Republic of Namibia

Ministry of Health and Social Services

THE NAMIBIA AIDS RESPONSE PROGRESS REPORT 2015

Reporting Period: 2013 - 2014

Directorate of Special Programmes
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Preface

Namibia is committed towards meeting the Millennium Development Goal of reversing the HIV and AIDS epidemic in the country and promoting the achievement of universal access to HIV prevention, treatment, care and support services in line with global commitments. It is with pride that we submit the Country's Report on Namibia's contribution to the Global AIDS Response. The report provides feedback with respect to goals agreed upon in the MDGs and 2011 HLM Commitments. The country has seen the epidemic profile change significantly from HIV prevalence of 22% in 2002 to 16.9% in 2014 with support from all stakeholders in the country.

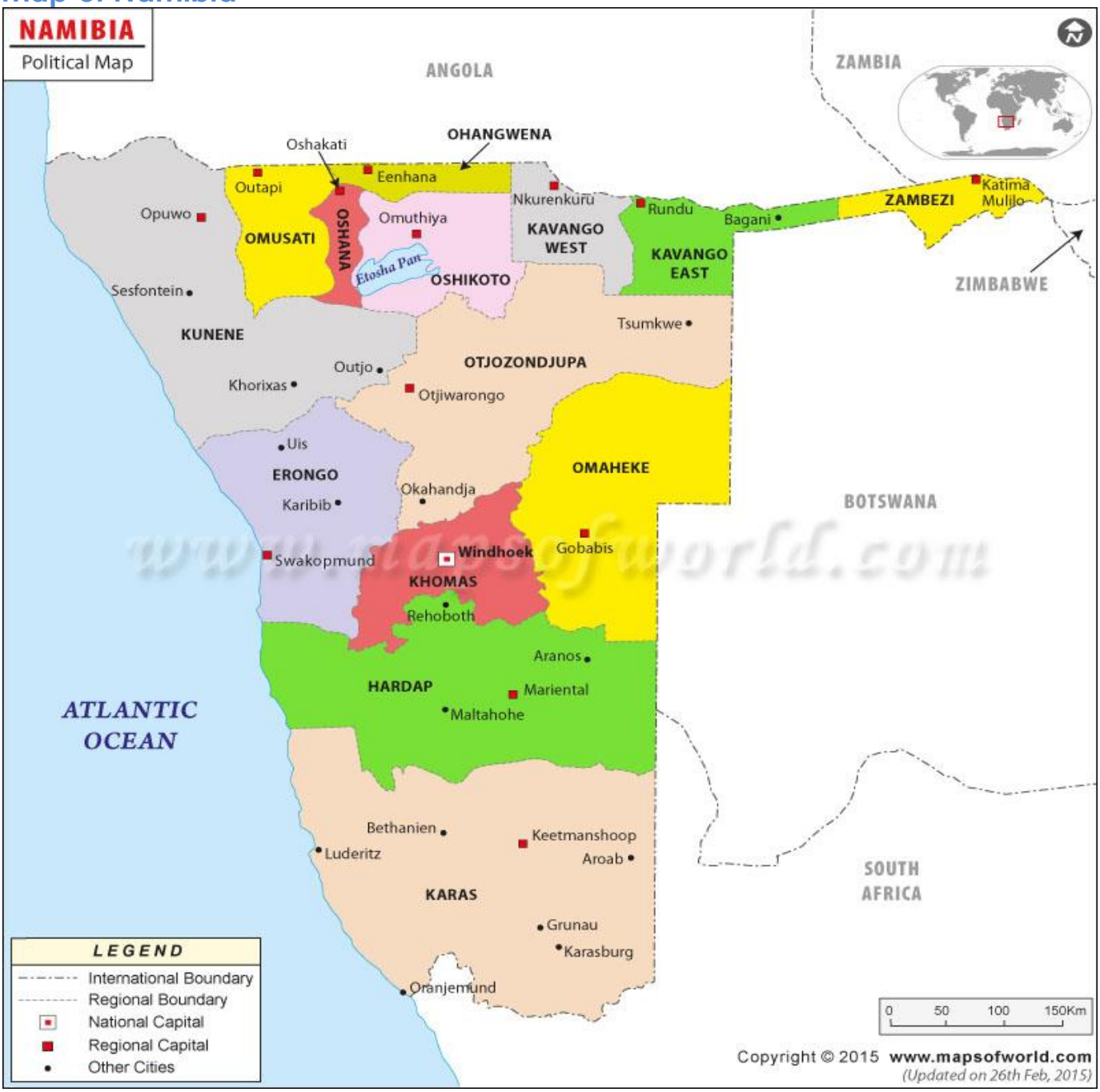
During this reporting period, Namibia has conducted the Mid-term-review of the NSF 2010/11-2015/16, which effectively aligned the revised NSF with Namibia's Vision 2030 and the Fourth National Development Plan (NDP4). Several guidelines, including the adaptation of the new WHO treatment guidelines, HTC Strategy, Combination Prevention Strategy, and the HIV policy have been reviewed. The acceleration of HIV interventions since 2008 has resulted in substantial increases in public sector funding to the AIDS response. A National AIDS Spending Assessment (NASA) conducted in 2014 indicates an increase in Government support to the AIDS response from 55% in 2012/13 to 65% in 2013/14 fiscal years. We are proud to say that there are now more than 130,000 Namibians on antiretroviral treatment, and the number of those who have been counselled and tested for HIV has increased steadily over the years. Policy advocacy continues with civil society organisations and the private sector. Community-based organisations and support groups of people living with HIV have been established countrywide, leading to further strengthening of the enabling environment at community level.

However, despite all the achievements, stigma and discrimination remain a critical challenge for services uptake and disclosure of HIV status. Inadequate implementation, enforcement and monitoring of policies and legislation have been identified to be weak.

This 2015 Country Progress report has been compiled with the full participation of government, civil society, business and development partners in accordance with the *UNAIDS 2015 Global AIDS Response Progress Reporting (GARPR)* guidelines. We would therefore like to acknowledge the enormous contribution and efforts of all partners towards the preparation of this Report. In particular, I would like to thank the Response Monitoring and Evaluation (RM&E) sub division of the Directorate of Special Programmes (DSP) for its leadership in putting this report together.

Mr. A. Ndishishi
Permanent Secretary
Ministry of Health and Social Services

Map of Namibia



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List of Abbreviations

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

M&E	Monitoring and evaluation
MFMC	My Future My Choice
MoE	Ministry of Education
MOHSS	Ministry of Health and Social Services
MRLGHRD	Ministry of Regional and Local Government, Housing and Regional Development
MTP II	Second Medium Term Plan on HIV/AIDS
MTP III	Third Medium Term Plan on HIV/AIDS
MGECW	Ministry of Gender Equality and Child Welfare
NABCOA	Namibia Business Coalition on AIDS
NAC	National AIDS Committee
NACOP	Namibian AIDS Co-ordination Programme
NAMACOC	Namibia Multisectoral HIV/AIDS Coordinating Committee
NANASO	Namibia Network of AIDS Service Organisations
NASOMA	Namibia Social Marketing Association
NBTS	Namibian Blood Transfusion Service
NCPI	National Composite Policy Index
NGO	Non Governmental Organisation
NHIES	Namibia Household Income and Expenditure Survey
NIP	Namibia Institute of Pathology
NLT	NawaLife Trust
NPA	National Plan of Action
NPC	National Planning Commission
NPPA	Namibia Planned Parenthood Association
NRCS	Namibia Red Cross Society
NSF	National Strategic Framework for HIV and AIDS 2010/11 to 2015/16
OMAs	Government Offices, Ministries or Agencies
ORN	Out Right Namibia
OVC	Orphans and Vulnerable Children
PDNA	Post Disaster Needs Assessment
PEP	Post Exposure Prophylaxis
PEPFAR	The US President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV/AIDS
PTF	Permanent Task Force
RACOC	Regional AIDS Co-coordinating Committee
RM&E	Response Monitoring and Evaluation Subdivision
SFH	Society for Family Health
SHOPPs	Strengthening Health Outcomes through Private Partnership
SPM	System for Program Monitoring
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organization

UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UNODC	United National Organization for Drugs and Crime
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WOH	Window of Hope

I. Status at a glance

Introduction

Namibia has a surface area of approximately 824,116 square kilometers with a population of 2.3 million people, having thereby the second lowest population density in the world (2.5 inhabitants per square kilometer) (Namibia Statistics Agency, 2010). Namibia is divided into 14 administrative regions where health services are delivered. The regions vary in size in terms of square kilometres and populations served. Regional demographic profiles serve as important indicators for planning, monitoring and evaluation of service programmes.

The population is spread unevenly across the country with the North-Central and North Eastern parts accounting for 60% of the population. Two thirds of the population lives in rural areas and engages in subsistence farming and livestock production. About 43% of the population is under the age of 15 year while life expectancy has significantly improved to 60 years of age. Namibia's per capita income of US$5,610 (The World Bank, 2013) places it in the World Bank's upper middle income grouping; this average income paints a misleading picture since Namibia income distribution is among the most unequal in the world, and this number conceals the enormous differences in wealth within the population. In fact, Namibia has one of the highest levels of inequality in the world with a Gini coefficient at 0.5971 (Namibia Statistics Agency, 2010).

Infant mortality was 39 per 1,000 in 2014 and maternal mortality 180 per 1,000 births in 2008. The under-five mortality rate (U5MR) dropped from 83 per 1000 live births in 1992 to 62 per 1000 live births in 2000 but has slightly increased to 69 per 1000 live births in 2006 (Ministry of Health and Social Services, 2008).

The economy is largely dependent on mining, fishery, large-scale farming and high-end tourism. This has resulted in a highly mobile population characterized by a system of circular labour migration to mines, ports, farms, urban areas and tourism nodes. Rural-urban migration is substantial and has resulted in growing informal settlements in cities, towns and smaller semi-urban localities. Internal mobility and socio-economic factors have tended to increase the likelihood of risky sexual behaviors and vulnerability to HIV infection.

Namibia's average spending on the health sector is above that of most of sub-Saharan Africa countries and that of the upper- middle income countries. Namibia spends more than 6% of her GDP on health.

Since independence, Namibia focused more on preventative care and expansion of services to all Namibians. But, despite a relatively high rate of

spending on health, Namibia is struggling to meet its health-related Millennium Development Goals (MDGs) with respect to infant, under five and maternal mortality rates. (Ministry of Health and Social Services, 2013)

Table 1: Namibia Key Basic Indicators

Total Population	2,113,077 (2013, NSA)
Density (population/km^2)	2.6 (2013, NSA)
Population urban	43% (2013, NSA)
Life expectancy at birth (years)	(2013, NSA)
Male	53
Female	61
Literacy rate (15-24 year olds)	94.4
Under 5 mortality	
Infant mortality:	
Total:	45.64 deaths/1,000 live births
Male:	48.6 deaths/1,000 live births
Female:	42.59 deaths/1,000 live births (2014 est.)
Maternal mortality	130 deaths/100,000 live births (2013 est.)
% Population using improved drinking water source	
Total:	91.7% of population
Urban:	98.4% of population
Rural:	87.4% of population
% Population with access to improved sanitation facilities	
Urban:	56.1% of population
Rural:	16.9% of population
Total:	32.2% of population

Inclusiveness of the stakeholders in the report writing process

This progress report was developed in a participatory manner, with overall coordination by the Directorate of Special Programmes within the Ministry of Health and Social Services, Namibia. The M&E unit at the Directorate of Special Programmes directly facilitated all consultations and relevant data collection endeavors.

This progress report was developed over the course of several national consultation meetings including the M&E and Prevention TAC meetings, interviews and individual meetings with the key stakeholders, desk reviews. Data for the indicators used in this report were reviewed by staff from government, NGO, private sector and development partners. The progress report was presented, discussed and validated at the broad inclusive meetings involving representatives of the Government of Namibia and other state and non-state actors, both national and international.

After developing a first draft of the report, it was shared with the wider audience allowing all stakeholders to comment on the draft. All the comments were discussed and incorporated into the final report. The consultant presented the final draft document at the M&E and Prevention TAC meetings attended by a broad forum of stakeholders.

The report writing exercise utilized a variety of methods to collect qualitative and quantitative data relevant to the above objectives including: review of background documents, Pre-assignment briefing, in depth interviews with key informants and review of secondary data. This was a participatory approach to provide meaningful opportunity for diverse stakeholder participation in the narrative writing process. The process included the following:

1) Regular consultations with MOHSS and UNAIDS to further clarify and articulate the scope of the assignment and the understanding of the client expectations. The consultative meetings also reviewed the proposed data collection methodology; the consultants work plan and the schedule.
2) An in-depth literature review of relevant reports and documents including reports of the MoHSS, development partners and other sectors in the HIV/AIDS response.
3) Data was also collected using key informant interviews with MoHSS staff, NANASO, Health Works Business Coalition and WBCC and additional literature review.
4) The consultants used the data and strategic information generated through the desk/literature review, key informant interviews and data generated through the process to develop the narrative report. The report was subjected to validation through email, Prevention and M&E TAC's. The consultants submitted the report by incorporating comments and suggestions from the TAC's and from the peer review teams.

Status of the epidemic

Namibia's first case of HIV infection was reported in 1986. Consequently and in line with guidelines from the World Health Organization (WHO), the government adopted ANC sentinel surveillance as the system for assessing the epidemic with the first one implemented in 1992. Namibia has a generalised epidemic, where HIV is primarily transmitted through heterosexual and mother-to-child transmission (MTCT).

