Republic of Namibia

Ministry of Health and Social Services

FOLLOW-UP TO THE DECLARATION OF COMMITMENT ON HIV/AIDS (UNGASS)

NAMIBIA COUNTRY REPORT

Reporting Period:
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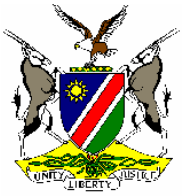

Republic of Namibia

Ministry of Health and Social Services

Follow-up to the Declaration of Commitment on HIV/AIDS

Namibia Country Report 2005

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List of Abbreviations

ABC	Abstinence, Be Faithful, Condoms
AIDS	Acquired Immuno-deficiency Syndrome
ALU	AIDS Law Unit
AMICAALL	Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa
ARV	Anti Retro-Viral
ART	Anti Retroviral Therapy
ANC	Antenatal Care
CAA	Catholic Aids Action
CBO	Community-Based Organisation
CCM	Country Coordinated Mechanism
CDC	US Centers for Disease Control and Prevention
CMS	Central Medical Stores
COL	Change of Lifestyle
CACOC	Constituency AIDS Coordinating Committee
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
DAPP	Development Aid from People to People
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short-course
DACOC	District AIDS Coordinating Committee
EC	European Commission
FBO	Faith-Based Organisation
GRN	Government of the Republic of Namibia
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GF	Global Fund
GTZ	Gesellschaft für Technische Zusammenarbeit
HBC	Home-Based Care
HBsAG	Hepatitis B surface antigen
HAART	Highly Active Anti-Retroviral Treatment
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
IEC	Information, Education and Communication
ITECH	International Training and Education Centre on HIV
KNCV	Royal Netherlands Tuberculosis Association
LAC	Legal Assistance Centre
M&E	Monitoring and Evaluation
MIS	Management Information System
MTP	Medium Term Plan on HIV/AIDS
MGECW	Ministry of Gender Equality and Child Welfare
MOE	Ministry of Education
MIB	Ministry of Information and Broadcasting
MIR	Management Information and Research Subdivision, MOHSS
MoHSS	Ministry of Health and Social Services
MWACW	Ministry of Women Affairs and Child Welfare
NABCOA	National Business Coalition on HIV/AIDS
NAC	National AIDS Committee
NAT	Nucleic Acid testing

NACCATUM	Namibia Coordinating Committee on HIV/AIDS, TB and Malaria
NAMACOC	National Multisectoral AIDS Coordination Committee
NDF	Namibian Defense Force
NHTC	National Health Training Centre
NIP	National Institute of Pathology
NISG	National Injection Safety Group
NHTC	National Health Training Centre
NAEC	National Aids Executive Committee
NACP	National Aids Control Programme
NACOP	National AIDS Coordination Programme
NANASO	Namibian Network of Aids Service Organisations
NASOMA	National Social Marketing Association
NDP	National Development Plan
NGO	Non-Governmental Organisation
NPC	National Planning Commission
NRCS	Namibia Red Cross Society
NPRAP	National Poverty Reduction Action Programme
NTCP	National TB Control Programme
OI	Opportunistic Infections
OPM	Office of Prime Minister
OVC	Orphans and Vulnerable Children
OVC PTF	Orphans and Vulnerable Children Permanent Task Force
PEP	Post-Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan For AIDS Relief
PLWHA	People Living with HIV/AIDS
POA	Plan of Action
PS	Permanent Secretary
PLWTB	People Living with Tuberculosis
PMTCT	Prevention of Mother-to-Child-Transmission
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Plan
RPM+	Rational Pharmaceutical Management Plus
RACOC	Regional AIDS Coordinating Committee
RM&E	Response Monitoring & Evaluation
SADC	Southern African Development Community
SANBS	South African National Blood Services
SMA	Social Marketing Association
SSS	Sentinel Sero Survey
STI	Sexually Transmitted Infections
TC	Take Control
TB	Tuberculosis
TTI	Transfusion transmissible infections
TWG	Technical Working Group
UN	United Nations
UNAIDS	United Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
URC	University Research Co., LLC
USG	Government of the United States of America

USAID	U.S. Agency for International Development
VCT	Voluntary Counselling and Testing
VD	Vaginal Discharge
WHO	World Health Organization

I. Status at a glance

	UNGASS INDICATORS – GENERALIZED EPIDEMIC	2003 RESULT	2005 RESULT	DATA SOURCE
NATIONAL COMMITMENT AND ACTION				
Expenditure (USD)				
1	Amount of national funds spent by governments on HIV/AIDS	**35,000,000 GRN**[1]	**38,558,000 GRN 40,563,812 DP 79,121,812 Total**	MOHSS-GFATM R2 & R5
Policy Development and Implementation Status				
2	National Composite Policy Index	**18 / 20**		NCPI score
3	Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year	**Data not available (n/a)**	**Data n/a**	
4	Percentage of large enterprise/companies that have HIV/AIDS workplace policies and programmes	**Data n/a**	**Data n/a**	
5	Percentage of women and men with STIs at health-care facilities who are appropriately diagnosed, treated, and counselled	**Data n/a**	**Data n/a**	
6	Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT	**6.84%**	**25%**	Programme reports / estimates
7	Percentage of people with advanced HIV infection receiving antiretroviral combination therapy	**Data n/a**	**27.5%**	Programme reports / estimates
8	Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	**Not Required**	**Data n/a**	
9	Percentage of transfused blood units screened for HIV	**Not Required**	**100%**	Programme reports
KNOWLEDGE AND BEHAVIOUR				
10	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[2]	**77% women 15-19 84% women 20-24 89% men 15-19 93% men 20-24**	**38.89% women 15-24 50.71% men 15-24**	2000 NDHS
11	Percentage of young women and men who have had sex before the age of 15	**Not Required**	**8.8% women 15-24 27.29% men 15-24**	2000 NDHS
12	Percentage of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	**Not Required**	**80.22% women 15-24 85.07% men 15-24**	2000 NDHS
13	Percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner	**49%**	**47.94% women 15-24 69.43% men 15-24**	2000 NDHS
14	Ratio of current school attendance among orphans to that among non-orphans, aged 10-14	**Data n/a**[3]	**1:2.53**	2001 Census
IMPACT				
15	Percentage of young people aged 15-24 who are HIV-infected	**17%**	**15.2%**	2004 HIV sentinel survey
16	Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	**Not Required**	**91%**[4]	**Programme reports / estimates**

[1] Data for this indicator in the 2003 UNGASS reported only domestic expenditure towards the national response. DP (Development Partner) contributions make up **7,200,000 USD for a total of 42,200,000 USD in national expenditure. DP** sources for this indicator include donor, private sector and NGO contributions.

[2] Data for this indicator in the 2003 UNGASS reported only on knowledge of some components of the indicator, that is: **abstaining from sex**, **using condoms and limiting the number of sexual partners**; while the 2005 reports on the full composite indicator.

[3] Data for this indicator was mistakenly omitted from the 2003 UNGASS and recorded as unavailable, although in actuality it was available from the 2000 NDHS report.

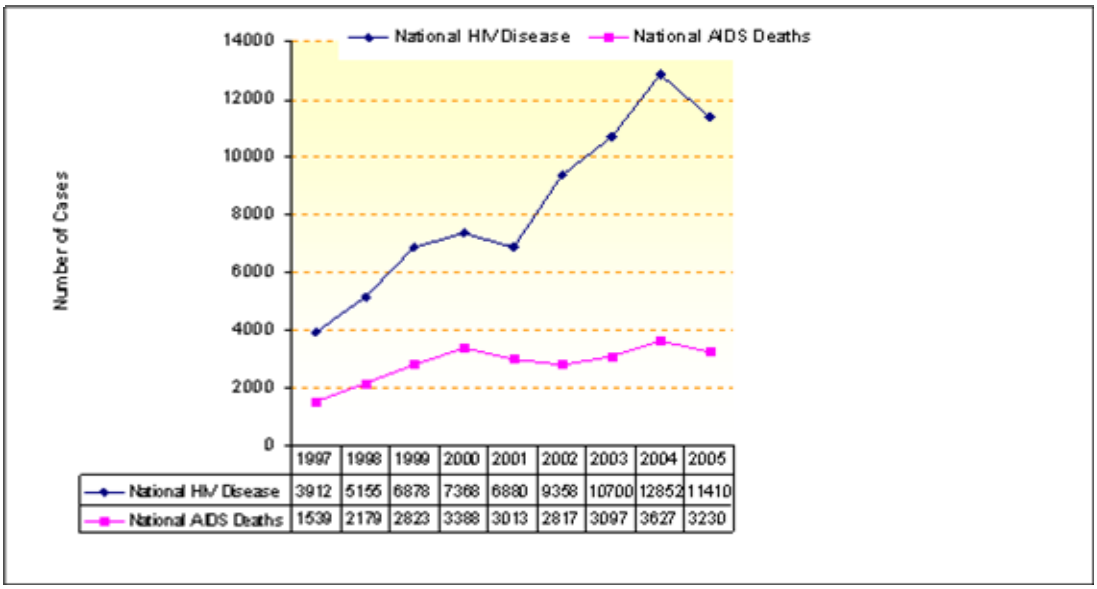
[4] Data for this indicator was estimated using the cumulative percent of ARV patients reported being alive from those ART sites which provided monthly summary reports to MoHSS national level. It should be noted that data for this indicator is incomplete as not all sites reported therefore only providing partial representation.

	UNGASS INDICATORS – GENERALIZED EPIDEMIC	2003 RESULT	2005 RESULT	DATA SOURCE
17	Percentage of HIV-infected infants born to HIV-infected mothers	**Data n/a**	**28%**	Programme reports / estimates

2. Overview of the AIDS epidemic

HIV/AIDS is the primary cause of hospitalization and death in Namibia. Figure 1 below shows a decline in HIV related hospitalisations and a slight levelling off in national AIDS deaths in the period from 2004 - 2005. Despite these recent statistics, the Government of the Republic of Namibia (GRN) has responded to the HIV/AIDS epidemic through substantial investment into the fight against the disease, particularly in recent years.

Figure 1: Hospitalizations for HIV disease and AIDS deaths by year



	1997	1998	1999	2000	2001	2002	2003	2004	2005
National HIV Disease	3912	5155	6878	7368	6880	9358	10700	12852	11410
National AIDS Deaths	1539	2179	2823	3388	3013	2817	3097	3627	3230

Source: Health Information System, Ministry of Health & Social Services

Since the first HIV prevalence study among pregnant women done in 1992 (4.2%), prevalence rose rapidly over the following four years to 15.4% in 1996 and continued to rise for the following six years to a peak of 22.3% in 2002. UNAIDS in 2003 estimated the adult prevalence rate to be 21.3%, with a range of 18-25 %.

The 2002 HIV sentinel sero-survey sample also included clients with sexually transmitted infections (STI), with a HIV prevalence rate of 38.6%. There is no reliable data on HIV-prevalence among TB patients; estimates are that over 50% of TB patients are co-infected with HIV. Namibia has not yet implemented HIV prevalence studies in other specific vulnerable groups such as sex workers.

The latest HIV sentinel sero-survey in Namibia was conducted among pregnant women in 2004 with a sample size of 4,373.women at 24 sites throughout the country. The overall prevalence dropped for the first time from 22.3% to 19.7%. The HIV prevalence declined in all age groups except the 35-39 year group where a 3% increase was observed. The five year age group interval most

affected by HIV is between 25-39 years (respectively 26%; 24%; 24%) and represent the economically active age groups. The prevalence in the below-20 age group is 10% and for 20-24 is 18%.

In terms of geographic distribution and severity of the epidemic, the worst-affected regions are Caprivi (43%) in the Northeast, Oshana (25%) and Ohangwena (18%) in the North, and Khomas (17%) and Erongo (27%) in the centre of the country. The epidemic is relatively less pronounced in the extreme Northwest and South, but prevalence rates are generally still increasing in these parts of the country, albeit at slower rates. The region with the lowest HIV prevalence is Kunene Region at 8.5%.

Young people and women are particularly vulnerable to HIV infection due to their lack of financial means which in turn leads to sex-for-favours and/or cash. At the end of 2001, infection among young people (15-24 years) was estimated to be in the range of 9-13% for men and 19-29% for women. Condom use at last sexual intercourse for youth currently stands at 50%[5]. Women, who constitute 55% of the Namibian adult population, generally have weakened power negotiate safe sex practices within their sexual relationships and often they are victims of gender based violence. Also the general population living in the Northern regions of the country is considered to be especially affected if only for the sheer numbers of PLWHA.

Among the most affected population groups are orphans and vulnerable children, who still have limited access to services, schooling and opportunities for their future lives. The estimated number of orphans and vulnerable children in 2005 ranges between 90,000-150,000 children. The estimated number of children (<15) infected by HIV stood at 15,000 at the end of 2003 (without PMTCT implementation).

Independent studies have been conducted in recent years on some of the most-at-risk populations, such as truck drivers, commercial sex workers, and youth; however, without a national behavioural surveillance, it is difficult to ascertain causes related to the differing HIV prevalence rates from region to region. Regardless, in Namibia there exist certain socio-economic and cultural factors which are generally accepted as linked to the epidemic. For example, the northern area of the country finds the highest levels of poverty and unemployment, with subsistence agriculture as the primary means of support. This also contributes to the high levels of mobile people in search of gainful employment, usually migrating to the capital or other urban areas. Other mobile populations are truck drivers and other transport specialists, due to the sheer geographical expanse of the country. In the west, the coastal town of Walvisbay has a busy port which experiences a continual influx of foreigners on a long- and short-term basis and subsequently realises significant numbers of commercial sex workers. Other high HIV prevalence areas are towns situated on main roads and in cross-border areas. In addition, certain cultural practices found in some regions have been attributed to an increase in the transmission of HIV.

[5] 2000 Namibia Demographic and Health Survey

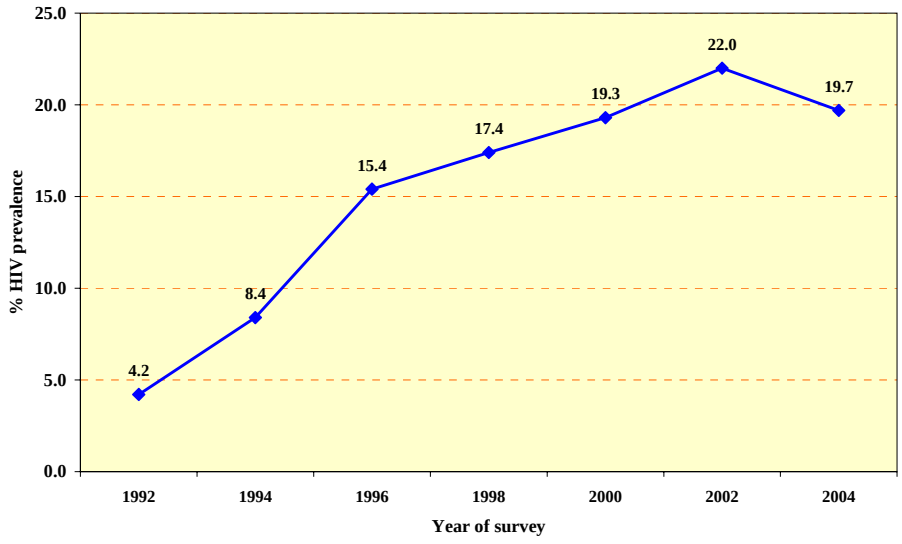
Financial resources for HIV/AIDS responses have increased considerably (the last three years alone recorded an increase of 53%[6]) and concerted efforts are being made to extend care, treatment and support to infected and affected people in all regions. As of December 2005, two hundred facilities (186 public and 14 free-standing centres) are providing VCT; one hundred and thirteen health facilities are providing PMTCT (34 public hospitals and 79 health centres & clinics); and thirty facilities are providing ART.

