Republic of Namibia
Ministry of Health and Social Services

GLOBAL AIDS RESPONSE PROGRESS REPORTING 2012

Monitoring the 2011 Political Declaration on HIV/AIDS

Reporting Period 2010 & 2011

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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
BTC	Break The Chain campaign
CACOC	Constituency AIDS Coordinating Committee
CBO	Community based Organisation
CBS	Central Bureau of Statistics
CC	Community Counsellor
CDC	Centers for Disease Control and Prevention (U.S)
CMS	Central Medical Stores
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
ePMS	Electronic Patient Monitoring System
ETR	Electronic TB Register
EU	European Union
FBO	Faith-based Organisation
FSW	Female Sex Worker
GAMET	Global AIDS Monitoring and Evaluation Team
GFATM	Global Fund to fight HIV/AIDS, TB and Malaria
GIPA	Greater Involvement of People Living with HIV/AIDS
GRN	Government of the Republic of Namibia
GTZ	Gesellschaft für Technische Zusammenarbeit
HAART	Highly active anti-retroviral therapy
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
IEC	Information, education, communication
KAP	Knowledge, attitudes, practices
LAC	Legal Assistance Centre
MCP	Mulltiple and Concurrent Partnerships
M&E	Monitoring and evaluation
MFMC	My Future My Choice
MoE	Ministry of Education
MoHSS	Ministry of Health and Social Services
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
NLT	NawaLife Trust
NPA	National Plan of Action
NPC	National Planning Commission
NRCS	Namibia Red Cross Society
NSF	National Strategic Framework for HIV and AIDS 2010/11 to 2015/16
OMAs	Government Offices, Ministries or Agencies
ORN	Out Right Namibia
OVC	Orphans and Vulnerable Children
PDNA	Post Disaster Needs Assessment
PEP	Post Exposure Prophylaxis
PEPFAR	The US President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV/AIDS
RACOC	Regional AIDS Co-coordinating Committee
RM&E	Response Monitoring and Evaluation Subdivision
SPM	System for Program Monitoring
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organization
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UNODC	United National Organization for Drugs and Crime
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WOH	Window of Hope

PREFACE

As a member state of the United Nations, Namibia is committed to meeting its international obligations including those related to HIV and AIDS. In line with the UN General Assembly declaration of commitment on HIV and AIDS in 2001 to monitor the AIDS response and renewed mandates in the 2006 and 2011 assemblies, Namibia has prepared a report on its progress towards achieving the global targets by 2015.

The 2011 United Nations General Assembly Political Declaration global targets by 2015 include halving the transmission of HIV, eliminating mother to child transmission, increasing access to ART to 15 million and reducing TB deaths in PLHIV by 50%. The targets of the Namibia National Strategic Framework (NSF) for HIV and AIDS are aligned to the global targets. Efforts by the Government of the Republic of Namibia and its partners are consequently yielding results that indicate that the global targets for 2015 can be achieved if the NSF is implemented as planned.

Namibia's progress report is an important aspect of the mutual accountability mechanism for measuring the progress and impact of the global AIDS response. The country level process of preparing these reports has strengthened partnerships between governments and civil society, improved transparency and provided a platform for shaping national policies and programmes based on evidence and data.

The report provides information on the commendable efforts of stakeholders in addressing the HIV epidemic which continues to plague the country at a hyperendemic level. Acknowledging with thanks the collaboration and cooperation from the stakeholders in providing information during the development stage of this report, the Ministry would like to express its appreciation for the highly valued information and encourages you to keep up the good work. We thank the UNAIDS Country Office for coordinating the UN system support to Namibia in preparing their biennial country progress reports (also formerly known as UNGASS reports).

Finally, the Ministry would like to express its gratitude and appreciation to all those who have commented on the various drafts of this report especially the National M&E Technical Advisory Committee, the staff of the Directorates of Special Programmes, other Directorates and Ministries, development partners and the USG.

It is hoped that all stakeholders will continue to value the importance of reporting on their efforts as a means of guiding the implementation of the national response.

MR. K. KAHUURE

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

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1. Status at a Glance

Indicator	Dis aggregation	2006/07	2009/10	2010/11	NSF Target 2015/16
Target 1: Reducing sexual transmission of HIV by 50 percent by 2015/16					
General population					
***SADC:* #Annual New infections**		11330	9900	9300	5800
Empowering young people to protect themselves from HIV					
Global 1.1 & MDG 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	***women***	64.9%	N/A	N/A	90%
	men	61.90%	N/A	N/A	90%
UA & Global 1.2 Percent of young women and men 15-24 who had sex before the age of 15	***women***	7.4%	N/A	N/A	4%
	men	19.20%	N/A	N/A	10%
Global 1.6 & MDG Percentage of young people aged 15–24 who are living with HIV	***women****	22%(2000)	14.7%(2005)	8%(2010)	
	Pregnant women	14.2% (2006)	10.8% (2008)	10.3% (2010)	5%
	men	8.4%(2000)	5.5%(2005)	3.5%(2010)	
Global Percentage of schools that provided life skills-based HIV education within the last academic year (primary (P) and secondary (S)	***primary***	63%	75% (2008/90	N/A	100%
	secondary	70%	86% (2008/09)	N/A	100%
Global 1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	***women***	3%	N/A	N/A	1%
	men	16%	N/A	N/A	5%
Global 1.4 & MDG Percentage of women and men aged 15-49 who had multiple partners in the past 12 months who reported the using a condom the last time they had sex	***women***	66%	N/A	N/A	85%
	men	74%	N/A	N/A	90%
Global 1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	***women***	29%	N/A	N/A	50%
	men	18%	N/A	N/A	50%
UA Number of condoms distributed (male and female)	***male***	28,092,483	22,307,208	27,931,826	55,000,000

	female	455,439	502,177		3,400,000
	Total	28,547,922	22,809,385	N/A`	58,400,000
Sex Workers					
Global 1.7 Percentage of sex workers reached with HIV prevention Programmes		N/A	N/A	N/A	80%
Global 1.8 Percentage of female and male sex workers reporting the use of a condom with their most recent client		N/A	N/A	N/A	50%
Global 1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results		N/A	N/A	N/A	80%
Global 1.10 Percentage of sex workers who are living with HIV		70% (Katutura)	N/A	N/A	40%
Men who have sex with men					
Global 1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner		N/A	N/A	N/A	Increase by 50% of baseline
Global 1.13 Percentage of men who have sex with men have received an HIV test in the past 12 months and know their results		N/A	N/A	N/A	80%
Global 1.14 Percentage of men who have sex with men who are living with HIV		N/A	N/A	12.6% (small study, 2009)	N/A
Target 3: Eliminate mother-to-child transmission of HIV by 2015/16 and substantially reduce AIDS related maternal deaths					
UA & Global 3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission[1]		42%	77%	90%	95%
Global 3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth		36%	59%	60%	85%
Global 3.3 Percent MTCT rate		25%	16%	12%	4%

[1] Denominator used is the high bound estimates of PMTCT in need as obtained from Spectrum 4.392 (2011)

Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015					
UA & Global 4.1 & MDG Percentage of eligible adults and children currently receiving antiretroviral therapy	***Adults***	56%	88% (CD4 200)	67% (CD4 350)	95%
	Children	88%	>95% (CD4 200)	75% (CD4 350)	95%
Global 4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	***Adults***	69%	80% (Jan-Dec 2010)	81.5%	90%
	Children	82%	82% (Jan-Dec 2010)	83.9%	95%
Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015/16					
National Percentage of TB patients with known HIV status		34%	74%	93%	95%
Global 5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV		N/A	35%		95%
Target 6: Reach 70% (U$ 213,711,339) of annual National HIV and AIDS expenditure that is domestic by 2015/16					
Global 6.1 Domestic and international AIDS spending by categories and financing resources (% domestic*)*	***Amount***	USD 130,000,000	USD 194 000\(2008/9)	N/A	USD 305,000,000
	domestic	50.80%	52%	N/A	70%
Target 7: Critical Enablers and Synergies with Development sectors					
Removing punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS					
National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)		Done	Done		Done
National	***women***	39%	N/A	N/A	70%

Percent of women and men aged 15-49 expressing accepting attitudes on 4 questions about HIV	***men***	36%	N/A	N/A	65%
Global 7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months		40.7% (2007/8)[2]	N/A	N/A	N/A
Enhancing social protection for people affected by HIV					
Orphans and vulnerable children					
Global 7.3 & MDG Current school attendance among orphans and among non-orphans aged 10–14	***Ratio***	1	N/A	N/A	1
National Number of children receiving welfare grants	***Number***	65,000	113,995	124,351	160,000
Vulnerable households					
Global 7.4 Proportion of the poorest households who received external economic support in the past 3 months					

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

2. Background

2.1 Introduction

Ten years after the landmark UN General Assembly Special Session on HIV/AIDS (UNGASS), progress was reviewed at the 2011 UN General Assembly High Level Meeting on AIDS. A new Political Declaration on HIV and AIDS with new commitments and bold new targets was adopted.

The 2011 declaration builds on two previous political declarations: the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS. At UNGASS, in 2001, Member States unanimously adopted the Declaration of Commitment on HIV/AIDS. This declaration reflected global consensus on a comprehensive framework to achieve Millennium Development Goal Six-: halting and beginning to reverse the HIV epidemic by 2015. It recognized the need for multisectoral action on a range of fronts and addressed global, regional and country-level responses to prevent new HIV infections, expand health care access and mitigate the epidemic's impact. The 2006 Political Declaration recognized the urgent need to achieve universal access to HIV treatment, prevention, care and support.

The purpose of this report is to review the progress made by Namibia toward reaching the targets agreed to in the 2011 Political Declaration on HIV/AIDS.

The report was written by the Ministry of Health and Social Services with significant contribution from civil society and other development partners. The National M&E Technical Advisory Committee reviewed the process of developing the report and reviewed the drafts. The NCPI questionnaire was administered to Government (Part A) and non-Government partners (Part B) by an independent consultant. In addition, special separate consensus meetings of non-government and government were held in March 2012 to review the results of the National Composite Policy Index (NCPI). A summary of the results is presented in this Global AIDS Progress report and details of the raw data are available in the NCPI report which is submitted with the narrative.

This report is a shortened version of the NSF Progress Reports for 2010/11 and the MTPIII report for 2009/10. The reports use the same process of requesting significant contribution from civil society and development partners. The financial year reporting period for Namibia is from April to March and therefore most of the annual indicators are last reported for that period unless stated otherwise.

2.2 Namibian Country Profile

Independent for 22 years, Namibia's institutions and systems (including civil society) are still "maturing" and need further strengthening and development. This is also true for institutions involved in the AIDS response due to the scale and impact of the epidemic, the need for innovation and the challenges of multi-sectoral collaboration.

The economy (GDP of 5,330USD/inhabitant in 2009[3]) is largely dependent on mining, fishery, large scale farming and high-end tourism. With 51.2%

[3] World Bank (2011). World Development Indicators

unemployment[4] and the highest Gini index (74.3%[5]) in the world, socio-economic inequality is widespread and multi-dimensional and is considered to be both a structural driver of the HIV epidemic and a major challenge for the response as the poor and marginalized have limited access to the full range of HIV-related services.

A vast country with only 2.1m inhabitants and the second lowest population density in the world (2,5 inhabitants per square km), Namibia's geographic and demographic characteristics pose serious challenges to the planning, organization and logistics of the AIDS response..

The country is regularly hit by floods, especially the north (Okavango and Zambezi River) which is also the area of highest HIV prevalence. A 2009 Post Disaster Needs Assessment (PDNA) in the flood stricken areas of Namibia found that floods caused significant disruptions in outreach (81%) and OVC (79%) services. Antiretroviral treatment disruption affected 23% of PLHIV (UNAIDS PDNA Report 2009)). However, the Government is trying to put systems in place to avert such occurrences.

Namibia has a highly mobile population characterized by a system of circular labour migration to mines, ports, farms and urban areas as well as transport corridors from neighbouring countries to Walvis Bay. Rural-Urban migration is important and has resulted in growing informal settlements in cities, towns and smaller semi-urban localities. Mobility and migration are associated with increased risk behaviour and vulnerability to HIV infection and inadequate access to services.

2.3 HIV/AIDS in Namibia

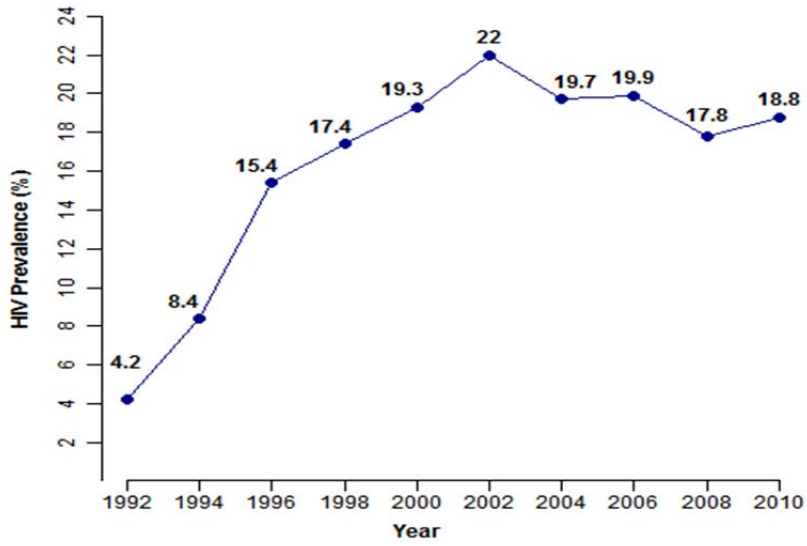
Namibia's first case of HIV infection was reported in 1986. Today the country has a generalised, mature epidemic throughout society, with HIV primarily transmitted through heterosexual and mother to child means.

HIV prevalence among pregnant women attending ANC in the country was determined to be 18.8% in 2010 a non-statistically difference compared to 17.8% in 2008. There was no significant difference between the urban (18.5%) and the rural (19.1%) areas. The prevalence increased from 1992 and peaked in 2002 at 22% followed by a slight decrease and apparent stabilization between 2004 and 2010 (Figure 1). The ANC survey result indicates that HIV prevalence peaks in the age group of 35-39 years with 29.7 percent and in the age group 30-34 with 29.6 percent. During the last years we see the HIV-prevalence peak moving to older age. This is likely a consequence of the HIV ART coverage and decreasing incidence.

[4] MoLSW (2010). Namibia Labour Force Employment survey 2008

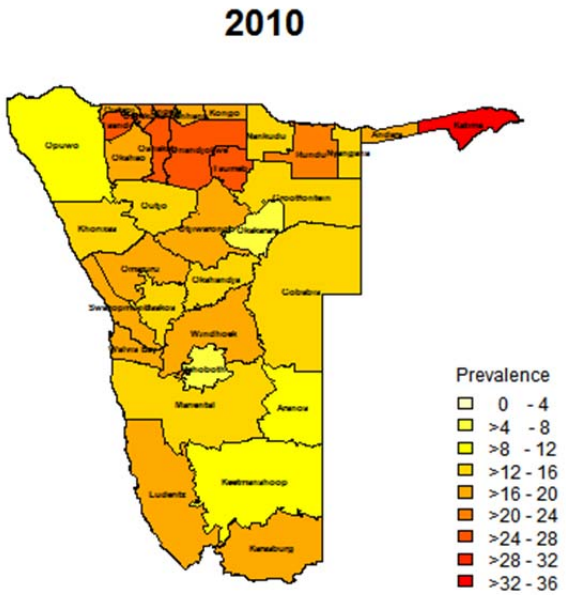
[5] UNDP (2009). Human Development Report 2009

Figure 1: ANC HIV Prevalence trends between 1992 and 2010



The epidemic appears to be centred in the three geographic areas namely North East (Katima Mulilo, Rundu), North (Engela, Oshakati, Oshikuku, Tsandi, Tsumeb, and Onandjokwe) and Central (Katutura state hospital) (Figure 2). These are places where mobile populations are most likely to take temporary residence such as tourist areas, commercial and border entry and exit points.