HIV prevalence amongst people aged 15 – 49 is estimated to be 16% and the total population of PLHIV aged 15 and above is estimated at 260,000. The revised 2015 estimated projects People living with HIV to increase to over 273,000 in 2017, and over 296,000 by 2020 (Ministry of Health and Social Services, 2015b). The expected increase in the number of PLHIV has been attributed

mainly to the outcome of reduced AIDS mortality due to improved and high coverage of ART. It is also estimated that new HIV infections have stayed the same at about 11,000 per year from 2010 to 2014. New female infections are estimated to remain above new male infections significantly during this period (Ministry of Health and Social Services, 2015b). The Government has taken a decision to implement the new WHO 2013 Treatment Guidelines and will extend ART treatment to children below 15 years living with HIV including hepatitis B patients.

Amongst pregnant women attending Antenatal Clinics (ANC), the overall prevalence was 16.9% according to the 2014 National HIV Sentinel Survey, a reduction from 18.2% in 2012. It should however be noted that there was considerable variation between the sites. The sites with the highest HIV prevalence rates were Katima Mulilo (36.0), Rundu (24.1%) and Engela (22.8%). The sites with the lowest HIV prevalence were Opuwu (3.9%), Windhoek Central (4.1% and Okakarara (9.0%) (Ministry of Health and Social Services, 2014b).

By age group, HIV prevalence was observed to be highest among women age 40-44 years (30.6%) and women age 35-39 years (30.3%) according to the 2014 HSS. HIV prevalence was lowest among women age 15-19 years (5.8%) and women age 20-24 years (9.8%). In 2014, the lowest HIV prevalence among women age 15-24 years was observed in Opuwo (0.0%) followed by Omaruru (1.3%) while the highest HIV prevalence among women age 15-24 years was observed in Katima Mulilo (24.3%) and Engela (14.3%). In 13 (37%) out of 35 sites, more than one quarter of the women within the older age group (25-49 years) were HIV positive (Ministry of Health and Social Services, 2014b).

The GRN has conducted a Demographic and Health Survey (DHS) in 2013 which has further validated the NHSS. The survey confirmed the geographical heterogeneity, already proven by the results of sentinel surveillance among pregnant women. Indeed, Northern regions of Namibia are the most affected by the epidemic, and particularly Zambezi (23.7%), Omusati (17.4%), Kavango (17%), Oshana (16,1%) and Ohangwena (15.6%).

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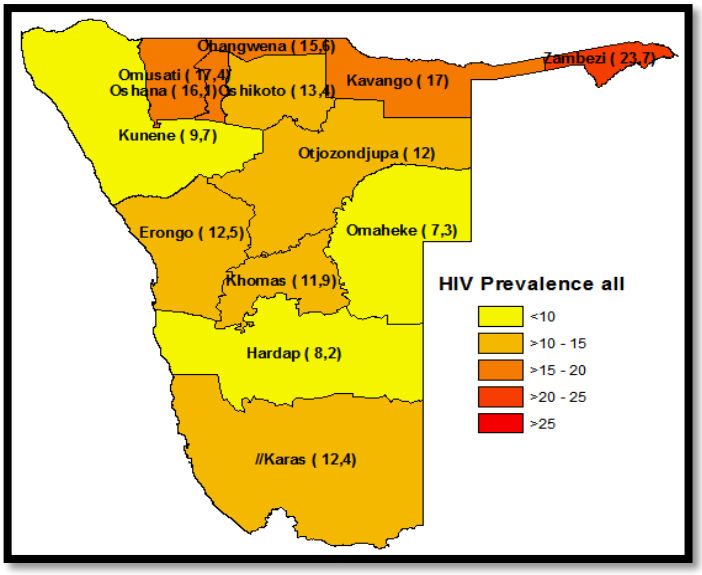
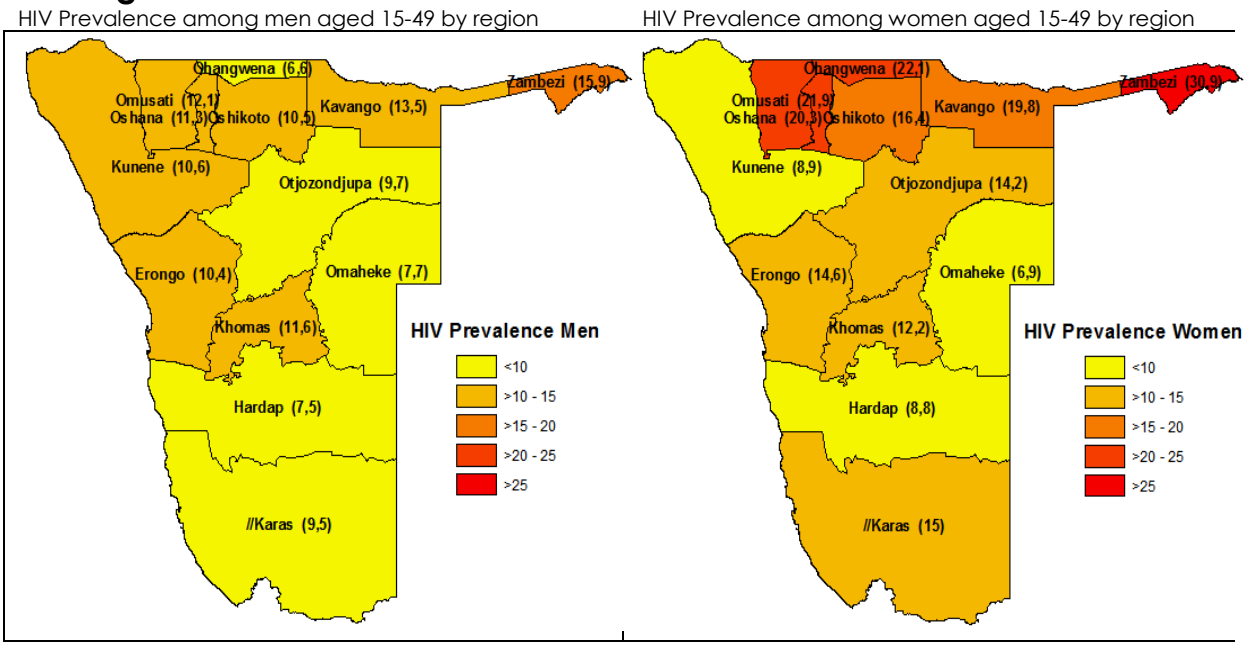
Figure 1: Geographical variations in the national HIV Prevalence



Source: 2013 National Demographic and Health Survey

The NDHS+ survey also highlighted a higher prevalence in rural than in urban areas, with more a feminization of the epidemic which in that is more pronounced in rural areas where the HIV prevalence among women is almost double that of men with the exception in of the regions of Omaheke and Kunene regions where the HIV prevalence is higher among men than women. The study also found that 14% adults age 15-49 and 16.4 % of this age 50-64 are infected with HIV. HIV prevalence among respondents age 15-49 is 16.9% for women and 10.9% for men. HIV prevalence peak in the 35-39 age groups for both women and men (30.9% and 22.6%, respectively) while it is lowest among respondents age 15-24 (2.5-6.4% for women and 2.0-3.4% for men). As with the HSS, HIV prevalence is highest for women (30.9%)and men in Zambezi. (15.9%) (Ministry of Health and Social Services, 2013).

Figure 2: Regional variations in the national HIV prevalence between men and women aged 15-49



Source: 2013 NDHS

A number of factors are likely contributing to the high prevalence or incidence of HIV in Namibia. The Behavioral and Contextual Factors Driving the Epidemic study done in 2009 has identified multiple and concurrent partnerships and intergenerational sex as the main drivers of the HIV epidemic in Namibia. Other contributing factors include alcohol abuse and low levels of HIV risk-perception and high levels of population mobility (Ministry of Health and Social Services, 2009).

The policy and programmatic response

In recognition of the increased health burden associated with HIV and AIDS, the Government of Namibia has utilized various mechanisms and resources to mitigate the impact of the epidemic. Coordinated involvement of various national and international stakeholders, including broader civil society, has been deemed essential in effective HIV response. HIV and AIDS continues to strain the struggling health system and reverse many developmental gains of the recent past including maternal and under-five mortality rates.

Namibia has developed a number of laws and policies to guide the multi-sectoral response to HIV and AIDS. The Namibian Constitution guarantees the fundamental right of every citizen to life and freedom from discrimination and provides a wide range of protections to all residents of Namibia and it further articulates the roles and obligations of duty-bearers in protecting those rights. The rights of Namibians affected by HIV and AIDS are protected by the courts

and the Office of the Ombudsman. In addition, Namibia has ratified the major human rights protocols and international instruments. The National Policy on HIV and AIDS, which was developed in 2007, is currently under review to include emerging issues from the National Strategic Plan review. The policy provides regulations and guiding principles on topics ranging from prevention of new infections and behavior change, treatment, care and support for infected and affected persons, institutional architecture and resourcing, advocacy, legal issues and human rights, monitoring and evaluation, research and knowledge management and policy implementation. A number of large businesses have instituted workplace policies; some have implemented workplace programmes. The responsibility for the monitoring and evaluation of existing workplace programmes is not clearly defined as also indicated in the coordination and management of the response section. Both Vision 2030 and NDP3 call for the mainstreaming of HIV and AIDS into sectoral policies and programmes. HIV and AIDS policies have been developed in many organisations within both government and the private sector. Within government, the National Strategic Framework for HIV and AIDS Response in Namibia 2010/11 - 2015/16 has been developed which was extended until 2017 following the Mid-term Review in 2013.

The revised National Coordination Framework (NCF) for HIV and AIDS 2013-2017 was developed with the purpose to articulate the institutional arrangement for an effective and efficient coordination and management of the national multisectoral HIV and AIDS response. The NCF is premised on the "Three-Ones" principle of One Strategic Plan, One Coordinating Authority and One Monitoring and Evaluation System. The Cabinet, Meeting of Senior Civil Servants (MSCS), the National AIDS Executive Committee (NAEC), the Regional AIDS Coordinating Committees (RACOCs), the Constituency AIDS Coordinating Committees (CACOCs) and the Sector Steering Committees are the core institutions to coordinate the multi-sectoral response (Ministry of Health and Social Services, 2014a).

The Cabinet, chaired by the Prime Minister, is the highest policy-making body on HIV and AIDS and its membership comprised of Ministers and Regional Governors. The MSCS's mandate is to provide policy guidance, leadership and to ensure good governance to the response (Ministry of Health and Social Services, 2014a).The National AIDS Executive Committee (NAEC) provides the technical leadership, support and the overall oversight responsibility for ensuring the implementation of the National Strategic Framework (NSF). The NAEC work through thematic Technical Advisory Committees (TACs) and specialized steering committees that facilitate specific programme initiatives and partnerships.

Regional coordination is under the auspices of the Ministry of Regional and Local Government, Housing and Rural Development (MRLGHRD). The Regional AIDS Coordinating Committees (RACOCs) coordinate the regional HIV and AIDS response, and provide technical support to Constituency AIDS Coordinating Committees (CACOCs). The CACOCs are responsible for constituency level coordination. The functions of the Sector Steering Committees are to promote sector coordination and participation in the implementation of the sectoral response to HIV and AIDS outlined in the NSF (Ministry of Health and Social Services, 2014a).

Other coordinating structures are those with civil society organisations, private sector and development partners. The overall coordination of civil society organisations in Namibia is the mandate of Namibian Non-Governmental Organisations Forum (NANGOF). NANGOF has delegated the responsibility for coordinating of CSO involved in the HIV and AIDS response to the Namibian Association of AIDS Service Organisations (NANASO), which is a member of NANGOF (Ministry of Health and Social Services, 2014). The private sector institutions are coordinated through Health Works Business Coalition on AIDS formally known as NABCOA, and it mainly focuses on private sector response through HIV and AIDS work place programmes. The Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL) supports the coordination of HIV and AIDS initiatives within the Local the Authorities (Ministry of Health and Social Services, 2014a).

Namibian Coordinating Committee for HIV and AIDS, Tuberculosis and Malaria (NaCCATuM) was established in 2002 and serves as the country coordination mechanism (CCM) for The Global Fund and overall oversight on the implementation of all Global Fund grants in Namibia. The Government of Namibia in collaboration with respective partner agencies have established Partnership Steering Committees in order to facilitate coordination of agency specific partnership relationships i.e. the President's Emergency Plan for AIDS Relief (PEPFAR) and the Joint United Nations Team on HIV and AIDS (JUTA). Most of the development partners' coordination is premised on their bilateral agreements with the Government of Namibia. Development partners are represented on the NAEC and the NaCCATuM (Ministry of Health and Social Services, 2014a).