2.I Impact indicators

2.I.I. Reduction in HIV prevalence

The overall HIV prevalence from the 2004 Sentinel surveillance survey was 19.7%, representing an apparent decrease of 2.3% from the 2002 survey. Though not statistically significant, it is noteworthy that the slight decline in prevalence between 2002 and 2004 is the first observed since ANC HIV sentinel surveillance began in 1992. This could indicate the epidemic is levelling off as displayed in Figure 2. There is need to develop the HIV sentinel surveillance to a second generation surveillance so as to help provide comprehensive explanation on observed changes of the epidemic curve through data triangulation.

Figure 2: Percent HIV prevalence in pregnant women aged 15-49 years biannual surveys 1992-2004, Namibia



Source: 2004 National HIV Sentinel Survey

HIV prevalence was found to be the highest in the group 25-29 years of age (25.8%) which was significantly higher than age groups younger than 25 or older than 40. The lowest HIV prevalence (< 10%) was found in women less

[6] NACCATUM (2005) GFATM Round 5 country proposal

than 20 years of age (9.9%); again this prevalence was markedly lower than age groups between 20-39 years. At this prevalence level, this HIV incidence proxy group presents an opportunity to scale up preventative efforts through facilitating behaviour change intervention programmes targeting youth.

2.I.2. HIV treatment: survival after 12 months on antiretroviral therapy

The best estimate available for survival after 12 months on ART is 91%. This estimate comes from monthly reports submitted by health facilities providing ART services and represents cumulative survival since the beginning of service delivery, thus it is somewhat different from the indicator requested. However, given Namibia's current point in ART roll-out, it is expected that cumulative survival will not be markedly different from 12 month survival. Cumulative survival is, however, expected to somewhat over-estimate 12-month survival as more than half of current ART patients began treatment in the past 12 months.

Efforts are on-going to obtain data for this indicator directly using the patient tracking component of the HIV Management Information System (MIS). Namibia has rolled out a patient-based electronic ART database as part of the HIV MIS. However, due to under-reporting at the level of service delivery this database is not yet able to provide individual-level survival over 12 months. The Health Information System (HIS) and Monitoring and Evaluation (M&E) teams are currently working together to improve the completeness of reporting to a point where 12 month survival will be obtainable using the electronic MIS.

2.I.3. Reduction in mother-to-child transmission

Services for the Prevention of Mother-to-Child-Transmission of HIV (PMTCT) have been rapidly rolled out since December 2003. The dramatic impact of this roll-out on the proportion of HIV+ mothers and their infants receiving prophylaxis is demonstrated in Table 1 below. Using MoHSS assumptions to estimate the number of deliveries by HIV+ women, it is evident that reported PMTCT coverage of HIV+ women has increased from 0% in 2003 to 16% in 2005. When examining this table, it should be noted that service provision estimates come from the HIS and thus experience substantial under-reporting. The PMTCT component of the HIS is a new addition and some sites are reporting irregularly or not reporting at all.

It is notable that messages on proper nutrition to avoid mother to child HIV transmission were delivered to all these women, particularly with respect to breast feeding. Because there is no national database for follow-up of these women, statistics on the impact of these messages are not available.

Table 1: PMTCT programme outcomes: 2003-2005

	Women receiving PMTCT evaluation	Women receiving PMTCT prophylaxis	Babies receiving PMTCT prophylaxis	Estimated HIV+ deliveries**	% HIV+ mothers receiving prophylaxis	% of babies of HIV+ mothers receiving prophylaxis
2003	101	22	22	18,046	0.1%	0.1%
2004	10,334	733	732	16,356	4.5%	4.5%
2005*	22,586	2172	2246	13,985	15.5%	16.1%

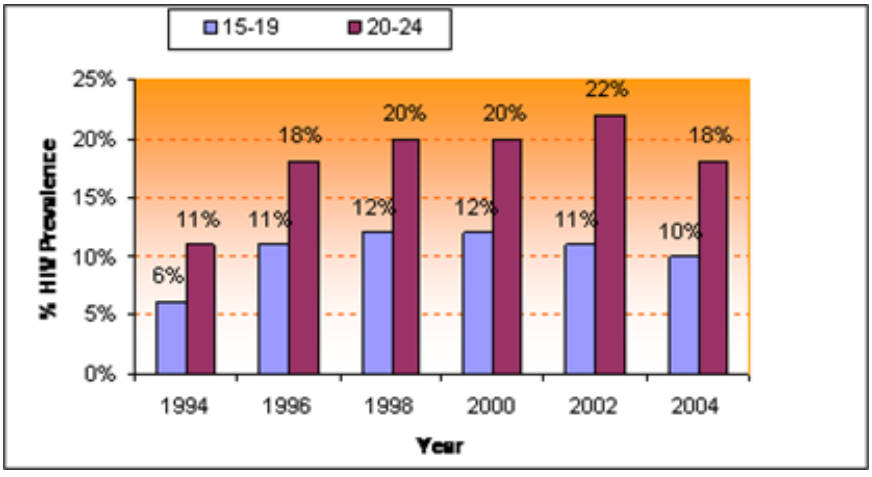
* Data for 2005 represents activity through October
** Estimated HIV+ deliveries calculated using data from the HIS and ANC surveillance estimates of HIV prevalence among pregnant women

Rapid HIV testing, officially rolled out as from August 2005, is expected to markedly increase the percentage of mothers and babies receiving PMTCT prophylaxis. This service has been observed to dramatically increase the proportion of women receiving their HIV results in a PMTCT setting due to same-day results availability in rapid testing.

2.I.4. Most-at-risk populations: reduction in HIV prevalence

Figure 3 below presents the trends in HIV prevalence among age groups 15-19 and 20-24 years from 1994-2004. HIV prevalence was higher in the group 20-24 years of age than in the age group 15-19 throughout the indicated time span. The age group of 15-19 years has experienced a slight decrease in HIV prevalence between 2000, 2002 and 2004. The 20-24 year age group showed a rapid rise from 1994 (11%) to 1996 (18%) then a gradual rise over the next 6 years to 22% in 2002, followed by a substantial decrease to 18% in 2004. The 15-19 year age group demonstrated a rapid rise from 6% in 1994 to 11% in 1996, a gradual rise and levelling by 2000 (12%) and then a gradual decrease over the past 4 years to 10% in 2004.

Figure 3: HIV prevalence by age group for the period 1994-2004



Source: 2004 National HIV Sentinel Survey

3. National Response to the AIDS epidemic

3.1 National commitment and action

Namibia gained its independence in 1990 and soon thereafter launched the National AIDS Control Programme (NACP) based in the Ministry of Health and Social Services (MoHSS). This was followed by the First Medium Term Plan covering the period 1992-1998. This first plan was reviewed in 1997 and found that extensive awareness campaigns undertaken have had good effect, that political commitment had been clearly demonstrated and that management structures such as Cabinet, the National AIDS Committee (NAC), the National Multi-sectoral AIDS Coordination Committee (NAMACOC), the National AIDS Executive Committee (NAEC) and the National AIDS Coordination Programme (NACOP) were in place and functioning.

The Second Medium Term Plan (MTPII) was launched in 1999 for the period 1999-2004. MTP II provided a comprehensive framework for the national multi-sectoral and sub-regional response to HIV/AIDS. The second National Development Plan (NDP II) 2002-2007 has set as priorities for the nation, the prevention and control of HIV/AIDS and disparity reduction in Namibia's human development. The NDP II complements the strategies and targets laid in MTP II. MTP II was externally reviewed (The Royal Institute, Amsterdam, the Netherlands, 2003) and the recommendations from this review informed the development of the third strategic plan on HIV/AIDS.

The Third Medium Term Plan 2004-2009 (MTPIII), launched in 2004, builds on the strengths of the previous programme and addresses the area identified for renewed attention and commitment, as well as for human resource capacity building, improved financing and enhanced coordination and cooperation.
At national level, the Ministry has a well-established National AIDS Coordination Programme, managed by the Directorate for Special Programmes (TB, Malaria and HIV/AIDS) established in 2004. The Directorate has a staff establishment of fifty posts of which 50% of the positions have been filled. The Directorate is responsible for providing assistance to all sectors in the development of sector-related HIV/AIDS activity plans in accordance with sectoral obligations.

In addition, the MoHSS as the Principal Recipient for the Global Fund to Fight HIV/AIDS, TB and Malaria (GFATM) Round 2 has established a Programme Management Unit based in the MoHSS that is responsible for the programmatic, financial, procurement and M&E management of the grant. The team consists of 20 staff members. Furthermore, the Directorate has also acquired additional staff through GF Round 2 to work directly in the areas of Case Management, PMTCT and condom logistics. Additional technical assistance is provided through the U.S. Centers for Disease Control (CDC), the European Commission (EC) and Voluntary Service Overseas (VSO).

The Directorate is working with the Office of the Prime Minister (OPM), the National Planning Commission (NPC), the Namibia Business Coalition on AIDS (NABCOA) and the Namibia Network of AIDS Service Organisations (NANASO) to strengthen HIV and AIDS programmes and activities and to build capacity in all sectors.

In Vision 2030, HIV/AIDS is viewed as a cross-cutting issue in all sectors, and addressed more specifically under the theme of Population, Health and Development. The strategies highlight the need for leadership at all levels, a multi-sectoral approach, the promotion of policies to combat stigma and discrimination, the inclusion of HIV/AIDS in all development plans, a greater understanding of the impact of HIV/AIDS on all of the sectors, and an enhanced ability to monitor and evaluate the impact. It also acknowledges the effects of HIV/AIDS and its impact on health status, service delivery and poverty and for continued awareness raising, prevention, treatment and care and workplace programmes.

Namibia is in the process of finalising a stand-alone National HIV/AIDS Policy. Currently the following individual policies and strategy elements are in place:

- The Namibian Constitution provides a Bill of Rights that addresses issues of HIV/AIDS and human rights;
- The Namibian HIV Charter of Rights and a Code on HIV/AIDS in Employment under the Labour Act has been compiled, defining the legal and human right of PLWHAs and making education for AIDS awareness and prevention available at all workplaces;
- Policies, strategies and guidelines have been developed for a wide range of health interventions such as Prevention of Mother to Child Transmission, Post-Exposure Prophylaxis, Highly Active Anti-retroviral Therapy (HAART), Home Based Care, Nutrition, recruitment of Community Counsellors as well as guidelines for Voluntary Counselling and Testing, Rapid HIV Testing, and others on reporting, notification, confidentiality, surveillance and infant feeding; Research Management Policy and guidelines on clinical trials involving human subjects;
- Other sectors have also developed some policies, strategies and guidelines including the HIV/AIDS Policy for Local Authorities, the Education Sector HIV/AIDS Policy, National OVC Policy, Sector specific HIV/AIDS plans etc.

3.1.1. Resources

Health services in Namibia are provided by Government working in both urban and rural areas (70-75%), missions fully subsidized by the Government and working primarily in rural areas (15-20%), and the private sector, working primarily in urban centres (5%). In total, the public sector has 35 hospitals, 37 health centres and 246 clinics providing a total of 7,653 beds, while the private sector has a total of 13 hospitals, 9 health centres and 17 clinics. Despite this network of facilities, many communities, particularly in sparsely populated rural areas, must depend on mobile outreach services for health care. MoHSS has 9,000 professional and semi-professional posts on its staff establishment.

In addition to MoHSS, the response draws on the resources of many internationally recognized NGOs and well-established local NGOs with extensive volunteer networks at community level and various faith-based organisations (FBOs).

Namibia has shown strong political commitment to expand service delivery for HIV/AIDS and has over the past few years made tremendous progress in bringing services to the people in need. Increasing amounts of funds have been made available from national budgets to cover these costs. Despite considerable resources from GRN and international partners, there remains a funding gap which needs to be addressed. While the main donors, the Government of the United States of America (USG) and the Global Fund to Fight HIV/AIDS, TB and Malaria (GFATM) Round 2, support mainly OVC, ART, PMTCT and VCT, the European Commission (EC) supports the education sector and multi-sectoral strengthening.

Of the current expenditure (2005) the major contributors include GRN (41.7%), USG (33.1%), GFATM Round 2 (11.1%), The EC (4.3%) and the Government of Germany (2.9%). The remaining balance (6.9%) is funded by fifteen other development partners, (comprising national Governments, UN agencies, other global agencies and a private sector foundation).

Namibia's proposal (for HIV/AIDS, TB and Malaria) was accepted in the 2nd Round of GFATM in early 2003; however, due to delays in grant negotiations, funds were only disbursed in January 2005. Unfortunately this time lapse in funding hampered critical programmatic expansion that could have otherwise been realized. In June 2005, Namibia's Country Coordinating Mechanism (CCM) again developed a proposal this time for the fifth round application to the GFATM, and out of three separate proposals (HIV/AIDS, TB and Malaria) only the TB proposal has been accepted.

3.1.2. Expanded Partnerships

Ongoing multi-sectoral collaboration for mainstreaming HIV, including development of comprehensive workplace programmes, targets 90% of enterprises, civil society and line ministries. The public sector effort is coordinated by the Office of the Prime Minister (OPM) whereas private and civil society efforts are coordinated by NABCOA and NANASO respectively.

Many line ministries have been particularly active in their response to the obligations under MTPIII and NDP II; all line ministries are allocating funds to initiate and implement HIV/AIDS activities. The OPM has established an HIV Unit responsible for coordination of the workplace programmes for all public sector ministries and agencies. The National Planning Commission (NPC), under the Office of the President, has also established an HIV Unit which is actively involved in mainstreaming HIV and AIDS activities in the public sector.

The public service posts of Regional AIDS Coordinators have been filled in all thirteen regions by the Ministry of Regional & Local Government, Housing and Rural Development. The government is in the process of establishing permanent positions for HIV Focal Persons in all public sector institutions. Also, with financial support from the GF R2 proposal, many NGO's, FBOs, and public and private sector organisations have increased their staff capacity.

The involvement of People Living With HIV/AIDS (PLWHA) needs overall strengthening to build a coordinated approach at all levels of the national response. PLWHA support groups are scattered throughout the country with varied degrees of national and regional level support. Lironga Eparu, the national umbrella organisation of PLWHA groups has received greater support in the last few years through a World Bank grant, GFATM Round 2 funding and other partners. However, the organisation still requires dedicated, long-term financial commitment to strengthen and build capacity in the areas of management and coordination.

Civil society plays a significant role in directly meeting the needs of people infected with and affected by HIV/AIDS. NANASO is the national umbrella organization which provides support to individual network members across the country. NANASO offers dissemination of information, particularly national- to local-levels, general HIV/AIDS related information sharing through its Resource Centre, networking opportunities for members, and member trainings. This organization has with about 240 member organisations employing about 845 full time staff members and 15,000 volunteers. Support to NANASO has also increased within the last few years, particularly through GFATM Round 2, the European Commission, SAfAIDS, and other partners.

