VCT management information system results in potential under-reporting of data. Moreover, there is a critical challenge of staffing in the MGECW to oversee implementation of a national OVC M&E plan which has been officially adopted in 2007.

MoHSS, with support from CDC, developed a database to track infant PCR diagnosis of HIV. This will allow evaluation of the mother to child transmission rate in Namibia. CDC/MoHSS has developed ART patient record-keeping system and computerised database. This M & E data is used in planning and implementation, particularly for ARV's. However, timeliness and reliability of this data present challenges.

None of the government respondents knew when the last M & E training was conducted. However, this level of detail may not be relevant to the particular job description of the respondents. Improvement was noted from 2005 to 2007 in the M&E efforts of the AIDS programmes.

It was noted that MoHSS has forecasted the expected number of ART patients through 2008. Development partners have strengthened the M&E system capacity by providing funds and technical advisory services.

Issues Arising From Government Interviews

Good progress has been made on strategy planning efforts in the HIV/AIDS programmes, but more effort is now required for coordination of HIV/AIDS activities. The NAC promotes interaction between government, PLWHA, civil society and the private sector for

implementing HIV/AIDS strategies programmes and must be even more active. Leaders at higher levels are not as active as they could be, while at lower levels it is often difficult to obtain multi-sectoral cooperation.

The percentage of the national HIV/AIDS budget that was spent on activities implemented by civil society in the past year was reported as either "difficult to quantify" or "no idea." This reflects the concerns voiced by civil society that money is not being allocated.

Conclusions

There was improvement from 2005 on all questions from civil society and government, with the exception of including civil society activities in the national budget. It should be noted however that civil society activities are supported by development partners. Civil society, including umbrella organisations, needs more financial and technical support in order to strengthen and scale up efforts.

Stigma and discrimination needs to be confronted and overcome at all levels (national, regional, district and community) as well as in health care settings in order to achieve and sustain universal access. Stigma and discrimination remain major obstacles to the access and up-take of HIV services. It cannot be overemphasised that due to the large geographic area of Namibia, services are not equally available. ART and other HIV treatment services, including essential commodities, must be provided free and must be geographically accessible.

NGOs and community organizations should be more involved in monitoring and evaluation activities to assess the quality and delivery of collaborative HIV activities and services. IEC efforts must be targeted to raise general awareness of important programmes such as VCT, PMTCT, ART, TB-HIV and other HIV/AIDS interventions.

Overall the policy environment in Namibia is strong and ready for expanded implementation efforts.

3.2. Prevention

Prevention of the transmission of HIV remains the cornerstone of the strategy to overcome the epidemic. In the Third Medium Term Plan, the prevention component is based on processes that influence attitudes to create intentions to change behaviour. MTP III therefore sustains the awareness programmes and encourages individuals to change behaviour to reduce the risk of infection.

Improved knowledge and skills contribute to behaviour change. This sub-component of the MTP III seeks to strengthen the knowledge and skills of organisations delivering prevention interventions. This is done through different training methods. Since 2004, much progress has been made in strengthening the capacity of civil society organizations, private organisations as well as line Ministries in their efforts towards prevention.

Despite the millions of dollars being spent on prevention in Namibia there has been little change in HIV prevalence (see earlier section). This stabilization in the total number of infections has led to the Directorate of Special Programmes to call for the development of a national HIV prevention strategy. The development of this strategy will include a comprehensive review of the drivers of the HIV epidemic and an assessment of the current HIV prevention activities. The strategy will focus on evidence based approaches to slowing new infections in the country.

3.2.1 Target Vulnerable Populations

Namibia has recognized military and armed services personnel as a high-risk group and has targeted prevention programming accordingly. The Ministry of Defence and the National Defence Forces, supported by the US Department of Defence through Social Marketing Association (SMA) has been implementing the Military Action and Prevention Programme (MAPP) since 2001. The programme includes four components; HIV prevention education, voluntary counselling and testing, edutainment on military bases, prevention and capacity building workshops. Soldiers receive prevention messages in the form of edutainment sessions undertaken at the military bases while soldiers going on peacekeeping missions are provided with MAPP prevention messages in the form of posters, leaflets, booklets, T-Shirts and condoms. MAPP opened two military VCT sites during 2006/2007, voluntarily counselled and tested 705 soldiers, trained 122 NDF members in testing and counselling, reached 9662 soldiers and trained 385 soldiers.

Another vulnerable population is women/girls and men/boys who engage in sex work. Sex work is illegal under Namibian law (Shanghala, 2000) and is considered socially unacceptable or undesirable. Accordingly, public perception tends to deny its existence. However, recent studies have shown that sex work is common in Namibia. Women's Action for Development (WAD) estimates that in the city of Windhoek's Katutura suburb alone, there were as many as 1,240 prostitutes (Ahrens, 2006). Additional data on sex work in the country as a whole are scarce. One study of sex workers in Windhoek found that 83% of the interviewees reported either not using a condoms at all, or irregular use of a condom due either to condoms tearing or to their customers' preference for sex without condoms (Kiremire, 2007). Of the close to 1,240 subjects tested for HIV in one year through the Catholic Mission's "Stand Together" project, which has been working with female prostitutes and other vulnerable women in Windhoek for the last 15 years, 70% were HIV-positive (Ahrens 2006).

In addition, clients of the sex workers not only are themselves at risk of infection but they return to often unsuspecting regular partners who are then at much higher risk of HIV and STIs.

Additional populations at increased risk to HIV are men who have sex with men and injecting drug users, however limited data exist on either the size of these populations in Namibia or the behaviours of these groups.

3.2.2 Target Behaviour Change Interventions at Young People

The after school voluntary life skills programmes My Future My Choice (MFMC) and Windows of Hope (WOH) have been rolled out nationwide through the Ministry of Education (MoE). In 2006 MFMC covered approximately 48-50% of secondary schools. In 2007 the coverage of these programmes was 79% of secondary schools. Since 1997 MFMC has reached nearly 190,000 youth. The target is at least 15,000 youth each year. Since its roll out in 2004, the Window of Hope programmes has trained teachers covering 80% of schools on Junior Windows (grades 4-5) and 64% of schools in Senior Windows (grades 6-7).

Components of the Window of Hope HIV Prevention course were incorporated into the revision of two mainstreamed school subjects namely Natural Science and Health and Social Studies for grades 6 and 7. The Government implemented the programme from January 2007. The teachers guide for mainstreamed life skills programme for grades 11 and 12 were

redesigned and improved. Pre-service training institutes for teachers will incorporate these programmes during the 2007/2008 year.

In response to the diverse health needs of young people, the MoHSS initiated an Adolescent Friendly Health services (AFHS) approach in collaboration with WHO, UNICEF and UNFPA in 2002. Adolescent Friendly Health Services are services rendered to young people in a supportive environment by providers that understand the needs and issues of adolescents and with the involvement of the young people themselves. The initiative has been operating in 12 out of 34 health districts. Thirty health facilities, out of the 37 that have been assessed, were certified as one star health facilities. The assessment function has been decentralized to the regions and focal persons were trained on how to conduct the assessment and certification process including monitoring of AFHS activities.

In addition, Ombetja Yehinga Organization produces a bi-monthly magazine to help youth with risk taking and HIV education. This year the series covered issues important to young people including orphans' issues, rape, and gender roles. Red Cross/MorningStar also developed and implemented the Desert Soul campaign which produces television shows (edutainment) and contain messages on HIV for young people.

These activities appear to be paying off as the level of knowledge of HIV prevention among young people 15-24 years of age has increased significantly since 2000. Despite the improvement, over 35% of young people still do not know the basic facts about avoiding HIV infection. According to the preliminary DHS 2006 results, the 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 increased from 39 to 65 percent among young women and 51 to 63 percent among young men.

In addition the proportion of women aged 15-19 who had sex before age 15 decreased between 2000 and 2006 from 9 to 7 percent respectively. The decrease in early sexual debut was more striking among young men aged 15-19 where the proportion decreased from 27 to 17 percent over the same time period.

<i>UNGASS Indicators</i>		<i>2003</i>	<i>2005</i>	<i>2007</i>
11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	Secondary schools		49% (2006 education census)	79% (2007 education census)
13. 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	Females	38.9%		64.9%
	Males	50.7% (2000 DHS)		61.9% (2006 DHS)
15. Percentage of young women and men who have had sexual intercourse before the age of 15	15-19 Females	9.8%		7.4%
	15-19 Males	31.3%		19.2%
	15-24 Females	8.8%		7.0%
	15-24 Males	27.3% (2000 DHS)		18.0% (2006 DHS)

3.2.3 Target the General Population

Led by the Ministry of Information and Broadcasting, the Take Control campaign plans events such as World AIDS Day, World Population Day and also coordinates the development of targeted multimedia interventions. The Take Control Task Force also supports regional outreach through the MIB regional information offices, in cooperation with regional AIDS coordinating committees, and NGO partners. The main focus of the prevention programmes is aimed at youth, with a certain bias to the sexually active youth.

In 2006 Take Control has focused on the relationship between alcohol abuse and HIV infection. Extensive research and consultations with youth and communities has identified alcohol as one of the main determinants of high risk behaviour. Therefore the main aim of the 2006 campaign was providing information on the link between HIV and alcohol and empowering young people to protect them from risky sexual behaviour associated with alcohol abuse.