Figure 2: ANC HIV prevalence by Health District in 2010



The epidemic has sustained itself through specific sexual practices, community norms and practices, alcohol abuse that affects decisions on sexual behaviour and low levels of HIV risk perceptions. Studies have highlighted the drivers that fuel new infections are of a biological, behavioural, social and structural nature. The main epidemic drivers which have been identified are multiple and concurrent partnerships, inter-generational sex, transactional sex, varying and inconsistent condom use, low perceptions of risk of HIV infection, low levels of male circumcision, alcohol use and abuse, peoples mobility and migration in and outside the country, gender inequality, income inequality, fewer Namibians getting married or living together and early sexual debut[i].

HIV Estimates and Projections 2010/11

The number of new HIV infections peaked around 1998 to 2000 and began to decrease thereafter which could demonstrate the impact of prevention programmes among other factors. In 2010/11, HIV prevalence in the general population among people aged 15 to 49 years was estimated at 13.5%, resulting in around 4,500 AIDS-related deaths in 2010/11 which amounts to approximately 18% of all deaths in Namibia (Table 1). In 2010/11, approximately 9,300 people were infected with HIV. This steady stream of new infections over a long period of time has resulted in an estimated 189,000 adults and children living with HIV (PLHIV) in Namibia in 2010/11[6].

Approximately, 40 percent of the new infections in 2010 are estimated to be among young people ages 15-24 which is similar to the situation in 2000. Therefore, HIV prevention efforts among the youth still needs to be emphasized so as to obtain the same or greater impact than in other age groups. Among the new infections of the ages 15-24 in 2010, 60 percent are estimated to be among young women ages 15-24. The estimated large proportion of new infections among young women is critical for programme managers to address. For young women, 15-24 years, attending ANC saw a decrease in prevalence from 15.2% in 2004 to 10.3% in 2010[ii].

During 2010, it is estimated that around 10% of the new infections were children under 15 years. With an approximation of 250,000 children below 18 years were orphans or vulnerable children, around 28% (70,000) had been orphaned by AIDS.

Slightly less than one tenth (919) of the total annual new HIV infections in 2010/11 were through Mother to Child transmission. The modeled Mother to Child Transmission (MTCT) rate with breast feeding in 2010/11 is approximately 12 percent and is expected to reduce to 4% by 2015/16 if the current prevention efforts are maintained. With over two babies being born positive each day, HIV will remains an important cause of infant and child mortality and reaching the virtual elimination of MTCT target will require sustained effort (MDG 4).

[6] MOHSS, 2011, Estimates and projection of HIV impact 2010/11.

Table 1: Namibia HIV Epidemic update for the Fiscal year 2010/11 at a glance

Epidemic variable	2002/03	2010/11	2015/16 Target
HIV Adults + Children	172000	188500	201000
HIV Adults 15 +	160000	170000	187000
HIV Adults 15-49	155000	160000	167000
Percent Prevalence Adult (15-49)	15.75	13.54	12.55
Percent Prevalence Males (15-24)	6.23	2.85	2.39
Percent Prevalence Females (15-24)	16.35	6.67	5.22
Percent Prevalence Children	1.44	2.11	1.68
HIV 15 + female	94000	101000	110000
HIV 15 + male	66000	69000	77000
HIV population – Children (0-14yrs)	11000	17500	14000
Annual AIDS deaths	10000	4500	3100
Annual AIDS deaths- Adult	8500	3900	2800
Annual AIDS deaths-Children (1-4)	880	370	70
AIDS orphans	43500	70000	56000
Number of new HIV infections	18000	9300	5800
Incidence-Adults	1.63	0.79	0.48
Need for ART- Adult (15+) (High Bound est.)	27700	87000	145000
Need for ART- Children (0-14 yrs) (High Bound est.)	6000	12600	12800
Total in need ART (High Bound est.)	33700	99600	157800
Mothers needing PMTCT (High Bound est.)	12300	9900	8200
Percent MTCT rate	32	12	4

SOURCE: Spectrum Policy Modeling System, Version 4.392 (2011); Namibia model July 2011

3. Overview of Progress made in the National Response

3.1. Prevention

Spectrum model HIV estimates and projections for Namibia suggest that new infections are on a decrease. However, at the current rate the annual number of new infections will reduce by 37% in the next 5 years and not 50% as targeted meaning that prevention efforts need to be further scaled up.

The findings of the HIV ANC sentinel surveillance report for 2010 indicate that there was a slight reduction in the percentage of pregnant women attending ANC aged 15-24 who are HIV infected from 10.6% in 2008 to 10.3% in 2010. Although this finding still indicates a trend in reduction of new infections, the decline may not be as rapid as initially estimated.

Modelled estimates of mother to child transmission rates show a decrease from the FY 2009/10 to 2010/11 from 6% to 4% at 6 weeks and from 18% to 14% at 18 months respectively. At this rate it is projected that the 18 months MTCT rate will have reduced to slightly under 5% in 2015/16 which is the global and national target for elimination of mother to child transmission. This is mainly due to the rapid scale up of Prong 3 (PMTCT prophylaxis) using ARVs for mothers and their babies and the change of guidelines to a more efficacious regime.

Representative data on HIV prevalence rates among key populations most at risk is not available. However, one independent study reported in 2008 found a prevalence of 12.4% amongst MSM with a small sample size of 218[7] .

3.1.1 Social and Behaviour Change

Indicator	***Dis aggregation***	2006/07	2009/10	2010/11	NSF Target 2015/16
UA & Global 1.2 Percent of young women and men 15-24 who had sex before the age of 15	***women***	7.4%	N/A	N/A	4%
	men	19.20%	N/A	N/A	10%
Global 1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	***women***	3%	N/A	N/A	1%
	men	16%	N/A	N/A	5%
Global 1.4 & MDG Percentage of women and men aged 15-49 who had multiple partners in the past 12 months who reported the using a condom the last time they had sex	***women***	66%	N/A	N/A	85%
	men	74%	N/A	N/A	90%

[7] Baral et al 2009. HIV Prevalence, Risks for HIV Infection, and Human Rights among Men Who Have Sex with Men (MSM) in Malawi, Namibia, and Botswana

The NSF 2010/11 to 2015/16 aims at increasing sexual debut, reducing multiple partnerships and advocates for the use of condoms in high risk sex.

The NSF 2010/11 to 2015/16 aims at increasing age of sexual debut, reducing multiple partnerships and advocates for the use of condoms in high risk sex. However, impact determination of social and behavioural change will only be possible after a National Population Based survey which had not been conducted by the time of writing the report.

In- and out- of School Skills based HIV prevention education

Comprehensive SRH is given to all learners (during life skills education) from grade 5 through grade 12. During the period under review, 64 238 learners in school were reached with comprehensive SRH education compared to a target of 87%. All regions reported the continuation of life skills education programmes “Windows of Hope” and “My Future is my choice”. Life skills as a subject is compulsory for all schools. However, the current M&E system (Education Management Information System (EMIS)) does not make provision of collecting/capturing life skills information because it is not an examinable subject. Schools only submit information/data of examinable subjects. The indicator will be piloted and it is hoped that it will become routine thereafter.

“Break The Chain” Campaign

As a joint effort between Namibian GRN through MICT and MoHSS, UN, USAID and NGO partners, the “Break the Chain” (BTC) campaign is the first campaign in Namibia to address MCP. NLT led the process of communication strategy development, took responsibility for the development of all mass media activities and materials relating to the adult target group (25–49 year olds), and implemented a substantial part of IPC activities. There were two campaign phases – Phase I (Dec-Mar) focused on heightening risk awareness and introducing the concept of sexual networks. Phase II introduced risk reduction methods and started, together with the scale-up of IPC activities late, in March 2010.

This campaign earned international recognition. NLT entered the national “Break the Chain” Campaign for the *“AfriComNet 2010 Annual Awards of Excellence in HIV/AIDS Strategic Communication in Africa.”* The campaign was recognized as the first runner-up in the category “Best Multi-Channel campaign”. Several countries have expressed great interest in the campaign and have indicated that they would like to visit NLT to learn more about the campaign.

MCP campaign (BTC) Evaluation

The Break the Chain (BTC) campaign in Namibia seeks to reduce HIV incidence through disrupting sexual networks by reducing concurrent relationships and promoting protected sex among people in concurrent partnerships. An evaluation of the campaign for the period 2009-2011 was carried out. Findigs of the evaluation include:

Achievements of the BTC campaign

- The reach of the BTC campaign has been very high, with all respondents having been exposed to at least one component, and the vast majority being able to recall or recognise the campaign slogan and logo.
- There were overall high levels of perceived MCP-related practices occurring at community level, although it was also promising to note that such practices were perceived to be disapproved of by the majority of community elders and friends, and people were being encouraged to have fewer partners and to avoid concurrent partners by their friends.
- The majority of respondents reported having changed their sexual practices and behaviours in the past year with most reporting that they used condoms more often; over a fifth said that they had broken the chain or avoided having concurrent partners.
- There was a statistically significant trend towards concurrent partner reduction among respondents with higher exposure to the BTC campaign.
- There was also a sense that community members in general are becoming less tolerant of MCP and more pointed about directing mild admonishments towards people who are perceived to have multiple or concurrent partners.

Challenges:

- Although male and female participants both described engagements with the campaign and changing their behaviours and practices, there remained a concern that men were less likely to participate in community-level activities. The potential for greater integration of people living with HIV into the campaign was also voiced.

Programmes addressing alcohol misuse

The NSF aims at reducing the number of people having sex under conditions that impair their judgement. The MoHSS through the Coalition on Responsible Drinking (CORD) and NLT, have been trying to address the misuse of alcohol in Namibia since 2002. Together with interventions that target excessive and dependant drinkers and initiatives to strengthen the enforcement of existing laws, the most recent campaign; namely, “Stand Up! against alcohol misuse”, attempts to tackle alcohol misuse through social and individual behaviour change communication. Launched in Windhoek on 6 July 2010, the “Stand Up!” campaign shifts the focus from the drinker and aims to raise awareness on the many negative effects of alcohol misuse on our society; help end general tolerance of alcohol misuse and drunken behaviour; and advocate for and reinforce personal, community and policy action on alcohol misuse. As alcohol has been identified by the NSF as a key driver of HIV, HIV risk is embedded in all campaign materials as a key consequence of uncontrolled drinking.

NLT developed the communication strategy, all mass media materials and activities as well as initiated the social movement through the implementation of the alcohol meetings.
A key element of the communication strategy is to organize individuals concerned about alcohol misuse in the 'Stand Up!' community. A cellphone-based SMS system was used extensively to generate sign-ups to the "Stand UP!" Movement through mass media bookings. Additionally, concerned community members could also sign-up to the Stand Up! community at a series of regional alcohol community meetings.

By March 2011, 9,102 members of the public signed up to the "Stand UP!" Movement.

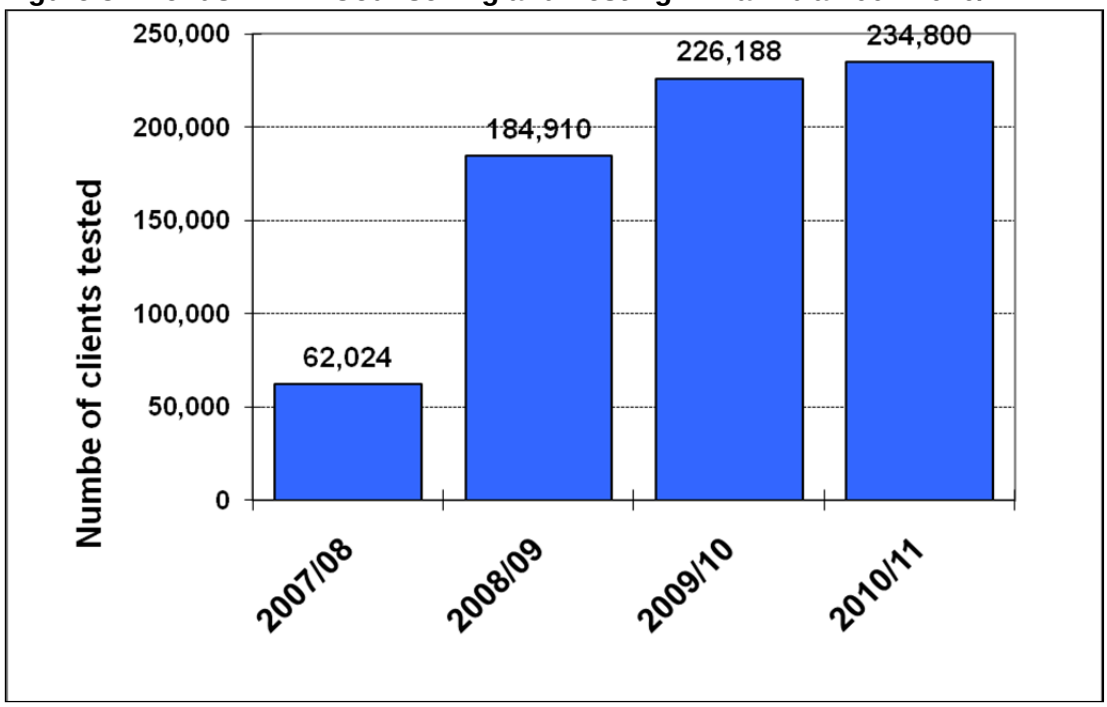
3.1.2 HIV Counseling and Testing

Indicator	***Dis aggregation***	2006/07	2009/10	2010/11	NSF Target 2015/16
Global 1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	***women***	29%	N/A	N/A	50%
	men	18%	N/A	N/A	50%

Voluntary counselling and testing remains essential for HIV prevention as it the entry point to other care and treatment services. Only by accessing counselling and testing can people living with HIV learn their HIV status. For those who test positive, referrals are immediately provided for ongoing support and to health facilities and medical interventions. For those who test negative, referrals are provided to prevention activities such as the Catholic AIDS Action prevention activities to help support individuals to stay negative.

The NSF aims at increasing the percentage of people being counselled and tested for HIV and receiving results. During the period under review, 234, 800 clients were counselled, tested and received their results compared to an annual target of 202,500 (Figure 3). HCT services expanded through roll out of rapid test sites country wide. NTD results also boosted performance (33 858 clients tested).