Private sector efforts are sporadic at best, with a few large companies offering comprehensive workplace programmes to employees and their families. The Namibia Business Coalition on AIDS (NABCOA), launched in late 2003 aims to help manage and coordinate the private sector effort and in recent years has begun to establish baseline data on workplace initiatives and to offer training to members, particularly SMEs, in the area of workplace programme development and design. NABCOA has an increasing number of members from the private sector (50 in 2005), covering about 27,000 employees. They also offer an inexpensive cost-analysis service to companies wishing to analyse the effect of HIV/AIDS on their industry or organisation. NABCOA receives support from a World Bank grant, GTZ and other partners.

The private sector is governed by the Health Facilities Act and comprises both private hospitals and family physicians. The private hospitals offer the most modern medical facilities in the country and several medical aid schemes ensure access to these services. Collaboration between the private sector and public sector is beginning to improve, especially in the field of HIV/AIDS, where the Government is including private doctors in training on the national ART guidelines.

3.2. National Programmes

The description of national programmes in this section highlights achievements made since 2003 UNGASS reporting. Each section is organised according to the five components of MTPIII and also provides the objective of each strategy area for ease of reference. The sub-headings that follow are the related programme areas according to the sub-components found in the national strategy.

3.2.1. Enabling environment

Strategic Result: People infected and affected with HIV/AIDS enjoy equal rights in a culture of acceptance, openness and compassion.

3.2.1.1. PLWHA involvement & actions to reduce stigma and discrimination

MTPIII provides for the effective participation of PLWHA in the design and implementation of HIV/AIDS programmes as essential to realise an effective national response to the epidemic. Programmes should focus on reducing stigma and discrimination against PLWHA through advocacy and the involvement of political, traditional, and religious leaders.

Namibia adopted a new Labour Act in 2005 that specifically condemns HIV/AIDS-related stigma and discrimination in the workplace setting. This Act is enforced through the implementation of workplace programmes in all sectors.

In 2004, Lironga Eparu conducted a rapid quality assessment of services provided for PLWHA. A follow-up study has begun in mid-2005 which undertakes a more comprehensive look into quality and satisfaction of service delivery to PLWHA and involves consultation with a wider range of service delivery providers, civil society organisations, and other stakeholders.

There is a recognised need for strengthening of the overall coordination and capacity of PLWHA groups and in particular, emphasis on the increased engagement of PLWHA in all aspects of policy review, planning, strategy development and programme implementation.

3.2.2. Prevention

Strategic Result: Reduced new infections of HIV and other STIs.

3.2.2.1. Targeting vulnerable populations

Social Marketing Association (SMA) commenced working with the Namibian Defence Force (NDF) and the Ministry of Defence (MoD) in 2001, with funding from the U.S. Department of Defence HIV/AIDS Prevention Programme (DHAPP). The Military Acton and Prevention Programme (MAPP) was established as the official military response to HIV/AIDS crisis in the governments national strategic plan on HIV/AIDS.

Military personnel soldiers are considered a ”high risk group”, therefore MAPP continues to focus on the three primary methods of HIV prevention (ABC) in edutainment sessions on bases, educational sessions at the Remember Eliphas Education Centre and in workshops and training. The programme also involves

training on HIV and AIDS and correct condom use for solders preparing for deployment. During 2005, the SMA / MAPP accomplished unprecedented milestones resulting in the training of ninety-six commanders. This training offered NDF commanding officers comprehensive information on HIV and AIDS pandemic and programmes available for prevention, treatment, care and support.

The SMA has also extend its behavioural change and HIV prevention activities to the police and other uniformed services, including a special focus on female police officers. POLACTION started in 2005 and involves ongoing STI/HIV/AIDS prevention, care and support training and capacity building for the Namibian police force.

3.2.2.2. Targeting Young People

The Ministry of Information and Broadcasting (MIB) coordinates the national HIV/AIDS media campaign, *Take Control*. The Ministry with its partners, including ministries, UN agencies and other development partners and NGOs, annually has two prime intensification campaigns when it produces and disseminates new material on HIV and AIDS. Project objectives are to provide correct sexual health information to adolescents and to encourage parents, teachers and service providers to encourage risk-reduction behaviours by adolescents.

Achievements by MIB in partnership with UNICEF, UNFPA and the Namibian Johns Hopkins University office in this reporting period were the production of new radio, television and print advertisements as well as a newspaper speak-out series. In addition, MIB and the Namibian Federation for People with Disabilities, under support from the Namibian Global Fund Round 2 allocation, are developing HIV and AIDS materials for the visually and hearing impaired. Youth consultations are carried out annually to give youth opportunity to review existing information material and give input into the development of new material.

All primary and secondary schools have HIV/AIDS life-skills programmes through the Ministry of Education which provide young people with facts about sexual health and reproduction, pregnancy, STIs and HIV/AIDS, and help to improve communication skills. These are supported by extracurricular programmes, namely Windows of Hope, My Future is My Choice, and Let's Talk; for primary, secondary, out-of-school youth and parents, respectively.

Finally, civil society organisations target schools with programmes such as “Stepping Stones” and "True Love Waits", Lifeline/Childline’s "Feeling Yes, Feeling No" programme for pre-primary and junior primary classes and the Early Childhood Development Project. Ombetja Yehinga organisation implements school programmes and clubs with innovative cultural programmes that incorporate dance, music, and fashion. With regard to outreach, DAPP Namibia implements the Hope Youth Programme in cooperation with local level partners and in 2005 alone has reached over 23,000 youth through a comprehensive peer education programme. DAPP also organises youth club course plans that cover basic facts about HIV/AIDS, drug and alcohol abuse,

teen pregnancy and counselling and testing. Change of Life Style (COLS) implements a Christian Family Life Education programme with nineteen churches in two regions. In addition, Lutheran church organisations have promoted Christian HIV prevention curriculum through 45 congregations.

3.2.2.3. Prevention of transmission in health care settings

Under the President's Emergency Plan for AIDS Relief (PEPFAR), University Research Co., LLC (URC) assisted the MOHSS in creating an enabling environment for safe injection and waste management practices in four pilot regions. A rapid assessment was conducted to examine existing injection and waste management practices to identify quality gaps as well as opportunities for improvements. A National Injection Safety Group (NISG) was established to lead, support and monitor injection and waste management practices.

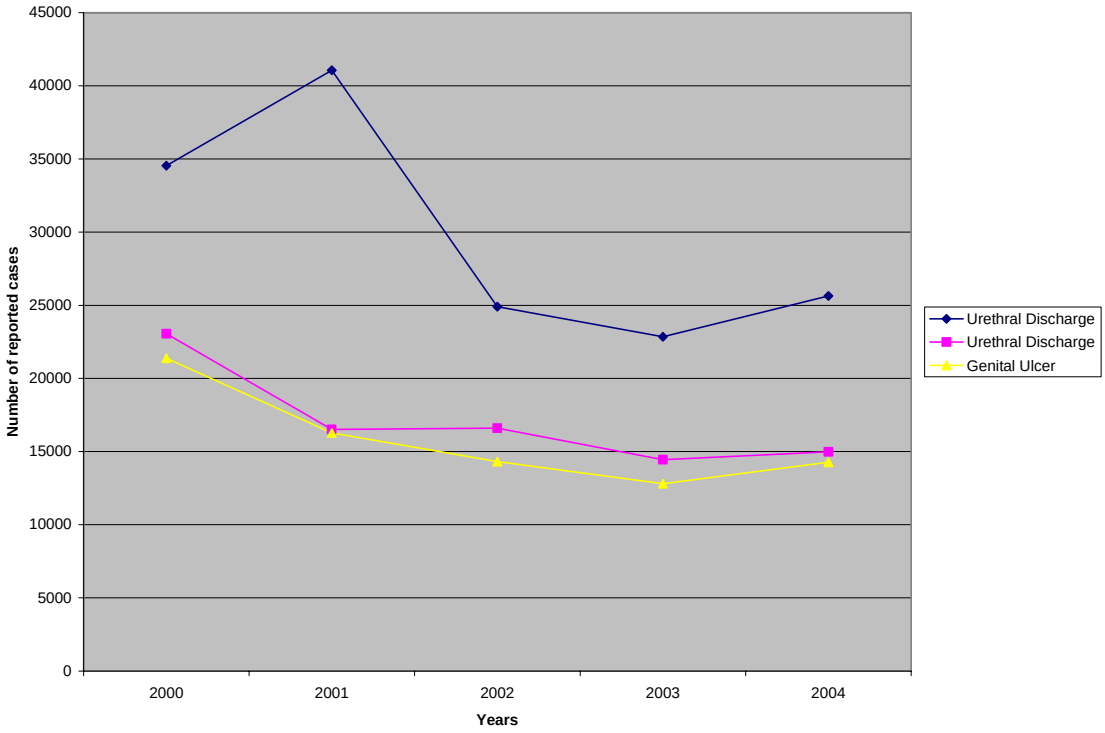
The URC/Namibia team worked closely with NISG in a number of interventions to promote safe injection and waste management practices in the country. Based on the national and regional improvement plans, URC supported MOHSS in developing draft policy guidelines on injection safety (as part of the infection control policy), quality assurance and medical waste management. In commodity management, the URC continues to support the MoHSS to strengthen the logistic systems for ensuring the availability of medical injection related supplies. To change the community's perception on injection, URC conducts regular community awareness meetings on unnecessary injections. A system for monitoring and evaluation of injection and waste management practices has been established through quarterly facility assessments followed by PDSA (plan, do, study, act) meetings at the regional level. NISG meets monthly to assess and support progress in injection safety and waste management.

3.2.2.4. STI management

Namibia has experienced a heavy STI burden that ranks 8th among all hospital consultations. In 1995 syndromic management was implemented as an intervention for STI control. However, due to lack of human resources and capacity, implementation was not as smooth as anticipated. Implementation efforts were strengthened in 2003 through the GTZ Reproductive Health Project which expanded health worker training and supervision in nine regions.

The general picture of STIs over four years has shown a downward trend. Vaginal discharge (VD) has decreased significantly from 41,054 in 2001 to 22,844 in 2003.

Figure 4: STI trends for the period 2000-2004



Source: MoHSS STI programme, 2005

3.2.2.5. Safety of blood transfusion products

The MoHSS bears the overall responsibility for the national blood programme. It has delegated the responsibility for collecting, testing and distribution of blood and blood products to the Blood Transfusion Service of Namibia (NAMBTS), a non-governmental organization. NAMBTS headquarters are situated in the capital city of Windhoek and two NAMBTS blood banks are located in the north and western coast, Oshakati and Swakopmund respectively. The Namibian Institute of Pathology (a parastatal) is performing the cross-matching in eight hospitals and helps with the distribution of blood and blood products for those hospitals not being served by NAMBTS blood banks. At hospitals where cross-matching is not available, use is made of group 0 blood.

NAMBTS employs three donor recruiters and all blood is collected from voluntary, non-remunerated donors only. Prior to donation donors complete a screening questionnaire which helps to determine donor deferral according to medical assessment guidelines compiled by the South African National Blood Service (SANBS).

NAMBTS employs the 'Standards for the Practice of Blood Transfusion in South Africa' (third edition, 1999) for blood transfusion process (collecting of blood, processing of blood, testing of blood, storage and distribution of blood).

Each single unit of donated blood is routinely tested for HIV 1+2, Hepatitis B, Hepatitis C and Syphilis before it is released into the blood bank for issue. Every unit that is tested positive for any of the above-mentioned transfusion transmissible infections (TTI's) is discarded. Currently all testing for TTI's is

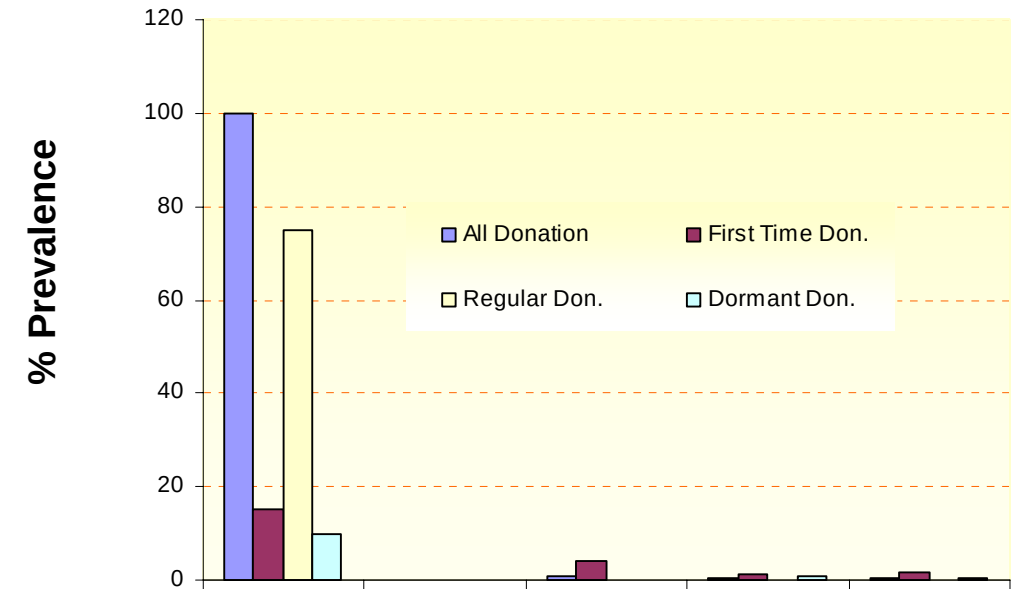
done at SANBS Head Quarters (Johannesburg, RSA) where a fully automated process is used to prevent human error.

The following tests for TTI's are currently employed:

- HIV 1+2: HIV 1+2 antibodies, nucleic acid testing (NAT)
- Hepatitis B: HBsAg, NAT
- Hepatitis C: Hepatitis C antibodies, NAT
- Syphilis: TPHA

A comprehensive situation analysis of the NAMBTS and all laboratories and hospitals involved with blood transfusion has been done in collaboration with WHO, MoHSS, NAMBTS and NIP and plans are being developed for the strengthening of the national blood programme.

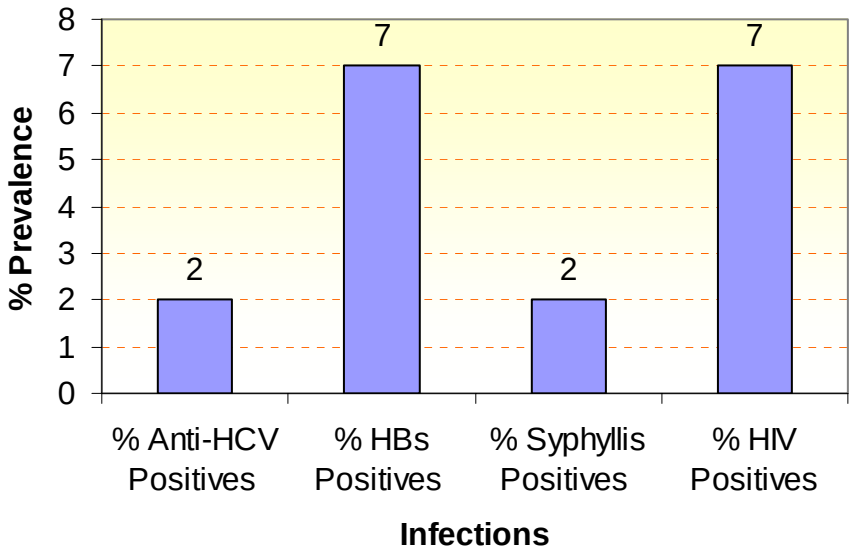
Figure 5: Blood Donations by Type of Donor and Prevalence of Screened Infections, 2004



	All Donations	% Anti-HCV Positives	% HBs Positives	% Syphyllis Positives	% HIV Positives
All Donation	100	0.02	0.68	0.25	0.36
First Time Don.	15	0	3.99	1.1	1.71
Regular Don.	75	0.02	0.07	0.02	0.07
Dormant Don.	10	0.02	0.05	0.64	0.43

Regular blood donors contributed most (75%) of the blood screened in 2004 followed by first time donors (15%) and least was the dormant donors (10%); Figure 5 above. HIV and Hepatitis B caused equivalent proportion for blood discard at 7% prevalence while the other screened infections of Syphilis and Hepatitis C were detected at 2% (see Figure 6 below).