The process of developing materials has been highly consultative with input from youth, communities, shebeens (local bars) and people living with HIV/AIDS and guided by the core group of the Take Control task force.

Change in risky behaviour among the general population has not varied much over the past 6 years. The percentage of young adults who had sexual intercourse with a non-regular (non-marital, non-cohabitating) partner reduced among women from 80 percent in 2000 to 75 percent in 2006, however the proportion actually increased among young men from 85 to 90 percent respectively. The proportion of adults (15-49 years) using a condom with a non-regular partner increased between the two surveys. Based on the latest survey approximately two-thirds of women used a condom with a non-regular partner and over four-fifths of men used a condom with a non-regular partner.

A very significant risk factor for HIV is when people have multiple partners at the same time, or concurrently. When a person has more than one partner in a short period their chances of passing a recent infection on to another partner are greater. The UNGASS indicators have changed to reflect this information. In Namibia the proportion of 15-49 year old women who had multiple partners in the last year (a proxy for concurrency) was 2.5 percent. This has not changed much from 2000 when the proportion was 3 percent. However, among men the percentage has reduced from 22 percent to 16 percent – a positive sign for behaviour change. Among those who had multiple concurrent partners two-thirds of women and three-quarters of men used a condom at last sex.

<i>UNGASS Indicators</i>		<i>2003</i>	<i>2005</i>	<i>2007</i>
2005 UNGASS indicator Percent of adults aged 15-24 who had sex with a non-regular partner in the past 12 months	Females Males	80.2% 85.1% (2000 DHS)		75.5% 90.1% (2006 DHS)
16. Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Women Men	3.0% 22.0% (2000 DHS)		2.5 16.2 (2006 DHS)
2005 UNGASS indicator Percent of adults aged 15-24 who had sex with a non-regular partner in the past 12 months who report the use of a condom at last sex	Females Males	47.9% 69.4% (2000 DHS)		64.2 % 81.1 % (2006 DHS)
17. Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	Females Males		NA	65.7% 74.4 % (2006 DHS)

3.2.4 Expand Condom Provision

Correct and consistent use of the male condom reduces the risk of sexual transmission of HIV by 80-90%; an efficacy rate that exceeds those reported for many of the world's standard vaccines. Observational studies, laboratory experiments and mathematical modelling indicate that female condoms may also offer strong protection against HIV

infection. In Namibia, the uptake of condoms in the general public and especially youth has increased, but much work remains to be done in this area.

As shown in Table 3.1, distribution of male condoms by the public sector to the regions is high in comparison with the female condom. Although fewer female condoms were distributed during the reporting period, almost all the regions had femidoms except Ohangwena and Kunene region.

Table 3.1: Number of public sector male and female condoms distributed to the region April 2006- March 2007

Region	Male Condom	Female Condom
Otjozondjupa	2,016,000	12,200
Omusati	812,160	3,000
Kunene	944,640	n/a
Oshana	6,681,600	11,000
Oshikoto	567,360	7,000
Ohangwena	100,800	n/a
Hardap	512,640	1,000
Karas	819,360	19,000
Erongo	1,126,080	11,100
Kavango	2,355,840	9,000
Caprivi	244,800	5000
Khomas	3,286,080	13,540
Omaheke	792,000	5,000
National (multiple regions)	4,723,200	56,000
NASOMA		90,000
Total	24,982,560	242,840

Source: Chief Medical Stores, MOHSS

Table 3.2 shows the increasing levels of both male and female condoms available in Namibia. There is less demand for femidom, which needs more lobbying and sensitisation among both men and women in society. Consequently, the percentage of adults who had more than one sexual partner and who reported the use of condom is high among men (74.4%) compared to 65.7% among females (preliminary DHS tables, 2006).

Table 3.2 Data on condom distribution through different channels in Namibia

	2003/2004	2004/2005	2005/2006	2006/2007
Number of male condoms distributed free to the general public by the public sector	5,712,336	12,171,888	17,700,000	24,982 560
Number of male condoms distributed to the general public through social marketing.	4,007,680	4,090,500	4,965,750	3,109,923
Number of female condoms distributed free to the general public by the public sector	32,320	50,500	100,800	242,840
Number of female condoms distributed to the general public through social marketing.	-	-	460,000	212,599
Total # of condoms distributed	9,752,336	16,312,888	23,226,550	28,547,922
# of condoms distributed per capita (15-59 years)	10	17	23	28

Source: Chief Medical Stores, MoHSS

According to the preliminary results of the DHS 2006, the percentage of women aged 15-24 reporting the use of a condom with their last non-regular (non marital, non-cohabiting)

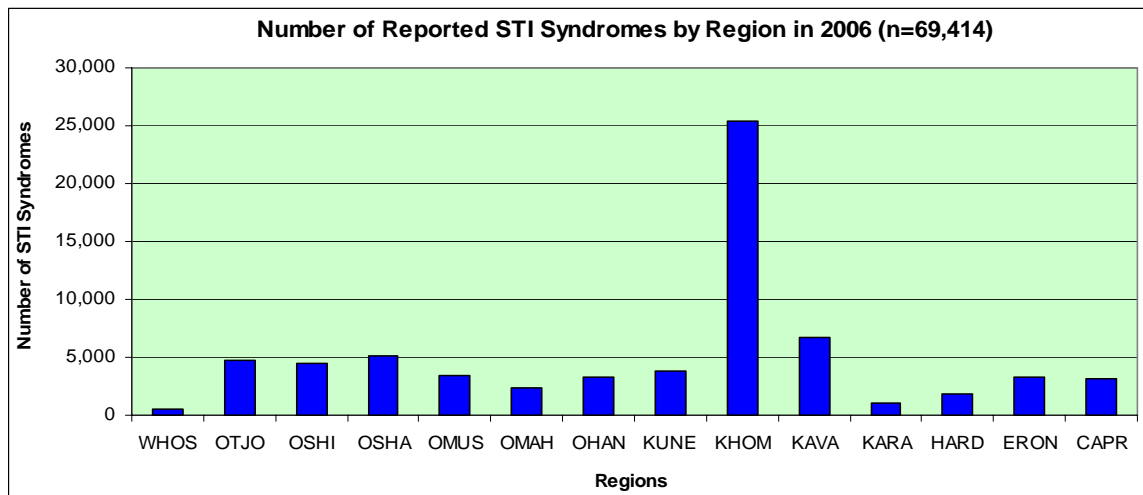
sexual partner increased from 48% in 2000 to 64% in 2006. There was no statistically significant difference among men using a condom with their last non-regular partner over the same time period.

3.2.5 Strengthen STI Management

Sexually Transmitted Infections including HIV continue to pose a major health challenge in Namibia. Failure to adequately diagnose and treat STI's has contributed to complications and increased HIV infection rate.

In 2006, a total of 69,414 STI cases were reported. This accounts to 2.9% of all out-patient consultations. Khomas region reported the highest number of STI cases in 2006 followed by Kavango contributing to 37% and 10%, respectively, of the overall reported STI burden nationally (see Figure 3.2).

Figure 3.2: Number of all STI syndromes reported by region in 2006



Source: HIS, MOHSS

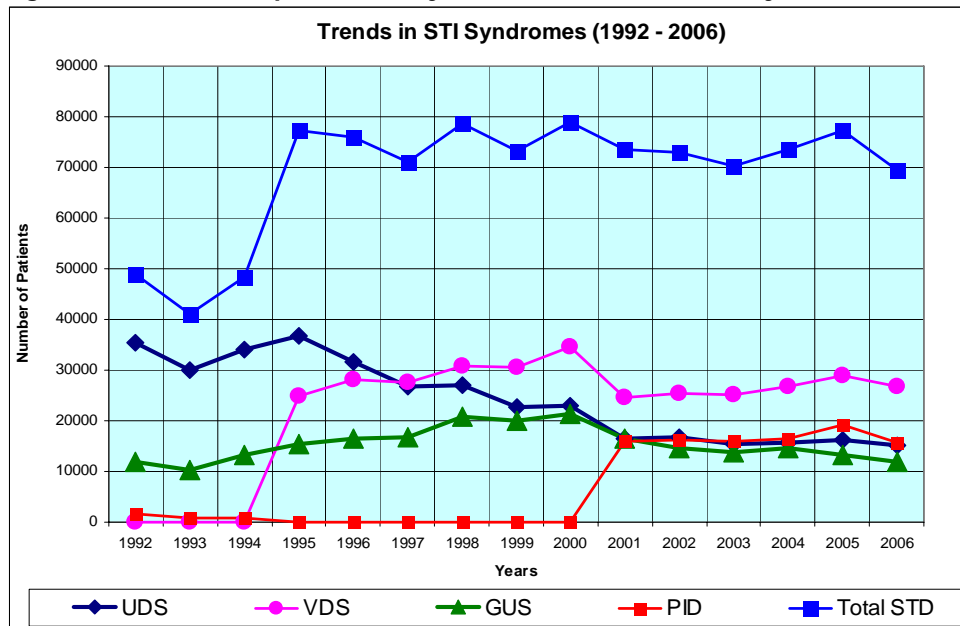
The majority (94%) of STI cases are among persons aged 18 years and above. About 5% and 1% of STI cases are reported from patients aged 5 - 17 years and less than 5 years, respectively. This indicates the need to address the sexual health needs of adolescents adequately to prevent and control STIs. The large number of reported cases among children under age 5 could indicate high levels of sexual violence against children but should first be verified to ensure they are not misreported. There is a possibility that such reports (STI syndromes in under 5 years of age) happen because of problems in accurate diagnosis, recording and reporting of syndromes and patient's age.