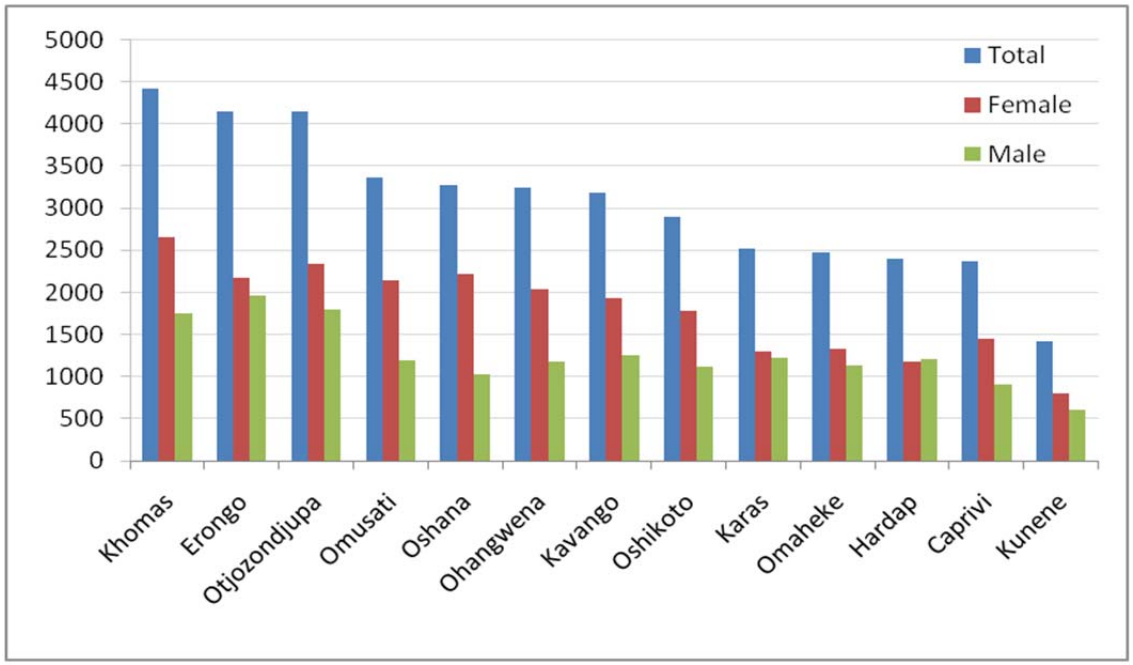
Figure 3: Trends in HIV Counselling and Testing in Namibia 2007-2010/11



National Testing Day 2010

During the 2010 one-day National Testing Day event, a total of 39,858 people got tested. As seen in the graph below, Khomas region recorded the highest number of participants, followed by the Erongo and Otjozondjupa regions.

Figure 4: Number of people that participated in the 2010 National testing Day per Region



In most of the regions (92%), the majority of the people that were enrolled were women (Figure 4). This is in support of the literature that more women are tested as opposed to men.

A smaller proportion of NTD clients tested positive for HIV during the 2010 NTD than during the 2009 NTD. Of the 39,355 registered clients for whom demographic information was available in 2010 (gender, region), 2,229 tested HIV positive (5.66%). This compares to 7.27% of clients who tested positive during the 2009 NTD (6,141/84,527). Regional differences were evident in both years. In 2010, Caprivi reported the highest proportion of HIV positive clients (9.94%). Omaheke reported the lowest proportion of HIV positive clients (3.28%).

Creation of demand for HCT

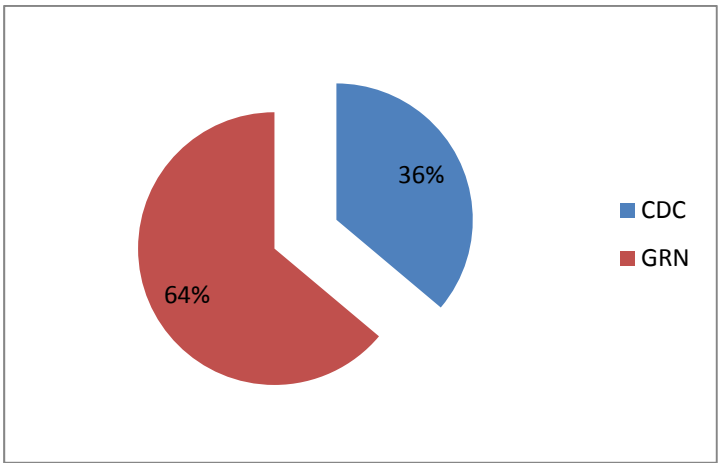
NLT collaborates with the MoHSS and IntraHealth to create demand for the New Start and public health system CT services. This year, NLT in collaboration with the MoHSS and IntraHealth was involved in the development and implementation of the "Be Strong, Get Tested" campaign which aimed to get more men to utilize HCT by promoting VCT as the "strong" thing to do. Most notably, NLT contributed to National HIV Testing Day 2010, by managing the promotion of the event for MoHSS, using the "Be Strong" campaign creative platform.

With regard to the main campaign indicators, we observed desired changes, mainly during the campaign peak period. Using different measures (raw uptake, average client flow/day), uptake during May, June and July reached record levels. May and July 2010 were particularly strong and represent the months with the highest number of clients during (May) and outside a National Testing Day Month (July) in the history of the New Start network.

More men used the services as a result of the campaign. During the first campaign month, the male/female ratio changed from 75 men/100 women to 84 in May 2010 and 85 in June 2010. The average male female ratio (excluding NTD clients) for the campaign period was 81 (vs. 75 during the four months before the campaign). These results are embedded into a larger trend of higher uptake and more male clients which was in motion since early 2010 and only ended with centre closures in September/October 2010. The campaign appears to have further boosted this development.

During the period under review, Most kits were procured by GRN which is good for sustainability of the program (Figure 5).

Figure 5: Percentage breakdown of payment for Rapid Test Kits for FY 2010/2011 by GRN and CDC



Achievements

A total of 33 new delivery points were certified to conduct HIV RT during the reporting period. The cumulative total for MoHSS, rapid HIV testing delivery points is 275 out of a total of 343 facilities giving a coverage rate of 80% for 2010/2011. The HCT progamme reach the target of 175 000 set for the year.

The Ministry also assisted other sectors such as Namibia Prison Services in the Ministry of Safety and Security in rolling out HIV Rapid Testing to their correctional facilities. During the period under review 2 more Prisons rolled out HCT services bringing the total to 11. In addition, the MOHSS assisted Namibian Planned Parenthood Association (NAPPA) to roll out 1 RT in Windhoek. Plans are underway to extend the services to the 2 remaining correctional facilities as well as other NAPPA branches.

A total of 26 Community Counselors (CCs) were recruited during the reporting period**.** Currently 628 Community Counsellors are deployed in Public Health Facilities countrywide. The Ministry through CDC support recruited and deployed 7

Quality Assurance Officers for the period under review, a cumulative total of 10 QA officers have been recruited. To date three QA Officers have resigned. The primary duty of the Quality Assurance officers is to ensure provision of quality HCT Services in their respective regions. More QA Officers are yet to be recruited for the remaining regions.

3.1.3 Condom Social Marketing and Distribution Programme

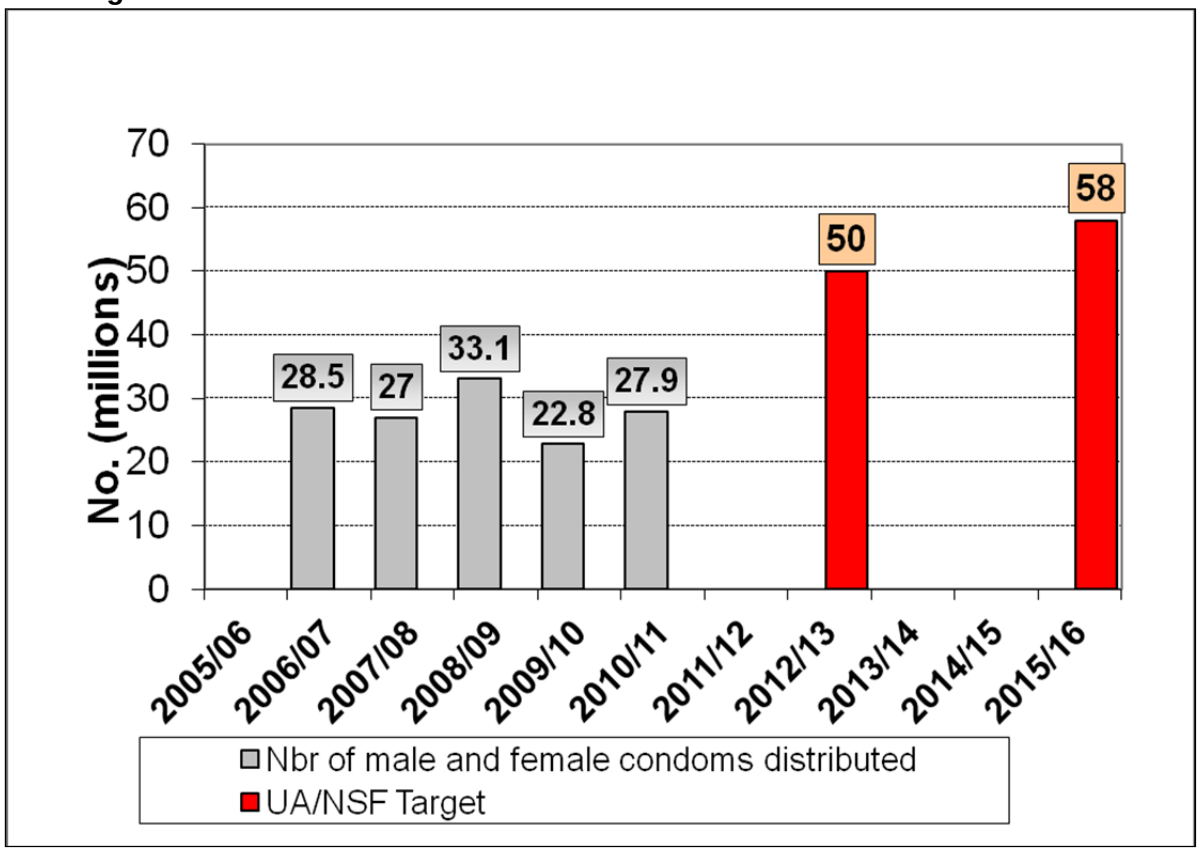
Indicator	***Dis aggregation***	**2006/07**	**2009/10**	**2010/11**	**NSF Target 2015/16**
UA Number of condoms distributed (male and female)	***male***	28,092,483	22,307,208	27,461,232	55,000,000
	Female (Femidom)	455,439	502,177	470, 594	3,400,000
	Total	28,547,922	22,809,385	27,931,826	58,400,000

The NSF aims at increasing condom distribution and use. During the period under review, 25, 816, 520 condoms were distributed for free through the public sector. In total, 27,931,826 were distributed inclusive of socially marketed condoms (Figure 6). 98% of condoms distributed were male condoms and 2 percent were female condoms. There are still challenges in the uptake of the female condom.

This indicates an increase in the number of condoms distributed when compared to the financial year 2009/10. However, there is still a need to further increase condom distribution for the national targets for 2015/16 to be realized.

NASOMA distributes condoms which includes the selling and free distribution of socially marketed condoms. The distribution channels include; telesales, salesmen and vending machines. The free condoms are distributed to vulnerable groups, partner organisations and during condom promotions.

Figure 6: Annual trend of numbers of condoms distributed (2006/07 to 2010/11) and NSF targets



Achievements

The National condom strategy was drafted.

Challenges

- The biggest challenge remains that of establishing targets and determining uptake within specific districts/regions.
- The floods in the northern regions of the country made distribution of condoms difficult. Some areas were inaccessible, whilst others could not procure condoms due to flood.
- Low uptake of female condoms, the organisation had to distribute these condoms at no cost as the expiry date was nearing. Thus affecting the sales figures
- Most of the vending machines are not working properly, this affects distribution channels
- The sales department is under staffed
- Delayed disbursement of funds for activities, resulting in freezing certain activities.
- Shortage of female condoms as compared to male condoms remains a challenge

3.1.4 Prevention of HIV among the Key Populations most at risk and vulnerable

Indicator	2006/07	2009/10	2010/11	NSF Target
Sex Workers				
Global 1.7 Percentage of sex workers reached with HIV prevention Programmes	N/A	N/A	N/A	80%
Global 1.8 Percentage of female and male sex workers reporting the use of a condom with their most recent client	N/A	N/A	N/A	50%
Global 1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	N/A	N/A	N/A	80%
Global 1.10 Percentage of sex workers who are living with HIV	70% (Katutura)	N/A	N/A	40%
Men who have sex with men				
Global 1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	N/A	N/A	N/A	Increase by 50% of baseline
Global 1.13 Percentage of men who have sex with men have received an HIV test in the past 12 months and know their results	N/A	N/A		80%
Global 1.14 Percentage of men who have sex with men who are living with HIV	N/A	N/A	12.6% (2009)	N/A

Data on the key populations most at risk and vulnerable is important to determine the drivers of the epidemic as well as coming up with targeted interventions. Despite of its importance, there is still lack of this data and studies are planned for 2011/12. However, during the period under review, a sero survey in correctional facilities conducted and study protocols for population based serosurveys with size estimation have been finalised for SWs and MSM.

3.1.4.1 Commercial sex workers (CSW)

Examples of HIV control activities addressing Sex workers include services provided by the King's Daughters Organisation (KDO) which is a Non-Profit organization which was registered in March 2009-with the objective to rehabilitate, educate, and empower CSWs in Namibia. The total registered members on the database up to date are 72 CSWs. The following activities were conducted for the CSWs:

- Human Trafficking Training with 39 members (sex workers) at CCN hall

- From June 2010-July 2010 KDO was involved in 'Trafficking Persons' Awareness raising B1 Road trip. The group visited the different border posts towns and had sessions with customs staff, police, social workers, sex workers and truck drivers.
- During Aug and Sept 2010- KDO placed 15 members (sex workers) with alcohol and drug addictions in Etegameno Rehabilitation and Resource centre (Brakwater) for 6 weeks in-patient professional treatment.
- Other trainings during the year included computer training; Home based care training, needlework skills training and beads jewellery skills trainings. In addition, other forms of care and assistance provided by KDO to sex workers during the reporting period included monthly food packs and cosmetics packs, also helping with payment

In 2011 a TWG on Key Populations was created under TAC Prevention to coordinate all the actions and programmes with sex workers in Namibia. Representatives of sex workers organizations also participate in this TWG.

African Sex Workers Alliance (ASWA) Namibia was constituted in 2011 and it is coordinating all sex workers' CSO (The Red Umbrella-TRU-,Rights not Rescue Trust –RNRT- and King's Daughters). A steering committee with 2 representatives of each sex workers organizations was created. This platform has strengthened the sex workers movement and is improving coordination among sex workers.

A Literature Review on Sex Work and HIV in Namibia was undertaken by UNFPA and UNAIDS, which has contributed to bring all the previous studies together and set a starting evidence baseline.

A Sex Work Community Assessment was conducted in 5 towns by sex workers with the support of UNFPA, UNAIDS, ASWA Namibia and SFH. Sex workers were trained as focus groups facilitators and conducted the focus groups in their towns. This assessment has contributed to raise qualitative information at the local level and has empowered sex workers to advocate for their rights.

A National meeting on Sex Work, HIV, and Access to Health Services took place in 2011organized by UNFPA, UNAIDS, ASWA Namibia and SFH. Sex workers representatives from different regions, national stakeholders and ministry of health participated actively in the discussions. A report of the meeting has been published with the main recommendations agreed for the way forward.