Figure 6: Percent Prevalence of Infections in Regular Blood Donors, 2004



3.2.2.6. Voluntary Counselling and Testing (VCT)

Counselling and Testing is an essential component of the PMTCT and ART programmes. To improve capacity and to provide counselling and testing in the public health care system, the community counsellor's initiative was launched in December 2004. To date, the following progress has been made:

- The Namibia Red Cross Society was contracted to coordinate and manage the Community Counsellor programme;
- Lifeline/Childline was contracted and provided 6-week training for all new counsellors, with support from NHTC, NIP and Johns Hopkins University;
- A total of one hundred and forty-three Community Counsellors have been trained and deployed to forty-three health facilities;
- Fourteen SMA franchise freestanding VCT centres have been established and are operational;
- The Standard Operation Procedures Manual for Rapid Testing has been developed;
- Thirty-seven health workers have been trained in Rapid Testing and rapid testing has been rolled out to 10 of 13 regions.

3.2.2.7. Expand condom provision

A number of institutions are involved in condom programming including government ministries, NGOs, private companies and business associations, and international development agencies. There has been and continues to be extensive support from international development agencies in terms of commodities, financing and technical support for condom provision. Condoms are available in Namibia through a number of mechanisms: free through the public sector, subsidized by social marketing programmes and at market price through the commercial sector. On-going programmes specifically target the most-at-risk populations.

A Standing Committee on Condom Procurement and Distribution was established in 2002 with membership extending to all sectors. To date, the following progress has been made:

- A total of 6,140,499 male and 69,657 female condoms were distributed through all mechanisms during 2004/2005;
- A Condom Manager and a Condom Logistics Officer has been appointed through GFATM Round 2 funds;
- A public sector pharmaceutical distribution system to regions has been established.

3.2.2.8. Interventions to reduce vulnerability

A legal framework is in place to respond to the needs of women and girls in Namibia. The Namibian Constitution guarantees women protection from discrimination and enacts affirmative action. In 1992, the GRN ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and a National Gender Policy has been in place since 1997. Further strengthening comes from a variety of laws and policies that are in place to protect women and girls from circumstances that make them vulnerable to HIV infection and the impacts of HIV/AIDS. The most recent legislation to be enacted since the last UNGASS reporting period is the Combating Domestic Violence Act of 2003, Guidelines for the provision of Post-Exposure Prophylaxis (PEP), the Labour Act, and a draft Children's Act.,

Since Independence, the Government has established several institutions that address gender issues and has developed a framework for addressing gender inequalities. One important milestone was the upgrading of the Department of Women Affairs (DWA) in the Office of the President to the Ministry of Gender Equality and Child Welfare (MGEACW), with its core function to provide other departments with gender mainstreaming support.

The Namibian Gender Policy and Plan of Action (PoA) identify areas of concern and set out the GRN Plan of Action. Programs such as legal literacy, civil education, gender sensitization and paralegal training for communities, training for traditional leaders and parliamentarians either through workshops or media are ongoing, and on average over 3000 people are reached per year.

Other institutional mechanisms have been established that include multi-sectoral AIDS coordinating bodies from the national to the constituency level, such as Regional AIDS Coordinating Committees (RACOC) and Constituency AIDS Coordinating Committees (CACOC) and include representation by relevant organisations such as local offices of the MGECW and related civil society groups.

Programmatic responses for women and girls at national and local levels exist on a limited basis; however to date there are no existing HIV/AIDS initiatives that seek to explicitly challenge gender inequality or promote women's rights as a core objective.

3.2.3. Treatment, Care and Support

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

3.2.3.1. Provision of HAART

The MoHSS has adopted a public health approach to ART/care and a clinical model based on Communicable Disease Clinic's in all district hospitals that provide comprehensive ART/care to eligible patients including pregnant women, TB patients and children. The ART programme is linked with VCT, PMTCT and community-based services. The objectives of the programme are to provide access to ART to all Namibians.

The ART programme was launched in Namibia over the last two and a half years with considerable coverage expansion and uptake of case management and ART services. Since implementation of the programme, the following achievements have been realised:

- Guidelines for the Rollout of ART, PMTCT, and VCT;
- Change in criteria for ART and cotrimoxazole prophylaxis;
- Expansion of ART Sites from seven public hospitals in 2003 to the present thirty health facilities (88% of public health facilities in the country);
- Staff Training through the National Health Training Centre (NHTC), with the support of ITECH, with a total of five hundred and ninety health workers trained to date;
- Increased utilization of ART services with monthly enrolment exceeding 1,200 new patients and a total of 14,400 patients on treatment as of November 30, 2005 (compared to <400 in December of 2003);
- A site assessment for renovations by MOHSS Facility Planning Subdivision to accommodate ART expansion at hospitals;
- The Management Committee on Patient Care and Disease Management held seven meetings in 2005 and completed support visits to all thirteen regions by July 2005;
- Members of the HIV Namibian Clinicians Society, comprised of public and private sector clinicians, received training in adherence counselling and advanced ART.

3.2.3.2. Palliative Care/TB-HIV

Namibia continues to be one of the world's leading countries with the highest incidence of tuberculosis. The total number of all forms of TB cases reported in 2004 was 16,156 translating into a case notification rate of 822/100,000 population. The first TB Medium-Term Plan 2004-2009 (TB-MTPI) was launched on World TB day in March 2005. The TB guidelines (2nd edition) were revised which address the following topics: routine counselling and testing for TB patients, isoniazid prevention therapy for asymptomatic patients with HIV/AIDS, cotrimoxazole prophylaxis for all HIV positive TB patients, and antiretroviral therapy issues.

The TB burden in Namibia is fueled by the HIV/AIDS epidemic. HIV infection is the major known individual risk factor for development of TB disease in a person infected with TB. Case notifications have increased steadily with the

advance of HIV infection. Table 1 shows the results of a 1998 HIV-prevalence survey in TB patients in which 45% of tuberculosis patients were HIV positive, with a range from 80% in Katima Mulilo to 16% in Nankudu.

Table 2: HIV prevalence among TB patients in sentinel sites, Namibia, 1998

SENTINEL SITES	Total	HIV +	% Positive
Katima Mulilo	44	35	80%
Oshakati	56	33	59%
Onandjokwe	49	26	53%
Windhoek	99	52	53%
Walvis Bay	103	54	52%
Swakopmund	50	25	50%
Otjiwarongo	19	9	47%
Nyangana	17	8	47%
Keetmanshoop	40	18	45%
Engela	51	22	43%
Andara	28	11	39%
Rundu	100	38	38%
Gobabis	91	26	29%
Opuwo	58	12	21%
Nankudu	19	3	16%
Total	**824**	**372**	**45%**

Source: 2004 NTCP Annual Report

The programme implementation is supported by various activities such as advocacy and social mobilization, capacity building and training, laboratory network for TB diagnosis, drug supply as well as resource mobilization.

The GRN is committed to the control of TB as reflected by an uninterrupted supply of TB medicines, ensuring TB diagnosis by funding all smear examinations including culture and sensitivity, and the provision of staff for TB case management, as well as supporting core programme activities. The government in its efforts to control TB in Namibia is supported by the USG through the CDC, PEPFAR, ITECH and USAID, The Royal Netherlands Tuberculosis Association (KNCV), the World Health Organization (WHO) and the EC.

3.2.3.4. PMTCT + services

In response to the HIV/AIDS epidemic, the GRN through the MoHSS launched the PMTCT programme in 2002 at two pilot hospitals in the country. Through the years, services have been rolled out to additional public and faith-based hospitals. By the end of November 2005, 34 hospitals and 79 health centres and clinics are implementing PMTCT services.

The goal of the PMTCT programme is in line with that of MTP III, which is to ensure that 90% of HIV positive pregnant women, their children and partners,

have access to PMTCT services and receive a complete course of ARV prophylaxis to prevent MTCT of HIV by 2009, with the ultimate goal to reach 100% of all pregnant women. The main objective of the programme is to prevent the transmission of the HIV to babies through integrating an effective PMTCT programme into routine maternal and child health services.

PMTCT services have been integrated into routine ANC and Maternity Services. Services provided include pre-test counselling, testing, post-test counselling, partners counselling and testing, and provision of ARV (nevirapine) to mother and baby. To date, the PMTCT programme has achieved the launching of national guidelines and in addition to the site expansion noted above.

3.2.3.5. Drugs and supplies

All drugs and commodities for the public sector are centrally received by the Central Medical Stores in Windhoek, and distributed directly to some hospitals and clinics or through two regional medical stores. Currently the MoHSS, with support from USAID, has engaged the Rational Pharmaceutical Management Plus (RPM Plus) programme of Management Sciences for Health (MSH) for assistance to further develop this area. MOHSS is receiving technical assistance to strengthen the supply chain for health products in Namibia and to ensure optimal reliability, efficiency and security to support the scale up of interventions.

ARV and specific donated products are distributed and dispensed under the same strict control and record keeping measures as are applicable to narcotic medicines. The system is well established and currently in use to the satisfaction of the sponsor as part of the Diflucan Partnership Program.

The CMS has a fleet inventory of four (20 ton) trucks and one (5 ton) truck which covers thirty-four state hospitals country-wide on a weekly basis. Current MOHSS capacity is however inadequate to monitor and track the drug distribution pipeline at the various important points in the supply chain. To address this shortage, the MOHSS through GFATM Round 2 has hired Condoms Logistics Officers based at CMS for coordination of condom and related medical commodity procurement and distribution.

3.2.4. Impact Mitigation

Strategic Result: Strengthened and expanded capacity of local responses to mitigate socio-economic impacts of HIV/AIDS.

3.2.4.1. Services for orphans and other vulnerable children

Namibia holds a comprehensive policy and strategic framework for OVC care; however, exact data on the number of OVCs is unavailable, with estimates ranging from **90,000-150,000** children. Most of OVC are living in the North and Northeast of the country where the highest burden of the disease is found. The OVC programme responds to the care and support priorities identified in MTPIII and to the five-year strategy developed by the OVC Permanent Task Force (OVC PTF) which is implemented through the MGECW. Services in this area are highlighted by a growing foundation of policies and strategies that have

been developed since the last reporting period which aim to ensure adequate attention to this growing need in Namibia.

A National OVC Policy was developed in 2004, which creates a multi-sectoral and multi-disciplinary framework for the protection and promotion of the well-being of all OVC. Other related strategies and plans include those of the OVC PTF, a policy on Educationally Marginalised Children and a plan on HIV and AIDS for the Education Sector. The various reports, studies, surveys and evaluations which are conducted on this topic are disseminated annually at a national conference. The Third National Conference on Orphans and Vulnerable Children was opened by His Excellency the former President of Namibia, Dr. S. Nujoma and well-attended by other distinguished guests and stakeholders, including embassies, UNICEF and other United Nations organisations, related ministries, and NGOs.

The orphan and vulnerable children programme now permanently resides with the MGECW since 2005. Implementation of the social grant system has also been shifted to the Ministry of Home Affairs and Social Welfare in 2005. While a variety of support services are available nationwide, this effort is contested by the ever-increasing numbers of children orphaned and made vulnerable due to HIV/AIDS and other factors such as violence against women and poverty.

Table 3: Types of support available to OVC

OVC Support					
Food	**Education**	**Health**	**PSS**	**Protection**	**Other**
School feeding	Uniforms	Referrals	Home visits	Life skills	Homes
Soup kitchens	School fund	ART compliance	Camps and clubs	Child diversion	Temporary shelters
Food parcels	Exemption	Exemption	Training	Information on rights	Outreach to caregivers
Agriculture	Vocational	Nutrition monitoring	Counselling	Will writing	Grants
	Hostel accommodation		Sport & recreation		

Source: Full Report: 3rd National Conference on Orphans and Vulnerable children, February 2005

Tables 3 and 4 summarise some of the support provided to OVC and examples of different types of assistance. Note in Table 3 that accurate information about unregistered homes and shelters are not available; therefore these numbers are not reflected. Also, although figures represent the minimum, they are probably higher and there are most likely overlaps (i.e., numbers of children receiving assistance is greater than number of estimated orphans due to one child receiving more than one form of assistance). Civil society plays a major role in assisting the GRN in providing the bulk of these services, with support provided through the MOHSS, MOE, MGECW, UNICEF, UNFPA and other UN agencies, the USG through Family Health International, and a variety of NGOs.

Table 4: Some Aspects of OVC Service Coverage

Form of Assistance	*# of children*
Social assistance grants	>20,000
Feeding: school feeding programmes, food parcels, after-school meal programmes	**>210,000**
Homes and shelters	>600
Hostel accommodation	Unknown
Trained teachers and hostel workers	>1,500
Caregivers and others trained in PSS	Unknown
After-school programmes	>2,500
<6 placed in early childhood centres	1,200

Source: Full Report: 3rd National Conference on Orphans and Vulnerable children, February 2005

3.2.4.2. Addressing poverty

In spite of the fact that Namibia is officially classified as a Lower-middle-income country, this rating hides a severely skewed distribution of income distribution and the reality that a large proportion of Namibia's population is poor and is affected by problems associated with poverty. The high prevalence of HIV/AIDS exacerbates these problems, thus the burden of HIV falls disproportionately on the poor.

Poverty reduction has been the overarching policy goal in Namibia since independence. The 1998 Poverty Reduction Strategy (PRS) focuses on equitable and efficient delivery of public resources, agricultural expansion, and consideration of food security and options for non-agricultural economic empowerment. It directs efforts to invest in the education and to ensure the good health of all citizens; to develop new ways to generate income amongst poor communities; and to address safety nets to assist the poor. HIV/AIDS is integrated within this framework.

Vision 2030 envisages Namibia as a high-income country, with equal access to productive resources and employment opportunities that allows Namibians a life well above the poverty level. It also acknowledges the effects of HIV/AIDS and its impact on health and poverty.

Through the Medium-term Expenditure Framework and the annual budget, the GRN seeks to promote poverty reduction by stimulating economic growth, investing in social sectors, and funding social safety nets, as well as through programmes and projects funded by the development budget.