Generally, the total number of reported STI syndromes has stabilized since 1995; yearly reporting has varied between 70,000 and 80,000 cases (See Figure 3.3). WHO recommends urethral discharge syndrome (UDS) in men and non-vesicular genital ulcer as STI surveillance indicators.

The decreasing trend in UDS (as seen in Figure 3.3) can be a genuine decrease not only in UDS but also in the overall STI burden due to HIV and STI prevention efforts that include condom promotion in the past decade. However, there could also be other explanations for the declining trend. STI data is only collected from public health facilities and we are not

sure whether or how many of the patients seek care in private health care providers and traditional healers. The growing association between STIs and HIV in the last 10 years could also have led to more stigmatization of STIs and a reluctance of individuals to receive treatment.

Figure 3.3 Trend in reported STI syndromes over the last 14 years (1992- 2006)



Source: HIS, MoHSS

3.2.6 Voluntary Counselling and Testing

UNGASS Indicators		2003	2005	2007
Percentage of women and men aged 15-49 who have ever been tested for HIV	Women	23.7%		54.8
	Men	24.6% (2000 DHS)		34.3 (2006 DHS)
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	Women			28.6%
	Men			17.6% (2006 DHS)
		NA		

Increased availability and use of voluntary counselling and testing (VCT) services is an important component of the prevention efforts. Learning one's HIV status can motivate a negative person to stay negative or can alert a positive person to the need for services and additional precautions. Given the vast distances in Namibia it is especially important to be able to provide same day results services. Thus the government is in the process of rolling out rapid testing in most of the VCT sites.

Fifty-three sites have developed the capacity to do rapid testing during the reporting period. In some regions the rapid testing sites rolled out faster than in other regions, but all 13 regions were covered. During the same period 188 testers were certified and 518 testers passed training.

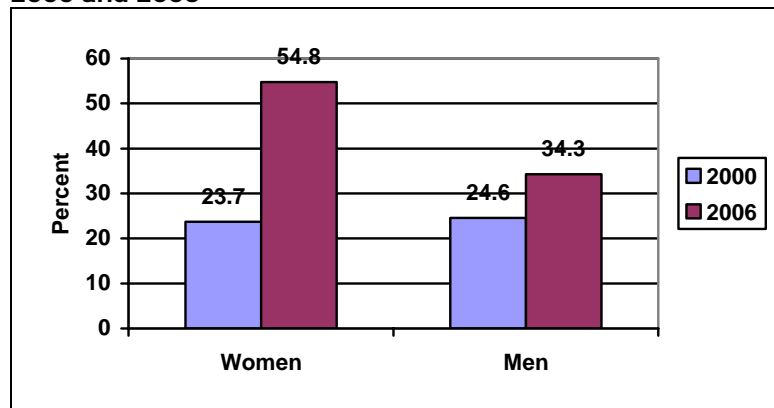
An increasing number of people get tested for HIV through both the public sector and the Social Marketing Association's "New Start" centres every year. In 2005, MoHSS introduced rapid testing in collaboration with the Namibia Institute of Pathology (NIP). At the end of

March 2007, 53 MoHSS sites and all 19 New Start centres (including two MAPP VCT centers) were offering rapid testing. The implementation of rapid testing in 2005, reduced non-return rates (clients not returning for their test results) from a monthly high of 13% to below 2% in New Start sites.

All five mission hospitals have approved rapid testing sites in place and offer same-day results counseling and testing services. The percentage of clients getting their post-test results and counseling has increased dramatically. Also, the percentage of mothers with known HIV status at delivery has increased from <10% before the implementation of rapid testing to almost 95% after the introduction of rapid tests in these hospitals. The number of service outlets that provide counseling and testing according to national and international standards increased from 7 to 31 sites that cover 7 different districts.

According to the preliminary DHS, 2006, the percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results stands at 28.6% for female and 17.6% for male which could be the results of rapid testing as well as the scale up of VCT sites. This question was not asked in the 2000 DHS. However the 2000 and the 2006 surveys did ask whether men and women had ever been tested for HIV. Figure 3.4 shows that the proportion of women ever tested has risen by 131% (from 24% to 55%) over the 6 years, probably because of the roll out of PMTCT services. However, the percentage of men who have ever been tested has increased only by 39% (from 25% to 34 %).

Figure 3.4 Percentage of women and men 15-49 who have ever been tested for HIV, DHS 2000 and 2006



Source: MoHSS and Macro International 2003 and MoHSS and Macro International, 2007 -- 2000 NDHS and preliminary 2006 NDHS.

3.2.7 Safety of Blood Transfusion Products

UNGASS Indicator	2003	2005	2007
3. Percentage of donated blood units screened for HIV in a quality assured manner		99.5%	99.6%

Namibian Blood Transfusion Services (NBTS) is responsible for the provision of blood transfusion services in Namibia. NBTS runs a relatively centralized system with very limited network for distribution nationwide. The centre in Windhoek is responsible for collection of all blood from donors nationwide; screening of all donor blood and distribution to all hospitals and NIP laboratories that serve as hospital blood banks. Two satellite centres are responsible for storage of processed blood from Windhoek and distribution to some hospitals

in their proximity. The results of blood screening at blood banks shows that the blood supply is of quite high quality (see Table 3.3).

Table 3.3.: Reactive results for Transfusion transmissible infections (TTI) per year

Marker	2004	2005	2006
Syphilis	0.40%	0.44%	0.20%
Hepatitis C	0.07%	0.09%	0.10%
Hepatitis B	0.80%	0.78%	0.90%
HIV	0.51%	0.53%	0.39%

Source: MoHSS, 2007b.

Compatibility testing has been strengthened through the introduction of an improved crossmatch procedure at all NBTS blood banks, a change that involved the extensive re-writing of procedures and the re-training of staff. In addition a quality policy has been developed and implemented for handling blood collected in areas where malaria is present, and for donors visiting these areas.

3.3. Access to Treatment, Care and Support Services

The MoHSS is committed to providing HIV/AIDS-related treatment and care services to all Namibians in need. MoHSS estimates that in 2006 Namibia had 200,000 adults and children living with HIV (MoHSS Forthcoming[a], Spectrum version 3.13).

3.3.1 PMTCT+ Services

The ultimate goal (impact) of the PMTCT programme is to eliminate mother to child transmission of HIV in Namibia. It is a package of strategies that target pregnant women and includes HIV counselling and testing, referral to HIV care/treatment for those found positive, provision of prophylactic ARV medication to HIV positive mothers before delivery and infants within 72 hours of birth, infant feeding counselling, and DNA polymerase chain reaction (PCR) testing for infants born to HIV positive mothers.

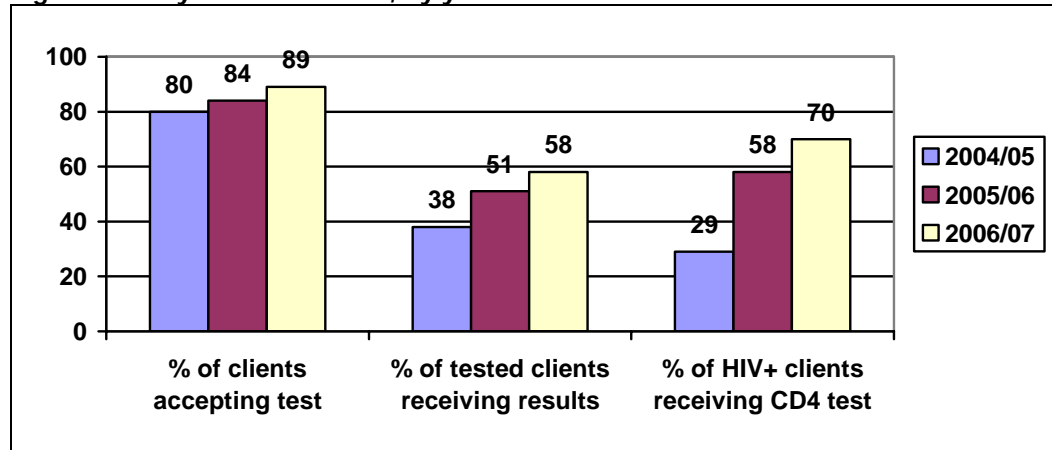
Interventions to prevent mother to child transmission are accessed through antenatal clinics and/or labour and delivery wards. If a woman does not attend antenatal care **and** does not deliver at a health facility she will not have access to PMTCT. The most recent estimate of ANC attendance based on the 2006 Demographic and Health Survey preliminary tables shows that 96% of pregnant women attend ANC at least once and 81% of deliveries in the last 5 years were conducted by trained health professionals in a health facility (MoHSS and Macro International, 2007). Thus, the potential to reach most pregnant women with PMTCT+ services is high. The 2006 NDHS also asked women who gave birth in the prior two years whether they recalled receiving HIV counseling and testing during ANC care. Among all women who gave birth in the past 2 years, 73 percent said they received HIV testing and counseling during an ANC visit. Only 62 percent of women reported having received the results (either they refused the test or did not come back for the results).