3.1.4.2 Men having sex with Men

Out-Right Namibia (ORN) is a newly established Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) organisation in the country and as part of its mandate to aid new movements in Namibia, Positive Vibes is hosting and supporting ORN. ORN is an autonomous and legally registered entity and PV is currently assisting in financial administration of the project as well as jointly implementing the MSM prevention project under the Global fund.

ORN as a sub-sub recipient of the GFATM RD2 RCC has been implementing HIV prevention sessions among Men having sex with Men (MSM) in 8 regions of Namibia namely Erongo, Hardap, Karas, Khomas, Kunene, Oshana, Oshikoto and Otjozondjupa. Project implementation started in October 2010. From October 2010 to December 2010, 323 MSM were reached with safer sex messaging as part of the deliverable of this project. The talk-shops entail the following topics: basic facts on HIV and STI (including HTC and treatment), Safer sex for MSM, basic facts on human sexuality (including sexual orientation), Gender and gender based violence, Stigma and discrimination, Human Rights and AIDS Law in Namibia as well as Advocacy and community outreach. Sixteen (16) community facilitators are engaging in 8 regions of Namibia as part of the project.

Beyond the GFATM MSM project, ORN is also implementing other projects and doing organisational development. It is foreseen that by June 2012, ORN will be a fully fledged organisation administering its own funding. ORN currently receives core funding from The Open Society Initiative for Southern Africa (OSISA) for organisational development which will end in December 2011.

3.1.4.3 Namibia Defence Force Services

During the period under review NDF peer educators and SFH regional staff conducted various BCC activities at all bases countrywide reaching a total of 8,568 NDF members with various BCC messages that promote HIV prevention through reduction in concurrent sexual partnering (CSP), condom use, knowing own HIV status and other HIV/AIDS prevention methods.

In Omaheke, the Community Liaison Officer attended a sensitization session at the Army Base in May 2010. The day was organized by Society for Family Health (SFH) as they implement the workplace programme of the Uniform Services and the CLO rendered technical support and provided HIV and AIDS information of the Region as well as IEC materials and condoms. It was then followed by a video show (Remember Eliphas) and the topics covered amongst others were discontent partnership, disclosure of one's HIV status, multiple concurrent partnership, stigma and discrimination, acceptance and support. A facilitation process followed thereafter.

3.1.5 Involvement of people living with HIV in prevention

Nawalife Trust (NLT) works closely with partners such as Positive Vibes to create messages relevant to this audience and is also involved in communication work that is geared exclusively towards people infected and directly affected by HIV. NLT has also been involved in creating media and informational materials that promote healthy living with HIV for GRN. Working with Positive Vibes, NLT has finalized content for a PHDP/PWP community outreach toolkit over the past year. The toolkit consists of a series of comprehensive resource sheets, brief fact sheets (as IEC materials) and flipchart sessions on the larger topic areas.

During the period under review, a pilot project that targets HIV prevention interventions for HIV positive patients was commenced at Katutura, Oshakati, Outapi and Swakopmund. The pilot amongst others evaluates the impact of interventions on HIV patients' sexual risk behavior, alcohol use, unintended pregnancy as well as the delivery of services at the intervention sites. During the reporting period, the different working groups addressing different drivers of the epidemic to ensure desired outcome and output result of social and behavior change have been operating and reporting to TAC prevention.

Training of health worker in regions other than those participating in the study started and this enabled the roll-out of the PWP prevention toolkit intervention to get implemented in all the regions. The training for community counselors both were also conducted in the Kavango region during the reporting period.

3.1.6 Medical Male Circumcision

3.1.6.1 Piloting Medical Male circumcision in Namibia

Medical Male circumcision is a novel strategy in the Namibia AIDS response that is expected to contribute greatly towards achievement of the prevention goal of reducing the annual number of new HIV infections by 50% by 2015/16. The Voluntary Medical Male Circumcision (VMMC) programme was still at the pilot phase during period under review. During 2010/11, 2622 circumcisions were carried out in the pilot sites compared to 262 in 2009/10. The number of sites has increased from 3 by March 2010 to 19 by February 2011. Training of Health workers (Doctors and Nurses) at the sites is on-going. There are waiting lists but the demand is yet to pick up. Over 95% of those receiving the VMMC service tested HIV negative.Ten dedicated MC staff was recruited and assigned to regions. These were 10 registered nurses and 4 medical officers. The regions assigned with nurses are Omusati, Oshana, Oshikoto, Ohangwena, Otjozondjupa, Kavango, Omaheke, Hardap, Erongo and Khomas, while five of these regions are covered with medical officers, thus have a complete MC dedicated team.

3.1.6.2 Creating demand for Voluntary Medical Male Circumcision

NLT has produced a communication strategy and two IEC pamphlets in 4 local languages: a general information leaflet and client pamphlet outlining what male circumcision entails as well as the benefits thereof.

Challenges

- There is still very low coverage of voluntary medical male circumcision and at this rate the target of 450,000 circumcisions by 2015/16 is unlikely to be achieved.
- Human resource capacity for voluntary medical male circumcision is in adequate and needs to be increased.
- The M&E system is yet to be developed following the pilot phase

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

Indicator	2006/07	2009/10	2010/11	NSF Target 2015/16
UA & Global 3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission[8]	42%	77%	90%	95%
Global 3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	36%	59%	60%	85%
Global 3.3 Percent MTCT rate	25%	16%	12%	4%

3.1.7.1 Availability of Services at Health Facilities in 2010/11

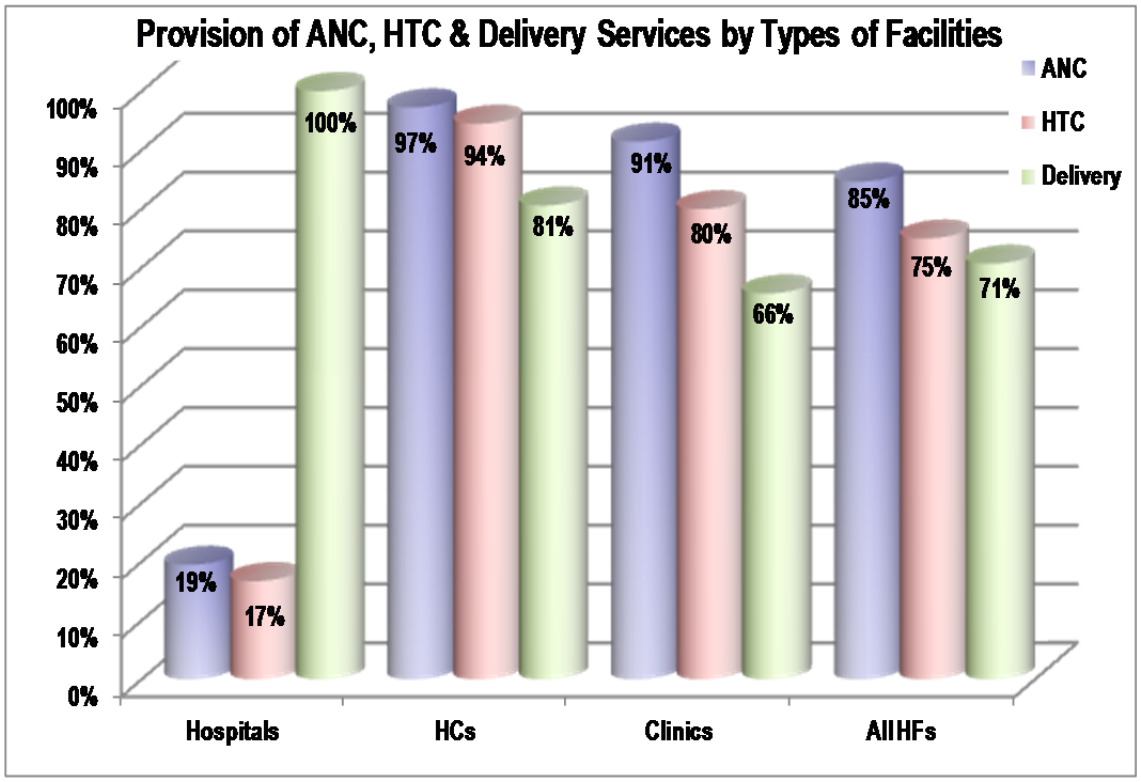
Out of the 36 hospitals registered in the national PMTCT database, all (100 percent) reportedly provided delivery services but only 7 (19 percent) provided antenatal care services and 6 (17 percent) provided HIV testing and counselling services within the context of PMTCT (Figure 7).

Out of the 36 health centres registered in the national PMTCT database, 35 (97 percent) reportedly provided antenatal care services; and 34 (94 percent) provided HIV testing and counselling within the context of PMTCT. In addition, 29 (81 percent) of the health centres provided delivery services;

Out of the 279 clinics registered in the national PMTCT database, 255 (91 percent) reportedly provided antenatal care services; and 223 (80 percent) provided HIV testing and counselling services within the context of PMTCT. In addition, 183 (66 percent) of the clinics provided delivery services in the same period.

[8] Denominator used is the high bound estimates of PMTCT in need as obtained from Spectrum 4.392 (2011)

Figure 7: Provision of ANC, HTC & Delivery by Types of Facilities



(Source: National PMTCT Database)

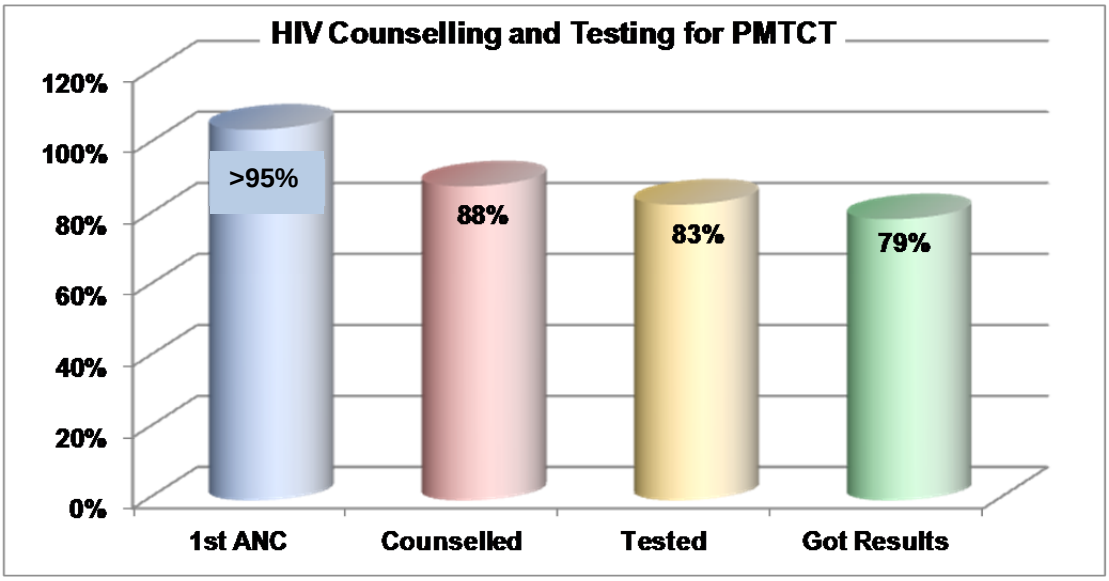
3.1.7.2 Access to ANC Services in 2010/11

The majority of clients who accessed antenatal care services (81 percent) were aged 20 years and above. Approximately 18 percent of all the 1st ANC clients reportedly came during the first trimester and 65 percent during their second trimester of pregnancy.

3.1.7.3 Coverage of HTC for PMTCT

As illustrated in Figure 8, out of all the estimated number of pregnant women in the country during 2011/11, >95% percent made the first antenatal care visit. Approximately 88 percent of the estimated total number of women in the country were counselled on HIV; 83 percent got tested and 79 percent got their HIV results. However, when the clients who came with known positive HIV status was taken into consideration, then about 97 percent of the women were counselled; 92 percent tested for HIV and 88 percent received their HIV results.

Figure 8: Coverage of HTC Services in 2010/11



(Source: National PMTCT Database)

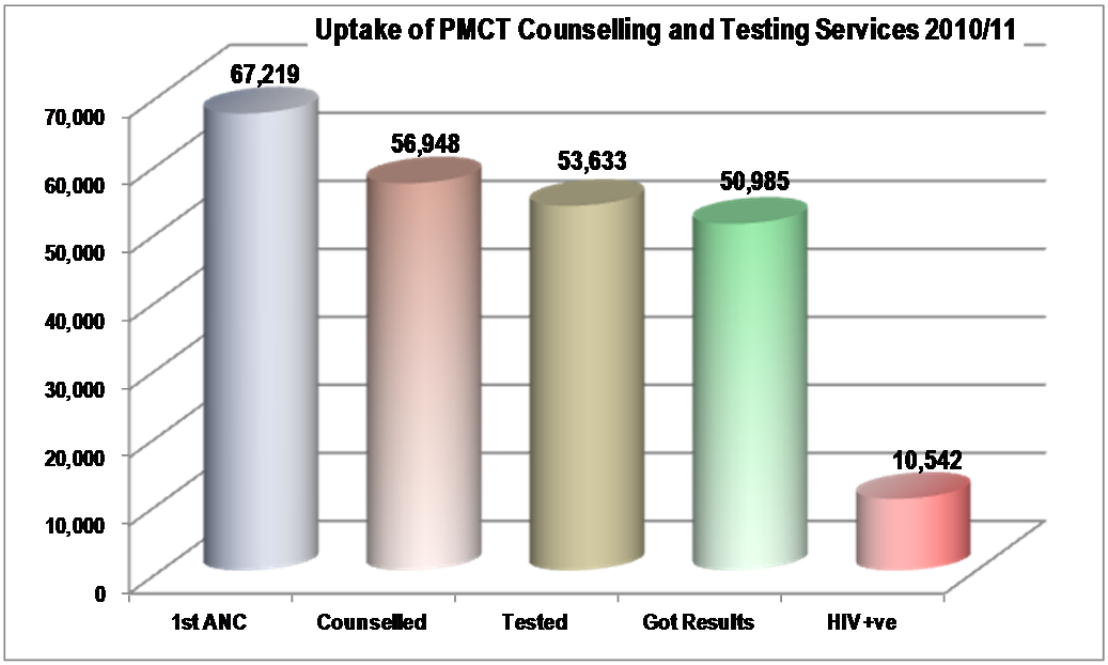
3.1.7.4 Uptake of HCT for PMTCT in 2010/2011

As illustrated in Figure 9 below, there were 67,219 pregnant women who made the first antenatal care visit during the year 2010/11 at health facilities that provided PMTCT services. Out of that number, 56,948 (85 percent) were offered pre-test counselling for HIV. During the reporting period, 5,497 pregnant women reportedly presented with a known positive HIV status and required neither pre-test counselling nor HIV testing. When this number was taken into consideration, 92 percent of the eligible pregnant women received pre-test counselling.

Out of the 56,948 pregnant women who got counselled, 53,633 (94 percent) accepted to be tested for HIV. Of these, 50,985 (95 percent) got their HIV results.

There were in total 10,542 HIV positive pregnant women identified through the PMTCT programme, which translated to overall prevalence of about 18 percent (out of 53,633 tested plus 5,497 of known HIV positive status). However, among the 53,633 who were newly tested in 2010/11, there were 5,045 HIV positive women (9.4 percent).