Indicator data in an overview table

Indicator	Disaggregation	Source	Numerator	Denominator	2013/14
Target 1: Reducing sexual transmission of HIV by 50 percent by 2015/16					
General population					
Empowering young people to protect themselves from HIV					
1.1 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	***Female***	2013 DHS	2270	3692	61.6%
	Male	2013 DHS	886	1730	51.2%
1.2 Percentage (%) of young women and men 15-24 who had sex before the age of 15	***Female***	2013 DHS	199	3691	5.4%
	Male	2013 DHS	227	1730	13.1%
1.3 Percentage (%) of women and men aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	***Female***	*2013 DHS*	202	9176	2.2%
	Male	*2013 DHS*	261	4021	6.5%
1.4 Percentage (%) of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse	***Female***	*2013 DHS*	NA	NA	NA
	Male	*2013 DHS*	302	420	72.1%
1.5 Percentage (%) of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	***Female***	*2013 DHS*	4505	9176	49.1%
	Male	*2013 DHS*	1532	4021	38.1%
1.6 Percentage (%) of young people aged 15–24 who are living with HIV	***16 - 19***	*2014 National HIV Sentinel Survey*	78	1335	5.8%
	20 - 24		219	2225	9.8%
Sex Workers					
1.7 Percentage of sex workers reached with HIV prevention			N/A	NA	NA
1.8 Percentage (%) of sex workers reporting the use of a			N/A	NA	NA

1.9 Percentage of sex workers who received an HIV test in the			N/A	NA	NA
1.10 Percentage of sex workers who are living With HIV			NA	NA	NA
Men who have sex with men					
1.11 Percentage (%) of men who have sex with men reached with HIV prevention programmes			N/A	NA	NA
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner			N/A	NA	NA
1.13 Percentage (%) of men who have sex with men who received an HIV test in the past 12 months and know their results			N/A	NA	NA
1.4 Percentage of men who have sex with men risk who are living with HIV			NA	NA	NA
Target 2: Reduced Transmission of HIV among people who inject drugs by 50% by 2015					
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes			***NA***	***NA***	***NA***
2.1 Percentage (%) of people who inject drugs who report the use of a condom at last sexual intercourse			***NA***	***NA***	***NA***
2.3 Percentage (%) of people who inject drugs who reported using sterile injecting equipment the last time they injected			***NA***	***NA***	***NA***
2.4 Percentage (%) of people who inject drugs that have received an HIV test in the past 12 months and know their results			***NA***	***NA***	***NA***
2.5 Percentage of people who inject drugs who are living with HIV			***NA***	***NA***	***NA***

Target 3: Eliminate mother-to-child transmission of HIV by 2015/16 and substantially reduce AIDS related maternal deaths					
3.1 Percentage (%) of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission		HIS Maternity data and Spectrum	8786	8779[1]	
3.1a Percentage of women living with HIV who are provided with antiretroviral medicine for themselves or their infants during the breastfeeding period			NA	NA	NA
3.2 Percentage (%) of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth		EID Testing laboratories and Spectrum	9684	NA	NA
3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months: MTCT rate (including Breastfeeding)			538	7704	7%
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015					
4.1 Percentage of adults and children currently receiving antiretroviral therapy	***Female***	Pharmaceutical	77006	142054	54.2%
	Male	Pharmaceutical data from EDT	44141	121464	36.3%
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	***Female***	ART programme data ePMS	3031	3812	79.5%
	Male	ART programme data ePMS	1874	2536	74.7%

[1] Estimate from Spectrum is less than numerator (Programme data)

Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015/16					
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both	***Total***	National TB Control	3360		
Target 6: Reach 70% (U$ 213,711,339) of annual National HIV and AIDS expenditure that is domestic by 2015/16					
6.1 Domestic and international AIDS spending by categories and financing resources (% domestic)	***Domestic (Namibia Government)***	2014 NASA	136,620,606	213,346,629	64%
	International (PRPFAR, Global Fund, GIZ, UN, Others)	2014 NASA	74,283,368	213,346,629	34%
Target 7: Eliminate Gender Inequality					
Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months					**NA**
Target 8: Eliminate Stigma and Discrimination					
Percentage of women and men aged 15–49 who report discriminatory attitudes towards people living with HIV					NA
Target 9: Eliminate Travel Restrictions					
National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)					Done

II. Overview of the AIDS epidemic

Namibia has a high prevalence, high incidence, generalized and mature HIV epidemic, with the majority of new HIV infections transmitted through unprotected heterosexual sex and mother-to-child transmission. Co-morbidities and opportunistic infections add to the HIV burden. Namibia has implemented an aggressive and tireless campaign against HIV and AIDS including surveillance, prevention, treatment, care and support, and impact mitigation. HIV and AIDS continue to pose a significant challenge to Namibia's socio-economic development; and the revised strategy would guide on how to deliver a multi-sectoral response to the on-going challenge. In 1986, the first case of HIV was reported in Namibia and the epidemic was estimated to have risen in the 1990s. Namibia has a generalized and mature epidemic where HIV is transmitted primarily through heterosexual and mother-to-child transmission (MTCT).

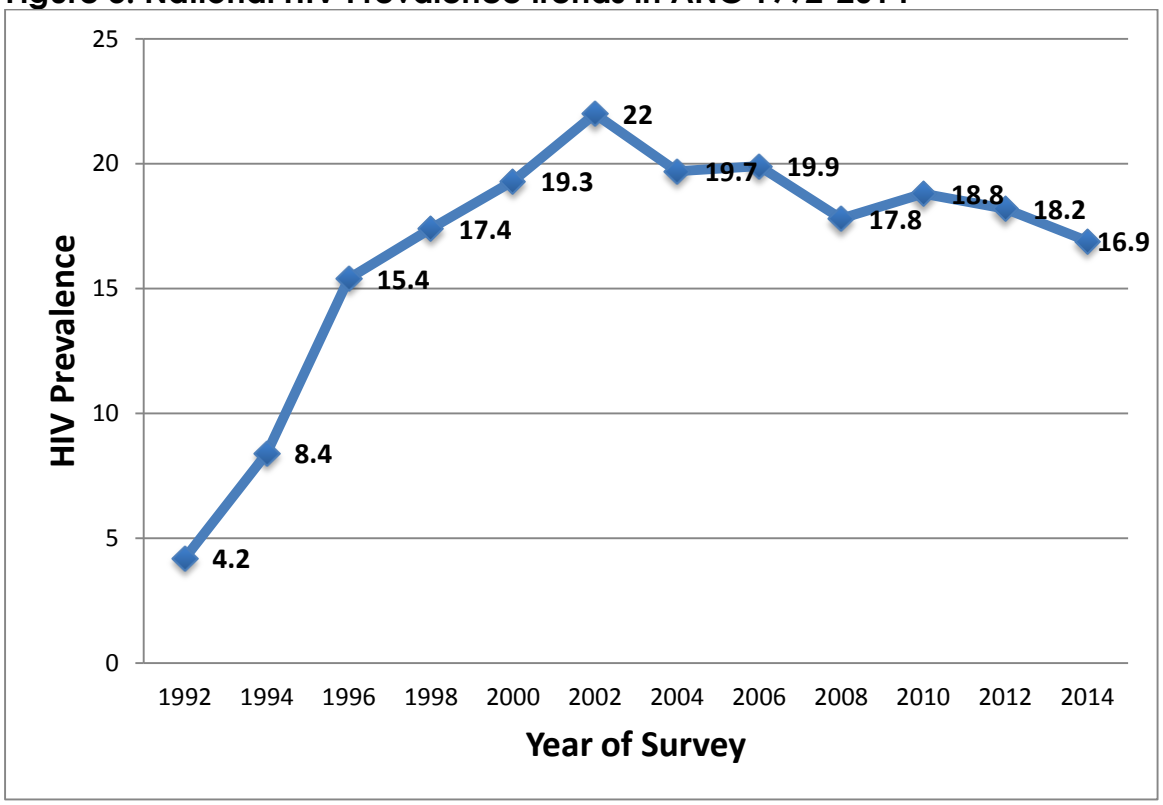
Like many countries, Namibia conducts national-level population and health survey as part of the global Demographic and Health Surveys (DHS) and the 2013 Namibia Demographic and Health Survey (NDHS) is the fourth comprehensive survey. Also, Namibia depends on the National HIV Sentinel Survey (NHSS) which is conducted every second year in order to determine the HIV prevalence among pregnant women attending antenatal care (ANC) clinics at public facilities in order to monitor more closely changes in HIV seroprevalence.

HIV Prevalence

Namibia's HIV epidemic is mature and generalized, with wide variation in prevalence within the country, within different aged groups and regions/towns. HIV in Namibia is primarily transmitted through heterosexual and mother-to-child transmission. Between 1992 and 2002, the country has witnessed an increase in the prevalence of HIV from 4.2% to 22% as seen in figure 1. Since then, the incidence declined sharply till 2010, showing leveling off

Amongst pregnant women attending Antenatal Clinics (ANC), the overall prevalence was 16.9% according to the 2014 National HIV Sentinel Survey, a reduction from 18% in 2012 (Ministry of Health and Social Services, 2014b). According to the 2013 NDHS, In Namibia, 14% of adults aged 15-49 and 16.4 % of those age 50-64 are infected with HIV (Ministry of Health and Social Services Namibia, 2013). It is also estimated that the estimated adult HIV prevalence is 16%, similar to that of the NDHS and HSS (Ministry of Health and Social Services, 2015b).

Figure 3: National HIV Prevalence trends in ANC 1992-2014



Source: 2014 HIV Sentinel Survey

HIV prevalence was observed to be highest among women age 40-44 years (30.6%) and women age 35-39 years (30.3%) and was lowest among women age 15-19 years (5.8%) and women age 20-24 years (9.8%). The 2013 NDHS found that the HIV prevalence among people aged 15-49 is 16.9% for women and 10.9 % for men. The HIV prevalence rates among women and men in the age group 50-64 are similar (16.7 % and 16.0 %, respectively) (Ministry of Health and Social Services Namibia, 2013).

The lowest HIV prevalence among women age 15-24 years was observed in Opuwo (0.0%) followed by Omaruru (1.3%) while the highest HIV prevalence among women age 15-24 years was observed in Katima Mulilo (24.3%) and Engela (14.3%). In 13 (37%) out of 35 sites, more than one quarter of the women within the older age group (25-49 years) were HIV positive (Ministry of Health and Social Services, 2014b). Among people age 15-49, HIV prevalence is highest for women and men in Zambezi (30.9 percent and 15.9 percent, respectively) and lowest for women in Omaheke (6.9 percent) and men in Ohangwena (6.6 percent) (Ministry of Health and Social Services Namibia, 2013).

Among women and men age 15-49, the percentage HIV positive decreases with education and it generally decreases with wealth. More than half of widowed women (51.7 percent) are infected with the AIDS virus. Men age 15-49

with a sexually transmitted infection (STI) or STI symptoms in the past 12 months are much more likely to test HIV positive than those who did not have an STI or STI symptoms (24.8 percent versus11.7 percent). According to the 2013 NDHS, in 76.4 percent of the 1,007 cohabiting couples who were tested for HIV, both partners were HIV negative; in 10.1 percent of the couples, both partners were HIV positive; and 13.5 percent of the couples were discordant (that is, one partner was infected with HIV and the other was not).

The 2013 NDHS confirmed the geographical heterogeneity, already proven by the results of sentinel surveillance among pregnant women. The Northern regions of Namibia are the most affected by the epidemic, and particularly Zambezi (23.7%), Omusati (17.4%), Kavango (17%), Oshana (16,1%) and Ohangwena (15.6%).This survey also highlighted a higher prevalence in rural than in urban areas, with more a feminization of the epidemic which is more pronounced in rural areas where the HIV prevalence among women is almost double that of men with the exception in the regions of Omaheke and Kunene where the HIV prevalence is higher among men than women.

According to the 2014 HSS, the sites with the highest HIV prevalence rates were Engela (22.8%), Rundu (24.1%) and Katima Mulilo (36.0) while Opuwu (3.9%), Windhoek Central (4.1% and Okakarara (9.0%) are the lowest (Ministry of Health and Social Services, 2014b).

Comparison of the 2013 NHDS and 2014 HSS confirmed that the HIV prevalence among pregnant women aged 15-49 years measured by the NDHS is exactly the same as the one informed by the HSS among women aged 15-49 years (16.9%). Also, the highest prevalence were observed in districts located in the northern regions, already identified through the DHS to be the most affected by the HIV epidemic (see table 2). However, very high prevalence are observed in districts located in regions where the prevalence remains below the national average: Luderitz in Karas and, Katutura State Hospital in Khomas.