The PMTCT programme was launched in March 2002 initially on a pilot basis at Katutura and Oshakati state hospitals and reached all 34 district hospitals as well as 170 health centres and clinics by the end of fiscal year 2006. The recommended ARV regime and infant feeding practices in the PMTCT guidelines has a potential of reducing HIV transmission dramatically.

Of the estimated 55,882 pregnant women who attended antenatal services for the first time during that pregnancy in 2006/07, 51,780 were recorded at facilities providing PMTCT services. As shown in Figure 3.5, the percentage of ANC clients receiving an HIV test improved from 79% in 2004/05 to 86% in 2006/07. The percentage of those tested who

received post-test counselling improved from 38% to 58%. And the percentage of HIV positive women who had a CD4 test increased from 29% to 70% over the period. These positive trends can likely be attributed to the rollout of PMTCT services, particularly the roll out of rapid testing. The opt-out strategy adopted by the MoHSS has also likely contributed to the high proportions of pregnant women enrolled in the PMTCT programme. All statistics exclude clients with a known positive status at the beginning of the ANC process.

Figure 3.5 Key ANC Indicators, by year 2004 – 2006

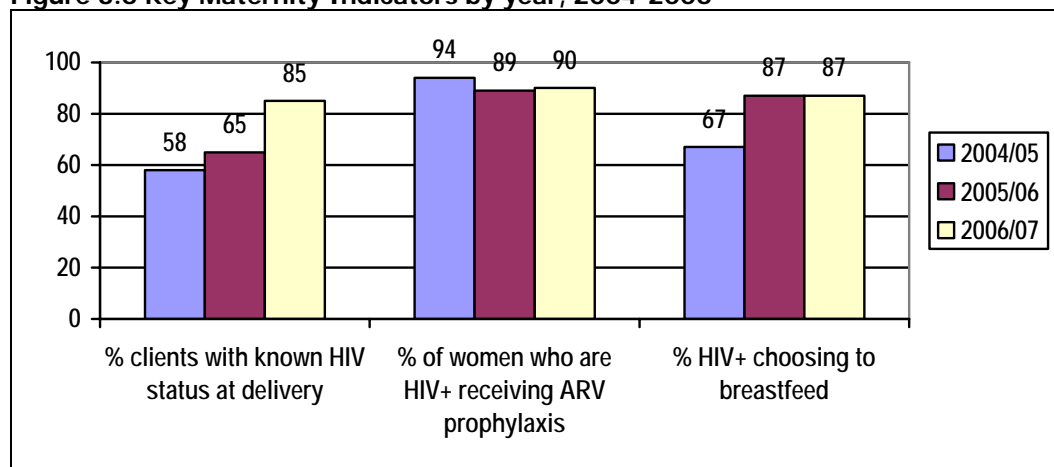


Source: MoHSS Forthcoming[b].

There were some variations in these indicators by region in 2006. Approximately 73% of women attending ANC in Caprivi accepted tested while in Omusati and Hardap the percentage was 93%. Test acceptance was below 80% only in Caprivi, Erongo and Kunene. The percentage of HIV positive clients receiving a CD4 test ranged from 20% in Kunene to over 90% in Omusati and Khomas. This indicator was less than 50% in five regions (Caprivi, Erongo, Karas, Kunene, and Otjozondjupa)

Figure 3.6 shows that the proportion of women delivering with known HIV status has risen considerably between 2004 and 2006 from 58% to 85%. ARV uptake among those with known HIV status has decreased slightly from 94% to 90%. The drop in the percentage receiving ARV prophylaxis between 2004 and 2006 is not a drop in absolute numbers since the number delivering with known status increased rapidly between those two years. ARV uptake in infants has remained constant between 2004 and 2006 at around 95% to 97% (data not shown). The proportion of women choosing to breast feed climbed dramatically between 2004 and 2006 from 67% to 87%.

Figure 3.6 Key Maternity Indicators by year, 2004-2006



Source: MoHSS, forthcoming[b].

Based on the programme data, 90% of women identified as HIV positive during antenatal care or delivery received ARV prophylaxis to prevent the transmission of HIV to their infants. However, if we consider all women that are estimated to be HIV positive and pregnant in the country – not just those HIV positive women identified during antenatal care or delivery – the proportion of women receiving prophylaxis is only 49 percent (UNGASS indicator 5).

<i>UNGASS Indicators</i>	<i>2003</i>	<i>2005</i>	<i>2007</i>
5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	6.8%	25%	49%
25. Percentage of infants born to HIV infected mothers who are infected		28%	25%

DNA Polymerase Chain Reaction (PCR) Testing for HIV Exposed Infants

Standard serology testing for HIV antibody is not valid in infants less than 18 months of age as maternal antibodies may still be present until then. This presents a significant challenge as HIV positive infants can suffer severe morbidity and even mortality before they are old enough to be diagnosed using standard serology. DNA PCR, however, allows definitive diagnosis of HIV-1 infection in an infant as early as 6 weeks of age. With this test, infected infants can be identified as early as at age 6 weeks and then receive relevant care and treatment.

The MoHSS issued a policy to make DNA PCR part of routine paediatric care in December, 2005. DNA-PCR was subsequently introduced in Katutura Paediatric Clinic in December 2005 and reached 58 facilities by the end of 2006. Dried Blood Spot (DBS) technique is used for collecting blood for DNA-PCR. By the end of 2006 approximately 7,000 tests had been completed identifying over 900 HIV positive infants. A national level information system was designed and rolled out to record information from the PCR programme. Results from this information system demonstrate that impact of MTCT is markedly lower (12%) when both mother and infant received ARV (single dose nevirapine) compared to 30.4% when no NVP was administered. HIV transmission was also markedly lower when mothers did not provide mixed feeding to their infant. It should be noted that the proportion of infected infants is much lower in the group which were measured in PCR because these mother-infant pairs were enrolled in PMTCT programmes. Not all women are enrolled in PMTCT programmes and thus the national estimate of HIV infection among infants born to women living with HIV is 25% (as noted in the Status at a Glance table UNGASS indicator 25).

3.3.2 Management of Opportunistic Infections

Increased access by PLWHAs to opportunistic infections prevention, comprehensive case management services and palliative care is essential. Guidelines for the treatment of opportunistic infections have been in place in Namibia since 2001. Training of health workers in these guidelines is integrated in the training on ART. Cotrimoxazole (CPT) and Isoniazid (IPT) preventative therapy for the prevention of opportunistic infections are provided at all public ART sites.

3.3.3 Collaborative HIV/TB Services

People living with HIV and people living with TB have access to a continuum of care and support services for HIV and TB diagnosis, in all health care facilities and home based care services in public and private sector

A total of 15,771 tuberculosis (TB) cases were notified in 2006 which is the equivalent of 735 registered forms of TB per 100,000 population. This places Namibia among the top-three worst TB-affected countries in the world, next to Swaziland and Lesotho.

In 2006, the treatment success rate was 75% for new smear-positive TB cases, a significant increase from 70% reported in 2004. This success rate is still below the national and global target of 85%. The defaulter rate has been reduced from 13% to 10%; transfer out from 7% to 6% and death rate from 8% to 7%, all which contribute to a low success rate. Treatment failure of new smear positive patients is reported at 2% as has been the case in the past years.

The number of TB patients tested for HIV has increased from 16% in 2005 to 30% in 2006, and currently stands at 44% in January – March 2007. Sixty-seven percent (67%) tested HIV positive as shown in Table 3.4 below. This compares well with the NTCP estimate that 60% of TB patients are also infected with HIV. All districts are now implementing the policy that all TB patients should be offered HIV tests and all PLWHA should be screened for TB disease in order to benefit from the life prolonging remedies offered by the two programmes. Kunene region tested 79% of TB patients, whereas Khomas region tested only 9%.