Figure 9: Performance of HTC within PMTCT in 2010/2011



(Source: National PMTCT Database)

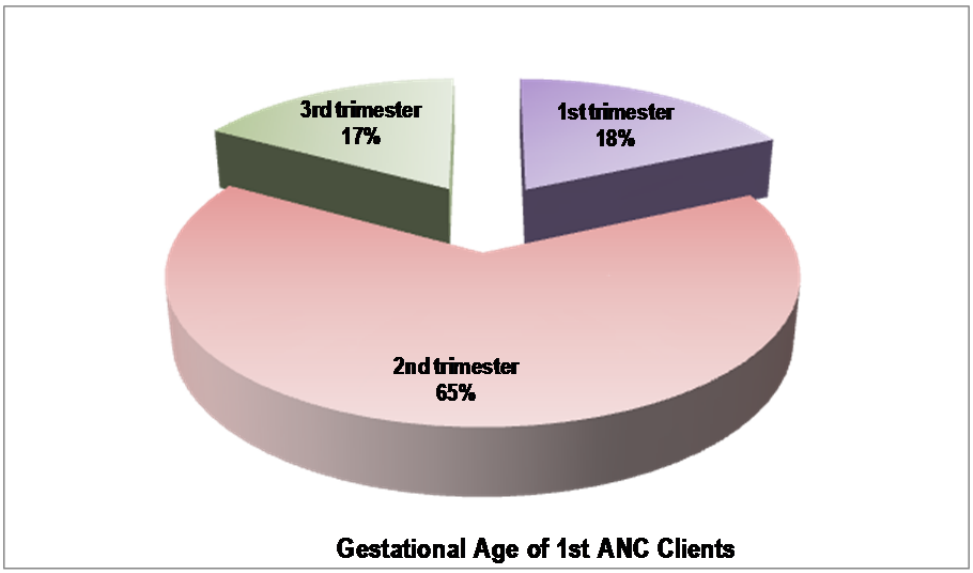
Uptake of ARVs for PMTCT in 2010/11

There were 9,304 HIV positive maternity clients in 2010/11 (18 percent of all the deliveries) and of these, 8,864 (96 percent) reportedly received ARVs for PMTCT (Figure 10). Using the high bound estimates of in –need of PMTCT from the Spectrum 2011 model, the coverage is 90%.

During the same period, 9,010 HIV exposed infants (97 percent) received antiretroviral prophylaxis for mother-to-child transmission of HIV. The majority of infants were on the nevirapine-based regimen.

Only 18%, start first ANC visits by the first trimester posing a challenge for PMTCT prophylaxis that requires to be started by 14 weeks (Figure 11).

Figure 10: Disaggregation of 1st ANC Clients by Trimester



(Source: National PMTCT Database)

3.1.7.5 Regional Magnitude of HIV among Pregnant Women in 2010/11

The regional HIV prevalence based on the 2010 National HIV Sentinel Survey revealed that Caprivi had the highest prevalence among antenatal women at 35.6 percent while Hardap had the lowest at about 10.2 percent. The six regions with HIV prevalence higher than the national average of 18.8 percent included Khomas (20 percent), Ohangwena (20.1 percent), Omusati (22.0 percent), Oshikoto (24.2 percent), Oshana (25.1 percent) and Caprivi. The 2010/11 PMTCT data revealed 5 regions with prevalence above 18.8 percent namely: Ohangwena (19 percent), Omusati (19 percent), Oshana (21 percent), Oshikoto (22 percent) and Caprivi (30 percent).

Out of all the HIV infected pregnant women identified in the country under PMTCT in 2010/11, 20 percent were from the six regions that accounted for the lowest burdens of HIV namely: Hardap (2 percent), Kunene (2 percent), Omaheke (2 percent), Karas (3 percent), Erongo (5 percent) and Otjozondjupa (6 percent).

3.1.7.7 DNA-PCR Tests for the HIV Exposed Infants in 2010/11

HIV DNA PCR testing was introduced by MoHSS end of 2005 in collaboration with partners and by March 2011, 224 (66%) health facilities were submitting DBS samples for DNA PCR.

The percentage of children that received virological testing for HIV within two months was 60% in the reporting period. The target is to have a coverage of 85% by 2015/16 which should be achievable.

3.1.7.8 Challenges

- Human Resource shortages that can be addressed through task shifting
- Prong 1 and 2 are not emphasised
- Poor male participation in PMTCT with only 3% of partners accepting to test
- Poor community mobilization for PMTCT
- Follow-up of HIV positive mothers and HIV exposed babies is still weak
- Quality of M&E (timeliness, completeness and harmonization of tools and capacity) is not good
- Late booking of pregnant women for first ANC visit

3.1.7 Post Exposure Prophylaxis

Post-exposure prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. Within the health sector, PEP should be provided as part of a comprehensive universal precautions package that reduces staff exposure to infectious hazards at work. Even facilities that do not officially offer HIV/AIDS services should have access to PEP. Data from the Namibia Health Facility Census (NHFC), PEP for staff was available at 81% of all facilities. A facility is regarded as having access to PEP if it provides PEP services to staff or refer staff elsewhere for those services. Of those facilities offering PEP, 96% had PEP guidelines while 12% had any record or register observed ad ARVs for PEP was observed in 28% of the facilities *(MOHSS, 2009:378).*

3.1.8 Prevention of Sexually Transmitted Infections (STIs)

During the period under review, the STI curriculum was reviewed after two years of implementation. The purpose of the review was to update the curriculum and also to change what was not working well during the implementation period. During the

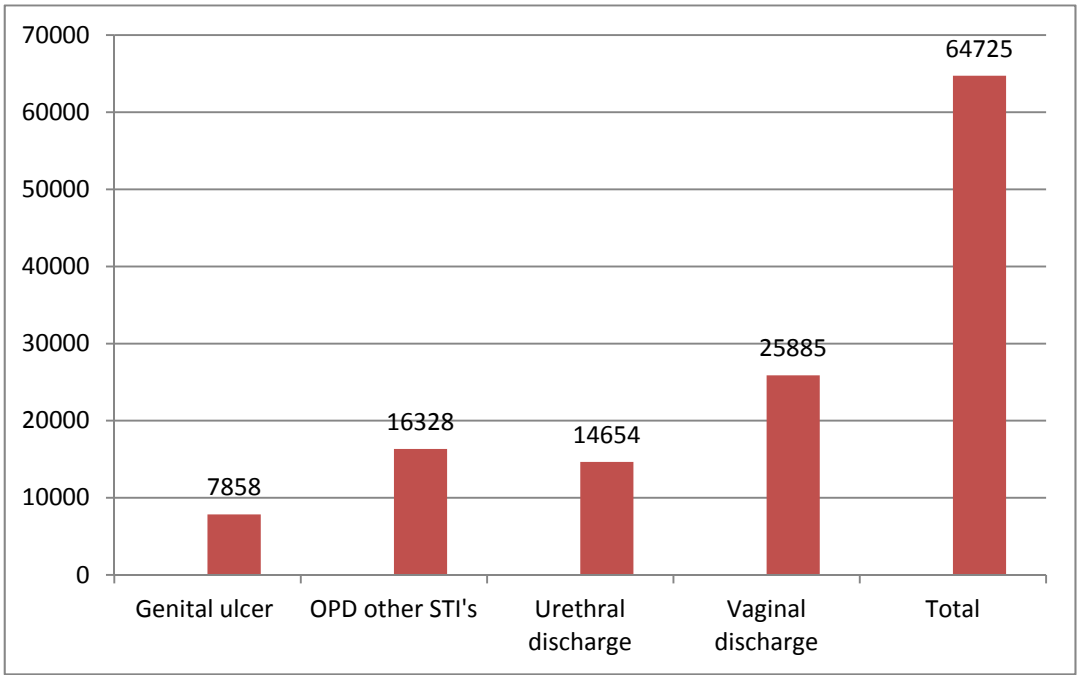
same period, the Cervical Cancer curriculum was also finalized and trainings were conducted. Pap smear register were reviewed to incorporate important information e.g. HIV testing etc.

A training of trainers (TOT) for cervical cancer was conducted; seven trainers were trained to be able to train other HWs. In total, 251 HWs comprised of 20 Doctors, 216 nurses, two Pharmacists and 13 Pharmacist Assistants were trained in syndromic management of STIs during the reporting period (Table 2). Seventy one nurses are trained in cervical cancer screening and training is still continuing in the last quarter to meet the target of 64 per annum.

Table 2: Number and category of HCW trained in STIs and Cervical Cancer Screening

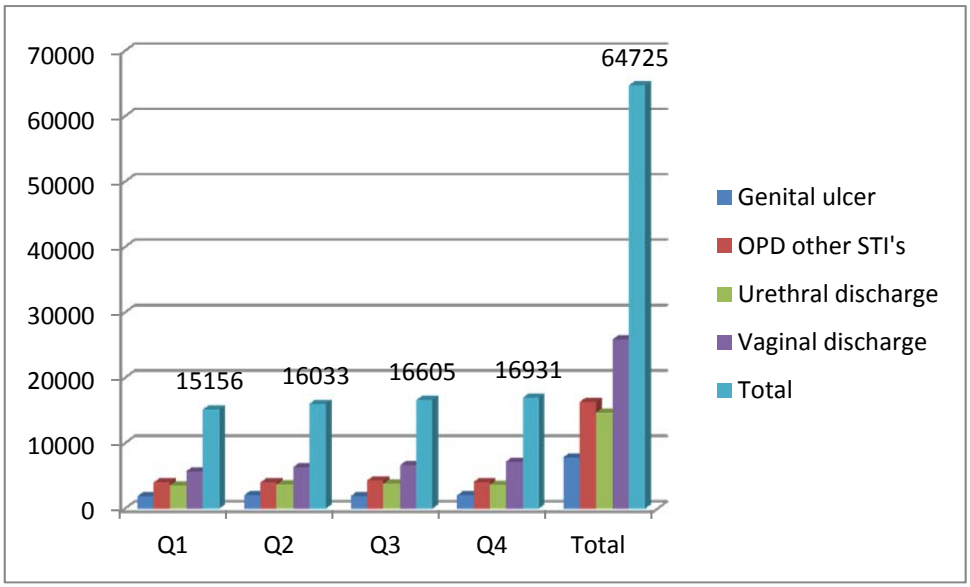
Type of Training	Doctors	Nurses	Pharmacist	Pharmacist Assistants
STI training	20	216	4	13
Cervical Cancer	0	71	0	0
TOTAL	**20**	**216**	**4**	**13**

Figure 11: STI's reported during the year 2010/11



Approximately 64,725 STI's were reported during the period under reporting (Figure 12). Of this STI's, majority (40%) were diagnosed with vaginal discharges while only 12% were diagnosed with Genital ulcer. Of the number of STI's reported; only 7 921 (12%) had their partners being referred.

Figure 12: STI's reported per quarter

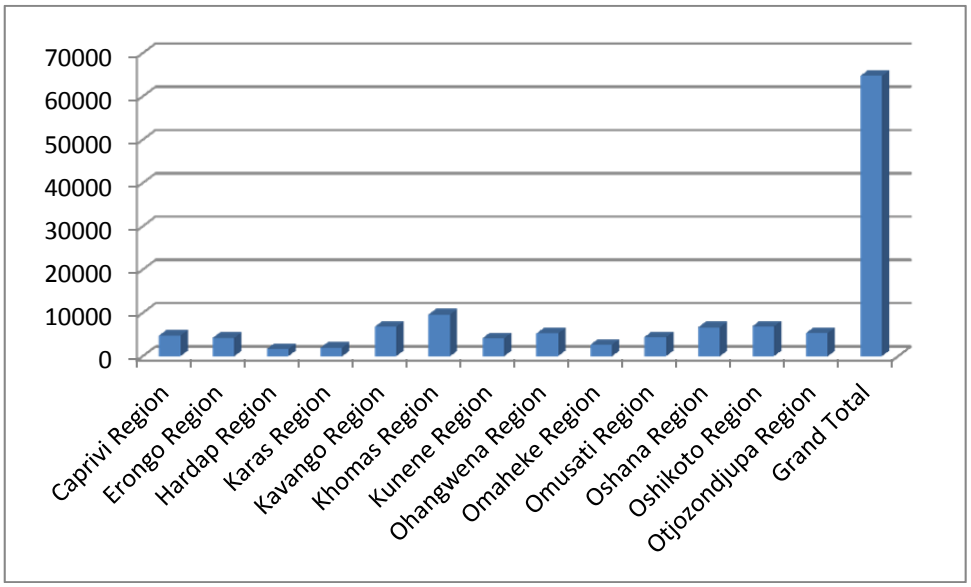


There is no significant difference in the number of STI's reported per quarter (Figure 13).

Table 3: Reported STI's per Region

Caprivi Region	4770
Erongo Region	4265
Hardap Region	1671
Karas Region	2005
Kavango Region	6796
Khomas Region	9661
Kunene Region	4172
Ohangwena Region	5265
Omaheke Region	2683
Omusati Region	4428
Oshana Region	6716
Oshikoto Region	6896
Otjozondjupa Region	5397
Grand Total	**64725**

Figure 13: STI's per region



Khomas had the highest STI diagnoses (15%), followed by Oshikoto with 11% and Kavango (10%) while the lowest was reported in Hardap region (3%) out of the total number of STI's reported in all the regions (Table 3 and Figure 14).

STI, IEC Materials disseminated to Health Facilities

Information, Education and Communication (IEC) materials were adopted form the STI guidelines and 1,300 wall charts (algorithm for the three main syndromes) were printed and distributed to the facilities. Laminated algorithms for training purposes produced and HCW can put them on their desks for reference. 1500 Partner referral slips were printed and distributed to all 13 regions

STI surveillance

A new surveillance tool has been finalized and the curriculum for training HWs will be developed in the next financial year with subsequent trainings in the identified sentinel sites

Supervisory visits conducted

The programme officers conducted supervisory support visits to all 13 regions during the period under review. Issues on proper diagnosis and treatment of STIs were addressed as well as identifying training needs for health workers in the area of STI management.

3.1.8 Blood Safety

During 2010/2011 46 hospitals were provided with blood and blood products from 31 hospital blood banks. The 13 largest blood banks provided fully cross-matched blood whenever possible, while the balance provided ABO identical blood or Group O blood only. The three largest blood banks were operated by NAMBTS, one private

hospital had its own hospital blood bank and the balance were operated by NIP. Table 4 shows the results of infectious disease testing of donated units from 2006 to 2010. 100% of the units were screened in 2010 and only 0.13% were HIV+ indicating an efficient selection of donors.

Table 3: Reactive results for Transfusion transmissible infections (TTI) per year

Marker	2006	2007	2008	2009	2010
Syphilis	0.21%	0.30%	0.38%	0.20%	0.50%
Hepatitis C	0.12%	0.17%	0.16%	0.10%	0.80%
Hepatitis B	0.92%	1.47%	0.90%	0.80%	0.10%
HIV	0.45%	0.59%	0.38%	0.60%	0.13%

Achievements

- Compatibility testing has been strengthened through the introduction of an improved cross-match procedure at all blood banks, a change that involved the extensive re-writing of procedures and the re-training of staff.
- A policy is being implemented for handling blood collected in areas where malaria is present, and for donors visiting these areas.
- Several policies have been developed for the implementation of the National Blood Policy, including:
  - A Quality Management System for the National Blood Programme
  - A code of ethics and professional conduct for the National Blood Programme
  - A policy for defining the level of blood service to be provided to the hospitals in Namibia
  - Guidelines for the management of health care risk waste
  - A haemovigilance policy
- In the period under review a total of 21,899 units of blood were collected from 11,691 different donors, of which 51% were males and 49% were females
- During 2011 NAMBTS published a second national “Haemovigilance Report” for Namibia, covering the period 1 April 2009 to 31 March 2010. This reports in detail on adverse reactions experienced by blood donors and also the by recipients of blood and blood products.