Namibia's 2004 report of the Millennium Development Goals recapitulates human development and poverty reduction as the overall development goals for the country. It sets out national progress in achieving the eight MDGs based on national targets tailored to Namibia's development circumstances. The MDG report illustrated how Namibia is one of the few countries on the African continent to maintain a social safety net for vulnerable groups such as senior citizens, orphans, people living with disabilities, and war veterans. In 2003 the GRN established a national drought aid scheme and allocated N$220 million for

food distribution, food-for-work programmes, and support to vulnerable children, pregnant/lactating mothers, the elderly and households affected by HIV/AIDS. The scheme covers a total of 640,000 people, about one-third of the total population.

In addition to the above, the government remains committed to expediting the national land reform programme in full accordance with the Constitution and using a range of means including state purchasing and resettlement, expropriation and the Affirmative Action Loan Scheme.
The third national strategic plan on HIV/AIDS links all Namibian international commitments and development plans, demonstrating a sincere and active commitment of the GRN political leadership to combat the HIV/AIDS epidemic through the establishment of appropriate policies and frameworks.

3.2.5. Programme Management

Strategic Result: Effective management structures and systems, optimal capacity and skills, and high quality programme implementation at national, sectoral and regional levels.

3.2.5.1. Developing HIV/AIDS management capacity

Capacity building and human resource development in overall HIV/AIDS programme management has been at its highest in the past few years, with significant support from the EC, USG , GTZ, UN agencies and other partners. Strengthening has targeted the expanded national AIDS response in the National AIDS Coordination Programme, Directorate of Special Programmes, regional and sectoral levels, and other key players such as NPC, OPM, NABCOA and NANASO.

For the past two years, NACOP has consistently led multi-sectoral supervisory visits to Regional AIDS Coordinators (RAC) in all thirteen regions. RACs, Regional Development Planners and MOHSS Senior Health Programme Administrators from each region have been brought together in biannual meetings aimed to enhance coordination, provide feedback on critical issues arising at the ground level, and to conduct training.

Management structures such as NAEC, NAMACOC and NAC have been enhanced through consistent support by the UNAIDS Namibia office in the form of Project Acceleration Funds.

A second national gap analysis occurred in 2005 in preparation of the country coordinated proposal to the Round 5 GFATM. This exercise provided another opportunity in which stakeholders and development partners came together to review national programmes in line with goals, targets, expenditures and actual programme development and implementation, enhancing national capacity in management and coordination efforts.

3.2.5.2. Surveillance and operational research

The Management Information and Research (MIR) Subdivision of the MOHSS has the mandate to coordinate, approve and monitor all research conducted in the country. MIR launched national Research Management Policy with well-

defined coordination and management structures in 2004, which also include guidelines on clinical trials involving human subjects. Members of the national research coordination committees are co-opted from the MOHSS, other research institutes and civil society.

The RM&E subdivision also is tasked to coordinate research related to HIV/AIDS, TB and malaria and represents NACOP on a number of research-related committees. For example, the Multi-Country Project in HIV/AIDS Social Science Research is supported by various development partners of the Netherlands. Its aim is to develop research capacity while conducting relevant social science research on HIV/AIDS in five African countries, and is chaired by the MOHSS. Another project is the South African HIV/AIDS Research (SAHART), an initiative that aims to establish information portals of HIV/AIDS research and build research capacity in SADC countries. The RM&E unit is represented in these committees as well as others that are related to HIV/AIDS, TB or malaria.

The advent of the national Monitoring and Evaluation system is bringing additional routine surveillance and research such as the annual workplace and health facility surveys planned for 2006. These, in addition to existing surveillance and data collection, will serve to inform future programme planning and help to better coordinate the national response using sound, empirical evidence.

4. Major challenges faced and actions needed to achieve the goals/targets

This section of the report focuses on key challenges faced at the conclusion of the reporting period and is arranged according to the five major components of Namibia's national strategic plan.

4.1 Component One: Enabling environment

People infected and affected with HIV/AIDS enjoy equal rights in a culture of acceptance, openness and compassion.

Capacity development: Leadership

Namibia has shown strong political commitment to expand service delivery for HIV/AIDS and has over the past few years made tremendous progress in bringing services to the people in need. National and regional sector leaders continue to show ongoing support for the fight against HIV/AIDS as well as assuming responsibility for implementation of sector responsibilities under MTPIII. However there are some constraints that need to be addressed:

- Increase the visibility of leadership at national and regional levels for the fight against HIV/AIDS;
- Strengthen the willingness of leaders to engage in the national response at all levels;
- Implement interventions that aim to empower leaders at all levels on HIV/AIDS issues and strengthen their participation and involvement in the response.

PLWHA Involvement

PLWHA involvement needs strengthening to provide a coordinated approach in all levels of the national response. Thus, key areas to focus on are to:

- Increase and fund interventions that aim to empower PLWHAs, eliminate stigma and discrimination and strengthen participation of PLWHA in the HIV response;
- Continue strengthening the capacity of the national PLWHA organisation, Lironga Eparu, to effectively coordinate and support all PLWHA support groups in all the regions.

Policy and law reform

The promotion and protection of human rights plays a crucial role in the impact of HIV/AIDS on a society and on the vulnerability of people to HIV infection. People living with HIV or AIDS face discrimination and stigma on a daily basis. Building capacity on legal and human rights issues associated with HIV/AIDS is one of the ALU's key activities. However, there are some key constraints to be addressed are

- Increase levels of human resources in the legal field to draft laws and legislation;

- Upgrade the technical capacity of lawmakers and related personnel in the field to update / renew legislation;
- Conduct a review to pinpoint potentially conflicting laws, acts and other legislation with regard to the issues surrounding HIV and AIDS and realign them as necessary.

4.2 Component Two: Prevention

Reduced new infections of HIV and other STIs.

Behaviour change interventions for in-and out-of-school youth

The Ministry of Education has implemented extracurricular life skills programmes since 1998 and has reached about seventy percent of secondary schools and forty percent of primary schools[7]. Despite its impressive success, there are specific areas to be addressed in order to further the programme and reach all of the targeted youth:

- Train and support school officials in programme monitoring and evaluation of youth programmes;
- Invest financial and human resources in national and regional levels to enable better programme management and coordination;

Prevention of transmission in health care settings

URC continues to work with multiple stakeholders in the integration of safe injection and waste disposal practices into all programmes. The following areas should be addressed in order to facilitate the objectives of this programme and to increase safety in healthcare settings in general:

- Complete the revision of the existing infection control policy to include injection safety;
- Develop quality assurance systems to improve service delivery at facility and provider levels;
- Implement a behaviour change strategy and finalise audiovisual materials for distribution;
- Finalise and implement a waste management policy, and upgrade sites with new technology and commodities;
- Assess and identify current practices and their impact on disease transmission;
- Provide training on the national policies and guidelines related to injection safety.

Social mobilisation and awareness

This activity is one of the main prevention strategies and although Namibia has made progress in terms of covering youth with HIV/AIDS education and life-skills training, there remain a number of gaps to ensure that the entire population, and in particular vulnerable sub-populations, are reached. These are:

- Finalise and implement the national strategy on social mobilisation;

[7] HIV/AIDS Management Unit, Ministry of Education, 2005.

- Increase involvement of several important groups in the overall IEC strategy such as men, local and traditional leaders, healers and traditional birth attendants, and PLWHA;
- Promote awareness and information about critical interventions, namely: VCT, PMTCT, ART, WPP;
- Strengthen outreach programmes and develop appropriate community-specific IEC materials to rural areas and hard-to-reach sub-groups, such as child-headed households, OVC and vulnerable families;
- Strengthen media coverage of HIV/AIDS issues through a training strategy for media professionals;
- Conduct appropriate research on social mobilisation and behaviour change;
- Increase resources to civil society organisations to expand IEC and BCC programmes;
- Create recreational and entertainment activities targeting children and youth in- and out-of-school and unemployed.

Workplace programmes

Attention to workplace programmes has increased considerably in the last two years. Gaps that need urgent attention are to:

- Increase resources and build capacity to implement comprehensive workplace programmes for all 80,000 civil servants in the public sector;
- Mainstream HIV/AIDS into all sectoral plans complete with adequate budget allocations;
- Implement comprehensive workplace programmes in large companies and SMEs;
- Provide additional support and strengthening of national umbrella organisations to coordinate private sector and civil society response, namely NABCOA and NANASO, respectively.

Expand condom provision

The uptake of condoms in the general public and especially youth has increased slowly but steadily, however not enough to curb spread of the disease. Some key constraints to be addressed are:

- Expand social marketing outlets for condoms which is consistent with the most-at-risk groups and also allows general geographic coverage;
- Develop diverse IEC materials and make available adequate numbers of male and female condom demonstration models;
- Increase availability of female condoms;
- Conduct an assessment of condom supply and demand;
- Create distribution channels that target young people.

Strengthen STI management

STIs in Namibia have indicated a decline in recent years, however the national programme requires some strengthening in order to maximise this downward trend. Areas to cover are to:

- Increase allocation of financial resources to the STI programme, particularly for training and supervision;

- Develop a training schedule which will be linked to the NHTC for consistent training and supervision of health workers;
- Develop IEC materials on all reported syndromes in local languages;
- Conduct community research on quality of STI services and use the findings to inform service delivery and partner-tracing strategies;
- Develop a partner tracing strategy in order to improve management and control of STIs;
- Review and update the current STI guidelines;
- Conduct an STI aetiology study and use findings to inform programme management and direction;
- Introduce other interventions for control such as social marketing of STI drugs.

Voluntary counselling and testing

Considerable progress has been made in increasing access to and coverage of VCT services and a policy for rapid testing has been developed and rapid testing has been rolled out. Constraints to be addressed are to:

- Increase availability of rapid testing in health facilities, including ANC clinics and New Start testing centres;
- Recruit and train community counsellors, social workers and/or trained nurse counsellors to implement and supervise the programme;
- Upgrade health facilities to accommodate private and confidential VCT services;
- Expand coverage of stand-alone VCT centres and mobile clinics;
- Build adequate referral systems and post-test facilities for HIV negative and positive clients;
- Design programmes to counter VCT counsellor burn-out;
- Strengthen male mobilisation to increase numbers of men seeking VCT;
- Fully develop VCT information systems to ensure accurate reporting;
- Voluntary counselling and testing for TB and STI clients needs too be encouraged.

Safety of blood transfusion products

In order to meet the objective of reducing risk of HIV/AIDS through blood transfusion, the following challenges in the national blood programme need to be addressed:

- Introduce a national blood policy and plan;
- Introduce a quality policy, quality plan or designated quality managers at all levels of the BTS;
- Implement a national blood donor programme, national programme officer or staff trained in donor recruitment and national testing protocols;
- Develop and implement a documented national blood component programme and strategy;
- Standardise specialised equipment, blood storage, blood stock management and blood distribution procedures at all levels of the BTS;
- Increase access to education, training and information for staff at all levels of the system.

Interventions to reduce vulnerability

While the legal framework and programmes are in place to address the issues of gender inequalities, violence and alcohol abuse, it is clear that this area of the national response still requires urgent attention to effectively meet the growing needs of vulnerable populations, namely the following:

- Narrow the gap between the policy environment and the ability of different agencies to implement these policies;
- Facilitate the integration of gender in to the implementation of the national AIDS response and ensure national capacity to specifically address gender issues;
- Empower the MGECW to serve its mainstreaming function rather than to directly implement programmes;
- Expand programming to address priority issues such as intergenerational / transactional sex, out-of-school youth, youth-friendly health services, and support to marginalised girls;
- Increase training to law enforcement and other officials to better enforce child abuse laws;
- Expand services for gender-based violence, including training of law enforcement officials and other officials and establish a national campaign on GBV;
- Increase numbers and support to safe houses and shelters;
- Conduct reviews on existing related legislation, and create appropriate regulations for issues such as property grabbing, asset stripping and dispossession;
- Establish a Traditional Practices and HIV/AIDS Forum to examine traditional laws and practices that increase vulnerability of women and children to HIV transmission;
- Develop training for health care workers and investigate less intensive home-based care alternatives;
- Conduct a national campaign to include men in gender issues at the household level.

4.3 Component Three: Treatment, care and support

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

Laboratory Services

Recommendations made in the will mid term review of MTP II in 2003 address the following constraints:

- Reduce burden on the NIP laboratory system by increasing medical technologist staff;
- Improve operational efficiency of the laboratory through management capacity;
- Improve diagnostic technology capacity for opportunistic infections including TB;
- Expand access of laboratory services to public health facilities rather than only at district hospital level;
- Enable laboratories to conduct HIV DNA PCR diagnosis for infants.

Drugs and supplies systems

Despite GFATM and expanded treatment programmes, there exists a problem to the already over-taxed system unless these constraints are addressed to handle the influx of medicines and medical commodities:

- Increase the number of trained professional staff and continue capacity building of existing staff to effectively manage implementation of all planned and unplanned activities;
- Enact the Medicines Control Act to ensure the proper control of medicines in Namibia;
- Clear the backlog of applications for registration of medicines;
- Secure adequate physical space for application dossiers and a quarantine at the CMS for medicines under test at the QSL;
- Improve the level of supplier performance to ensure availability of medicines in the drug supply system.

PMTCT+ services

Good progress has been made in rolling out the PMTCT programme; however, there exist some areas needing attention:

- PMTCT programme training of nurses in hospitals, health centres and clinics;
- Resolution of transport issues to enable adequate supervision for Regional and District PMTCT programmes;
- Improvement of VCT services, so that at the time of delivery women there are aware of their HIV status and can be identified for PMTCT intervention;
- Improve the follow-up mechanisms for HIV positive mothers and their newborns, for example, introduce record keeping of babies' HIV status after 18 months;
- Address human capacity at all levels to match the pace of planned service roll-out;
- Roll-out rapid testing (certification of sites) to improve services at the local level;
- Enable HIV DNA PCR diagnosis for infants;
- Increase the proportion of women receiving their HIV results in a PMTCT setting through training in rapid testing;
- Increase the proportion of PMTCT facilities submitting regular and accurate data to the central HIS office.

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Provision of ART

One of the fastest roll-outs of service delivery has been the health service implementation of the ART programme. Unfortunately the parallel community support systems and promotion of treatment has not expanded with the same speed. The following needs to be addressed in order to reach the country's goal of 77,000 people on ART by the year 2010:

- Recruit the necessary human resources (e.g. medical doctors, nurses, pharmacists, social workers, medical supply staff, clerks, community

counsellors) to implement public sector VCT, PMTCT+ and ART programmes and monitor the activity of these programmes;
- Renovate and upgrade health facilities to accommodate the uptake of ART and PMTCT+ services ;
- Motivate for funding of laboratory tests and ARV medicines to ensure programme sustainability;
- Train all related health personnel in ART;
- Resolve transport issues to enable community involvement in the ART programme;
- Improve data collection and reporting from sites to the national level;
- Urgently develop and disseminate IEC materials to educate communities about treatment options, adherence, nutrition, and related issues;
- Implement diagnostic PCR to detect HIV infection in young children.

Home Based Care

HBC activities themselves are implemented by civil society; however the resources are inadequate versus the need. Critical gaps that this programme needs to resolve are:

- Expand HBC service coverage to all constituencies;
- Strengthen coordination through programme support, supervision and standardisation of incentives for the 15,000 HBC volunteers;
- Establish linkages and referral systems between ART, the health care system and community-based HBC programmes;
- Increase resources for civil society organisations to properly expand HBC services;
- Improve coordination of M&E and commodity supply.