Table 3.4 HIV sero-prevalence among TB patients by region, Namibia, 2006

Region	TB Cases	No. Tested	% Tested	Total HIV +	% HIV+
Kunene	265	210	79%	111	53%
Karas	837	479	57%	212	44%
Oshana	1,470	290	20%	207	71%
Omaheke	495	194	39%	40	21%
Hardap	867	482	56%	187	39%
Caprivi	686	128	19%	95	74%
Erongo	1,585	380	24%	262	69%
Okavango	1,559	425	27%	292	69%
Omusati	1,246	576	46%	414	72%
Otjozondjupa	1,167	389	33%	265	68%
Ohangwena	1,115	201	18%	97	48%
Oshikoto	1,863	660	35%	532	81%
Khomas	2,616	239	9%	403	100
Namibia	15,771	4,653	30%	3,117	67%

Source: 2006/07 Annual Report of the TB Subdivision, MOHSS

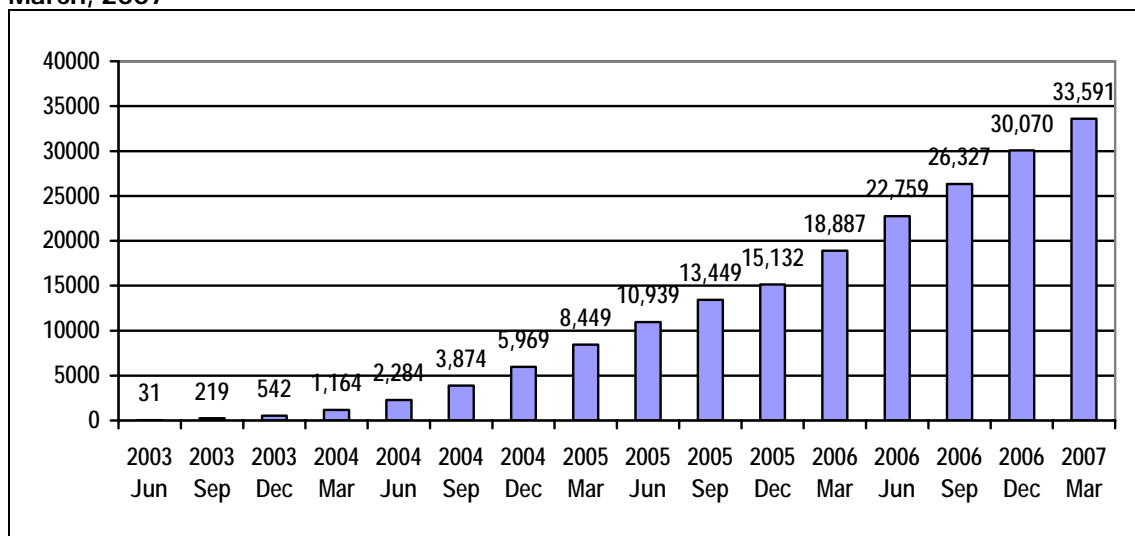
3.3.4 Provision of HAART

The national target of reaching 30,000 people with ART by 2008, originally set by MTP III, has been adjusted since this goal was achieved by the end of calendar year 2006.

Adjustment of this target is also in line with the Universal Access initiative targets approved by the 2006 African Union heads of state summit in Brazzaville.

The number of individuals on treatment reached 33,591 by the March 2007, while the number of people in care who were not on HAART was approximately the same. As indicated in Figure 3.7, the roll-out of ART services delivery accelerated in 2006 when compared with previous years. This is likely due to a combination of factors: (a) The service was rolled out to one additional district hospital in 2006 to cover all 34 public hospitals in the country, (b) The service was rolled out to 9 satellite sites; (c) The reputation of the program became more widely known, thus attracting more clients.

Figure 3.7 Total Number of Patients on HAART Nationwide In Public System June, 2003 – March, 2007



Source: HIS (ART System), MOHSS

As of 31 March 2007, 43 ART sites (34 district hospitals and 9 non-hospital sites) had been established in Namibia. Sixty-six percent of patients are women and 13% are paediatric patients. The total number on treatment represents approximately 64% of the estimated 52,500 ART-eligible patients in the country. The private sector has an estimated additional 6,000 PLWHA on ART at the end of 2006. Nationally, 57% of adults and 91% of children with advanced HIV infection are receiving antiretroviral therapy.

ART in the private sector is expensive and is thus primarily accessible by those with medical aid coverage. Namdeb a diamond mining company provides HIV/AIDS services to its employees including ART. Namdeb spent approximately N\$1,036,000 in 2005 and N\$1,098,000 in 2006 on HIV related services for their staff.

Nationwide the number of newly assessed patients was approximately the same between 2005 and 2006 after a large increase between 2004 and 2005. This is to be expected as the program matures and as the initially large numbers of potential patients are started in the programme.

The number of patients waiting to start treatment grew substantially each year, starting at 782 by the end of 2004, increasing to 1,435 by end 2005 and reaching 2,111 by end 2006. As patients waiting to start treatment (while eligible) represent a highly vulnerable sub-group, it is important to explore ways to support regions to decrease (or eliminate) the number of patients waiting to start therapy. This will likely include assignment of new staff members to these regions as lack of personnel is often a reason for the inability to serve patients in need, however, determination of the real core reasons for differences in this indicator will require that the national level Programme Managers combine statistical data with supervisory experience and further discussions with field-level implementers.

Reported outcomes for patients on ART in Namibia show that 84% of PLWHA are still alive since starting ART, 5% had died, 2% had defaulted, and the status of 9% was unknown. The percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy stands at 69% and 82% respectively.

<i>UNGASS Indicators</i>		<i>2003</i>	<i>2005</i>	<i>2007</i>
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Adults Children		27.5%	57% 91%
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV				Not available
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Adults Children		91.0%	69% 82%

3.4. Impact Mitigation

Strong community involvement is required to provide sustainable and appropriate responses to the impacts of the HIV epidemic. Without the contributions from communities, support to people living with HIV and families affected by HIV will not be possible to maintain into the future. In addition, communities know best what support is needed to families in distress. Finally, communities are the most capable of providing support in a timely and appropriate manner.

Impact mitigation addresses the need to develop capacity at community level to ease the impact of HIV. It covers three areas: (1) developing the capacity of communities to respond; (2) providing services to children affected by HIV and people living with HIV; and (3) addressing poverty. Each activity area contributes to the overall strategic result of the component – strengthened and expanded capacity of local responses to mitigate socio-economic impacts of HIV and AIDS.

Responding to these three areas ensures that interventions are both sustainable and community driven and that those made most vulnerable by the epidemic receive some support to improve their quality of life, which is the fifth key outcome to be achieved through the Third National Development Plan.

Using the results of the 2006 HIV sentinel surveillance, it is possible to estimate the number of people living with HIV in 2006 through models. The estimated number of people living with HIV is 200,000. These numbers provide planners and programmers an estimate of how many services will be required to serve those most in need of support and to reduce the impact of the epidemic.

3.4.1 Developing the Capacity of Local Responses

Decentralization is a priority of the Namibian Government. Regional coordination of the HIV response will ensure that the community is driving the response. Even beyond the regional level, constituencies and villages are organizing to coordinate, monitor, and respond to people in need of assistance. Under the MTP III constituencies are encouraged to develop work plans that ease the impact of HIV.

In 2006-07, there was a significant increase in the activity of the Constituency AIDS Coordinating Committees (CACOCs). The role of CACOCs is to coordinate and manage the multi-sectoral HIV activities in their communities. According to the 2005-06 MTP report, only 18 percent of CACOCs were functional; by April 2007, regional reports show that 120 CACOCs had been established. Of those, 79 had work plans and budgets to fund their activities. In addition, 80 CACOCs received training on how to coordinate the various programs within their purview. Overall, 66 percent of constituencies are implementing community action work plans.

Communities are also being empowered to care for OVC. The Ministry of Gender Equality and Child Welfare is establishing OVC Forums at regional and constituency level in all 13 regions. The OVC forum provides a platform for communities to assess the situation affecting OVCs, to bring the situation to the forum for discussion, and to develop locally appropriate responses to resolve the problems through community action and outside assistance. Currently 9 out of 13 regions (69%) have established Regional OVC Forums, and have brought together key OVC stakeholders, including the Regional Governor, government sectors, and civil society partners. Thirty-five of 107 constituencies (33%) in 13 regions have established constituency OVC forums (see Table 3.5). The regional and constituency OVC forums are at varying levels of functionality, but have been established.

Table 3.5: OVC forums per Region

Region	Functional OVC forum	# of constituencies per region	# of established constituency OVC forums
Omaheke	Yes	7	7
Hardap	Yes	6	5
Omusati	Yes	12	0
Otjozondjupa	Yes	7	6
Ohangwena	No	11	4
Oshikoto	Yes	11	1
Kavango	Yes	9	3
Oshana	No	10	0
Caprivi	No	6	6
Erongo	Yes	6	2
Karas	Yes	6	1
Kunene	Yes	6	0
Khomas	No	10	0
TOTAL	9	107	35

Source: MoHSS, 2007g.

Many of the people who have stepped forward to provide this critical support to children affected by HIV need additional training in caring for children who have recently lost a parent or are supporting a chronically ill parent. These caregivers need information on how to provide for the needs of children in these circumstances, referrals for situations that are beyond their capacity, and advice on how they themselves cope with the need for being consistently supportive. NGOs and MGEWCW conduct such trainings. Global Fund recipients reported that approximately 4,997 persons were trained to provide care and support for

OVCs (not including refresher trainings) (MoHSS, 2007b). Approximately 5,000 people were trained in 2006-07 to provide support to OVC

3.4.2 Services for OVC and Persons Living with HIV

National coordination of the OVC response to a collectively endorsed action plan is required to focus resources on the situation affecting OVCs. The 2006-2010 National Plan of Action for OVC was finalized in 2006 including the costing and development of a Monitoring and Evaluation framework.

The OVC Permanent Task Force, was established by a Cabinet directive in 2002, and is chaired by the Directorate of Child Welfare within the Ministry of Gender Equality and Child Welfare. This is the primary OVC coordinating body, which brings together key government ministries, donors, and civil society partners to coordinate the OVC response.