Challenges

- Many health facilities in the country have inadequate storage space for banked blood, and continue to use regular refrigerators for blood storage.
- Adverse events after transfusion are not always reported to NAMBTS. This should improve when the haemovigilance policy is fully implemented.
- Because of the high usage of group O blood for emergency use, there is a need to collect a higher proportion of group Os that are present in the general population. Although this can be quite difficult to achieve without offending

donors of other blood groups, and without turning away donors who present themselves at blood drives, it is a necessary step to reduce wastage.

3.1.10 Universal Precautions

Universal Precautions are designed for preventing the transmission of blood-borne diseases such as human immunodeficiency virus, hepatitis B, and other blood-borne pathogens when first aid or health care is provided. Under Universal Precautions, blood and certain body fluids of all patients are considered potentially infectious. The Precautions include specific recommendations for use of gloves, gowns, masks, and protective eyewear when contact with blood or body secretions containing blood is anticipated

Of the 396 facilities assessed during the 2009 Health Facility Census, 82% of the facilities had sharp boxes and two thirds of all facilities have adequate final waste disposal system (*MOHSS, 2009:50).* This implies that waste is collected and disposed of externally, incinerated in the facility of burned in a protected area or pit or dumped in a protected area and there is no unprotected infectious waste observed in any service site. Percentage of facilities observed with guidelines for disinfection and sterilization in any assessed sterilization area was 5%.

3.2. Treatment Care and Support

The number of AIDS related deaths is estimated to be decreasing rapidly mainly due to the rapid scale up of Highly Active Antiretroviral Therapy (HAART) for the health of those in need. The estimated number of annual AIDS related deaths has decreased from over 12,000 in 2005/06 to less than 4,500 in 2010/11 and is projected at the current rate to reduce further to about 3,160 in 2015/16.

3.2.1 TB/HIV Co-Infection and other opportunistic infections

Indicator	2006/07	2009/10	2010/11	NSF Target 2015/16
National Percentage of TB patients with known HIV status	34%	74%	93%	95%
Global 5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	N/A	35%		95%

Cotrimoxazole and INH prophylaxis is readily accessible in all public health facilities country wide. There has been a continuous supply of CTX and INH during the reporting period (Regional Technical Supervisory support visits report 2010). Increased access to ART and opportunistic infections (OIs) prophylaxis has made remarkable impact in the reduction of death among PLHIV and admission due to HIV related diseases (HIS 2010).

Latent TB therapy (Isoniazid Preventative Therapy (IPT)) is given to all eligible HIV-positive persons who are not yet infected with TB. During the period under review, there has been great achievement in the uptake of IPT which is mainly due to the training of health care workers on the implementation of the 3"I"s. The target for 2010/11 was 1,350, but due to an anticipated effect of the training, the number of eligible HIV-positive patients starting treatment of latent TB infection (IPT) was 8,857.

Namibia faces a high burden of both HIV and TB and has an HIV/TB co-infection rate of almost 60%. TB remains the leading cause of morbidity and mortality among HIV infected patients in Namibia. The established TB/HIV technical working group is coordinating TB/HIV activities. Trainings for health care workers on co-management of HIV and TB for private and public sector have been conducted. Components in both ART and TB national guidelines have been revised as well as training curricular to conform to the latest WHO recommendations.

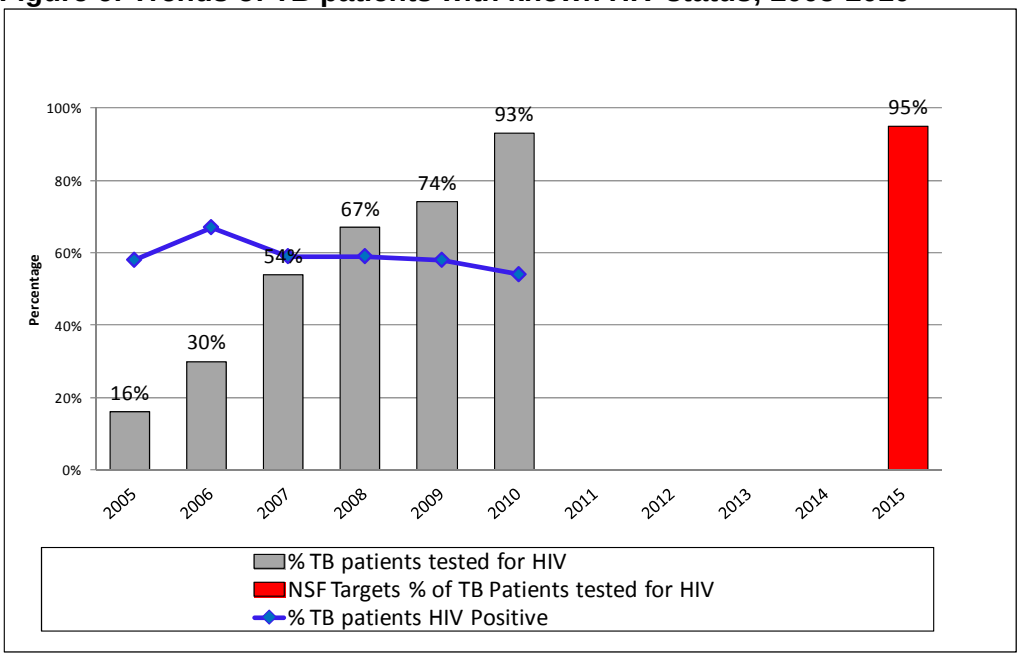
Opportunistic Infections Prophylaxis is readily available at all health centers including clinics. Provision of Cotrimoxazole prophylaxis to eligible client's coverage remains at 100%. The assessment report on the implementation of TB/HIV Collaborative activities, conducted by DSP and a Consultant from the Tuberculosis Control Assistance Program (TB CAP) in March 2010, recorded an improvement in IPT

provision. Base on HIVQUAL data of 32 facilities the IPT coverage where 25% which show a slight decrease by 5% from 30% reported in 2009/2010 report base on 16 pilot sites. This has been affected by the roll-out of HIVQUAL to more ART facilities and currently 37 facilities are implementing HIVQUAL.

TB/HIV Co-management

Management of TB/HIV co-infection is a high priority for Namibia as there is a high co infection rate. Efforts are being made to make sure that all TB patients have known HIV status, and the proportion of TB patients tested for HIV has increased from 16% in 2005 to 93% in 2010 (Figure 16), and 54% of these were HIV positive. The NSF target 2015/16 for percentage of TB patients tested for HIV is 95% and has almost been achieved. Co-management of these cases is being expanded as evidenced by the fact that 48% of them were on Cotrimoxazole preventive therapy while 24% were on antiretroviral therapy.

Figure 6: Trends of TB patients with known HIV status; 2005-2010



Challenges

The M&E system is not capturing IPT adequately and outcomes of patients on IPT

3.2.2 Anti Retroviral Therapy

Indicator	***Dis aggregatio***	2006/07	2009/10	2010/11	NSF Target
UA & Global 4.1 & MDG Percentage of eligible adults and children currently receiving antiretroviral therapy	***Adults***	56%	88% (CD4	67% (CD4	95%
	Children	88%	>95% (CD4 200)	75% (CD4 350)	95%

Global 4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	***Adults***	69%	80% (Jan-Dec 2010)	81.5%	90%
	Children	82%	82% (Jan-Dec 2010)	83.9%	95%

By March 2011, the percentage of people on ART still alive and on treatment 12 months since initiation was 81.7%; 83.9% (Children 0-14 years) and 81.5% (Adults 15+ years) (Table 5). The national target for 2015/16 is 90% for adults and 95% for children. Females showed a slightly higher survival rate of 83.2% compared to males at 79.4% (Table 6).

Table 4: Percentage of people on ART still alive and on treatment at 12 months since initiation by age group (Adults 15+ and Children 0-14)

Age Group	Alive_12 months
0-14	83.9%
15+	81.5%
Grand Total	**81.7%**

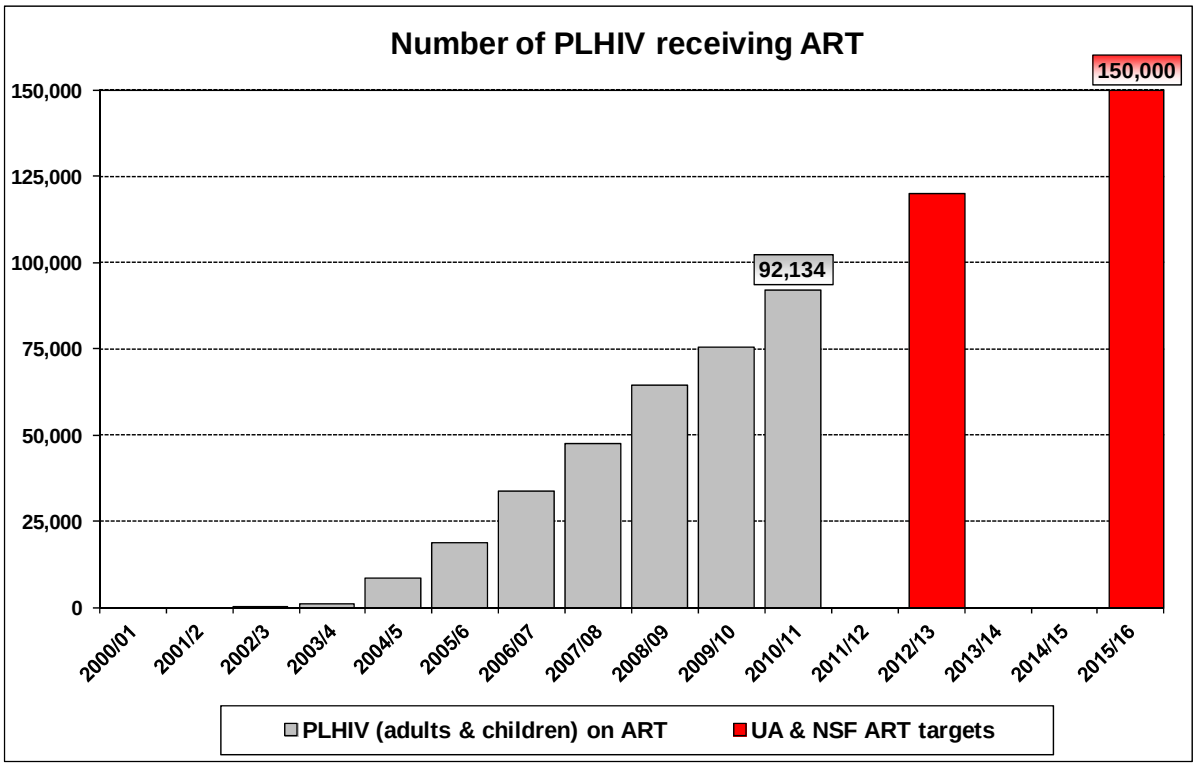
Table 5: Percentage of people on ART still alive and on treatment at 12 months since initiation by sex and age group

Sex	Age Group	Alive_12 months
Female	0-14 years	83.3%
	15+ years	83.2%
Female Total		83.2%
Male	0-14 years	84.5%
	15+ years	78.8%
Male Total		79.4%
Grand Total		**81.7%**

There continues to be a rapid scale up of ART services in Namibia (Figure 16). Over the past 12 months the numbers of people on ART increased by 16,453 between April 2010 and March 2011 compared to 11,044 between April 2009 and March 2010. This may be explained by the effect in the change in ART guidelines during the period under review with patients who had been enrolled into Pre-ART being started on ART. By March 2011, **92 134** people were receiving ART in the public sector while 56,835 were on pre-ART. This translates into a coverage of HAART of 74% using a CD4 count of 350 Spectrum high bound estimates of in need with 75% for adults and 67% for children. Of those on ART, 59% were female adults, 31% were male adults, 4% were male children aged 5-14 and 4% were female children aged 5-14 while 1% were male children under 5 years and another 1% were female children under 5 years (Table 7 and Figure 17). Therefore, in total there were 33 020 males representing 35.8% while 59 114 (64.2 %) were female. Progress made to the scale-up of ART services has largely been attributable to the mobilisation of resources from international partners such as the Global Fund and PEPFAR.

A major concern however is related to human resources, as scale-up will result in health workers being over-burdened and may compromise their ability to deliver quality ART services.

Figure 14: Total number of patients on HAART Nationwide in Public System, March 2004- March 2011



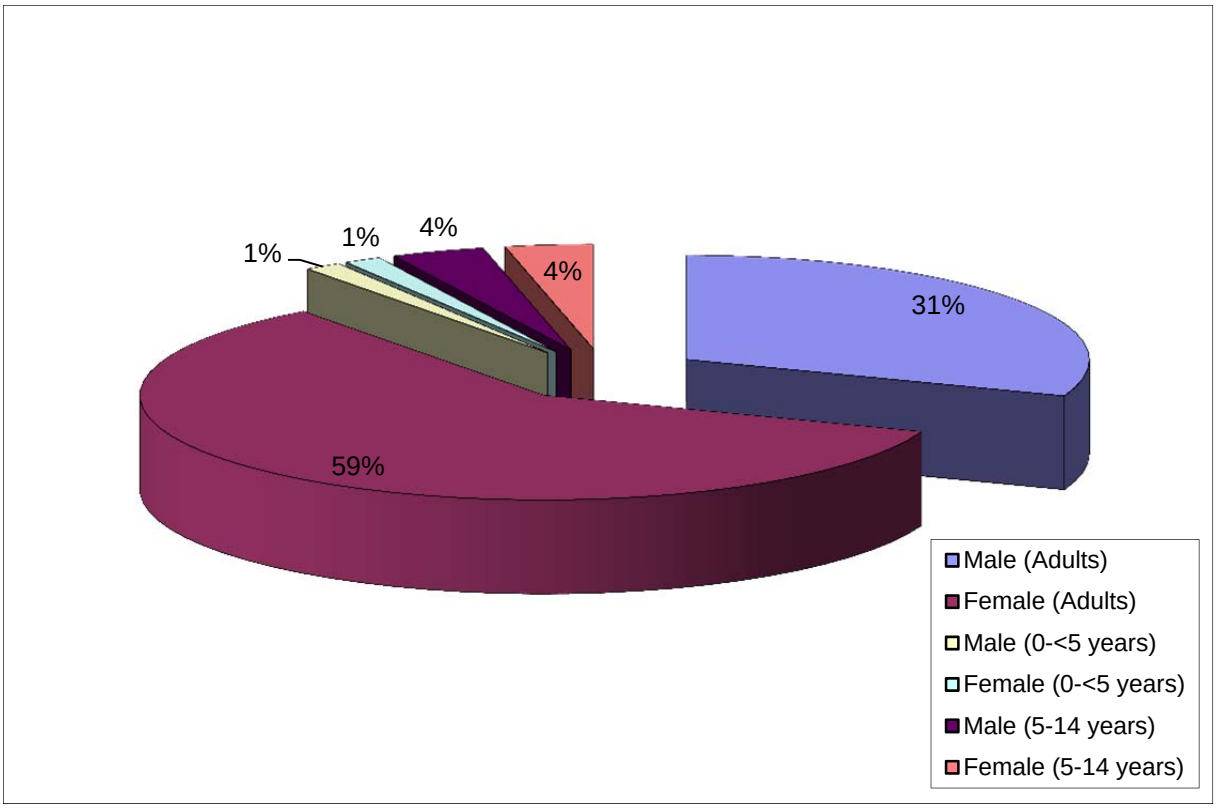
Source: ePMS DSP MoHSS 2011

Table 6: Number of patients on ART in public facilities by age category and sex as at 31st March 2011

Age Sex Category	Number	Percent
Male (Adults)	28250	31%
Female (Adults)	54523	59%
Male (0-<5)	1342	1%
Female (0-<5)	1364	1%
Male (5-14)	3428	4%
Female (5-14)	3227	4%
Total on HAART	**92134**	

Source: ePMS DSP MoHSS 2011

Figure 15: Percentage of patients by age category and Sex on ART in the public facilities as at 31st March 2011



Source: ePMS DSP MoHSS 2011

In addition to the public facilities providing ART, the Private sector also provides treatment specifically to patients that have medical aid. Patient registered with afa as of June 2010 were 1882. Of these patients, 1103 were males while 779 were female. The patients receiving ART under afa – a medical aid that covers patients from NHP, NAMDEB and Renaissance were 1654 as of June 2010, 16 of these patients were on PMTCT. Another medical aid administrator, Methealth had 1006 patients on ART as of June 2010 while 28 patients have received ARV prophylaxis for PMTCT.