Table 2: Comparison of population based and antenatal survey data

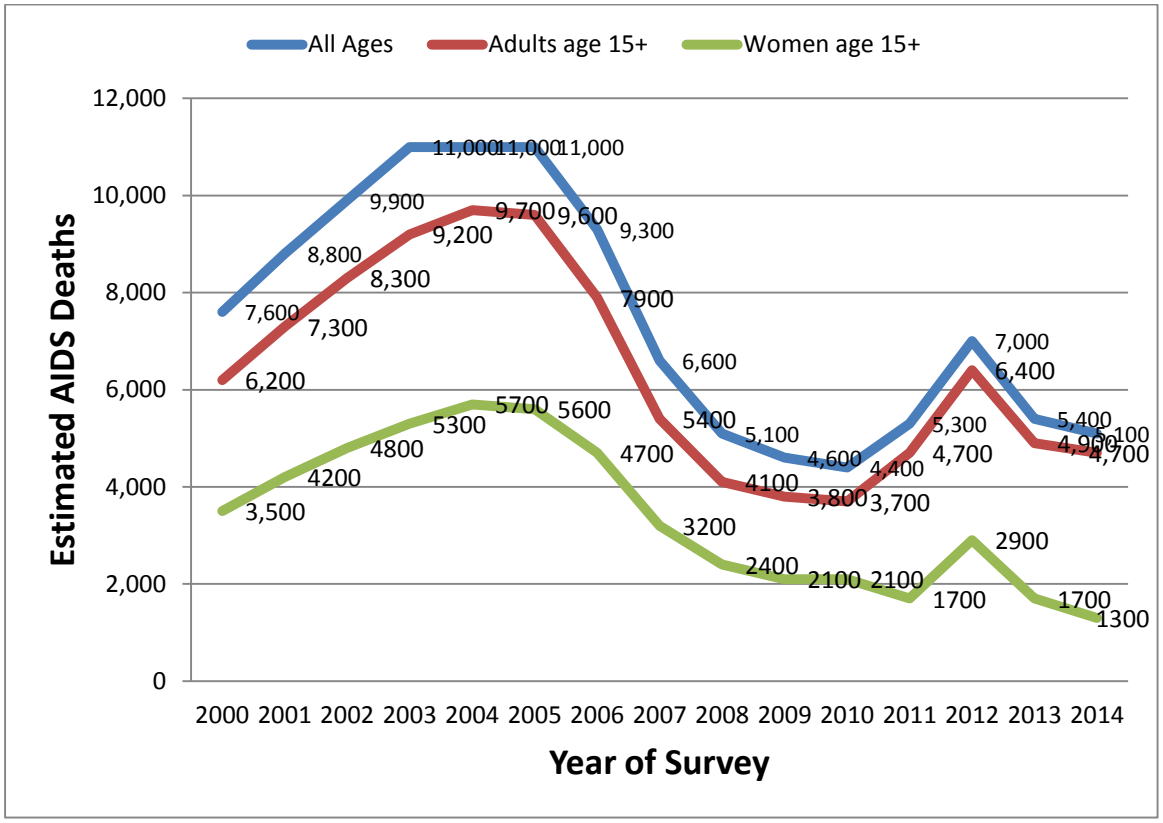
HIV Prevalence among women age 15-49 NDHS 2013		**HIV prevalence HSS 2013/2014**	
NAMIBIA	16,9	**NAMIBIA**	16,9
BY REGIONS		**By District**	
ZAMBEZI	**30,9**	Katima Mulilo	**36**
ERONGO	14,6	Omaruru	12,9
		Swakopmund	10,5
		Usakos	**21,9**
		Walvisbay	**19,6**
HARDAP	8,8	Aranos	11,6

HIV Prevalence among women age 15-49 NDHS 2013		HIV prevalence HSS 2013/2014	
		Mariental	12
		Rehoboth	9,1
KARAS	15	Karasburg	14,5
		Keetmanshoop	14,1
		Luderitz	**20,9**
KAVANGO	19,8	Andara	20
		Nankudu	15,9
		Nyangana	12,5
		Rundu	**24,1**
KHOMAS	12,2	Katutura State Hospital	**19,6**
		Windhoek Central Hospital	4,1
KUNENE	8,9	Khorixas	12,8
		Opuwo	3,9
		Outjo	11,2
OHANGWENA	22,1	Eenhana	13
		Engela	**22,8**
		Okongo	17,5
OMAHEKE	6,9	Gobabis	12,7
OMUSATI	21,9	Okahao	**20,6**
		Oshikuku	18,6
		Outapi	11,4
		Tsandi	**20,2**
OSHANA	20,3	Oshakati	**18,2**
OSHIKOTO	16,4	Onandjokwe	**22,4**
		Tsumeb	14,8
OTJOZONDJUPA	14,2	Grootfontein	14
		Okahandja	13,3
		Okakarara	9
		Otjiwarongo	14,4

Source: 2015 EPI Analysis of the Namibia AIDS Epidemic based on most recent Epidemiological data

According to the 2015 HIV Estimates and Projections the number of people living with HIV continues to increase as indicated in figure 6. Based on projected HIV estimates of 2015, about 260,000 people now live with HIV while it is estimated that 11,000 new HIV infections occurred in 2014. A total estimated of 5,100 people died from AIDS related cases in 2014. (Ministry of Health and Social Services, 2015b).

Figure 3: Estimated number of AIDS deaths. 2000-2014



Source: 2015 HIV Projections

HIV Incidence

The majority of infections occurring in Namibia are due to HIV transmission within the general population. Recent estimates indicate that the annual number of new infections in the country has been on a decline, decreasing from 21,000 in 2000 to 11,000 in 2014. Similarly, it decreased for women aged 15 and above as well as for children 0-14 years. This can partly be explained by the impact of ART scale up and reduction in incidence. Among the 11,000 total new infections in 2014, more than 50% are estimated to be among women aged 15 and above.

Table 4: Trends in estimated new HIV infections 2000 to 2014

Year	All Ages	Adults age 15+	Women age 15+	Children 0-14 years
2000	21,000	18,000	10,000	2900
2001	18 000	15,000	8900	3000
2002	17,000	14,000	7900	3000
2003	15,000	12,000	7100	2900
2004	14,000	11,000	6400	2800
2005	13,000	10,000	6000	2500

2006	12,000	9700	5600	2200
2007	11,000	9100	5200	2000
2008	11,000	8800	5000	1800
2009	12,000	10 000	5800	1500
2010	12,000	11,000	6200	1200
2011	11,000	11,000	6100	<1000
2012	11,000	10,000	5800	<1000
2013	11,000	10,000	5800	<1000
2014	11,000	10,000	5800	<1000

Source: 2015 HIV Projections

HIV prevalence among aged group 15-24 years is assumed to represent newer infections and therefore as a proxy for HIV incidence. HIV prevalence among age group15-24 is low (3.6%); 4.4% of young women and 2.7% of young men are HIV positive. By region, Zambezi has the highest HIV prevalence among young people (16.3%), followed by Erongo and Otjozondjupa (4.1% and 3.8%, respectively); the lowest prevalence is observed in Ohangwena and Kunene (1.4% and 2.0%, respectively). The HIV prevalence among young women is about twice as high as that among young men in Kavango and Oshikoto and nearly six times as high in Oshana (Ministry of Health and Social Services, 2014b). The low HIV prevalence in this age group according to the 2013 NDHS HIV testing indicates a low recent infection rate among youth estimated between 2.5 and 6.4 percent for women and between 2.0 and 3.4 percent for men (Ministry of Health and Social Services Namibia, 2013).

Findings from NDHS 2013, inform that the level of knowledge about HIV/AIDS is not high as only 62% of young women and 51% of young men have comprehensive knowledge of HIV/AIDS. Young men are more likely than young women to report having multiple sexual partners in the 12 months preceding the survey (Ministry of Health and Social Services Namibia, 2013).

HIV Prevalence among Key Populations

According to the 2013 NDHS, only 0.9% of men age 15-49 and 1.6% of those aged 50-64 reported paying for sex during the 12 months preceding the survey. Men living in Zambezi and Karas are more likely than other regions to have ever paid for sexual intercourse. Among men who paid for sex in the past 12 months, 67% reported using a condom at their last paid sexual intercourse.

Studies among Female Sex Workers suggests that HIV prevalence among in the sub-region is very high, especially in boarder regions. When compared to NHSS 2014 data in Namibia, levels of HIV prevalence are consistently higher among pregnant women in Namibia.

III. National response to the AIDS epidemic

It is generally knowledge that HIV and AIDS are a major development challenge as much as they are a health and human rights challenge. Namibia has made tremendous progress in its HIV response. The response has seen the country implementing a combination of interventions targeting behavioural, biomedical and structural drivers of the epidemic in accordance with the National Strategic Framework (NSF). The Six-year NSF 2010/11-2015/16 for HIV and AIDS was developed in 2010, and launched by His Excellency the President Hifikepunye Pohamba. The strategy was reviewed in 2013 and reprioritized based on the Investment Case Approach. As part of the reprioritisation process, the revised NSF 2010/11-2016/17 was aligned with the National Development Plan 4 (NDP4). Other associated documents, including the Costed National Operational Plan (NOP), National Coordination Framework, National Multisectoral M&E plan and Research Agenda, and a Costed Combination Prevention Strategy were revised..

The revised NSF has prioritised basic programmes that have the potential to yield the desired results of reducing new HIV infections and AIDS related deaths. It further notes that the success of these programmes will also depend on the effective implementation of corresponding critical social and programme enablers, and with clearly defined synergies with development sectors.

The critical social and programme enablers are necessary to ensure efficacy, equity and roll out of basic programmes activities. They will enhance the increase, availability, access and utilization of services and support the improvement of efficiency and effectiveness of the basic programmes. Strengthening synergies with development sectors will not only have a positive effect on HIV outcomes but will also consolidate the multisectoral response based on sectors development mandates and their comparative advantage. NSF has identified some key development sectors and the process of engagement will require mechanisms for multisectoral financing and governance.

The revised NSF has placed significant emphasis on community involvement and participation. It is anticipated that community mobilisation will be a major strategy to engage communities in creating demand for HIV services, promoting adherence, and strengthening behaviour change. Similarly meaningful involvement of people living with HIV (PLHIV) is critical to the overall success of the national response.

For programmes previously in the original NSF and not currently prioritised in the revised NSF, they will continue being implemented and integrated in the appropriate sector plans such as the Health Sector Strategic Plan. Some of them will be included as enablers of revised NSF basic programmes. For examples - PEP and STI in the case of addressing Gender-Base Violence currently prioritised as an enabler in the revised NSF.

It is anticipated that the implementation of the revised NSF will also meaningfully ensure the mainstreaming of gender, and human rights, effective targeting of interventions for key and vulnerable populations and having a clear focus on the epidemic hotspots, including informal settlements around major urban centres. Performance towards these results will be measured using the following impact indicators

Table 5: Impact level results

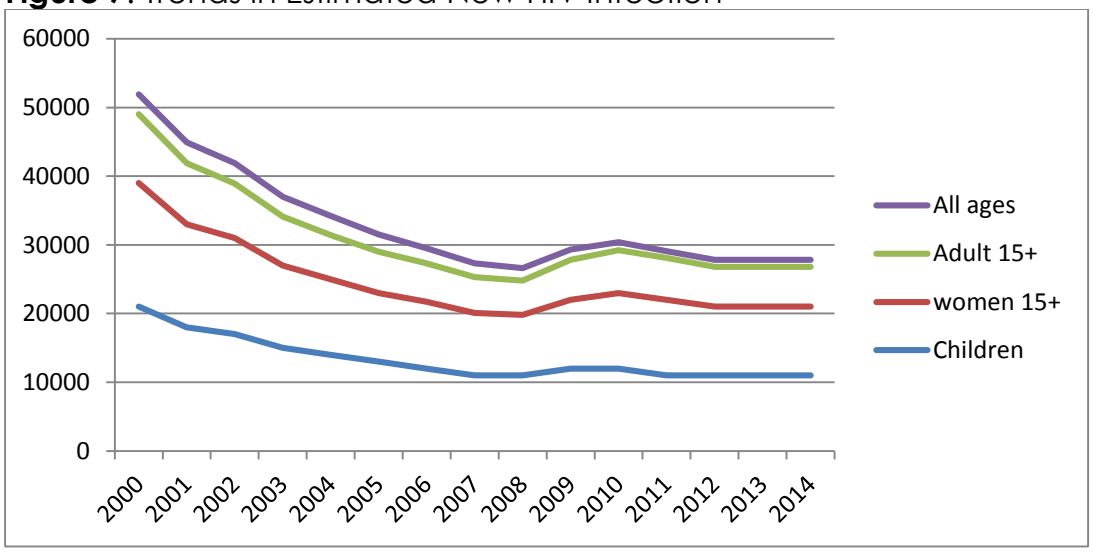
Indicator	Baseline	2013 Results	2017 Target
Number of new HIV infections in one year	10,542 (2008/09)	9493	5271 (50% reduction)
Number of new HIV infections in young women and men aged 15–29 years in one year	11% (ANC survey 2008)	9%	5%
% of HIV infected infants born to HIV positive mothers	12% (2007)	4%	4%
% of key populations who are HIV infected (MSM and sex workers)	70%	IBBS 2013/14	10% reduction from IBBS 2014 result
% of people reported dying from AIDS	23% (2008/09)	4334	18% reduction from baseline
% of NSF planned budget that is funded			

HIV prevention

The decline in HIV incidence in Namibia since the 90s suggests that HIV prevention efforts have been largely effective. However, the rate of incidence decline is leveling off, and it needs to accelerate to reach the critical non-replacement threshold to turn back the epidemic. The motivation for this is two-fold: better quality of life for Namibians, and a financial bonus that can be reinvested in the future to further avert new infections. This can be achieved with greater efficiencies, greater reliance on high impact interventions, and a prioritised, costed combination prevention strategy. Synergies are needed between biomedical and behavioural interventions, with close links to treatment and wider sexual and reproductive and other health services. These must be backed by enabling factors in the social environment, and integrated programmatic strategies.

The chart below shows that there has been a continued reduction in overall HIV infections in the adult and infant populations over the years. The 2013 NDHS+ and 2014 NHSS suggest that there are still hot spots particularly in the border towns and transport corridors, which are still fueling the epidemic.