4.4 Component Four: Impact Mitigation

Strengthened and expanded capacity of local responses to mitigate socio-economic impacts of HIV/AIDS.

Capacity development: Local responses

Major improvement in regional implementation has occurred during the last two years, with increased coordination efforts by the Ministry of Regional, Local Government, Housing and Rural Development. Constraints in the local response that need improved are:

- Increase overall human and financial resources to coordinate the local response;
- Increase leadership and political support at all levels, and educate staff and leaders on the multi-sectoral response to HIV/AIDS;
- Build infrastructure and regional level support in terms of transportation and communication needs.

Comprehensive services for OVC, their carers and PLWHA

In order to effectively expand coverage to reach all needy and vulnerable children, efforts need to address these main constraints:

- Increase material and financial assistance and outreach to OVC and their caregivers, and improve governmental guidance and quality control for the growing numbers of homes and shelters;
- Provide income-generating opportunities to increase economic empowerment for caregivers of OVC;
- Improve coordination and delivery of health and nutritional support services, and widespread coverage of comprehensive OVC services in all constituencies;
- Support civil society organisations to provide material, financial and technical assistance to fully enable local responses to OVC and their caregivers;
- Increase opportunities to hear the voices of children and gain insight into the impact of their situation;
- Increase the sharing of learning and networking opportunities for providers;
- Expand the amount of skilled personnel in the public service system, in particular, social workers, paralegals, counsellors, administrators, and financial managers to implement and manage programmes targeting OVC;
- Increase awareness efforts on children's rights, public OVC programmes and how to access these, exemption policies for education costs and insufficient materials available for psychosocial support;
- Develop and support the establishment of the national OVC database.

PLWHA

Some progress has been made in the area of psychosocial support for PLWHA over the years, however these efforts are hampered by an overall weakened structure at all levels. The PLWHA support system should address:

- Expansion of PLWHA support systems which include services such as: psychosocial and bereavement counselling, buddy counselling, food supplements, treatment adherence counselling, positive living, succession planning, and so on;
- Implement and resource interventions that aim to empower PLWHAs, eliminate stigma and discrimination and strengthen participation of PLWHA in the HIV response;
- Expand the number of counsellors to provide PLWHA services;
- Continue building capacity of the national PLWHA umbrella organisation, Lironga Eparu, in order to effectively coordinate and support groups at all levels.

Addressing poverty

While the third national strategic plan on HIV/AIDS links all Namibian international commitments and development plans, there remain priorities for development assistance in order to reduce the impact of HIV/AIDS through poverty alleviation efforts. Areas to address are to:

- Increase foreign direct investment in priority sectors such as manufacturing, infrastructure, tourism, agriculture and fisheries to create

jobs, boost economic growth and ensure transfer of knowledge and technology;
- Increase development assistance regardless of Namibia's high national average income, which hides the high ratio of income inequality;
- Provide technical assistance for institutional strengthening and capacity building, particularly in anticipation of the negative impact of HIV/AIDS on sectors, civil service and private businesses;
- Provide financial and technical assistance to implement the national emergency relief programme for food and non-food items, focusing on immediate relief to the poorest and most vulnerable, especially those affected by HIV/AIDS.

4.5 Component Five: Programme Management

Effective management structures and systems, optimal capacity and skills, and high quality programme implementation at national, sectoral and regional levels.

Developing HIV/AIDS Management Capacity

Despite the rapid expansion of priority services, Namibia is experiencing severe constraints in the overall health system with regard to human resources in numbers, capacity and skills. Attention should focus on the following:

- Increasing numbers of human resources to provide services at various levels, including the Directorate for Special Programmes, regional counterparts, and other health professionals for programme management, M&E and overall coordination;
- Increase funding for long-term training of doctors, nurses, pharmacists and social workers;
- Upgrade health facilities to meet the need of priority services (i.e., PMTCT, ART and VCT);
- Address the gap in funding for antiretroviral medicines and laboratory services to meet national targets;
- Create adequate storage capacity for medical and related commodities such as condoms and IEC materials;
- Establish adequate transport and communication technology for improved outreach and referral systems;
- Increase public/private sector collaboration in HIV/AIDS activities, particularly in the sharing of and reporting on data and in following national policies and guidelines ;
- Expanding hospital space to accommodate the increased number of patients for admissions hinders to allowed for example the isolation of MDR TB patients from patients that are HIV positive;
- Strengthening the capacity of the local level in the areas of financial and project management.

Programme monitoring and evaluation

Monitoring and evaluation is in its nascent stage of development, although significant progress has been made compared to the 2003 report. To further the national M&E agenda the following issues are important to resolve:

- Address the gap in funding for priority surveys and other data sources necessary to feed into the national M&E system;
- Strengthen overall M&E capacity throughout all sectors and at all levels of the country;
- Develop and implement financial and resource tracking and allocation mechanism for all sectors;
- Strengthen the MOHSS Management Information systems in human and technical capacity to address delays and problems in reporting;
- Institute an annual forum to systematically disseminate M&E results and promote the use of findings in programme decision-making and planning;
- Strengthen collaboration between RM&E, HIS and MI &R Subdivisions in the MoHSS.

Surveillance and operational research

Insufficient human capacity at all levels and under-staffing has hampered the execution of operational research activities in the country. In order to effectively gauge the impact of HIV/AIDS programmes and guide future programming, efforts need to focus on the following:

- Establish an HIV/AIDS (including TB and malaria) sub-committee to coordinate and promote social science and other HIV/AIDS research;
- Develop and implement a national research priority agenda on research necessary to inform national programmes;
- Institute an annual research forum to systematically disseminate research results and findings;
- Training on research methodology, proposal development, data analysis and epidemiology.

5. Support required from country's development partners

Namibia is currently implementing the Round 2 Global Fund proposal, which focuses on scaling up the country's national response in the areas of service provision and prevention has provided 8,608,497 USD in 2005 alone. Despite this, Namibia remains in need of coordinated and targeted efforts to address service provision coverage gaps, aid the groups most vulnerable to HIV, and strengthen the health delivery system and the overall management and coordination of the national response.

Of the planned expenditure from 2006 through 2010, an expected amount of about 545,000,000 USD will address the national response with the major contributors being GRN (44.4%), Global Fund Round 2 (17.1%), the US government (32.5%), UNICEF (1.7%) and the European Community (1.3%). The remaining balance (3.0%) is funded by other development partners comprising national governments, UN agencies, other multi-lateral agencies and private sector foundations. Despite considerable financial support, a recent gap analysis exercise demonstrated that Namibia still sits with a financial shortfall of roughly 298,000,000 USD for this period; a significant shortfall in light of Namibia's missing the GFATM Round 5.

With such a significant influx of financial resources flowing into the country, it is imperative that expenditures and efforts are carefully monitored to ensure the best possible use of all resources. Thus, in order to effectively assist Namibia to achieve its goals and targets, particularly its responsibilities to the UNGASS Declaration of Commitment, development partners should address the following key areas:

- Utilize the national HIV/AIDS strategic plan (MTP3) as the guide for sector responses as well as a management and coordination tool for all HIV/AIDS activities;
- Enforce a requirement that all implementers provide data on all HIV/AIDS activities to the MOHSS Directorate for Special Programmes to assist in monitoring and evaluation of the national effort;
- Focus financial support and technical assistance to address key constraints as described in section IV, in short:
    - Strengthen PLWHA involvement;
    - Develop targeted BCC approaches, particularly focusing on vulnerable groups, while maintaining other prevention efforts;
    - Strengthen workplace programmes and mainstreaming activities in the public and private sectors;
    - Focus on coordination and strengthening of the health delivery system for prioritised treatment and care programmes;
    - Expand capacity of care and support for OVC and PLWHA, their caregivers and families;
    - Strengthen overall management, coordination, M&E and research efforts of the national response;

    - Increase human resources for HIV/AIDS activities across all sectors.

- Strengthen capacity of national umbrella organisations which support PLWHA support groups, the private sector and civil society organisations;
- Support development of project and resource tracking through the CRIS Project / Resource tracking module or equivalent in order to effectively inventory, manage and monitor resources directed at the national response;
- Support implementation of national surveys, research and other social science research to adequately gauge national efforts and most importantly, support the utilisation of data in programme planning.

6. Monitoring and evaluation environment

Monitoring and evaluation efforts have significantly progressed in Namibia since the 2003 UNGASS report. At present, the Response Monitoring & Evaluation Subdivision (RM&E) sits within the MOHSS Directorate of Special Programmes. This unit is responsible to track progress of the national multi-sectoral response to HIV/AIDS, Tuberculosis and malaria and incorporates a variety of both new and existing data sources in the national M&E system.

An M&E operational plan has been developed with stakeholders including civil society and PLWHA, which includes standardised core national indicators, guidelines on tools for data collection, and strategies on data collection and analysis, assessing quality and accuracy of data, and data dissemination and usage.

Funding has been secured for implementation of some activities contained in the operational plan for trainings, capacity building exercises, national database development and additional staff. However, shortfalls remain in support of the major data sources, such as the Demographic and Health Survey, HIV Sentinel Surveillance, Health Facility Survey, Workplace Survey, and other surveys for the overall five-year period of the plan.

An M&E committee (see annexure x for membership list) comprised of multi-sector stakeholders and chaired by the MOHSS Under Secretary has existed since 2003; however, there is a need to strengthen the consistency of involvement by this group in M&E activities and overall coordination.

Information dissemination workshops are planned according to an annual reporting schedule contained in the operational plan. Due to constraints faced by the DSP, the M&E report of the first year of the national AIDS strategy will be released about six months behind schedule; however, the unit anticipates timely reporting and dissemination beginning in 2006.

6.1 M&E Constraints

- Overall, insufficient human resources both in numbers and in technical capacity in M&E has hindered finalisation of the M&E operational plan, the first annual HIV report and the implementation of planned activities in a timely manner;
- Financial commitment is needed for all major data sources, surveys and research in order to meet international and national reporting obligations;
- No clear policy on M&E data flow and sharing is currently available in the country;

6.2 M&E Recommendations

- The RM&E subdivision should ensure that the full staff complement is in place by the beginning of Year 2 of the M&E operational plan (1 April 2006) so that implementation of the plan can begin;
- The M&E committee should increase its role in strengthening overall M&E coordination amongst stakeholders and across sectors and in particular, emphasize the use of data in programme planning and coordination efforts;
- Funding should be secured for the remaining four years of the M&E operational plan to ensure full implementation of all required surveys and research;
- Strengthen collaboration between RM&E, HIS and MI &R Subdivisions and harmonize information systems and the use of information in programme planning and management.

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Annex 1: Consultation/preparation process for this national report

In preparation of the 2005 UNGASS country report, Namibia has followed the recommended steps as outlined by UNAIDS as described in the table below.

Table 5: Namibia consultation/preparation process for UNGASS reporting 2005

#	UNAIDS SUGGESTED PROCESS	ACTIVITY	DATE	DONE
1	Planning for data collections and vetting (Ongoing)	On-going as part of national M&E plan		✓
2	Collecting and compiling UNGASS data (October – November)	Data collection from various sources	15 Sept – 13 Dec	✓
3	Utilization of CRIS as data repository for UNGASS data	28-30 Nov Cape Town CRIS data entry workshop	RM&E staff attend CRIS workshop	✓
4	Identification within CRIS of MARP target populations	n/a	n/a	
5	Participation in the national vetting workshop (December)	M&E Committee meeting	12 Dec	✓
		NAEC input / validation	12-16 Dec	✓
		DSP Programme Managers input meeting	28 Dec	✓
6	Generation of relevant tables and graphics (October – December)	RM&E subdivision continues report drafting	28 Nov–16 Dec	✓
7	Insertion of graphics into the narrative report	RM&E continues report drafting	9-16 Dec	✓
8	Generate/Export the UNGASS Indicator file from CRIS and attach to email	RM&E finalises report and gets final MoHSS management approval	30 Dec	✓
9	Email completed narrative report and attached CRIS export files to UNGASSindicators@unaids.org (UNAIDS Geneva, Evaluation Unit)	Report sent to UNAIDS Geneva	30 Dec	✓

Care has been made to give credit to the major contributors to this report and we apologise for any errors or omissions of organisations or individuals.

We acknowledge with gratitude those who have assisted in the compilation and drafting of this report:

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Annex 2: National Composite Policy Index Questionnaire

National composite policy index questionnaire part A

I. Strategic plan

1. Has your country developed a national multi-sectoral strategy/action framework to combat HIV/AIDS?
(Multi-sectoral strategies should include, but not be limited to, those developed by Ministries such as the ones mentioned below.)

Yes X	**No**	**Not Applicable (N/A)**	**Period covered:** 01-04-2004 to 31-03-2009

1.1 *IF YES*, which sectors are included?

Sectors included	**Strategy/Action framework**			**Focal point/Responsible**		
Health	Yes	X	No	Yes	X	No
Education	Yes	X	No	Yes	X	No
Labour	Yes	X	No	Yes	X	No
Transportation	Yes	X	No	Yes	X	No
Military	Yes	X	No	Yes	X	No
Women	Yes	X	No	Yes	X	No
Youth	Yes	X	No	Yes	X	No
Others to specify: Public Services coordination, agriculture, child welfare, environment and tourism, finance, foreign affairs, information and media, lands, legal, legislative, mining and energy, prisons, regional and local government, civil society (FBOs, NGOs, etc), private sector.	Yes	X	No	Yes	X	No

Comments:

1.2 *IF YES*, does the national strategy/action framework address the following me areas, target populations and cross-cutting issues? (*Yes/ No*)

Programme	
a. Voluntary counselling and testing?	a. Yes

b. Condom promotion and distribution?	b. Yes
c. Sexually transmitted infection prevention	c. Yes
and treatment?	d. Yes
d. Blood safety?	e. Yes
e. Prevention of mother-to-child	f. Yes
transmission?	g. Yes
f. Breastfeeding?	h. Yes
g. Care and treatment?	i. Yes
h. Migration?	
Target populations	i. Yes
i. Women and girls?	j. Yes
j. Youth?	k. Yes
k. Most-at-risk populations[9]?	l. Yes
l. Orphans and other vulnerable children?	
Cross-cutting issues	m. Yes
m. HIV/AIDS and poverty?	n. Yes
n. Human rights?	o. Yes
o. PLHA involvement?	

1.3 *IF YES*, does it include an operational plan?	**Yes X**	**No**
1.4 *IF YES*, does the strategy/operational plan include:	**Yes X**	**No**
a. formal programme goals?	**Yes X**	**No**
b. detailed budget of costs?	**Yes X**	**No**
c. indications of funding sources?	**Yes X**	**No**
1.5 Has your country ensured "full involvement and participation" of civil society in the planning phase?	**Yes X**	**No**
1.6 Has the national strategy/action framework been endorsed by key stakeholders?	**Yes X**	**No**

Comments:
Namibia's third national strategic plan on HIV/AIDS incorporates the country's international commitments such as UNGASS, Abuja Declaration, MDG, etc. It also addresses workplace programmes, monitoring and evaluation, research, and regional profiles that indicate regional and sectoral obligations and commitments.

2. Has your country integrated HIV/AIDS into its general development plans (such as: a) National Development Plans, b) United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, and d) Common Country Assessments)?