3.2.3 Care and Support

Activities in this component range from complementing and enhancing prevention, to improve quality of life, maintain the working capacity of people infected and affected by HIV, decrease the social impact of AIDS, and prevent the secondary spread of infectious diseases like tuberculosis.

Challenges

- Higher turnover of volunteers due to lack of incentives
- Inconsistent reporting by some of the implementers to the regional council
- Lack of funds for Civil Society organizations to implement their activities
- Some of the institutions have workplace policy but no implementation takes place
- Unreliable future funding

3.3. HIV Impact Mitigation

3.3.1 Care and Support for OVC

Indicator	***Dis aggregatio***	2006/07	2009/10	2010/11	NSF Target
Global 7.3 & MDG Current school attendance among orphans and among non-orphans aged 10–14	***Ratio***	1	N/A	N/A	1
National Number of children receiving welfare grants	***Number***	65,000	109 000	124,351	160,000

3.3.1.1 Psychosocial Support provision to OVC

The Ministry of Gender Equality and Child Welfare (MGECW) has two centres that provide psychosocial support to OVC, as well as regional Social Workers. Those centres are Namibian Children's Home which is located in Eros and After School Centre located in Katutura. During the period under review, 2114 children received psychosocial support from the MGECW in all 13 regions.

Challenges

- Insufficient funds to support the support groups engaged in the IGA
- Insufficient nutritional support for people on ART treatment

Residential Child Care Facilities (RCCF) Caring for OVC
Thirty-six (36) Residential Child Care Facilities out of forty (43) were visited and through RCCFs Networks and 34 developed action plans. During the period under review, there were 17 registered RCCFs with 729 children and 26 unregistered ones with 533 children

Residential Child Care Facilities Network
Residential Child Care Facilities Network (RCCFN) is a recognized support network in pursuit of meeting the Minimum Standards through peer to peer trainings, sharing of uncommon resources, and facilitation of access to essential government and community services. This network is comprised of the MGECW and civil society organizations. The network is ensuring that Residential Child Care Facilities work together to provide the highest quality of care for children in these settings - working together dynamically and providing each other with peer support.

During the period under review, 6 RCCFN secretariat members, including the MGECW, were equipped with facilitation and mentoring skills in a quest to coach peer RCCFs in adopting standards. After the training, the network began the roll out of the standards and visited 36 RCCFs. 78 RCCF managers and staff were mentored on the minimum standards and 34 out of the 36 RCCFs visited developed action plans to address findings of the mentoring visits.

Child Friendly Versions on RCCF

A competition to develop a storyline on a Child Friendly Version Minimum Standards was launched in the reporting period. The guidelines for the competition were developed. Forty RCCFs are participating in the competition. The winning storyline will be used to develop a comic book for children in RCCFs. MGECW and Pact staff simplified the language of the Child Friendly Version (CFV) RCCF standards and current supporting the development of the storyline through a competition

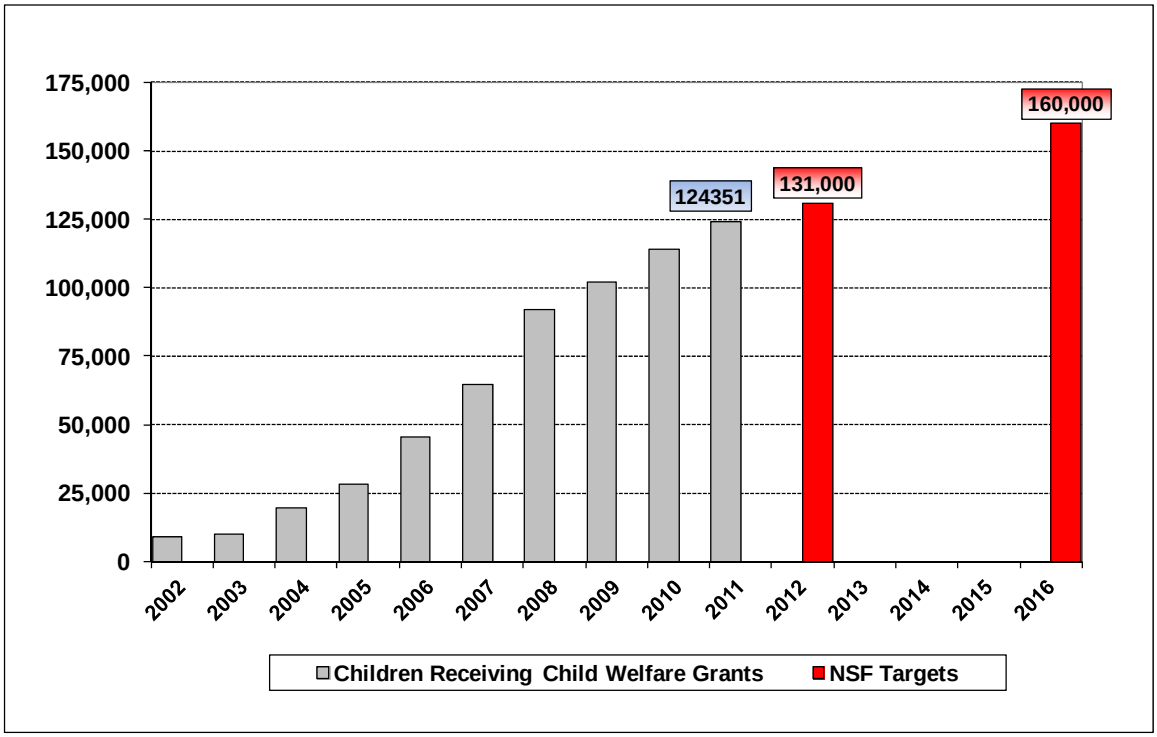
3.3.1. 2. Social Welfare Grants and Subsidies

There are different types of Social Welfare grants offered by the Child Welfare Directorate in the MGECW:

- Maintenance grants
- Special maintenance grants (Disability grants for children under 18)
- Foster Care grants

There are also subsidies provided to children who are staying in registered Residential Child Care Facilities and who have been found in need of care and placed by Children's Court order. By March 2011, 124,351 children were receiving social welfare grants from the MGECW. At this rate, the target of 131,000 children by 2012/13 is likely to be achieved (Figure 18).

Figure 16: Number of children receiving welfare grants by year, 2002 to 2011



3.3.1.1 National Plan of Action for children

Development of the National Plan of Action for Children
The NPA serves an important purpose in coordinating the inputs of different ministries and stakeholders that benefit children in Namibia. It is also referred to in the development of other national planning tools and expresses a commitment to the well being of children.

The NPA for 2006-2010 came to an end and the Ministry is preparing for the development of NPA 2012-2016.

Given that 29 percent of children in Namibia are stunted (DHS 2006) and that 21 percent of learners in grade 1 in 2008 were repeating the grade, while the survival rate of learners to Grade 11 was only 38% (EMIS), and that the rate of orphan hood and vulnerability is still high although HIV prevalence is coming down, there is a huge inputs for a new NPA that is supposed to be more focused and responsive.

3.3.2.2 Legal instruments, policies and laws and strengthen International conventions on Children

Child Care and Protection Bill
Consultative meetings on reviewing the Child Care and Protection Bill (CCPB) were held. The bill was reviewed and changes made were to be incorporated and the bill was presented to the Cabinet Committee of Legislation (CCL). One of the major recommendations from the CCL is that the bill should be costed before to be tabled in parliament. The bill was costed in terms of human resources.

A final report on the revision of Namibia's Draft Child Care and Protection Bill that provides a summary of various forms of consultation undertaken was compiled and published. It provides a basis for future law reform processes and presents an excellent example of how to include children and the public in the law-making process.

3.3.3 Legal Rights and Protection Services for Vulnerable Persons

Regional and Constituency Child Care and Protection Forums
By March 2011, there were 6 regional and 52 constituency child care and protection forums established country wide (Table 8).

Table 7: Number of Regional and Constituency Child Care and Protection Forums by March 2011

Regions	Regional Child Care Protection Forums Established	# of constituencies per region	# of established Constituency Child Care Protection Forums
Caprivi	1	6	6
Erongo	0	6	2
Hardap	0	6	0
Karas	0	6	0
Kavango	1	9	7
Khomas	0	10	0
Kunene	0	7	0
Ohangwena	1	11	7
Omaheke	0	7	7
Omusati	1	12	12
Oshana	1	10	10
Oshikoto	0	11	1
Otjozondjupa	1	6	0
TOTAL	**6**	**107**	**52**

Challenges

- Inadequate human resources continue to be a challenge in most of the regions especially Social workers. This will be addressed by advertising of vacancies outside Namibia and getting financial support for Social Work Students at UNAM.
- Inadequate logistics such as office space hampers service delivery.
- Co-ordination and monitoring (Child Care and Protection Forums and other regional structures) of services at regional level still needs to be strengthened.
- Outstanding Legislation on Children (Child Care and Protection Bill, Child Justice Bill) hampers service delivery.

Recommendations

Inadequate human resources continue to be a challenge in most of the regions especially Social workers.

- 13 interns were deployed into regions to assist social workers in executing duties.
- 19 social work students supported and will be bonded to work with the Ministry thereafter
- Aggressive recruiting strategy including looking beyond borders-Public Commission to be involved
- Regional career fairs are being held by Social Workers to market social work as a profession and motivate them to study.

The Child Care and Protection Bill is in advance process and it is expected to passed by the end of 2011.

Development of Communication materials for OVC Access to Critical Services

During the reporting period, the Ministry of Gender Equality and Child Welfare together with the Ministry of Home Affairs and Immigration with UNICEF Financial and Technical support developed communication materials for OVC to access critical services. The following materials were developed:

- A comic book on critical services for children in need in Namibia

- Leaflets on the following:
    - Services for Children in Need in Namibia
    - Caring for Children in Namibia
    - Child Welfare Grants in Namibia
    - Community Support for OVC
    - Education is Every Child's Right in Namibia
    - Registering Births and Deaths in Namibia
    - Protecting Children in Namibia

Materials were developed in 2009, printed in 2010 and disseminated from January 2011 across the country by the Child Welfare Directorate staff at regional and constituency level.

Soft copies of the above mentioned materials can be found on the Namchild Wiki Website "www.namchild.gov.na"

3.4 Response Management

3.4.1 Institutional Arrangement, Coordination and Management

National coordination

NAEC met once during the period under review. However, the Treatment, Prevention and M&E TACs were functional and met regularly on average once a month. NaCCATuM met quarterly to review reports and had adhoc meetings to address emerging issues such as Global Fund grant negotiations and reviewing new proposals totalling to 11 meetings between April 2010 and March 2011.

In September 2010 Namibia and USG signed a HIV and AIDS Partnership Framework in September 2010. The Framework is a 5-year strategic plan that will guide joint future investments. It's closely aligned with Namibia's National Strategic Framework on HIV and AIDS. Implementation of the Partnership Framework will be overseen by a multi-sectoral steering committee chaired by representatives of the two governments.

3.4.2 Enabling Policy and Legal Environment

Indicator	***Dis aggregation***	2006/07	2009/10	2010/11	NSF Target 2015/16
National Percent of women and men aged 15-49 expressing accepting attitudes on 4 questions about HIV	***women***	39%	N/A	N/A	70%
	men	36%	N/A	N/A	65%
Global 7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months		N/A	N/A	N/A	N/A

There has been high level commitment to the National AIDS response. H.E. President Pohamba while attending the UN MDG summit in New York in September 2010, committed to ensure that in Namibia no child should be borne with HIV and no women should die while giving birth.

Namibia lifted HIV-related travel restrictions as of 1 July 2010. Community outreaches related to Gender Based Violence were conducted in Caprivi and Ohangwena by NRCS.

3.4.3 Capacity Development

The total number of different cadres working on HIV and AIDS recruited annually has been steadily increasing from 581 in 2007/08 to 722 in 2010/11 (Table 9). However, with declining donor support the trend may change unless government steps in.

Table 8: Total Number of staff recruited since 2007

Job Category	2007/2008	2008/2009	2009/2010	2010/2011
Medical Officer	7	11	13	11
Registered Nurse	32	65	96	107
Enrolled Nurse	247	163	101	145
Pharmacist/ Pharmacist Asst	7	11	5	2
Specialist	2	1	8	2
TOTAL	**295**	**251**	**223**	**267**
Other Categories	286	385	383	455
GRAND TOTAL	**581**	**636**	**606**	**722**

3.4.4 Enabling Policy and Legal Environment

Indicator	Dis aggregation	2006/07	2009/10	2010/11	NSF Target 2015/16
National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)		**Done**		**Done**	

3.4.4.1 HIV and AIDS Workplace Programmes

The Office of the Prime Minister (OPM) supported coordination of workplace programme in the Public sector. The outcomes were:

Outcome 1: Strengthened capacity of the HIV Units in government Offices, Ministries and Agencies (OMAs) to accelerate HIV and AIDS responses as outlined in National Strategic Framework. For this outcome the following outputs were realised:

- Workplace Programme has been rolled out to 26 OMAs
- Twenty (20) OMAs have Workplace Programmes (14 programmes and 6 drafts programmes)
- Six (6) OMAs with an action plan
- HIV and AIDS Units established in five (5) OMAs
- Five (5) Focal Persons has been appointed on a permanent basis to address HIV and Wellness issues

Outcome 2: Strengthened capacity of the HIV Unit within OPM to improve coordination of AIDS responses the Public Sector.