Figure 7: Trends in Estimated New HIV Infection



Source: MOH 2015 Spectrum Estimates

Findings from the Mid Term Review of the Namibia NSF 2010/11-2015/16 indicate that investment in prevention over the past few years have been on the decrease. This is evidenced in the NASA conducted for the fiscal years 2008/9, 2009/10, 2010/11, 2012/13 and 2013/14. The study found out that total prevention spending declined by 47% from N$ 535.4 million in 2008/9 to N$ 281.8

million in 2009/10, and by a further 24.1% to N$ 213.9 million in 2010/2011. From 2009/2010, international investment for prevention declined from N$ N$253.1 million to N$ 157.8 million in 2010/2011 and, although domestic investment increased by over 50% during this time period (from N$ 30.2 million to N$ 46.8 million), the net result was a substantial drop in total investment in prevention. This creates serious concerns about sustainability of the prevention response in, particularly by civil society which relies primarily on international investment.

The Government has however demonstrated its commitment of ownership of the national response by steadily increasing the amount dedicated to its proportion of expenditures to the HIV/AIDS response over past years, which represents almost 60% of the total spending. The contributions of PEPFAR and Global represent respectively 31.8% and 5.8%. as indicated in the table below. Annex 1 provides a detailed matrix of National AIDS Spending by Source and AIDS Spending Categories.

Table 6: AIDS Expenditure by Funding Source

Sources	2009/10	%	2010/11	%	2012/13	%	2013/14	%
Central Government	121,051,282	50%	168,625,000	60%	111,050,386	55%	136,620,606	64%
PEPFAR	87,320,513	36%	92,375,000	33%	71,394,683	35.5%	57,658,447	27%
Global Fund	26,192,308	11%	9,319,444	3%	10,495,166	5.2%	11,978,348	6%
GIZ	346,154	0.1%	555,556	0.2%	1,505,475	0.7%	1,675,746	1%
UN Agencies	8,346,154	3%	7,847,222	3%	3,664,901	1.8%	2,448,193	1%
Private Sector	230,769	0.1%	319,444	0.1%	2,601,023	1.3%	2,442,655	1%
Other International					348,390	0.2%	522,634	0.2%
Total	243,487,179		279,041,667		201,060,024		213,346,629	

Source: 2014 National AIDS Spending Assessment

Social and Behaviour Change Communication

SBCC is an essential aspect of the Basic Programmes of the revised NSF 2010/11 – 2016/17. It is meant to address risky sexual partnership and behavioural norms and practices that increase the risk of HIV transmission. Social and behavior change is an essential part of the HIV prevention response, requiring complementary, intensive and sustained efforts. It also complements and

promotes the effectiveness of biomedical gains through male circumcision, treatment access and adherence, and pre-exposure prophylaxis and microbicides as these become available. Community mobilisation and social norm change are also required to create an enabling environment with greater gender equality and reduced gender violence; to reduce stigma and discrimination, and to ensure that PLHIV, key and vulnerable groups enjoy full human rights and equitable access to services.

Achievements:

1. A Combination Prevention Strategy and Operational Plan has been developed with strong provisions for SBCC, and providing a comprehensive perspective on prevention with a focus on healthy communities and relationships
2. Increased numbers of civil society organisations and some private sector organisations are involved in social and behaviour change programming, community mobilisation and awareness and demand creation, as well as government initiatives in schools and with young people. Although the specific contribution of these programmes to HIV prevention is difficult to quantify, they have undoubtedly contributed to the effectiveness of biomedical prevention services through increasing uptake, and raising awareness of risky behaviours
3. Networks such as Prevention Alliance Namibia, (PAN) coordinate efforts of several NGOs (Nawalife for sub-granting, Catholic AIDS Action, Society for Family Health, Positive Vibes, and Lifeline Childline) in extensive social and behaviour change work that reaches into all regions. Another example is a new alliance, Mutual Action in Development, (MAD) that links seven NGOs in integrated action. The Coalition on Responsible Drinking (CORD) is coordinating efforts to tackle alcohol abuse, including by children and young people. Health works Business Coalition on AIDS, coordinates private sector initiatives.
4. The health extension worker programme, with a staff based of about 1,000 is currently contributing positively in increasing prevention service and treatment access and adherence among communities.

Challenges:

1. The work of civil society organisations is under imminent threats as a results of the ongoing reduction in external funding from donors. The focus of the 2015 PEPFAR Country Operational Plan (COP 15) seems to have shifted from supporting core civil society interventions (SBCC) to biomedical interventions. It is unclear whether GRN will sufficiently fill the funding gap,

and whether there will be a drop in efficiency and effectiveness of SBCC programmes as a result.
2. Widespread alcohol abuse still persist as a factor fueling potential risky sexual behaviour
3. Unfavorable social and traditional norms have not been sufficiently addressed and continue to increase vulnerability particularly for women and girls

Opportunities:

1. The development of the Combination Prevention Strategy (CPS) with extensive civil society involvement can be harnessed to support a coordinated response for HIV prevention
2. The Result Based Management approach utilized in the development of CPS provides a strong result frameworks based on the NSF that can be used to assess the contribution of partners to prevention.
3. With the costing of the CPS as part of the building components of the Namibia Investment Case, there is potential for increasing private sector involvement financially and programmatically.

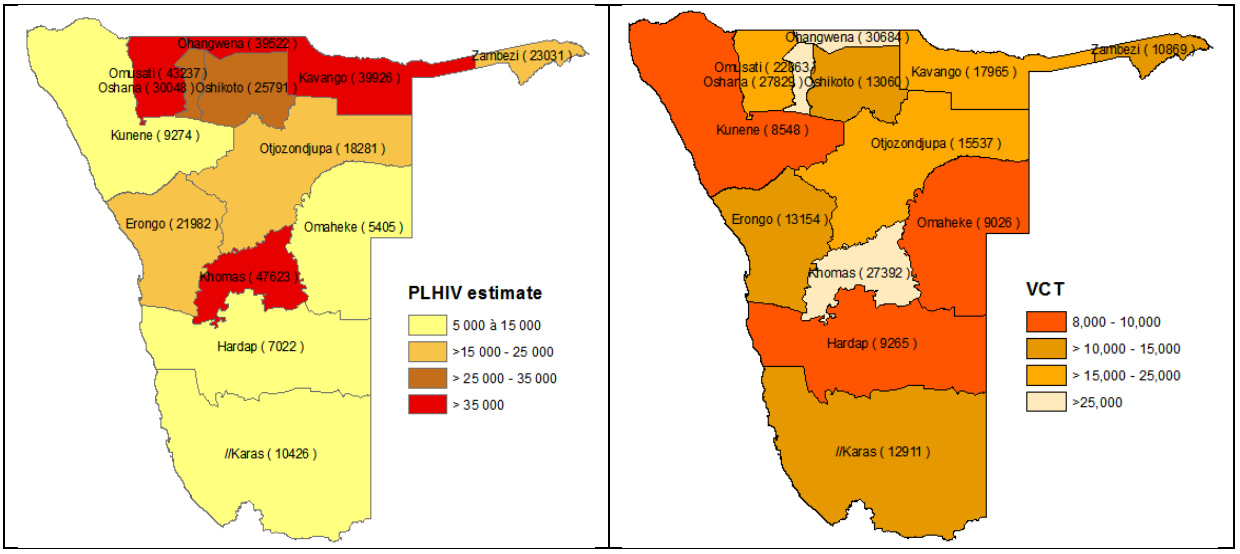
HIV Counseling and Testing

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

According to DHS results, 49% of women and 38% of men age 15-49 were tested for HIV in the year preceding the survey and received the test results. This is a notable increase since the 2006-07 NDHS, when the corresponding percentages were 29% and 18%. This trend is a result of the high uptake of HIV testing as show by programmatic data.

VCT data for 2014, indicates that VCT uptake is high in regions where there are numerous PLHIV such as Ohangwena, Oshana, Khomas and Omusati.

Figure 8: Number PLHIV Estimates and total VCT undertaken by region



Source: 2015 HIV Estimates and MOHSS Programme Data

Achievements:

1. By December 2014 a total of 209,103 adults were tested. A reduction from 384,970 in March 2013, but yet an impressive figure three months ahead of the end of the fiscal year in March 2014.
2. The MOHSS has developed and finalised a comprehensive national HCT Strategy and Operational Plan covering mixed methods for diverse service settings and population groups, standards, roles and responsibilities, operational requirements and M&E.
3. Mobile outreach services are available and expanding in a number of regions, as integrated PHC or as HCT services linked with strong referral for prevention and treatment and SRH. A recent pilot for home-based HCT (HBHCT) in Kavango and Oshana regions 15 found very few testing refusals, and report achieving over 90% referral of those testing positive to care and treatment facilities. As with rural mobile outreach, they also had higher rates of couples counselling.

Gaps and challenges:

1. In remote areas, mobile outreach and HBHCT referrals may be compromised by the lack of nearby health facilities
2. Despite progress, the coverage of couples, men, and key and vulnerable populations remains insufficient. Stigma remains a major deterrent to HCT uptake.
3. Follow up to Men Who have Sex with Men and mobile populations such as Sex Workers (SW) are particularly challenging.

Opportunities

1. Namibia is moving towards more integrated strategies for HCT so that referral to both prevention and treatment services can be strengthened and quantified.
2. The mixed methods for HCT are providing examples of good practice that can be closely assessed to guide scale up to reach different key and vulnerable population and the hard-to-reach.
3. Self-testing is a new approach that is being considered.

Condom Promotion and Distribution

Condom promotion and distribution has proved to be effective in preventing HIV, STI and unwanted pregnancy. Both male and female condoms have therefore been distributed for free through the public sector, and through social marketing. Targeting of condoms may be more effective when directed at discordant couples and for casual or transactional sex and sex work. A study undertaken in 2009 among schoolgirls reported that girls who carried condoms were labeled as 'sex addicts', and, as a result, only 40% of the sexually active girls carried condoms when they planned to have sex (ETC Crystal, 2012).

The main reported barriers to condom use include: unequal gender relations, alcohol and drug abuse. Shyness amongst youth and concerns about being seen to be 'promiscuous' by virtue of carrying a condom, particularly amongst young women, have also been highlighted as important barriers to condom use in studies conducted by UNICEF in 2008 and 2011. The 2008 UNICEF study found that 25% of boys and girls in the sample did not know how to use a condom and/or were too embarrassed to put a condom on.

Table 7: Revised NSF targets set for overall male and female condom distribution and the extent to which they were achieved

Indicator number	Indicator description	Baseline (in millions)	Mid-Term Target 2012/13	2011/12	March 2013	Revised NSF Target (2016/17)
Result: Risk of infection reduced by using condoms						
OP 17	Number of condoms distributed free by year	Male: 30.3 m Female: 1.16 m (2008/09)	Male: 45 m Female: 2 m	Male: Female: 0.281 m	Male: 25.836, 412m Female : 0.1831 m	Female:6.6 m Male: 50.4m (Total 60 000 000)
OP 18	Number of condoms distributed by social	Male: 1.6 m Female: 0.157,94	Male: 1.6 m Female: 0.3 m	Male: 2.509,608 m In 2011, NaSoMa	N/A	NA

	marketing by year	m (2007/08)		sold 2.4 million male condoms and 12,000 female condoms		

Achievements:

1. Although the consistent use of condom remains generally low, the 2013 DHS indicates that condom use among young people is high
2. Supplies of both male and female condoms are widely distributed through multiple outlets including community sites, workplaces and others beyond health facilities.
3. The disciplined forces have strong awareness programmes backed by their own branded condoms.
4. A pilot programme between GIZ, MoHSS and Namibia Breweries is seeking to improve condom distribution through private sector supply chains. This programme delivered 20% of all condoms in Ohangwena, the pilot region.

Gaps and challenges:

1. Logistical issues have in some occasions posed challenges to the distribution of condoms in the Public sector. This has been responsible for the low uptake and challenges in condom social marketing to meet NSF targets.
2. High teen pregnancies, such as documented in Kavango Region, indicate that condoms are not sufficiently and consistently used.

Opportunities:

1. The combination prevention strategy (CPS) will provide important new directions on scaling up condom distribution and uptake.
2. As a result of an MOHSS National Quantification Exercise in 2012/13, the GRN is now in a position to undertake procurement and distribution of male and female condoms.
3. Scale up of Public-Private Partnerships like the GIZ supported pilot are being considered.

Prevention of HIV among Key Populations and Vulnerable Groups

Key populations

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

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

The Walvis Bay Corridor Group selected by SADC through the Global Fund Round 9 funding to implement a Cross Border HIV initiative at three Border Crossing Sites namely, Wenela Border Post (Katima Mulilo), Oshikango Border Post and the Sesheke Border Post in Zambia has proved to be a coherence and effective response to HIV and AIDS in Namibia with regards to mobile populations, sex workers and their clients. A draft report from a size estimation and IBBS study among MSM and Sex Workers undertaken in 2013 with support from CDC has been submitted to the MOHSS for final review and circulation.