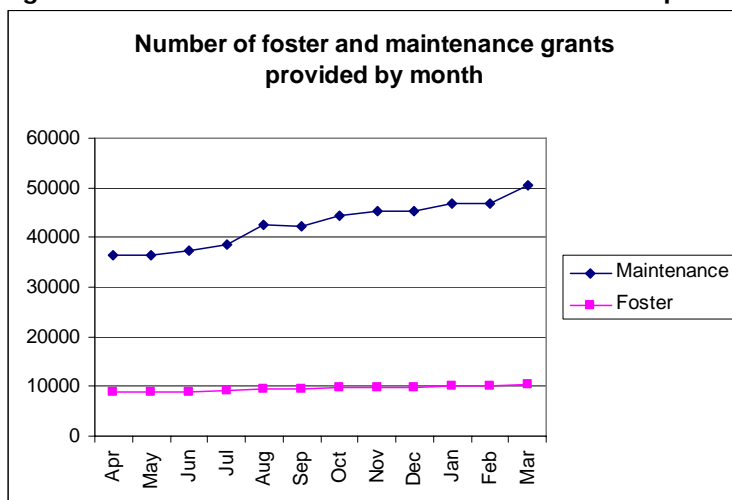
According to programme reports, approximately 93,675 children received support because they were orphaned or vulnerable. The support includes psychosocial support, food support, material support, and educational support.

Recent household survey data provide an estimate of the proportion of those vulnerable children who are receiving support. The 2006 DHS reports that 28% percent of children were orphaned or vulnerable (vulnerable in the survey was defined as children who are orphaned or have a chronically ill parent or who live in a households with a chronically ill adult or an adult that has recently died). Among those only 16.5% percent received any type of external support.

The Ministry of Health and Social Services (MoHSS) was mandated to manage children's social welfare functions, but in 2002 these responsibilities were shifted to the Ministry of Gender Equality and Child Welfare (MGE CW), which then established a Child Welfare Division. These functions include the management of foster care grants, adoptions, custody and control cases, and advocacy for children's rights across national, regional and community level. These grants play a key role in enabling caregivers to provide protection, care, and support for orphans and vulnerable children. In 2006/07 there were 65,099 (MGE CW, 2007) children benefiting from Child Welfare Grants (see Figure 3.8), of which there are four types:

- i) Maintenance,
- ii) Special maintenance grants for children, under age 16, with disabilities,
- iii) Foster care grants, and
- iv) Place of safety allowances.

Figure 3.8 Number of Foster and Maintenance Grant provided by month



Source: Ministry of Gender Equality and Child Welfare, 2007.

With the rapidly expanding number of orphans and vulnerable children (OVC), due to the HIV epidemic, demand for the grants has increased over three-fold, from 18,000 in 2004 to the 65,000 in 2007.

MGECW and the World Food Programme undertook a household survey using a purposive sample to measure the support they were providing to households. Among the survey sample, 11 percent of households received a cash grant. World Food Programme provides support to 90,000 children in Oshana, Kavango, Caprivi, Oshikoto and Omusati. Among these children 4,500 have transferred from the food programme to receiving government grants.

School attendance of OVC

One possible outcome of the HIV epidemic is that children who are orphaned lose their primary guardians and the primary person who ensures their rights are met. Basic rights to education and protection can be overlooked when a child is being passed between family members or left to fend for themselves. A useful indicator of such neglect is the ratio of school attendance for children 10-14 years comparing orphaned children to non-orphaned children. If the ratio is close to one then we can assume that the maintenance grants (which are only provided if the child is attending school) and the community interventions are successful in looking after the child's educational needs. The school attendance ratio of orphans aged 10-14 to non-orphans is 1.01 for males and 0.99 for females (MOHSS and Macro International, 2007 – preliminary NDHS 2006 tables), suggesting equal school access between the two groups of children.

A comparison over time shows that between 2000 and 2006 this differential access to school increased from 0.92 in 2000, a deficit for orphans to 1.0 in 2006, suggesting equal access to school for orphans and non-orphans. The current school attendance among orphans and non orphans ranges from 93.6 for double orphans and 94.0% for non-orphans ((MOHSS and Macro International, 2007 – preliminary NDHS 2006 tables).

<i>UNGASS Indicators</i>		<i>2003</i>	<i>2005</i>	<i>2007</i>
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child		NA		16.5
12. Current school attendance among orphans and among non-orphans aged 10–14	Double orphans Non-orphans Ratio	83% 90% 0.92 (2000 DHS)		94% 94% 1.0 (2006 DHS)

Civil Registration

It is a universal right that children have their births registered and have a birth certificate. In the 2006 DHS, mothers of children under five years old were asked if their child's birth had been registered and whether they had a birth certificate for the child. A child's birth was considered to have been registered if his or her mother could either provide a birth certificate or said the birth was registered.

According to the 2006 DHS, 67 percent of births in Namibia are registered; this is a slight decrease from 71 percent in the 2000 DHS. The main reason given in the 2000 DHS for not registering births is that it requires travelling too far. Other reasons given are that the child is too young and that the mother either did not know that births must be registered or did not know where to go to do so.

If a child loses a parent and does not have a birth certificate to identify his/her parents, the child will not be able to receive benefits. Similarly, it is critical for children to have access to their parents' death certificates. Without evidence of the death of their parent, it is impossible to access the welfare grants that are available for children. If deaths are not registered at all, the child has no chance of getting the certificate. In regions where HIV prevalence is high, there are complaints that children do not have birth certificates and that registration procedures are slow and cumbersome. Birth registration documents and death certificates are required for children to apply for child welfare grants and are an impediment to guardians accessing support to provide for children under their care.

3.5. Integrated and Co-Ordinated Programme Management

3.5.1 Management and Coordination of the National Response to HIV/AIDS

An expanded multi-sectoral response in the five main strategic areas requires improved management coordination. Implementing partners and coordinating bodies will need to be made responsible and accountable for achieving the desired results to which they commit themselves, at national, regional and local level. Hence the implementing partners and coordinators need to monitor performance and coverage in all regions and in each sector.

MTP III articulates the national HIV/AIDS management structure as follows:

The **National AIDS Committee (NAC)** is the highest policy decision making body on matters related to HIV/AIDS. It is attended by Cabinet ministers and Regional governors to ensure that policy and resource mobilisation is adequate.

The **National Multi-sectoral AIDS Co-ordinating Committee (NAMACOC)** provides the leadership for multi-sectoral and regional implementation. It is attended at Permanent Secretary level and includes equivalent regional and civil society participants. It reviews progress and adopt annual work plan and budgets. It meets at such times that fit well with the GRN budget planning cycle.

The **National AIDS Executive Committee (NAEC)** provides the technical leadership and it will be responsible for co-ordinating implementation of the multi-sectoral response. Its membership reflects the hand-on experience required to deal with implementation issues. It will be attended by key sectors and key technical people to cover the five components of the MTP III.

The **Sectoral Steering Committee** involves all key actors working in that sector and will thus be wider than most current Ministry HIV/AIDS committees. The Sectoral Steering Committee is responsible for the implementation of sector-specific interventions and for mainstreaming HIV/AIDS into all aspects of their organisation's core functions. Through impact assessment and establishing appropriate policies, the committee will ensure that the sector's core function minimise the spread of HIV/AIDS and support programmes which address the impact of the epidemic and their target groups. It actively works towards establishing workplace programmes across the sector.

The **Regional AIDS Co-ordinating Committee (RACOC)** co-ordinates between civil society and government at regional level and between the national and regional institutions. RACOCs take responsibility to co-ordinate and supervise HIV/AIDS development in each region and support local committees to take community actions.

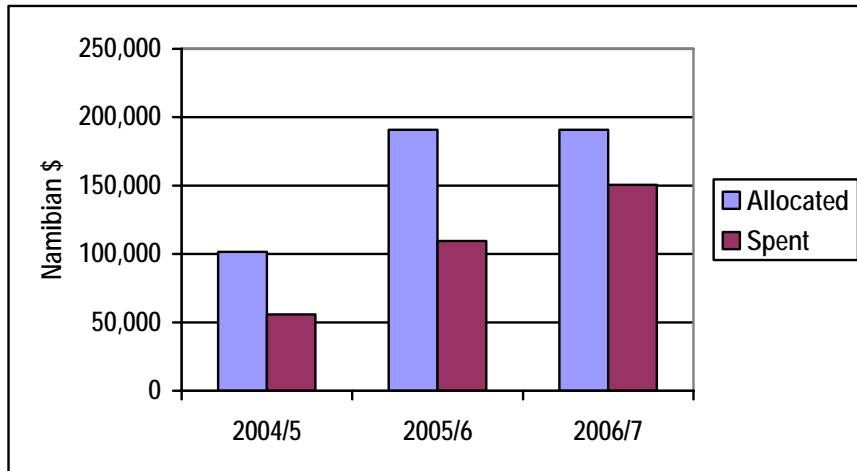
The **Constituency AIDS Co-ordinating Committee (CACOC)** takes responsibility to co-ordinate and manages the multi-sectoral response at local level. Some regions have established District-level AIDS Committees or other structures which have essentially the same function and same terms of reference as the CACOCs.