Yes X	No	N/A

2.1 *IF YES*, in which development plan? a) X b) X c) X other

Covering which of the following aspects? (*Yes/ No*)

	a)	b)	c)
HIV prevention	Yes	Yes	Yes
Care and support	Yes	Yes	Yes
HIV/AIDS impact alleviation	Yes	Yes	Yes
Reduction of gender inequalities as relates to HIV/AIDS prevention/care	Yes	Yes	Yes
Reduction of income inequalities as relates to HIV prevention/care	Yes	Yes	Yes
Others:	No	Yes	Yes

3. Has your country evaluated the impact of HIV and AIDS on its economic development for planning purposes?

Yes X	No	N/A

3.1 *IF YES*, how much has it informed resource allocation decisions? (*Low to High*)

Low										High
[0]	1	2	3	4	5	6	7	8	9	10

Comments:
The National Planning Commission recently conducted an evaluation of the impact of HIV/AIDS on economic development; however, since the NPC is still completing the final reports it has not been available for distribution and action.

4. Does your country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services, military, peacekeepers and police?

Yes X	No	N/A

4.1 *IF YES*, which of the following have been implemented?

HIV prevention	Yes X	No

Care and support	**Yes X**	**No**
Voluntary HIV testing and counseling Mandatory HIV testing and counseling	**Yes X** **Yes X**	**No** **No**
Others to specify: Support for OVC and families of staff that have died	**Yes X**	**No**

Comments:
As per the mandate under MTPIII, the Ministry of Defence has drafted an HIV/AIDS sector policy and implements HIV/AIDS activities such as education and VCT under prevention; ART, Home Based Care and other support for infected personnel and their families. MOD participates in the Regional AIDS Coordinating Committee to form linkages with other partners in the response. With regard to M&E, a KAP study of the NDF was completed in Dec 2004 and a plan for an MOD M&E system is developed. Namibia Police have recently begun an HIV/AIDS initiative programme in conjunction with SMA. Some sporadic HIV/AIDS initiatives are in place within prisons, and the availability of condoms for prisoners is under debate with the national HIV policy. There are no reports on HIV/AIDS activities from Namibia's Navy or Air Force services.

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes?											
2005	Poor										Good
	0	1	2	3	4	5	[6]	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	[9]	10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

UNDAF and CCA strategies have aligned their plans with national strategic objectives. Poverty Reduction Strategy Papers were developed early in Namibia's epidemic and do not adequately reflect national needs; successively NDP2 better addresses national needs, and finally the third national strategic plan (2004-2009) best outlines the country's direction in alignment with global objectives. MTPIII includes sectoral obligations and provides regional profiles and obligations. Two successive national gap analyses have occurred in preparation for Round 2 and Round 5 GFATM applications, which have helped to refine documentation and understanding of Namibia's progress in the national response resource allocation needs.

II. Political support

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS programmes and effective use of government and civil society organizations and processes to support effective AIDS programmes.

1. Does the head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year?

Head of government	**Yes X**	**No**
Other high officials	**Yes X**	**No**

2. Does your country have a national multi-sectoral HIV and AIDS management/coordination body recognized in law? (National AIDS Council or Commission)*

Yes X	**No**	**N/A**

2.1 *IF YES*, when was it created? Year: 01-01-1999

2.2 Does it include?

Terms of reference	**Yes X**	**No**
Defined membership	**Yes X**	**No**
Including civil society	**Yes X**	**No**
People living with HIV	**Yes X**	**No**
Private sector	**Yes X**	**No**
Action plan	**Yes X**	**No**
Functional Secretariat	**Yes X**	**No**
Date of last meeting of the Secretariat	**Date: 24-11-2005**	

Comments:
Namibia's national coordinating structure to address HIV/AIDS consists of a National AIDS Committee, the highest decision-making body under Cabinet. Under this body falls the National Multi-sectoral AIDS Coordination Committee (NAMACOC) that is responsible for coordination and overall implementation of the national and sectoral response and is referred to above. Staffing support is provided by the National AIDS Coordination Programme Secretariat of the MOHSS: Directorate Special Programmes.

3. Does your country have a national HIV and AIDS body that promotes interaction between government, people living with HIV, the private sector and civil society for implementing HIV and AIDS strategies/programmes?

Yes X	**No**	**N/A**

3.1 *IF YES*, does it include?

Terms of reference	**Yes X**	**No**
Defined membership	**Yes X**	**No**
Action plan	**Yes X**	**No**
Functional Secretariat	**Yes X**	**No**
Date of last meeting	**Date:** 07-12-2005	

Comments:
The National AIDS Executive Committee (NAEC) falls under the NAMACOC (described above) and is a multi-sectoral group that includes civil society, private sector and PLWHA representation. NAEC is responsible for the implementation of the decisions of the National AIDS Committee and the NAMACOC with regard to the national and sectoral response. Staffing support is provided by the National AIDS Coordination Programme Secretariat of the MOHSS: Directorate Special Programmes.

4. Does your country have a national HIV and AIDS body that is supporting coordination of HIV-related service delivery by civil-society organizations?

Yes X	**No**	**N/A**

4.1 *IF YES*, does it include?

Terms of reference	**Yes X**	**No**
Defined membership	**Yes X**	**No**
Action plan	**Yes X**	**No**
Functional Secretariat	**Yes X**	**No**
Date of last meeting	**Date:** 01-11-2005	

Comments:
The Namibia Network of AIDS Service Organisations (NANASO) was established in 1991 to provide a network service to NGOs active in the field of HIV/AIDS. Its aim is to strengthen these organizations to maximize their potential to effectively address the HIV/AIDS pandemic in Namibia and to speak on their behalf on matters of common interest. NANASO is a member of both NAEC and NAMACOC in the overall national response structure.

Overall, how would you rate the political support for the HIV/AIDS programme?											
2005	Poor										Good
	0	1	2	3	4	5	6	[7]	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	[6]	7	8	9	10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

III. Prevention

1. Does your country have a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS to the general population?

Yes X	No	N/A

1.1 In the last year, did you implement an active programme to promote accurate HIV and AIDS reporting by the media?

Yes X	No

Comments:
In 2005 the Ministry of Information and Broadcasting, together with UNFPA and UNESCO, the Polytechnic and MISA Namibia hosted a workshop for approximately 20 media practitioners. Also MIB and UNESCO began week-long training workshops in the Caprivi Region for media practitioners and is rolling-out this training to other regions. In 2004 Johns Hopkins University also hosted a media workshop for more than 50 people.

2. Does your country have a policy or strategy promoting HIV and AIDS related reproductive and sexual health education for young people?

Yes X	No	N/A

2.1 Is HIV education part of the curriculum in:

primary schools?	Yes X	No
secondary schools?	Yes X	No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes X	No

Comments:
A national IEC strategy was drafted in 2002 and updated in 2004. The National Population Policy for Sustainable Human Development, Cabinet Decision No. 33rd/5.11.96/001 focuses strongly on sexual and reproductive health and formed the basis for the five-year programme supported by UNFPA, the National Planning Commission, and other partners. All primary and secondary schools have life skills programmes which provide young people with facts about sexual health and reproduction, pregnancy, STIs and HIV/AIDS, and help to improve communication skills. These are Window of Hope; My Future is My Choice, Stepping Stones, and Let's Talk, for primary, secondary, out-of-school youth and parents, respectively. Lifeline/Childline also supports the "Feeling Yes, Feeling No" programme for pre-primary and junior primary classes, and the Early Childhood Development Project.

Various faith-based organisations also target schools with programmes such as "True Love Waits", and Ombetja Yehinga implements school programmes and clubs with innovative cultural programmes that incorporate such activities as dance, music, and fashion. MIB makes a special effort to involve youth in the revision and design of new IEC material, hosting since 2004 a week-long Youth Consultation.

3. Does your country have a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk populations?

Yes X	**No**	**N/A**

3.1 Does your country have a policy or strategy for these most-at-risk populations?

Injecting drug users, including:	**Yes**	**No**	**N/A X**
- Risk reduction information, education and counseling?	**Yes**	**No**	**N/A X**
- Needle and syringe programmes?	**Yes**	**No**	**N/A X**
- Treatment services?	**Yes**	**No**	**N/A X**
- If yes, drug substitution treatment?	**Yes**	**No**	**N/A X**
Men who have sex with men?	**Yes X**	**No**	**N/A**
Sex workers?	**Yes X**	**No**	**N/A**
Prison inmates?	**Yes X**	**No**	**N/A**
Cross-border migrants, mobile populations?	**Yes X**	**No**	**N/A**
Refugees and/or displaced populations?	**Yes X**	**No**	**N/A**
Other most-at-risk populations? *Please specify*	**Yes**	**No**	**N/A**

Comments:
Namibia has a draft IEC strategy developed in 2002 and revised in 2004; however the strategy is in need of updating with key partners and aligned with the National HIV Policy. IEC strategies for most at-risk groups are implemented through a variety of different organisations. The National HIV/AIDS Policy also addresses the most at-risk or vulnerable groups.

4. Does your country have a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities? (These commodities include, but are not limited to; access to confidential voluntary counselling and testing, condoms, sterile needles and drugs to treat sexually transmitted infections.)

Yes X	**No**	**N/A**

4.1 Do you have programmes in support of the policy or strategy?

A social-marketing programme for condoms?	**Yes X**	**No**
A blood-safety programme?	**Yes X**	**No**
A programme to ensure safe injections in health care settings?	**Yes X**	**No**
A programme on antenatal syphilis screening	**Yes X**	**No**
Other programmes? *Please specify* Post-exposure prophylaxis (PEP)	**Yes X**	**No**

Comments:
URC is assisting the MOHSS to implement a programme for safe injections in health care settings. PEPFAR and WHO are supporting rapid strengthening of the National Blood Programme, and a draft National Strategy and Policy for Blood Transfusion Services. Syphilis screening is routinely conducted in antenatal clinics.

Overall, how would you rate policy efforts in support of prevention?										
2005	Poor									Good
	0	1	2	3	4	5	6	7	8	[9]	10
2003	Poor									Good
	0	1	2	3	4	5	6	[7]	8	9	10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

PEP procedures are in place for health workers in the event of occupational exposure. Infection control guidelines have been implemented based on universal precautions. Since 2003 the Blood Safety Programme has been assessed and implementation of a safe injections programme has begun in medical centres throughout the country.

5. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy?

(Check all programmes that are implemented beyond the pilot stage to a significant portion in both the urban and rural populations).

	2003	**2005**
a. A programme to promote accurate HIV and AIDS reporting by the media.	a. Yes	a. Yes
b. A social-marketing programme for condoms	b. Yes	b. Yes
c. School-based AIDS education for youth	c. Yes	c. Yes
d. Behaviour-change communications	d. Yes	d. Yes
e. Voluntary counselling and testing	e. Yes	e. Yes
f. Programmes for sex workers	f. Yes	f. Yes
g. Programmes for men who have sex with men	g. Yes	g. Yes
h. Programmes for injecting drug users, if applicable	h. N/A	h. N/A
i. Programmes for other most-at-risk populations	i. Yes	i. Yes
j. Blood safety	j. Yes	j. Yes
k. Programmes to prevent mother-to-child transmission	k. Yes	k. Yes

of HIV l. Programmes to ensure universal precautions in health care settings m. Other: (*please specify*) Post-exposure prophylaxis (PEP)	l. Yes m. Yes	l. Yes m. Yes

Overall, how would you rate the efforts in the implementation of HIV prevention programmes?

2005	Poor									Good
	0	1	2	3	4	5	6	7	8	[9]	10
2003	Poor									Good
	0	1	2	3	4	5	6	[7]	8	9	10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

The improvement noted above can be accounted for by the expansion of the National AIDS Coordination Programme into a full Ministerial Directorate with forty-eight posts (approximately half of which are filled). Technical support has been provided by the U.S. Centers for Disease Control, the European Commission and through the GFATM Round 2, in both a GF Programme Management Unit and additional staffing for individual recipients located within the MoHSS.

IV. Care and support

1. Does your country have a policy or strategy to promote comprehensive HIV and AIDS care and support, with sufficient attention to barriers for women, children and most-at-risk populations? (Comprehensive care includes, but is not limited to, confidential voluntary counselling and testing, psychosocial care, access to medicines, and home and community-based care.)

Yes X	No	N/A

2. Which of the following activities have been implemented under the care and treatment of HIV and AIDS programmes?

	2003	2005
a. HIV screening of blood transfusion	a. Yes	a. Yes
b. Universal precautions	b. Yes	b. Yes
c. Treatment of opportunistic infections (OI)	c. Yes	c. Yes
d. Antiretroviral therapy (ART)	d. Yes	d. Yes
e. Nutritional care	e. Yes	e. Yes
f. Sexually transmitted infection care	f. Yes	f. Yes
g. Family planning services	g. Yes	g. Yes
h. Psychosocial support for people living with HIV and their families	h. Yes	h. Yes
i. Home-based care	i. Yes	i. Yes
j. Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)	j. Yes	j. Yes
k. Cotrimoxazole prophylaxis among HIV-infected people	k. Yes	k. Yes
l. Post exposure prophylaxis (e.g., occupational exposures to HIV, rape)	l. Yes	l. Yes
m. Other: (*please specify*)	m. N/A	m. N/A

Comments:
An assessment of the national blood programme was conducted in September 2004 and a Rapid Strengthening of the National Blood Programme introduced thereafter with support from PEPFAR and WHO. Guidelines on HAART, PMTCT, and PEP for rape victims have been introduced since the 2003 UNGASS report.

Overall, how would you rate the efforts in care and treatment of the HIV/AIDS programme?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	[9]	10
2003	Poor										Good
	0	1	2	3	4	[5]	6	7	8	9	10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

Overall support for PLWHA groups has increased through Round 2 Global Fund and the World Bank. Namibia ranks 3rd in world treatment efforts, even though the ART programme was only rolled-out in the last two years. Efforts have been made to unify certification and incentives for Home Based Care providers, and an HBC Forum has developed among groups located in the hardest-hit regions of the country.

3. Does your country have a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)?

Yes X	No	N/A

3.1 *IF YES*, Is there an operational definition for orphans and other vulnerable children in the country?

Yes X	No

IF YES, please provide definition: Children under the age of 18 whose mother, father or both parents or primary caregiver has died, and/or is in need of care and protection.

3.2 Which of the following activities have been implemented under orphan and vulnerable children programmes?

	2003	2005
School fees for orphans and vulnerable children	No	Yes
Community programmes	Yes	Yes
Other: (*please specify*): Establishment of Orphans and Other Vulnerable Children Fund as well as government foster care grants.	Yes	Yes

Comments:
The Orphans and Other Vulnerable Children Fund was created by Cabinet to supplement state grants available to OVC and their caregivers.

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?

2005	Poor										Good
	0	1	2	3	4	5	6	7	[8]	9	10
2003	Poor										Good
	0	1	2	3	4	[5]	6	7	8	9	10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

A national OVC policy was launched in December 2004 which specifically outlines government's responsibility with regard to OVC, especially in connection with the impact of HIV/AIDS. The annual OVC Conference is the forum whereby stakeholders disseminate information, share best practices and review regional plans, and in 2005 this conference was supported by the President of Namibia as well as UN agencies and other partners.

V. Monitoring and Evaluation

1. Does your country have one national Monitoring and Evaluation (M & E) plan?

Yes X	No	In progress	Years covered: 01-04-2004 to 31-03-2009

1.1 *IF YES*, was it endorsed by key partners in evaluation?