Achievements:

1. Evidence in the sub region suggests that MSM and Sex Workers are well covered by prevention programs. This is as a result of several civil society organisations providing support for key populations, including mobile outreach to hot spots, advocacy and community sensitisation. SFH report increasing reach to multiple key populations with SBCC, and on SRH referrals.
2. An assessment in 2011 by UNODC contributed to providing based line information on prison in a survey that targeted the 13 prisons in Namibia, which highlighting HIV prevalence in both prison inmates and officers and making recommendations for scale up of prevention services and treatment in prison settings.
3. Through this SADC cross border HIV initiative, the Walvis Bay Corridor Group (WBCG) reached 2,341 mobile groups (long distance truck drivers) with HIV counselling and testing services since January 2012 at the Katima Mulilo and Oshikango Border Posts. Out of this figure, 210 or 8.9 % of truck drivers tested HIV positive and were all referred to HIV treatment, care and support services. The WBCG also tested 1616 sex workers at the same sites of which 201 or 12.4% tested HIV positive and were also referred to appropriate services. The remaining total of 5.320 consists of other general border community members that interact with mobile populations, of which 520 or 9.7% tested HIV positive during the same period

Challenges

1. Systematic data on key populations is still limited, making size estimates problematic, and HIV prevalence difficult to measure, as well as the measurement of impact of prevention interventions.
2. Widespread stigma and discrimination, gender violence and legal barriers continue to impede the realisation of human rights and HIV prevention and health care access of key populations, notably MSM and SW, thus exacerbating their already high risk for HIV, and that of clients.
3. Civil society coordination for the response is insufficient, partly hampered by the lack of guidelines, and declining civil society funding could diminish their scope.

Opportunities

1. When released, findings from the recently concluded Integrated size estimation and Bio-Behavioural Survey (IBBS) in eight sites among MSM, female sex workers will provide a new insight and perspective on the HIV epidemiology among MSM and Sex Workers
2. Findings from the report would also provide an opportunity to consider the provision of pre-exposure prophylactic (PREP) programme for key populations such as sex workers and MSM.
3. The UN Special Rapporteur on Extreme Poverty and Human Rights made strong and substantive recommendations in relation to MSM and SW in Namibia for the Human Rights Council 23rd Session, that were presented to the relevant Namibia Parliament Standing Committee on 17th September 2013 and could form the basis for serious reform of the policy and legal environment for key populations. Parliamentarians are seeking proposals for law reform on MSM and sex work.

Vulnerable groups

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

Achievements:

1. UNESCO and UNICEF in partnership with Ministry of Education are supporting an institutionalised HIV life skills education programme, and a sexuality education programme in Secondary schools.
2. A draft report from the "Know your epidemic, Know your response", (KYE/KYR) exercise in Katima Mulilo is being finalized. This study will complement the KYE/KYR study of the city of Windhoek (City of Windhoek,

CoW, study) in highlighting the gaps and opportunities for strengthening the urban response by understanding better the dynamics of the epidemic and mapping current efforts with respect to coverage, quality and effectiveness.
3. Several CSOs, through public private funding partnerships, operate mobile clinics for PHC, HCT and SRH services with outreach to remote rural populations and other hard-to-reach populations such as sex workers in known hot spots.
4. Established Women and Child Protection Units in 15 districts hospitals are still functioning in to assist in cases of sexual violence.

Gaps and challenges:

1. Interventions are not at scale and are uncoordinated.
2. Unfriendly and negative health worker attitudes towards young people and other key populations is an impediment to access sexual and reproductive health services among key populations
3. Poor urban populations, particularly those in informal settlements, are not yet being effectively reached despite the resources that could be brought to bear for them and their substantial share of HIV infections.
4. There is no national programming in place to reach people with disabilities, although small initiatives exist in some regions.
5. Setting up a user friendly Health Services that enable vulnerable populations to access sexual and reproductive health services in a conducive environment.

Opportunities:

1. A planned review of the HIV Strategy of the city of Windhoek, is an opportunity to engage the city on reaching out to key populations
2. If implemented, the recommendations from the KYE/KYR can go a long way address interventions for key populations in cities and other hot spots in the country
3. Establishing or engaging those populations found in hot spot on how sexual and reproductive health service should be made available to them

Involvement of PLHIV

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

Achievements

1. There is now a PLHIV Technical Working Group, which is a platform to engage PLHIV support group to lead on HIV technical issues
2. With support from development partners, progress is being made to involve PLHIV through the efforts of several PLHIV support organisations and through adoption of Positive Health, Dignity and Prevention (PHDP). For young people, Adolescents Living with HIV (ALHIV) is being rolled out.
3. Several PLHIV organisations exist, including Positive Vibes that operates through volunteers in all regions, and has a strong advocacy voice.

Challenges

1. With insufficient community mobilization and engagement from civil society organization stigma and discrimination against PLHIV will remain a challenge
2. Numerous small support groups exist, estimated at over 250, but their capacity is low and they are uncoordinated.
3. The PHDP approach is not yet at sufficient scale to have much impact.

Voluntary Medical Male Circumcision

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

Achievements:

1. The government has secured renewed funding from PEPFAR and the Global Fund to support the implementation of the VMMC strategy and rollout. The 2013 NDHS reported that 26% of males 15-49 years who were interviewed during the survey were circumcised (Ministry of Health and Social Services Namibia, 2013). Programme data indicated that during 2014 4,165 men had been medically circumcised, slightly higher that the numbers for 2012-2013 (3889).
2. Namibia has adopted the WHO target of 80% coverage and estimates it needs to reach a target of 309,376 male circumcisions for men aged 15-49.
3. The MOHSS is currently implementing the VMMC Strategy developed and finalized in 2013.
4. With renewed funding from the 2015 PEPFAR COP, VMMC is set to be scaled up throughout the country.

Gaps and Challenges:

1. The VMMC programme in Namibia has not met its mid-term target of 30% coverage for adults or 40% for infants due to a mismatch between service availability and demand.

2. Neonatal male circumcision is not part of the initial MC strategy, a potentially missed opportunity for future cost savings in HIV prevention, but it is scheduled to start later.

Opportunities:

1. The ongoing task shifting strategy will expand training of qualified nurses, with supervision from medical officers, to increase the efficiency, cost effectiveness and scaling up of service VMMC provision national wide.
2. The new Combination prevention strategy has strong provisions for scaling up SBCC efforts to include VMMC.

Prevention of Mother To Child Transmission

Namibia has made significant progress on eliminating mother to child transmission of HIV and AIDS. The 2013 MTR suggests that mother to child transmission rates in Namibia is a s low as 4%, putting the country on course to achieving the UN 2011 HLM Political Declaration on HIV/AIDS by end of 2015 – an aspirational goal, and to reduce substantially maternal deaths.

Table 8: Prevention of Mother to Child Transmissions 2006/7- 2013/14

Target 3: Eliminate mother-to-child transmission of HIV by 2015/16 and substantially reduce AIDS related maternal deaths	**2006/07**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**NSF Target 2016/17**
UA & Global 3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission[2]	42%	77%	90%	83%	91%	90%	95%
Global 3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	36%	59%	60%	67%	61%	88% (N=9684, D = 11000)	90%
Global 3.3 Percent MTCT rate	25%	16%	12%	14%	13%		4%

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

Achievements:

1. There has been a renewed commitment from the Namibia Government to the Global Plan of eliminating pediatric HIV transmission by 2015 as reflected in the stock taking plan to accelerate interventions to meet the global target. This follows the MOHSS alignment of the PMTCT Strategy to the Global Plan in 2013.
2. The PMTCT roll out prior to and during the NSF is impressive, with 94% of health facilities providing HIV testing and ART by March 2013 (against a mid-term target of 90%).
3. By September 2014 a total of 8,849 Pregnant women had received ART for PMTCT
4. The adopted Option B+ of the WHO recommendations, and roll out of this approach in 2014 has put the country strongly on course to achieve PMTCT targets by end of 2015.
5. Administering of ART by nurses (Nurse Initiated and Managed ART, NIMART) is a new pilot that is being scale up in more districts with the intention of scaling up.

Gaps and challenges:

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

Opportunities:

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

Blood Safety

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

Achievements:

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

Challenges:

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

Universal Precaution

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

Achievements:

1. The existence of national guidelines and procedures is important
2. Injection safety is clearly high. The only indicator with a baseline, from 2009, showed that 95% and 97% (2009), 96.8% and 97.6% (2013) of the men and women respectively reported that their last injection was from a new/unopened package, close to the target of 100%.

Challenges:

1. The lack of strategic information on universal precautions is cause for concern.

2. Sixteen priority actions are cited for universal precautions in the NSF but it was not possible to ascertain how far they are on track.

Treatment Care and Support

Decreased HIV related death and morbidity among PLHIV is the main goal for the treatment, care and support program. The NSF strategic objective in treatment, care and support is to increase access to cost effective and high quality treatment, care and support services for all people living with and affected by HIV and AIDS. By the end of the NSF period in 2017, it is expected that 95% of people who are in need of ART will be receiving high quality services in health facilities as well as through home and community-based services that support HIV and AIDS treatment.

Pre – ART

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

Table 9: Pre-ART result during the NSF period

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

Achievements

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

Challenges

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

Antiretroviral

Since 2014 the Namibia Government has been providing ART based on the CD4 500 eligibility criteria, following the adoption of the WHO 2013 treatment criteria. Since March 2009 there have been increases in ART coverage for adults from 67% baseline to over 83% by 2013 – midterm for the NSF. The Government also panned to expand access to ART services and address the unique needs of adolescents on ART.

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

Table 10: Percentage of People living with HIV on ART 2006/07 - 2013/14

Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015	Dis aggregation	2006/07	2009/10	2010/11	2011/12	2012/13	2013/14	NSF Target 2016/17
UA & Global 4.1 & MDG Percentage of eligible adults and children currently receiving antiretroviral therapy	***Adults***	56%	88% (CD4 200)	67% (CD4 350)	87% (CD4 350)	87%	81%	95%
	Children	88%	>95% (CD4 200)	75% (CD4 350)	65%	70%	54%	95%
Global 4.2 Percentage of adults and children with HIV known to be on	***Adults***	69%	80% (Jan-Dec 2010)	81.5%	86%	84%	77.5	95%

treatment 12 months after initiation of antiretroviral therapy	***Children***	82%	82% (Jan-Dec 2010)	83.9%	87%	87%	76.6	95%

Achievements

1. The number of public sector health facilities offering ART has increased from 141 in 2009 to 213 in 2012. This number includes main ART sites, Integrated Management of Adulthood Illnesses (IMAI) sites and outreach sites.
2. The MOHSS Training Network (TN) supported by development partners has expanded the number of training courses for HIV and AIDS prevention, treatment care and support.
3. The training of Health Extension Workers (HEW) is now being implemented. An increasing number of HEW have been deployed in most part of the country throughout the country.
4. MOHSS piloted the task-shifting model that was started in 9 public Health facilities is now in full implementation, after the pilot concluded that nurses are capable of successfully initiating ART. The MOHSS has approved the initiation of ART by nurses under the supervision and mentoring by doctors.
5. The number of adult PLHIV on ART has increased from 75,681 (March 2010) to 121146 (September 2014) representing over 90% coverage of people needing ART.
6. Quality of care improvement (HIVQUAL) –The HIVQUAL program has been introduced and is being implemented in 37 facilities across all the 34 districts.
7. Plans are ongoing to unify the PLHIV monitoring system (EPMS) and the ART Monthly reporting system used to dispense ART (EDT) to address the ongoing discrepancies in two systems.
8. The GRN through the National Institute of Pathology has established a network of 40 laboratories that offer the full range of lab test needed alongside the continuum of care.

Challenges

1. Shortage of skilled and experienced health workers still persists. Attrition is equally high. Implementation of the new treatment guidelines will increase in demand for ART and exacerbate the manpower shortage.
2. Inadequate storage space at some of the small ART sites.
3. HIV Viral load testing is only available in Windhoek and transporting specimens across long distances poses challenges. Long-distances from laboratories also cause delays in getting results.
4. Point of Care (POC) still not available in all ART sites

TB/HIV Co-infection

The MTR of the NSF in 2013 indicate that Namibia has a high burden of tuberculosis (TB). In 2012 the case notification rate was 529/100,000 population, making Namibia one of the worst affected countries in the world. Coupled with a high prevalence of HIV infection, TB/HIV co-infection is a major public health problem. In 2012, 47% of TB patients were co infected with HIV. By December 2014 the total Number of people with HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment was 33603. The high TB burden in Namibia is further compounded by an increasing numbers of cases of multi-drug resistant (MDR) TB and extensively drug resistant (XDR) TB. The strategy of the MOHSS to tackle the problem of TB/HIV co-infection is to strengthen coordination between HIV and TB programmes so that more people living with HIV are screened for TB and all TB patients are tested for HIV and put on ART if found to be HIV infected. In addition the NSF includes strategies to scale up implementation of the Three I's strategy which entails (a) Intensified case finding, (b) provision of Isoniazid Preventive Therapy (IPT), (c) TB Infection Control.

Achievements

1. The percentage of TB patients with known HIV status increased up to 89% in 2012.
2. % of PLHIV with new smear-positive TB who have been successfully treated was at 81% by March 2013 with the mid-term target (2012/13) of 80% and the end term target (2015/16) of 85%
3. 87% of HIV positive persons were screened for TB at their most recent visit.
4. The number of HIV infected persons who are getting Isoniazid Preventive Therapy (IPT) is increasing in most regions but the percentages are still low at some sites
5. The National Tuberculosis and Leprosy Programme (NTLP) has initiated the use of Gene Xpert diagnostic technology to improve case finding
6. TB management and coordination structures within the health sector have been established with roles and responsibilities for the different levels and individuals clearly spelt out. The roles of community level structures and those of other sectors have been well articulated.

Challenges

1. Despite all efforts to prevent new TB/HIV co-infections, the TB/HIV co-infection rate remains high, which suggests that interventions have not reached the desired level of effectiveness.