NAC and NAMACOC have endorsed the HIV/AIDS policy and presented it to the National Assembly in December 2006. The policy went through parliament and was approved in March 2007 and launched in July 2007.

The Regional AIDS Coordinating Committee Secretariats are also experiencing a human resource shortage. All 13 regions had Regional AIDS Coordinators (RACs), with 11/13 Regional Development planners (RDP), 10/13 Chief Health Programme Administrators (CHPA) and 8/13 Senior Health Program Administrators (SHPA) in place. Thus only six out of 13 regions are at full capacity. As a result some regions only had 2 meetings in twelve months, Erongo had five meeting, and five regions had four meetings in twelve months.

There is budget under-utilization within the RACOCs (see Figure 3.9). This could be due to insufficient staff in the regions, insufficient technical capacity among staff as well as cumbersome procedures that need to be followed before the funds are disbursed.

Figure 3.9 RACOC budget and spending 2004-2007 (average per RACOC)



Source: MoHSS, 2007g.

3.5.2 Developing HIV/AIDS Management Capacity

Training in areas of HIV, STIs, Malaria and TB prevention and treatment is one of the central elements in the Directorate Special Programs. The dynamism and often complicated nature of these diseases and particularly HIV/AIDS makes it essential that health workers and community members are thoroughly trained and constantly furnished with new information and strategies on the prevention and treatment of the disease.

In order to mitigate the impact of the HIV epidemic and guide the responses in all sectors (public, non governmental and private sector organisations), the Ministry of Health and Social Services developed three training modules focusing on a) basic understanding of the epidemic and the responses needed, b) workplace programme development for HIV/AIDS and c) mainstreaming of HIV/AIDS. These training modules were outsourced by the MoHSS to the Polytechnic of Namibia and Erongo Agencies to undertake training nationwide across all sectors.

A total of 324 persons were trained on the common module training on HIV, TB and STIs; 251 persons were trained on workplace programme development; and 248 participants were trained on mainstreaming HIV/AIDS. In addition to the courses developed by MoHSS, the Namibia Business Coalition on AIDS (NABCOA) also provided training. NABCOA is an umbrella network for the private sector, which provides training based on an annual plan and distributes a list of trainings provided by other organisations. NABCOA training is targeted at people in business organisations who are responsible for organising education, awareness and training in their businesses. Representatives from ministries and other public institutions are also welcome to attend NABCOA training events.

3.5.3 Monitoring and Evaluation

The Response Monitoring and Evaluation Sub-division is responsible for ensuring proper data collection, management and dissemination on all topics related to the national HIV, TB and malaria responses. The RM&E has made a number of strategic changes in 2006 to better coordinate national monitoring and evaluation efforts. These changes are guided by the 12 components for a functional national M&E system

The national M&E plan was developed in line with MTP III and launched in September 2006. The plan describes the set of national indicators, methods for collecting the required data and outlines the products that will result from the data.

An integrated action plan (IAP) was developed that includes all HIV M&E activities until 2009. It contains not only the HIV M&E activities of the Government, but also those of development partners, umbrella organisations, organisations implementing HIV interventions (i.e. those organisations providing HIV prevention, care, treatment and impact mitigation activities in the private sector, public sector and civil society). The IAP acts as a road map for strategically guiding M&E activities within the country and allows stakeholders to find areas for collaboration and avoid duplication. The IAP also allows the RM&E to ensure that the needs of the M&E plan are being met. All activities are costed in the IAP and funding sources have been indicated where funds have been committed. This allows RM&E to budget for activities over the next 2 years. The IAP is therefore a vehicle for the RM&E subdivision to use and with which to coordinate its own work and the work of other stakeholders.

Programmatic M&E activities have mainly been carried out in the health sector, collecting routine data from clinical (health facility level) HIV services and through routine and periodic surveys and surveillance. In addition data collection and information flow has been in place from development partners based on their thematic and sectoral monitoring systems. The routine data is currently mainly collected from the district level transferred to the national level. The key data sources from the MoHSS are Demographic and Health Survey, Electronic TB register, Health Information System (which includes ARV, VCT and PMTCT data), and the National HIV Sentinel Surveillance Report.

In late 2006, the RM&E started to develop a system for programme monitoring of non-clinical data for the national M&E system. Although various umbrella organisations and development partners are currently collecting data from non-clinical services; these data are not sent through the RM&E subdivision on a routine basis. The revised system will create one system that all stakeholders (including regional offices, development partners and umbrella organizations) can utilise for their data needs.

In addition, each regional office receives a support/monitoring visits from MoHSS and MRLGHRD one time per year. Additional stakeholders such as development partners and sectoral bodies (such as NANASO and NABCOA) also participate in these visits. The Regional bodies provide summary information on processes at regional level. The Multi-sectoral response team at DSP received reports from all 13 regions in 2006/07.

3.5.4 Surveillance and Operational Research

Since 1992, Namibia has been monitoring the prevalence of the HIV epidemic through anonymous unlinked sentinel surveillance of pregnant women attending antenatal clinics. The general objective was to estimate the prevalence of HIV-infection in pregnant women aged 15-49 years, to identify geographic and socio-demographic characteristics associated with higher prevalence, and to monitor infection trends over time.

The 2006 sentinel survey was conducted in 29 of the 34 health districts. A total of 7,422 pregnant women attending antenatal clinics participated. Unlinked anonymous blood samples were collected from June 19 to October 6, 2006 (and November 20th, 2006 to January 31st, 2007) and were tested for HIV antibodies at the Namibia Institute of Pathology in Windhoek.

The 2006 report focused on HIV sero-prevalence data and only collected limited individual characteristics data. Data from PMTCT programmes were also analyzed and triangulated with the sentinel surveillance data.

Most research implemented in Namibia is initiated by a variety of partners and if it involves humans the proposals need to be reviewed and approved by the Research Management Committee as well as the Biomedical Research Ethical Committee of the MoHSS. Results of research are often shared during dissemination seminars organised by the ministry and other partners. However, research conducted for academic reasons is often not widely publicized and is missed by potentially interested parties.

Although Namibia developed a research coordination mechanism and outlined a national research agenda in 2005, the results were not widely shared. This mechanism has not been adopted as the national mechanism for research coordination. Thus the coordination and planning of research activities are not harmonized.

4. Best Practices

The rapid roll out of antiretroviral treatment has been seen as a significant success in Namibia. This roll out took place despite the vast distances between major cities and towns in the country.

ART began in mid-2003 and reached 32 (94%) of 34 public hospitals by 2005 and has reached all hospitals and some clinics by mid-2007. Uptake increased significantly with additional personnel from the US President's Emergency Plan for AIDS Relief (PEPFAR) beginning in January 2004. The Global Fund support began in June 2005. By December 2005, 16,119 patients had been started on ART, exceeding the "3x5" target of 14,500. Six percent of those in need were on ART in 2003, 27.5 percent of patients in need were on ART by 2005, and by 2007, an estimated 64 percent of those in need were on ART.

Governmental leadership combined with donor support contributed to this achievement. Health worker attitudes towards HIV/AIDS care improved with ART availability. Consensus-building around national guidelines, rollout plan, training program, information system, and technical support facilitated rollout. Data from the information system were used by MoHSS to identify resource gaps and mobilize additional resources through PEPFAR and GF.

5. Major Challenges Identified in Previous Reports

Some of the major challenges identified through the previous UNGASS reporting and MTP III progress reporting process are described below.

Enabling environment

To ensure an enabling environment the report identified stigma and discrimination as a reason why some groups were not able to access available services. In addition, it was noted that there were legal barriers that restrict groups at higher risk from getting the specific services needed in their circumstances.

Prevention

IEC materials needed to be translated more often into local languages to ensure that all people have access to the materials. There was no information about whether people living with disabilities have access to HIV prevention, support, care and treatment programmes.

Sustaining youth peer education programmes was identified as a challenge due to the high losses of trained peer educators, sometimes to other organizations that offer better incentives. This highlighted the need to standardize incentive programmes on a national basis.

Also noted was that despite the large numbers of clients with STI's in the country, the number of partners treated and referred is still low. There were also no standardised partner notification slips available at the clinics and hospitals. Financial resources remain a major challenge for the STI programme as it was mostly government funded.

Managing VCT data was noted as a challenge because the submission of data is infrequent and quality is often low. It was also challenging to recruit, train and retain counselors with different language skills.

Some of the sites were still using Elisa testing which lowers the chances of follow up. It was recognized that rapid testing sites were needed to decrease the cost of transport for clients and to decrease the work load on the district hospital staff.

In 2005, many health facilities in the country still had inadequate storage space for banked blood, and continued to use regular refrigerators for blood storage. Adverse events after transfusion were not reported to the NBTS and thus haemo-vigilance required improved monitoring.

The report identified key areas to reduce vulnerability to HIV. Proposals included: expanding programming to address priority issues such as intergenerational and transactional sex, out-of-school youth, youth friendly health services, and support marginalised girls; expanding services for gender based violence; reviewing and address legislation on property grabbing; and establish a traditional practices and HIV forum to examine traditional laws and practices that increase the vulnerability of women and children.