Yes X	No

Comments:
The M&E operational plan has been developed through key stakeholder workshops and assistance from the World Bank M&E group, GAMET. The document is in the process of final approval through the national M&E Committee. The national strategic plan also refers to the required surveys, data sources and data collection procedures which inform the overall progress of national objectives and targets.

1.2 Was the Monitoring and Evaluation plan developed in consultation with civil society, people living with HIV?

Yes X	No

2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy	Yes X	No
well defined standardized set of indicators	Yes X	No
guidelines on tools for data collection	Yes X	No
a strategy for assessing quality and accuracy of data	Yes X	No
a data dissemination and use strategy	Yes X	No

3. Is there a budget for the Monitoring and Evaluation plan?

Yes X	No	In progress	Years covered: 03-09-2004 to 31-03-2007

3.1 *IF YES*, has funding been secured?

Yes X	No

4. Is there a Monitoring and Evaluation functional Unit or Department?

Yes X	No	In progress

IF YES,

Based in NAC or equivalent?	**Yes**	**No X**
Based in Ministry of Health?	**Yes X**	**No**
Elsewhere? *Please specify*	National AIDS Coordination Programme Secretariat (NACOP)	

4.1 If yes, are there mechanisms in place to ensure that all major implementing partners submit their reports to this Unit or Department?	**Yes**	**No X**

Comments:
The Response Monitoring & Evaluation Subdivision (RM&E) is in process of institutionalizing all data sources in the operational plan, which also includes all major implementing partners across the country for service coverage reporting. Right now, only those implementers under the Global Fund Programme are submitting service coverage data to the national M&E subdivision. As per the MTPIII, the RM&E subdivision of the MOHSS works in conjunction with the Office of the Prime Minister, the National Planning Commission, and other major partners to undertake and implement national M&E activities.

4.2 Is there a full-time officer responsible for monitoring and evaluation activities of the national programme?

Yes full time X	**Yes part-time**	**No Monitoring and Evaluation Officer**

4.3 *IF YES*, since when? : Year 20-12-2004

5. Is there a committee or working group that meets regularly coordinating Monitoring and Evaluation activities?

Yes regular	**Yes irregular X**	**No**	**Date last meeting:** 12-12-2005

5.1 Does it include representation from civil society, people living with HIV?	**Yes X**	**No**

6. Have individual agency programmes been reviewed to harmonize Monitoring and Evaluation indicators with those of your country?

Yes X	**No**	**N/A**

7. To what degree (*Low to High*) are UN, bi-laterals, other institutions sharing Monitoring and Evaluation results?

Low										**High**
0	1	2	3	4	[5]	6	7	8	9	10

Comments:
Progress in implementation of the operational plan has been delayed due to understaffing and competing national priorities of the DSP. Thus, the

institutionalization of data-sharing among agencies has also been delayed; however, all institutions provide data to the RM&E Subdivision upon request.

8. Does the Monitoring and Evaluation Unit manage a central national database?

Yes X	No	N/A

8.1 *IF YES*, what type is it? Access-based and CRIS

9. Is there a functional* Health Information System?

National level	**Yes X**	**No**
Sub-national*	**Yes X**	**No**

*(*reporting regularly data from health facilities aggregated at district level and sent to national level, analysed, and used at different levels)*

Comments:
The HIS is located in all health facilities in each district of the country. Data is aggregated and electronically entered at facility level and forwarded to the respective region and the national level on a monthly basis.

10. Is there a functional Education Information System?

National level	**Yes X**	**No**
Sub-national*	**Yes X**	**No**
* *If yes, please specify the level, i.e., district*	Educational regions and schools	

11. Does your country publish at least once a year an evaluation report on HIV and AIDS, including HIV surveillance reports?

Yes X	No	N/A

12. To what extent strategic information is used in planning and implementation?

Comments:
A biennial HIV sentinel surveillance report has been produced in the country since 1992, as well as a biennial Epidemiological report. The ARV and PMTCT programmes have also developed regular reports. The RM&E Subdivision is producing its first annual HIV/AIDS report on the first year of implementation of the current national strategic plan. It is anticipated that the annual report and dissemination meeting will lead to greater use of strategic information in planning and implementation. The Namibia Demographic and Health Survey will be conducted in 2006 along with a Health Facility Survey to assess and inform HIV/AIDS programmes, HIV/AIDS knowledge, awareness and behaviors, and quality of service delivery, respectively. In addition, a Workplace survey will be implemented in 2006 to inform national workplace status and programming.

13. In the last year, was training in Monitoring and Evaluation conducted

At national level?	**Yes X**	**No**
At sub-national level?	**Yes X**	**No**
Including civil society?	**Yes X**	**No**

Overall, how would you rate the monitoring and evaluation efforts of the HIV and AIDS programme?											
2005	Poor										Good
	0	1	2	3	4	5	6	[7]	8	9	10
2003	Poor										Good
	0	1	2	3	4	[5]	6	7	8	9	10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

Although severely impeded by understaffing, the RM&E subdivision has significantly grown from a one person operation into a subdivision of a new directorate with two full-time staff, plus an M&E Coordinator and M&E Technical Advisor. The M&E operational plan and 1st annual HIV M&E report are in the final approval process, and a five year work plan details not only M&E activities specific to the unit, but also costing for all required surveys, research and other data sources necessary to the system. Partial funding has also been secured for these data sources through bi- and multi-lateral organisations and the Global Fund. The two remaining staff positions in the RM&E will be filled effective 1 April 2006, which will enable the unit to better progress in implementation of the national M&E agenda.

National composite policy index questionnaire part B

I. Human rights

1. Does your country have laws and regulations that protect people living with HIV and AIDS against discrimination (such as general non-discrimination provisions or those that specifically mention HIV, that focus on schooling, housing, employment, etc.)?

Yes X	**No**	**N/A**

Comments:

2. Does your country have non-discrimination laws or regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination (i.e., groups such as injecting drug users, men who have sex with men, sex workers, youth, mobile populations, and prison inmates)?

Yes	**No X**	**N/A**

IF YES, please list groups:

3. Does your country have laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations?

Yes	**No X**	**N/A**

IF YES, please list groups:

4. Is the promotion and protection of human rights explicitly mentioned in any HIV and AIDS policy/strategy?

Yes X	**No**	**N/A**

Comments:
The Namibian Constitution protects and ensures the rights of people living with HIV/AIDS. In addition, a number of other policies are in place that explicitly protects the human rights of people living with HIV. It is anticipated that the National Policy on HIV which will be launched in early 2006 will extend this protection.

5. Has the Government, through political and financial support, involved vulnerable populations in governmental HIV-policy design and programme implementation?

Yes X	**No**	**N/A**

IF YES, please list groups:

6. Does your country have a policy to ensure equal access, between men and women, to prevention and care?

Yes X	No	N/A

Comments:
This is included in the National policy on HIV/AIDS which will be launched in 2006.

7. Does your country have a policy to ensure equal access to prevention and care for most-at-risk populations?

Yes X	No	N/A

Comments:
This is included in the National policy on HIV/AIDS which will be launched in 2006.

8. Does your country have a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)?

Yes X	No	N/A

9. Does your country have a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes X	No	N/A

9.1 *IF YES*, does the ethical review committee include civil society and people living with HIV?

Yes X	No	N/A

Comments:
The Biomedical Ethical Review Committee has recently been established and is comprised of; inter alia, members of civil society as well as other people with appropriate professional knowledge and background.

10. Does your country have the following monitoring and enforcement mechanisms?

Collection of information on human rights and HIV and AIDS issues and use of this information in policy and programme development reform	**Yes X**	**No**
Existence of independent national institutions for the	**Yes X**	**No**

promotion and protection of human rights, including human rights commissions, law reform commissions and ombudspersons which consider HIV- and AIDS-related issues within their work		
Establishment of focal points within governmental health and other departments to monitor HIV-related human rights abuses	**Yes X**	**No**
Development of performance indicators or benchmarks for compliance with human rights standards in the context of HIV and AIDS efforts	**Yes**	**No X**

11. Have members of the judiciary been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

Yes	**No X**	**N/A**

12. Are the following legal support services available in your country?

Legal aid systems for HIV and AIDS casework	**Yes**	**No X**
State support to private sector laws firms or university based centers to provide free pro bono legal services to people living with HIV and AIDS in areas such as discrimination	**Yes**	**No X**
Programmes to educate, raise awareness among people living with HIV and AIDS concerning their rights	**Yes X**	**No**

13. Are there programmes designed to change societal attitudes of discrimination and stigmatization associated with HIV and AIDS to understanding and acceptance?

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS?										
2005	Poor									Good
	0	1	2	3	4	5	6	[7]	8	9	10
2003	Poor									Good
	0	1	2	3	4	[5]	6	7	8	9	10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

There is an increased awareness and capacity in Namibia since the 2003 report in terms of

policies, laws and regulations related to HIV/AIDS.

Overall, how would you rate the effort to enforce the existing policies, laws and regulations?											
2005	Poor										Good
	0	1	2	3	4	[5]	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	[5]	6	7	8	9	10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

The past two years have recorded increased activity in HIV/AIDS workplace programmes and mainstreaming with concerted efforts from the Office of the Prime Minister, National Planning Commission, Ministry of Gender Equality, and NABCOA. In 2005 more than half of public sector departments have an HIV/AIDS Sectoral Steering Committee, which under MTPIII, is responsible to coordinate and manage the sector response.

II. Civil society participation

1. To what extent civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation?

Low										High
0	1	2	3	[4]	5	6	7	8	9	10

2. To what extent civil society representatives have been involved in the planning and budgeting process for the National Strategic Plan on HIV and AIDS or for the current activity plan (attending planning meetings and reviewing drafts)?

Low										High
0	1	2	3	4	5	[6]	7	8	9	10

3. To what extent the complimentary services provided by civil society to areas of prevention and care are included in both the National Strategic plans and reports?

Low										High
0	1	2	3	4	5	6	7	[8]	9	10

4. Has your country conducted a National Periodic review of the Strategic Plan with the participation of civil society in:

Yes	No	N/A X

Month _____ Year _____

5. To what extent your country have a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by an independent national/local ethical review committee *in which people living with HIV and caregivers participate?*

Low										High
0	1	2	3	[4]	5	6	7	8	9	10

Overall, how would you rate the efforts to increase civil-society participation?										
2005	Poor									Good
	0	1	2	3	4	5	6	[7]	8	9	10
2003	Poor									Good
	0	1	2	3	4	5	6	[7]	8	9	10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons

supporting such difference:

Civil society aims to influence leaders as described in point 1, but stigma in Namibia remains very significant. Civil society has had access to and participated in the whole range of planning and budgeting for the current national strategic plan on HIV/AIDS (MTP3), however, the Ministry of Finance carries final responsibility for budgeting. The Second Medium Term Plan on HIV/AIDS was reviewed in early 2003, and involved the participation of a broad spectrum of stakeholders, including civil society and PLWHA groups. When the mid-term review of the current plan takes place in early 2007, all sectors including civil society will again be fully included in the process. Overall, while there is openness towards civil society, there is still an underlying attitude of the government as the main doer and the concept of an enabling role is preached more than it is practiced. While this is valid in respect of central health care mechanisms it is less valid in relation to other aspects of the epidemic.

III. Prevention

1. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy?

(*Check all programmes that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations*).

a. A programme to promote accurate HIV and AIDS reporting by the media.	a. Yes	a. Yes
b. A social-marketing programme for condoms	b. Yes	b. Yes
c. School-based AIDS education for youth	c. Yes	c. Yes
d. Behaviour-change communications	d. Yes	d. Yes
e. Voluntary counselling and testing	e. Yes	e. Yes
f. Programmes for sex workers	f. Yes	f. Yes
g. Programmes for men who have sex with men	g. Yes	g. Yes
h. Programmes for injecting drug users, if applicable	h. N/A	h. N/A
i. Programmes for other most-at-risk populations	i. Yes	i. Yes
j. Blood safety	j. Yes	j. Yes
k. Programmes to prevent mother-to-child transmission of HIV	k. Yes	k. Yes
l. Programmes to ensure universal precautions in health care settings	l. Yes	l. Yes
m. Other: (*please specify*)	m. Yes	m. Yes

Overall, how would you rate the efforts in the implementation of HIV-prevention programmes?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	[9]	10
2003	Poor										Good
	0	1	2	3	4	5	6	[7]	8	9	10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

HIV prevention programmes increased efforts in addressing most at-risk populations such as truck drivers and other cross-border issues through the Corridors of Hope Programme. Individual programmes focusing on commercial sex workers, their clients and those targeting youth have also been addressed through civil society projects carried out by SMA since the 2003 report.

IV. Care and support

1. Which of the following activities have been implemented under the care and treatment of HIV and AIDS programmes?

a. HIV screening of blood transfusion	a. Yes	a. Yes
b. Universal precautions	b. Yes	b. Yes
c. Treatment of opportunistic infections (OI)	c. Yes	c. Yes
d. Antiretroviral therapy (ART)	d. Yes	d. Yes
e. Nutritional care	e. Yes	e. Yes
f. Sexually transmitted infection care	f. Yes	f. Yes
g. Family planning services	g. Yes	g. Yes
h. Psychosocial support for people living with HIV and their families	h. Yes	h. Yes
i. Home-based care	i. Yes	i. Yes
j. Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)	j. Yes	j. Yes
k. Cotrimoxazole prophylaxis among HIV-infected people	k. Yes	k. Yes
l. Post exposure prophylaxis (e.g., occupational exposures to HIV, rape)	l. Yes	l. Yes
m. Other: (*please specify*)	m._____	m._____

Overall, how would you rate the care and treatment efforts of the HIV and AIDS programme?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	[9]	10
2003	Poor										Good
	0	1	2	3	4	[5]	6	7	8	9	10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

Overall support for PLWHA groups has been on the increase, particularly through Round 2 Global Fund and the World Bank.
Namibia ranks 3rd in world treatment efforts, even though the country has only rolled-out ART in the last two years.
Home based care services have rapidly spread, as are efforts to unify training, certification and compensation of caregivers. An HBC Forum has emerged among caregivers who work in the hardest-hit regions of the country, and the group is discussing the potential to develop a community-based register of HBC patients and providers.

2. Does your country have a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)?

Yes X	**No**	**N/A**

2.1 Which of the following activities have been implemented under the orphan and other vulnerable children programmes?

	2003	2005
School fees for orphans and vulnerable children	**No**	**Yes**
Community programmes	**Yes**	**Yes**
Other: (*please specify*)		

Comments:

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?

2005	Poor										Good
	0	1	2	3	4	[5]	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	[5]	6	7	8	9	10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

A National OVC policy was launched in 2004 and complements the Education Act, Education Sector HIV/AIDS Policy and the MTP III in increasing capacity to coordinate and implement OVC services. Educational services for OVC include school fee exemptions and assistance with school uniforms, school feeding programmes, life skills and peer education programmes, clubs and camps, and other recreational diversions. In addition, shelters, orphanages and soup kitchens provide basic necessities and health referrals and outreach programmes attempt to provide support to caregivers. Despite the collective efforts of government and civil society, insufficient financial and human resources constrain a coordinated and expanded response.

Annex 3: National Return Forms

See attached CRIS file for national return forms