[3] Namibia 2015 GARPR report

2. It is also evident that the focus has concentrated on addressing the clinical management of the TB and TB/HIV co-infection. Strategies have not adequately addressed critical social enablers such as food security, adequate housing, general hygiene and sanitation.
3. The Private Sector (Health Works Business Coalition on AIDS, formerly known as NABCOA) has initiated a mobile TB management project targeting private companies conducting the screening with the use of Gene Xpert Machine

Care and Support

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

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

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

Critical Enablers and Development Synergies

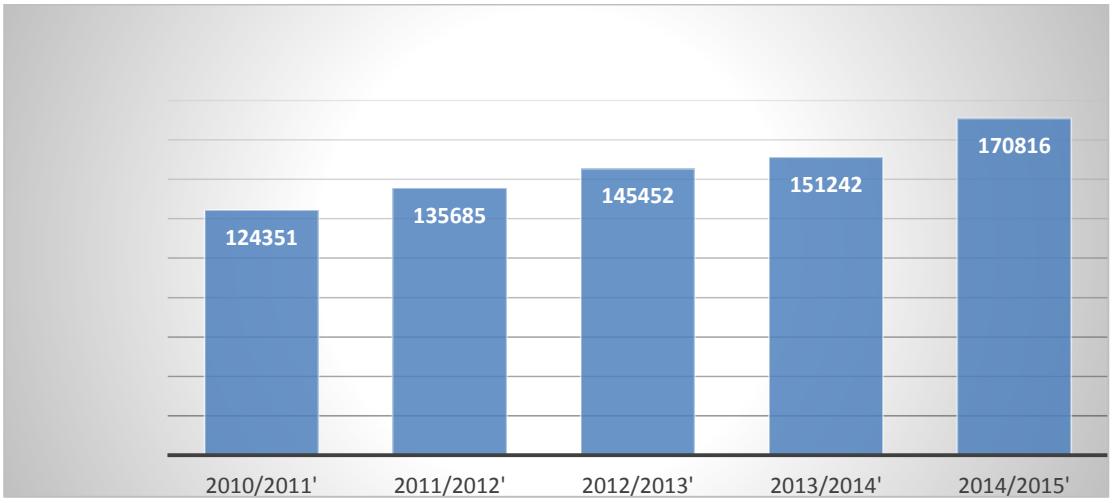
The revised National Strategic Framework has packaged enablers to cut across all programme areas, notably stigma and discrimination, gender equality and GBV, community mobilisation, legal and policy reforms. Social protection and poverty reduction are also essential development synergies to protect vulnerable households from HIV shocks. These enablers and synergies can help reduce risky behaviour that is driven by poverty by incorporating SBCC into existing programmes and other initiatives for women's empowerment. Legal reforms are needed to protect key populations such as MSM and sex workers, and to strengthen the enabling environment for the protection of rights of people living with HIV.

Support for OVC, and in particular ensuring equitable access to emotional, social/material, and school related support is a key objective for the revised National Strategic Plan 2010/11 – 2016/17 The 2011 Annual Census reports that 124,320 (13%) children have lost one parent and 6269 have lost both parents (2, 7%), giving a total of 130,589 OVCs.

Social protection and poverty reduction

Namibia has a well –established and long functioning social grants system, which provides for an Old Age Grant, a Disability Grant, a war Veteran Subvention and various Child Welfare Grants. Social grants, especially the old-age pension, are an important means of providing social protection against vulnerability and poverty. However, there has been a marked increase in number of children receiving a grant. This increase is partly due to outreach and awareness –raising activities as well as referrals of children from NGOs to the Ministry of Gender Equality and Child Welfare (MGECW) for registration. By the end of financial year 2014/2015 a number of 170816 were receiving a grant.

Figure 9: Number of Child Grant from 2010/11 to 2014/15



Source: Ministry of Gender Equality and Child Welfare

The National Agenda for children acknowledges that Child Grants are not yet fulfilling their potential as a mechanism for reducing poverty and vulnerability of children and their families due to the grants not reaching a broader group of poor and vulnerable children whose parents are alive, which in turn due to current grant-eligibility criteria. To that end the MGECW introduced a new type of grant for children from poor household whose parents are alive. During 2014/2015 financial year a number of 14092 were added on child grant system due poverty. (This number of children is included in the total number of children received grants in the above chart).

Achievements

1. The increase in number of old-age pensions to over 91% national coverage, and the increase in the monthly amount have a substantial and positive effect on poverty.
2. The Ministry of Education launched its progressive policy on pregnancy among learners in school. The National Gender Policy adopted by Parliament in March 2010 was launched in March 2012 by the President. A plan of action for the policy is being developed. A National Plan of Action on Gender-based Violence 2012-2016 was also developed.
3. Community Child Care and Protection Forum Guidelines were developed and distributed to constituencies. One hundred and fifty (150) Child Care and Protection Forum members were trained on child protection.
4. There are now 15 Gender-based Violence Investigation Units (GBVIU) formerly Women and Child Protection Units (WACPUs) intended as specialized units, which can provide child and gender sensitive responses to victims of gender-based violence and child abuse.

5. Over 88,409 caregivers were receiving a grant to care for a child (information provided by MGECW and OPM) in august 2013. A very important support mechanisms that that has been used for educational, medical and material needs for the child.
6. The MGECW and its sectoral partners developed the National Agenda for Children (2012-2015) with health and nutrition; education; HIV prevention, treatment and care; legal rights and standard of living; and protection from abuse as the priority results for children.
7. Support to Early Childhood Development (ECD) facilities expanded through the introduction of subsidies to ECD caregivers following a Cabinet directive (4th/27.03.12/006) to MGECW. From January – June 2013, 276 ECD caregivers (17 male; 259 female) from 264 ECD centres located in poor communities received an allowance through the Regional Councils for the first time. The budget for ECD programming in MGECW rose from N$5 million in 2011/12 to N$15 million in 2013/14. (Medium Term Expenditure Framework)
8. Ministry of Education abolished the school development fund, making primary education more accessible to all children. The 2012 Education Management Information System (EMIS) reported 125,250 orphans and 106,914 vulnerable children enrolled in school. The numbers of orphans attending school by region can be seen in the table below

Challenges

1. Households in rural areas are twice as likely to be poor than those in urban areas, and a higher percentage of female-headed households.
2. The resources available, including staff and financial resources are limited and scattered. Various sectors offer income generating grants or grants for community development projects but often without a clear well informed, evidence based and economically sustainable strategy.
3. Access to formal and non-formal skills training remains difficult for the vulnerable.
4. The delay in enacting the Child Care and Protection Bill means that the regulations to guide social workers is not up to date and that vulnerable children, especially the ones from poor households with parents alive do not qualify to access social welfare grants.

IV. Best Practices

Namibia has been aggressive in its commitments to strengthen its response to the HIV and AIDS epidemic through the implementation of multi-sectoral comprehensive intervention programmes. The local NGOs, private sector, CSOs and development partners have been committed to deliver programmes in the country t aimed at curbing the spread of the epidemic. Below have been

identified as best practices by the organisations which implement them at various levels.

NSF AREA	BEST PRACTICES
Prevention of New HIV Infections	Namibia is successfully moving towards more integrated strategies for HCT so that referral to both prevention and treatment services. The mixed methods for HCT provide examples of good practice that can be closely assessed to guide efficient and effective scale up to reach different key and vulnerable populations, couples and the hard-to-reach. The models are inclusive recently piloted home-based testing, door to door testing and provider initiative Counselling and Testing (PICT). With the implementation of rural mobile outreach services, there is expected to be a high rate of couple testing. HIV prevention in Namibia has been partly effective as evidenced by the rate of decline in new infections. The decline seems to have levelled off, thus the need for innovative prevention approaches to reach the critical tipping point that turns back the epidemic. Concerted efforts were made to support the scale up of prevention efforts for young people and key populations, notably sex workers, and promote enhanced participation and inclusion of these populations in programming. New approaches and technologies have become available such as the prepex device for VMMC, pre-exposure prophylaxis and the increased potential for treatment as prevention with the new WHO treatment guidelines including the Option B+ for PMTCT, The health extension worker (HEW) programme, recruiting over 4,200 health extension workers, can become a positive community development to increase prevention service and treatment access and adherence; HEW need to work closely with other community cadres and structures to ensure that non-health aspects of outreach are not lost. Global Fund Phase II provides important funding opportunities. Namibia is advancing towards eliminating vertical transmission of HIV by ensuring universal access to services for the prevention of mother-to-child transmission (PMTCT) of HIV. The PMTCT programme has registered tremendous successes over the period under review, with development partners providing

	technical assistance towards the implementation of the National Elimination Plan 2012–16, including the monitoring and evaluation components, integration of SRH in to eMTCT, condom and male circumcision strategies. PMTCT has been scaled up across all 14 regions and 35 districts, now reaching 345 health facilities (97%). The end-term impact result of 4% MTCT had already been achieved by March 2013 and the government has adopted and implemented the Option B+ for PMTCT as per the new WHO guidelines. A new development is the country's agenda to strengthen integration of SRH and HIV services. Through the EU funded SRH-HIV linkages project, Namibia embarked in 2013 on a service delivery pilot in 7 clinics across the country, whereby the preliminary results from the baseline assessment already indicate tremendous potential efficiency gains. An innovative approach to the HIV prevention response is further evidenced by the initiation of mobile service delivery in the capital city of Windhoek.
Treatment, care and support	International community and experts regard the Namibia's model of HIV/AIDS treatment and care as the best among countries Africa. The Directorate of Special Programmes in the Ministry of Health and Social Services has continued to use this mechanism to carry out their functions effectively. At the national level, TWGs provide advisory oversight to government implementing agencies. The Namibia ART programme have been the flagship of Namibia's AIDS response, with the country reaching its 2010 Universal Access target for ART already in 2009. Since then it has continued to register remarkable achievements, with the number of PLHIV on ART increasing from 75,681 in March 2010 to 131,722 in March 2014. Namibia has been in the forefront for implementing the WHO treatment guidelines including the previous threshold of 350 CD4 counts, which had a huge effect on increasing coverage to over 84% of those eligible on ART by 2012. Namibia has again revised its ART guidelines based on the 2013 WHO criteria; and the Government has taken a decision to implement the new guidelines starting 2014. The CD4 cut-off for eligibility has increased from 350 to 500 cells/mm2 'for adults. In addition, all pregnant women, all children under 15 years old,

	all HBV/HIV co-infected patients and HIV-positive persons whose partners are HIV-negative are eligible for ART irrespective of CD4 count. The obvious implication, although with accompanying high costs, is a dramatic increase in number of those eligible for treatment. Availability of Rapid Tests has made it possible for newly diagnosed persons with HIV to get counselling and treatment immediately. By March 2014 100% of newly diagnosed HIV positive people at ART sites were immediately enrolled on a pre-ART program. At the majority of sites 100% of clients get Cotrimoxazole (CTX) prophylaxis. Strong collaboration and alignment exist between HIV and tuberculosis (TB) services. Development of a national strategy on HIV/TB resulted in a scaling-up collaborative activities, including the establishment of a HIV/TB working group, screening for TB and HIV, and provision of free health services. The Nutrition Assessment and Counselling Support (NACS) program was initiated in 2011 and is being implemented in 16 districts. Through the NACS program, Ready to Use Therapeutic Food (RUTF) and Fortified Blended Flour (FBF) is being given to PLHIV. Since the program started in 2011, a total of 23,849 patients have been nutritionally assessed at the implementation sites and 1262 have been enrolled into the NACS program and provided with therapeutic and supplementary foods.
Impact mitigation	The NSF midterm target of decreasing poor households to 28% by FY2012/13 was achieved. The incidence of poor and severely poor individuals from the 2009/10 NHIES was estimated at 28.7 and 15.3 percent, respectively. The MGECW and its sectoral partners developed the National Agenda for Children (2012-2015) with health and nutrition; education; HIV prevention, treatment and care; legal rights and standard of living; and protection from abuse as the priority results for children. The National Agenda is monitored through the Permanent Task force for OVC under the chair of the MGECW. The Namibian Alliance for Improved Nutrition (NAFIN), chaired by the Prime Minister, developed a multi-sectoral plan (2012-

	2015) that was launched in March 2013. The Declaration of Commitment signed by the Governors at the Governors Nutrition meeting on August 15, 2011 committed Governors to several key steps for nutrition.
Response management and coordination	The National Strategic Framework for HIV and AIDS and M&E plans 2010/11 to 2015/16 were reviewed during the year of reporting. Various political leaders actively participated in this exercise by providing their views during the consultation processes. The HIV and AIDS Policy of 2007 is currently under review. Various consultations were held with key stakeholder and population. The reviewed policy is expected to include key emerging issues identified during the review of the NSF and M&E plans.

V. Major challenges and remedial actions

Many stakeholders believe that the NSF is a key strategic document for the national multisectoral response. However, its overall implementation has been slow. While communities and CSO have been engaged in different ways, their potential in the implementation of the national response has not been realised. Similarly the participation of private sector beyond workplace / wellness programmes has been limited.

Demand creation, service delivery and monitoring have also been inadequate for some critical programmes such as voluntary male circumcision, HIV testing and counselling, condom use, and outreach services to key populations.

The analysis concludes that the NSF intentions for targeted interventions were good, but never realised. Currently there are limited targeted interventions for example for young women 15-24, who contribute 67% of the 40% new infections from young people.

Although the NSF was aligned to NDP3, and now NDP4, in practical terms, the indicators, the targets and data collection mechanisms are not yet aligned. Similarly, sectors' alignments between NDP 4 and NSF remain a challenge.