Treatment and care

Although the expanded ARV treatment programmes was seen as a success, the drugs and supplies systems needed to be supported to support and maintain the workload. Specifically more trained professionals were needed, not only for pharmaceutical services but also for nurses in hospitals, health centres, and clinics.

Regarding PMTCT systems, rapid testing was needed so women become aware of their status before delivery. A follow up mechanism was needed for HIV positive mothers and their newborns through PCR testing. Finally PMTCT+ data needed to be provided more routinely to the central HIS sites.

The report noted that health facilities providing ARV services needed to be renovated to adequately accommodate the ARV and PMTCT+ services. And doctors as well as other health personnel needed to be trained on ART.

Home based Care services received inadequate funding given their critical importance. Programme coordination was needed to help measure coverage and determine standards of services. In addition a referral systems was needed between ARV clients in the health system and community HBC programmes.

Impact mitigation

A number of challenges were identified around OVC support. Both civil society and government needed to increase their material and financial support to OVC and their caregivers. It was proposed that government should provide guidance and control the quality of OVC support services; opportunities for children to voice their opinions on their situations should be increased; and opportunities for caregivers to network and share learning experiences should be developed. Finally the government should increase the number of health workers, paralegals counselors, and other administrative personnel who implement and manage government services for OVC.

Services for PLWHA still needed to be expanded to include psychosocial counseling, treatment adherence and nutrition counseling, succession planning. The national PLWHA umbrella organisation needed to be strengthened to help coordinate and advocate for these services.

Improvement to poverty alleviation efforts were also identified, such as increasing development assistance to Namibia, providing technical assistance, institutional strengthening, and capacity building to government, civil society and private sector.

Coordination and management

Monitoring and evaluation structures needed to be established at the regional level to support the health sector response and also the community response through the regional AIDS coordinating committees (and constituency committees at their levels). Capacity building for M&E needed to take place at all levels and in all sectors; including training and support for stakeholders in collecting programme data, training in M&E systems development, and training in data use and report writing.

An urgent need was identified for programme and survey data from most at risk populations.

The 2005 UNGASS report listed a number of actions required to meet the challenges identified in that report. Those actions are summarised below with an indication of the follow up activities taken to respond to those recommendations.

Summary of 2005 recommendations	Follow-up took place
Increase leadership around HIV	No
Empower PLWHA	No
Improve resources available on legal assistance for PLWHA	No
Invest in human resources for management, coordination and monitoring of behaviour change projects	Yes

Prevent infections in health care settings	Yes
Strengthen social mobilisation strategy	Yes
Increase resources for workplace programmes in public and private sector	Yes
Expand outreach of condoms (male and female) with a special focus on youth	Partial
Increase financial resources for STIs management especially around training health workers and developing a partner notification system	No
Increase rapid testing, and provide space for confidential counselling	Yes
Develop VCT reporting systems	No
Improve interventions to target vulnerable populations	No
Expand services for gender based violence and review the legal context around issues that affect gender equality	No
Expand programmes to address priority issues such as intergenerational/ transactional sex, out of school youth, adolescent friendly health services, and marginalised girls	No
Resolve transport issues for supervision of PMTCT services	Yes
Ensure follow up of HIV exposed babies and enable PCR	Yes
Identify additional health personnel for ARV roll out	No
Improve ARV data collection and reporting	Yes
Implement treatment literacy campaign	Yes
Increase resources for local response	Yes
Ramp up services for OVC including material and financial, income generating health and nutrition	Partial
Ensure government offices providing services are aware of referral systems and increase awareness of children's rights	No
Develop capacity of DSP staff at all levels to manage response and share information	Partial
Strengthen capacity for M&E	Yes
Institute research forum to disseminate results	No

6. Support from Development Partners

Despite being classified as a lower-middle income country, Namibia receives significant external assistance for its fight against HIV. The US Government and the Global Fund provide the largest amount of funding with additional technical and financial assistance coming from the United Nations and European Union. A number of other donors also provide technical and financial assistance.

Namibia is a priority country for the US Government and thus receives large amounts of financial assistance through the different branches of the US Government. Along with the financial assistance there are approximately 10 technical advisers seconded to the Government of Namibia assisting in the areas of VCT, ARV, laboratory services, M&E, pharmaceuticals, etc.

Namibia successfully applied for HIV funding from Round 2 of the Global Fund on AIDS, TB and Malaria. The money was disbursed in 2005 and is continuing to be used for implementation currently. The primary recipient is the MoHSS and is housed as a separate directorate in the MoHSS.

A recently completed resource needs estimation found that there was a funding shortfall of N\$1.6 billion (US\$ 225 million) per year between 2007 and 2012 for HIV activities. According to the model used for this assessment, 37 percent of the resources are needed for treatment and 25 percent are needed for prevention (MoHSS, 2007e).

The development partners meet quarterly in an HIV/AIDS Partnership Forum. The purpose of the Forum includes information sharing and policy dialogue with the government on strategic issues of the national response. Ideally such a forum makes a better contribution when led by government. Alternatively, government representation at this forum should be regular and at a level that facilitates policy dialogue and follow up action. This would enable the Partnership Forum to strengthen its role by harmonizing its advice and assistance to the country.

In addition the development partners need to support the government to play the lead and coordinating role in the HIV response. Specific actions that development partners can undertake are:

- Avoid bilateral meetings on programmes that are to be implemented by government
- Coordinate M&E and surveillance activities through the Directorate of Special Programmes: Response Monitoring and Evaluation Sub-Division and the National M&E Committee
- Ensure that prevention, treatment and care, strategies align with government priorities in order to reach national targets
- Strengthen the capacity of NGOs, CBOs, FBOs to respond to HIV
- Provide technical assistance to strengthen the government's management and leadership capacity around HIV

References

- Ahrens, Lara-Lyn. 2006. "Sexual commodities" Space, 2, 9. Windhoek: E Smith.
- GRN/Government of the Republic of Namibia. 2004. Vision 2030. Windhoek: Office of the President.
- Hubbard, Dianne. 2000. Gender and law reform in Namibia. Windhoek: Legal Assistance Centre.
- Kiremire, Merab Kambamu. 2007. Prostitution in Windhoek Namibia: An exploration of Poverty. National Institute for Democracy, Analysis and Views 4(2).
- LAC/Legal Assistance Centre. 2002. Whose body is it? Prostitution in Namibia. Windhoek: LAC.
- Ministry of Gender Equality and Child Welfare. 2007. National Figures on OVC Receiving Maintenance and Foster Parent Grants: 2006/07 Financial Year.
- Ministry of Health and Social Services. 2004. The National Strategic Plan on HIV/AIDS. Third Medium Term Plan (MTP III) 2004-2009. Directorate of Special Programmes. Windhoek, Namibia; 2004.
- Ministry of Health and Social Services. 2006. Plan for National Multisectoral Monitoring and Evaluation of HIV/AIDS, 2006/7 – 2008/9. Directorate of Special Programmes. Windhoek, Namibia; 2006.
- Ministry of Health and Social Services. 2007a. MTP III Annual Progress Report 2006. Windhoek, Namibia.
- Ministry of Health and Social Services. 2007b. Namibia Global Fund Programme Annual Report 2006. Windhoek, Namibia; 2007.
- Ministry of Health and Social Services. 2007c. National Policy on HIV/AIDS. Windhoek, Namibia; 2007.
- Ministry of Health and Social Services. 2007d. Report of the 2006 National HIV Sentinel Survey. Windhoek, Namibia; 2007.
- Ministry of Health and Social Services. 2007e. Revised Costing of Namibia's Third Medium Term Plan (MTP III): Technical Report. Windhoek, Namibia; 2007.
- Ministry of Health and Social Services. 2007g. Multi-sectoral Regional Support Visist on HIV/AIDS in 2006: Summary and final reports. Windhoek, Namibia; 2007.
- Ministry of Health and Social Services. Forthcoming[a]. National Estimates and Projections of HIV/AIDS (Draft). Windhoek, Namibia. Based on Spectrum 3.13.
- Ministry of Health and Social Services. Forthcoming[b]. PMTCT Annual Report. Windhoek, Namibia.
- Ministry of Health and Social Services and Macro International. 1993. Namibian Demographic and Health Services 1992. Columbia, Maryland; 1993
- Ministry of Health and Social Services and Macro International. 2002. Namibian Demographic and Health Services 2000. Calverton, Maryland; 2002
- Ministry of Health and Social Services and Macro International. 2007. Preliminary tables of the Namibian Demographic and Health Services 2006. Windhoek, Namibia.
- National Planning Commission. 2001 Population and Housing Census, National Report Basic Analysis with Highlights. Windhoek; Namibia; 2003
- National Planning Commission. 2006. Preliminary Report, Namibia Household Income and Expenditure Survey, 2003/2004. Central Bureau of Statistics. Windhoek, Namibia; 2006.
- Shanghala, Sakeus E. 2000. The legalization of the profession of commercial sex workers in Namibia. Windhoek: University of Namibia.
- SIAPAC. A Situation Analysis of Orphan Children in Namibia. Report prepared for Ministry of Health and Social Services. Windhoek, Namibia; 2002.
- UNDP. 2006. Human Development Report 2006.