For outcome 2, the following outputs were produced during the period under review:

- A coordination strategy was developed and approved for managing the response
- A strategy for accelerating the response was developed
- Full unit is now established headed by a Deputy Director
- The established staff members has under gone Business Process Re-engineering (BPR) at the National Institute of Public Administration and Management (NIPAM)

Outcome 3: Strengthened the monitoring and evaluation system to track implementation of HIV and AIDS programmes in the public sector
As for outcome 3, the outputs for the period were:

- Quarterly Focal Person's meeting conducted to get and provide feedback on the response
- Quarterly reports are received from OMAs and the information is consolidated and submitted to Ministry of Health and Social Services
- Monitoring and Evaluation capacity building has been conducted for the OMAs
- Site level database system has been developed to be used by OMAs for data collection and storage
- A pilot survey was conducted in 2010/2011 to establish the success of Workplace Programmes in three (3) OMAs
- A bigger survey is planned to cover the whole Public Service in 2011/2012
- An assessment of the impact of HIV and AIDS on Public Service delivery has been conducted and the report has been produced

Outcome 4: Advocacy sessions conducted for OMAs to ensure implementation of the national strategy on HIV and AIDS in the public Sector.

One output was produced under outcome 4.

- Discussion sessions were held with 19 OMAs on site

Challenges
A successful workplace programme (WPP) needs an established structure, however out of the 28 OMAs only five of OMAS has structure in place and Focal Persons in some OMAs are not fulltime. Particular concern is that this issue has been ongoing since 2004. For the Public Sector response to HIV and AIDS to be effective, the matter needs to be resolved as a matter of urgency.

Further concern is that the majority of the OMAs do not have dedicated budgets for the implementation of HIV and AIDS programmes. For those that have HIV and AIDS budget their funds are quickly verimented for other purposes.

Management support still remains a challenge in some of the OMAs. Another key concern is the low positioning of Focal Person in the management structure of ministries.

Recommendations

- An assessment shall be conducted to determine the WPP status of the OMA'S in terms of the Mandate, Size, Budget and Workplace Progamme Activities.
- OMAs need to ensure inclusion of HIV and AIDS and Wellness issues in their Strategic Plans.
- Review the structure of HIV and AIDS Units in OMA's and level of full time HIV and AIDS Focal persons.

3.4.5 Resource Mobilisation and Management

Indicator	***Dis aggregatio***	2006/07	2009/10	2010/11	NSF Target
Global 6.1 Domestic and international AIDS spending by categories and financing resources (% domestic*)*	***Amount***	USD 130,000 ,000	USD 194 000\(20 08/9)	N/A	USD 305,000, 000
	domestic	50.80%	52%		70%

Global Fund

During the financial year 2010/2011 Namibia submitted a successful TB Round 10 funding proposal. However, there were protracted delays in the negotiations for the HIV RCC and the Round 10 grants and reduced disbursements during the reporting period.

PEPFAR

Namibia continues to receive significant support for its National AIDS Response from the United States Presidents Emergency Fund for AIDS Relief (PEPFAR). The approved FY 2010 funding totalled US$ 102 million. The planned use of FY 2010 funding represents an evolution in the vision and methods that underpin the planning, organization, and implementation of PEPFAR support for HIV/AIDS programs. In coming years, starting with FY 2010 funds, investments will be shifted to further strengthen Namibian capacity and ownership, especially in the areas of human resources, and the financing and operation of national healthcare systems.The USG and the Government of Namibia signed a PEPFAR Partnership Framework in September 2010.

Financial Sustainability

Following recommendations in the NSF 2010 to 2016, cabinet directed MoHSS to explore ways of sustaining the National AIDS Response. The urgency for addressing sustainability was been further exacerbated by challenges Namibia is facing with the Global Fund disbursements and reducing PEPFAR funding. In response the MOHSS has sought Technical Assistance from UNAIDS to propose alternative financing of the National response.

3.4.6 Monitoring and Evaluation, and Research

The Response Monitoring and Evaluation Division is responsible for the development, management, coordination, implementation execution of national policies, instruments, strategic plans and guidelines, which facilitate a harmonized response and support to all sectors (NGOs, CBOs, FBOs, private and public sectors and parastatals) in order to effectively respond to HIV and AIDS, STI, TB and Malaria related diseases so as to materialize the vision, mission and objectives of the National Strategic Plan on HIV and AIDS in Namibia and the Directorate of Special Programs.

An HIV M&E Advocacy and Communication strategy development workshop was held and the strategy was finalized. Monthly M&E committee meetings were held as planned. Meetings held for the reporting period amount to 9. 50,000 ART patient care booklets were printed during the reporting period. ART tools (patient care booklets, Registers, Cohort chart) reviewed and will be finalized next year. Data validation exercise between the ART Electronic Patient Monitoring System (ePMS) and the ART Dispensing tool was conducted during July and September. 170 ART Filing cabinets bought for facilities and were distributed to all the districts. During the second quarter, a consultant was recruited to review the SPM guidelines.

The protocol for a formative assessment, size estimation and Integrated Bio-Behavioural Surveillance Surveys for Commercial Sex Workers (CSWs) and Men having Sex with Men (MSM) was drafted and submitted to the Ministry of Health and Social Services Ethical Review committee and CDC Atlanta for approval. The HIV Sentinel Survey data collection was completed successfully, report writing completed, printed and the report was launched on **1 December 2010**.

RM&E led the process on the development of HIV M&E plan. The plan was successfully completed and it was submitted to peer reviewers for inputs before it was finally printed.

Reports and products produced

The following reports were produced during the report period:

- Universal Access report for 2010
- HIV ANC sentinel Surveillance report 2010
- Final MTP III 2009/10 progress report
- The Annual Integrated Action Plans (AIAPs) for HIV, TB and Malaria were completed and send to Geneva for comments and approval as it was a condition precedent. These AIAP’s were finalized
- National HIV M&E Plan
- SPM guidelines were reviewed and are finalized

- HIV M&E Advocacy and communication strategy
- Research and Evaluation Agenda

4. Best Practices

4.1 Political Leadership

H.E the President, Hifikepunye Pohamba has been at the fore front in advocacy for HIV Prevention, care and treatment. He officiated at the launch of the National Strategic Framework for HIV and AIDS 2010/11 to 2015/16 and the Report on the 2010 National HIV Sentinel Survey. At the PMTCT meeting at the UN MDG summit, H.E the President commited that in Namibia, no child will be born with HIV and no woman will die while giving birth.

Recognising the importance of male participation in ANC and PMTCT and the current low (3%) testing of male partners during ANC, the first lady Madam Penehupifo Pohamba, together with her husband launched a national campaign for male involvement in March 2011.

4.2 Supportive policy environment

Namibia has developed a Natinal Strategic Framework for HIV and AIDS 2010/11 to 2015/16. The NSF has set ambitious targets for 2015/16 and outlines the strategy and critical interventions to ensure that current gains are sustained and further scale-up and the MDG goals for 2015 are attained.

4.3 Scale up of effective HIV prevention programmes

Namibia recently revised its PMTCT guidelines in line with the 2010 WHO guidance by shifting ARV prophylaxis to a more effective regimen starting AZT from 14 weeks of gestation. The coverage of ARV prophylaxis has exceeded Universal Access targets and continues to increase.

The number of male condoms distributed per male aged 15 years and over per year increased from 18 in 2003/04 to 32 by 2009/10 which is amongh the highest in Africa.

4.4 Scale up of care and treatment and support programmes

The percentage of TB patients who know their HIV status has increased from 16% in 2005 to 93% in 2010.

ART coverage exceeded the Universal Access targets (90%) for 2010 based on the ART guidelines of a CD4 count eligibility threshold of <200/ cumm.

Namibia is scaling up the number of children receiving welfare grants and with 119,000 children receiving in 2010/11, the country is on course to achieve the ambitious target of 131,000 by 2012/12.

4.5 Monitoring and Evaluation

HIV ANC sentinel surveillance reports are produced every two years in time for the World AIDS Day. HIV estimates and projections reports are published when there are changes in the model and availability of new data e.g. HIV ANC data

5. Major Challenges, Successes and Actions to be taken

5.1. Major Challenges

HIV and AIDS remains the single most important public health and socio-economic development issue in Namibia.

The per capita expenditure per year of Namibia's HIV response was estimated at around US$ 100 in 2008/9 and projected to reach up to US$ 150 during the NSF period up to 2015/16 thus amounting to an HIV spending range of 2.5 – 3.0% of GDP per capita. This is considered high since other high prevalence countries typically report HIV-related spending in the range of 1.5-2.0% of GDP per capita. The high cost is partially explained by the primarily vertical nature of HIV programmes,

Namibia is facing limited capacity of domestic human resources both in terms of numbers and critical skills/expertise and therefore depends substantially on external funding and technical assistance to support core functions, processes and services for HIV and AIDS. In December 2010, the total number of donor supported positions in the Ministry of Health (clinical and non-clinical) was close to 1,500 valued at over 23.9 million USD per annum. In addition, there were 512 unfilled vacancies in the MoHSS for medical workers and the Ministry relies on foreign health care workers (mostly from the sub-region) to fill these in.
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PLHIV, young people and other vulnerable and key populations continue to face stigma and discrimination in their communities, workplace and when accessing public services. This negatively affects their psycho-social well-being and their capacity to access critical HIV prevention, treatment and care services.

5.2. Actions to be taken

5.2.1 Implementation of the new National Strategic Framework for HIV and AIDS 2010/11-2015/16

Namibia's new national strategic framework (NSF) outlines the path for the country to build upon recent success and continued scale-up of all elements of the HIV response by 2015/16. Efforts to ensure that the NSF is implemented as planned are required.

5.2.2 Revolutionising HIV Prevention

Namibia is currently investing in the generation and dissemination of HIV epidemiological and behavioral data as well as secondary analysis and synthesis of HIV data to inform HIV policy, plan and programme formulation. Data from these

strategic information generation exercises will be used to target HIV prevention efforts.

5.2.3 Sustainability at the Core of the Response

A sustainability strategy for the national AIDS response is under development. With support from UNAIDS, an assessment of options for alternative financing of the AIDS response has been carried out. Recommendations from the assessment include Public Sector mainstreaming, Private sector insurance, airline levy, increase private sector contribution, efficiency savings and creation of an HIV Trust Fund for extrabudgetary support for HIV and AIDS activities. A Human resource for Health committee was established to develop a strategy on transition of staff from the donor funded positions into Government positions.

5.2.4 Promoting Human Rights, Gender Equality and Social Transformation

There is the need to further strengthen the human rights approach in the response to AIDS and establish mechanisms to ensure that both public and private services are free of stigma and discrimination towards PLHIV and other vulnerable populations. A scale up is required of programmes addressing stigma and discrimination against PLHIV and key populations at risk as well as those targeting both women and men that address gender disparities, gender-based violence and social norms which increase vulnerability and weaken HIV prevention programmes. In addition, societal structures, beliefs and values that exacerbate poverty, gender inequality, inequity in health and education systems, should be addressed. Finally, there is a need to build on broad-based social movements, led by people living with HIV, affected communities, women and young people to demand for the necessary social and legal change to shift social norms that exacerbate vulnerability to HIV.

5.2.5 Taking Full Ownership of the Response

In order to take full ownership of the response there is the need to allocate adequate financial, human and technical resources to strengthen the institutional arrangements and systems for the efficient coordination, management of the response to HIV and AIDS to enhance national ownership of policy, resources and processes and to provide for adequate participation, resource mobilisation, mutual accountability and efficient planning, implementation and monitoring of the response.

There is also the need to strengthen alignment to national policies and harmonisation with national systems of financial and technical support by development partners. It is necessary to strengthen leadership across government, civil society, affected communities, scientists, trade unions, the media, faith-based organizations and the private sector by investing in new leaders, especially young people, who use inclusion and solidarity to drive coordinated partnerships and engage with the communities hardest hit. Finally, the participation of people living with HIV and those most at risk in decision-making and oversight mechanisms should be strengthened.

6. Support from Development Partners

USG PEPFAR

The planned funding from the United States Government for Namibia during the fiscal year 2010 was US$ 98 million. Of this, US$ 22 million was allocated to adult care and treatment, US$ 1.9million for ARV drugs, US$ 3.5 million for biomedical prevention including male circumcision, US$ 7.2 million for counseling and testing, US$ 7.8 million for health systems strengthening, US$ 1.7 million for laboratory infrastructure, US$ 8.1 million for OVC, US$ 5.5 million for paediatric care and treatment, US$ 4.3 million for PMTCT, US$ 13.7 million for sexual prevention, US$ 4.6 million for strategic information and US$ 3.2 million for TB/HIV. This support is expected to decrease in the forthcoming years.

In September 2010 Namibia and USG signed a HIV and AIDS Partnership Framework in September 2010. The Framework is a 5-year strategic plan that will guide joint future investments. It's closely aligned with Namibia's National Strategic Framework on HIV and AIDS. Implementation of the Partnership Framework will be overseen by a multi-sectoral steering committee chaired by representatives of the two governments.

GFATM

Namibia received a Global Fund Grant (Rolling Continuing Channel) totaling US$ 104 million for HIV/AIDS for 5 years with phase 1 (Apr 2010 to March 2012) having an agreed amount of US$ 26 million and 78 million for year 3 onwards. A Global Fund TB grant of US$ 48.8 million was also received of which phase one has an agreed amount US$ 17.8 million and for phase two a projected amount of US$ 31 million. The Global Fund Country Coordinating Mechanism (NaCCATuM) met quarterly to review reports and had adhoc meetings to address emerging issues such as Global Fund grant negotiations and reviewing new proposals totalling to 11 meetings between April 2010 and March 2011.

United Nations

The United Nations Joint Team (JUTA) has been supporting the National AIDS response in three results areas: 1) Further scale up and increased sustainability of the national response to HIV/AIDS has a strong focus on HIV prevention and is guided by evidence and driven by effective multi-sectoral participation, 2) adolescents and young people aged 10-24, and most-at-risk and especially vulnerable populations, 3) HIV prevention, treatment and care services in the health sector; and 4) scale up of OVC support. The support has included the following: operationalisation of the National Coordination Framework for HIV and AIDS, supporting strategic information generation processes including protocol design and report preparation. JUTA supported a survey of HIV in the prisons and was key in the support to MoHSS for the assessment of alternative financing options for the sustainability of the national AIDS response, as well as the situational analysis of sex workers. JUTA also supported the bottleneck review of the PMTCT programme to inform action planning for elimination of MTCT. A rapid assessment of the SRH/HIV integration and linkages in Namibia was supported by JUTA to guide the implementation. JUTA supported alignment of the gender operational plan to the NSF.

WHO with support from the Spanish Government provided support to develop the HIVDR strategy. The strategy looks at the Early Warning Indicators (EWI), prevention monitoring and Threshold survey. The EWI is embedded in the routine data collection system.

Through the visit of the Executive Director of UNAIDS to Namibia, JUTA provided high level advocacy for revolutionizing prevention, eliminating MTCT and increased ownership and sustainability of the national AIDS response.

JICA
The MOHSS received support from Japan International Corporation (JICA) in the development of non-community based M&E system as well as capacity building. Another application for the next three years was submitted for potential funding.

7. National Funding Matrix

Preparations for determining the National Funding Matrix and indicator 6.1 are underway and will be reported at the end of May 2012.

8. NCPI Questionnaire Response

The completed questionnaire on National Commitments and Policy Instruments (NCPI) has been attached as an Annex.

References

[i] MoHSS. "2008/09 Estimates and Projections of the Impact of HIV AND AIDS in Namibia". 2009
[ii] MoHSS. "Report on the 2010 National HIV Sentinel Survey". 2010.