The current NSF embraced all the programmes, despite the intentions to strategically prioritise. This has to some degree compromise efficient use of resources in addressing critical programmatic areas necessary to stop new

infections and prevent deaths related to AIDS.

Substantial improvements in prevention results in Namibia will require the development and implementation of the combination prevention strategy (CPS). It will also emphasise integration with other areas of SRH and PHC, and with treatment, and greater efficiencies in programming. Increased prevention funding will be needed in the short term.

Namibia needs to urgently develop its health human resource workforce to address the increasing demand for services as well as fill the gap that may be left by internationally recruited health workers as donor funds decline. Along the same lines, Namibia will need to tap into the vast resources that are in its people in the communities.

Capacity to serve coordination functions is insufficient and fragmented. Many key actors remain unclear about their roles and responsibilities. The response remains poorly integrated in structures dealing with other social and development issues, especially at the local level, leading to missed opportunities and considerable inefficiencies.

The National Development Plan 4 offers opportunities to strengthen planning and accountability processes. Currently, however, the NSF is not well aligned with the sectors and results identified in the NDP4. This has particular relevance for the development of sectoral responses.

The effectiveness of Research Monitoring and Evaluation is undermined by three conditions 1) the multiplicity and fragmentation of M&E systems 2) the skills deficit in M&E and 3) the substantial measurement burden imposed by the current NSF Results Framework. The optimal utilization of strategic information is challenged further by data management related issues, including difficulties in accessing and integrating the various data sets for analysis; gaps in data; and indications of problems with data quality, the extent of which is currently uncertain.

Capacity to coordinate the expanded multi-sectoral response to HIV and AIDS at national level remains insufficient and fragmented. The Directorate of Special Programmes in the MOHSS serves as the secretariat for most of the national-level structures and custodian for the overall multi-sectoral response. It has suffered a number of staff shortages and changes over the period of review, and more changes are likely in the context of on-going government restructuring.

Male involvement in maternal child issues is a challenge, several measures/approaches has ben put in place however this area needs high impact policy intervention.

VI. Support from the country's development partners

PEPFAR

Commitments and support to the GRN in 2012 – 2014 under the PEPFAR Country Operational Plan (COP) 14 will be continued under COP 15, in partnership with civil society, multilaterals and the private sector. COP15 supports the national goal of 80% ART coverage among all PLHIV by 2017. Consistent with principles set forth in the USG-GRN Country Health Partnership Letter of Intent (July 2014), PEPFAR works to jointly plan, implement and monitor USG-GRN co-investments to achieve epidemic control and foster a sustainable response.

Support is being provided to facilitate monitoring, quality improvement, and scale up of GRN's combination prevention core interventions, including: 1) test and treat for children under 15, pregnant women, discordant couples, and HIV/TB co-infected individuals; 2) voluntary medical circumcision for men 15-29 years of age; and 3) Option B+.

In addition to supporting Strategic Information related interventions through CDC, PEPFAR is focussing on seven regions with the highest HIV burden and unmet ART need and eight urban hotspots outside these priority regions with the greatest known numbers of key populations or high-volume ART sites. Priority areas represent 80% of all PLHIV. To close the ART gap in priority region/hotspots, an additional 38,615 adults and children need to be initiated on ART (16,246 in COP15 and 22,369 in COP16).

Support has been identified to target key populations (men who have sex with men and female sex workers) and address the inequitable HIV burden among adolescent females and young women through HIV prevention and early access to ART. Support is being provided to civil society and GRN to foster stigma-free access to comprehensive HIV services for key populations. At the national and regional levels, work is being done to improve systems that support epidemic control, in particular quality assurance, HIV supply chain, human resources for health, domestic resource mobilization and strategic allocation.

GFATM

The Global Fund to Fight AIDS, Tuberculosis and Malaria in 2013 is an approved and signed agreement with Namibia for US$110.6 million to further support the national HIV response programmes. The programmes focus on high impact interventions including treatment, care and support, Prevention of Mother to Child Transmission of HIV, scaling-up of voluntary male medical circumcision, basic prevention for men who have sex with men and sex workers; and cross cutting activities such as strategic and targeted behavioural change communication, HIV counselling and testing and condom promotion and distribution. These programmes are being implemented jointly by the Ministry of Health of Namibia and Network of AIDS Service Organisations (NANASO) under the RCC Phase II grants. Support is being provided to the GRN to reconstitute and build the capacity of the CCM, including the reprogramming of the existing grant.

United Nations

Support to the AIDS respond by the UN to the GRN has been channelled primarily through the Joint United Nations Team on AIDS (JUTA) Technical and financial support has been provided in a range of areas over 2012 -2015 including the provision of technical assistance (TA) towards the National Elimination Plan of MTCT 2012–16, development of the condom and male circumcision strategies; convene the national consultation on prongs 1 and 2 of PMTCT for PLHIV,of which civil society and community organizations informed the final eMTCT plan while UN advocacy fuelled dialogue on the 'treatment as prevention' strategy.

The UN supported the 2013 Mid-Term Review of the National Strategic Framework which was informed by the investment approach and led to a revision of the NSF to ensure a stronger focus on high impact interventions and efficiencies. UNFPA and UNAIDS have been supporting the EU and SIDA funded SRH-HIV linkages project, which aims at strengthening policy, systems and service delivery linkages and has led to a service delivery pilot in 7 clinics across the country Namibia's innovative approach to its HIV response is further evidenced by the initiation of mobile service delivery in the capital city Windhoek. Informed by the findings of the UNAIDS and UNDP supported KYE/KYR study in Windhoek, the MoHSS has joined the City of Windhoek and Pharm Access Foundation to provide HIV prevention and primary health care services

to previously under-served informal settlements in the city. Throughout 2012-2013, concerted efforts were made by the UN to support efforts to scale up prevention efforts for young people and key populations - notably sex workers, and promote enhanced participation and inclusion of these populations in programming.

UNAIDS in partnership with cosponsors have took action to operationalize and cost the National Combination Prevention Strategy and ART Guidelines.

JICA

Assistance to the AIDS response from JICA dates as far back as 2007 particularly in the areas of HIV/AIDS M&E Capacity building. JICA support has focused on strengthening the non-health facility based M&E system called the System for Programme Monitoring (SPM) which is still being used to collect data on indicators from non-health partners. Recently, JICA support as a follow up to previous assistance in strengthening data management system has been in the area of TA to develop a data ware housing system that links the numerous data based used to collect HIV related data. JICA has been supporting Namibia with capacity building in the following; Training for implementing organizations in all 14 Region of Namibia, training for Regional and sectoral M&E Officers as well as National level staff.

JICA has also supported the strengthening of data quality through training and joint supportive visits to the regional M&E Officers.

GIZ

The Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH on behalf of the German Federal Ministry of Economic Cooperation and Development (BMZ) has been supporting Namibia's response to HIV and AIDS through technical cooperation since 2005. The current development programme - 'Multisectoral HIV and AIDS response Programme in Namibia', started in July 2011 and is being extended until June 2016. The programme is planned and implemented in line with the National Strategic Framework for HIV and AIDS Response in Namibia for the period 2010/11 – 2016/17 (NSF). The Custodian and Implementing Partner of the programme is the Ministry of Health and Social Services (MoHSS) and the value of the current commission for July 2011 until June 2014 of the Federal Ministry for Economic Development and Cooperation (BMZ) is EUR 5.54 Million. On the request of the Ministry of Health

and Social Services there was an agreement in Namibian-German bilateral Government Negotiations held in November 2013 to extend the programme until June 2016 with an additional value of 3 Mill EUR.

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

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

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

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

VII. Monitoring and evaluation environment

Monitoring and Evaluation (M&E) is a key component of the multi-sectoral response to HIV and AIDS. The HIV and AIDS policy mandates the government to develop and maintain an operational monitoring and evaluation (M&E) plan for the purpose of tracking progress on the revised National Strategic Framework (NSF). The purpose of the RM&E Plan is to provide an organizing framework for the production and use of strategic information that supports accountability and strengthening of the national response to HIV and AIDS at policy and programmatic levels. As part of the review and prioritization process of the National Strategic Framework (NSF) for HIV and AIDS in 2013, the M&E Plan and Research agenda was also revised.

The M&E system for the national response consists of multiple data sets from multiple data systems within the broader Health Information System (HIS). Data from non-health facility based programmes, implemented by the private sector, civil society, government ministries and agencies are reported into the System for Programme Monitoring (SPM). The MOHSS has established an ART Monthly

Reporting system that uses an electronic dispensing tool (EDT) from which information on number of patients on various ART regimens, stock levels at the three levels, ART retention rates can all be generated. There is an Electronic Programme Monitoring System (EPMS) also based within the RM&E Unit that is used to track the profile of HIV clients from pre-ART, ART and even when they die.

The two critical institutions in the M&E system are DSP and the RACOCs, which in addition to collecting, collating and reporting data feed analysis back to implementers and other institutions to improve planning and programme implementation.

Achievements and Opportunities

1. M&E of the NSF is adequately aligned with Namibia's international commitments and data is available to report against key obligations.
2. Guidance, including tools for data collation and submission, has been produced and disseminated, and the RACOCs are producing reports on regional programme activities regularly.
3. An estimated 85% of health facilities report consistently on the HIV and AIDS response, despite a formidable data and administrative burden.
4. Efforts to resolve the fragmentation of data systems are supported by evidence provided in a comprehensive assessment of HIS in Namibia and this has lead to discussion and plans to unify data based and harmonise the reporting systems
5. The Government in collaboration with development partners is investing substantial resources in the training of M&E personnel as a way of addressing the M&E capacity deficit at DSP.
6. The ongoing organizational restructuring within the Ministry of Health will help provide adequate visibility for RM&E division in ensuring that the M&E Plan and research agenda provide sufficient political and organizational leadership that ensure the effective management and use of research and evaluation resources to support the National Strategic Framework for HIV/AIDS.

Gaps and Challenges

1. Reporting against international commitments demands considerable effort to extract data from Fragmented data sources
2. A review of the current functionality of the SPM reveals that less than 25% of implementers at regional level are submitting data to RACOCS on programme implementation.
3. The explanation for poor performance is to be found in system capacity challenges, and specifically the lack of M&E skills serving the system.
4. While an estimated 85% of facilities report consistently on the HIV and AIDS response, there is a widely held consensus that the data does not

accurately reflect reality.

5. Effective management, dissemination and use of the HIV and AIDS surveys and studies to the broader research community is still a challenge.

ANNEXES: NASA Funding Matrix

Country:		NAMIBIA	
Reporting cycle:		FISCAL YEAR	
Data Measurement Tool		National AIDS Spending Assessment (NASA)	
Amounts reported in:		US DOLLARS	
Please indicate month and year (M/YYYY)	From:	Month: April	Year: 2012
	To:	Month: March	Year: 2013
Name of Local Currency		NAMIBIAN DOLLAR	
Currency expressed in:		Millions (x 1,000,000)	
Average Exchange Rate for the year (local currency to USD)		9.255	

FUNDING MATRIX - 2012 - 2013

Financing Sources

2012 - 2013 AIDS Spending Categories	TOTAL US DOLLARS	Public Sources			International Sources						Private Sources (optional for UNGASS reporting)	
						Bilaterals		Multilaterals				
		Public Sub-Total	Central / National	All Other Public	International Sub-Total	PEPFAR	Other Bilaterals	UN Agencies	Global Fund	All Other International	Private Sub-Total	All Other Private
TOTAL US DOLLARS	201,060,024	111,050,386	102,099,987	8,631,250	87,408,615	71,394,683	1,505,475	3,664,901	10,495,166	348,390	2,601,023	2,601,023
1. Prevention (sub-total)	25,984,457	6,403,222	5,626,409	776,813	19,349,910	15,997,859	373,310	2,383,751	594,990	0	231,325	231,325
1.01 Communication for social and behavioural change (BCC)	1,389,763	0			1,389,763			1,125,160	264,603		0	
1.02 Community/social mobilization	237,628	0			237,628		38,741	198,887			0	
1.03 Voluntary counselling and testing (VCT)	9,438,230	2,509,350	1,905,162	604,188	6,928,880	6,823,848			105,032		0	
1.04 Risk-reduction and prevention activites for vulnerable and accessible populations	7,148	0			7,148		7,148				0	
1.05. Prevention - Youth in school	929,091	692,399	692,399		236,692			89,260	147,432		0	
1.06 Prevention - Youth out-of-school	288,553	0			288,553			288,553			0	
1.07 Prevention of HIV transmission aimed at people living with HIV	29,778	0			29,778			29,778			0	

1.08 Prevention programmes for sex workers and their clients	4,596	0			4,596			4,596			0	
1.11 Prevention programmes in the workplace	494,610	271,854	271,854		222,756		52,538	170,218			0	
1.12 Condom social marketing	2,756,994	2,756,994	2,756,994		0						0	
1.14 Public and commercial sector female condom provision	243,899	0			243,899			176,350	67,549		0	
1.17 Prevention of mother-to-child transmission	586,716	0			586,716	511,177		75,539			0	
1.18 Male Circumsicion	1,745,902	172,625		172,625	1,341,952	1,341,952					231,325	231,325
1.19 Blood safety	685,937	0			685,937	685,937					0	
1.22 Post-exposure prophylaxis	27,215	0			27,215	27,215					0	
1.23 Pre-exposure prophylaxis *(new category for GARPR 2014)*	769,955	0			769,955	769,955					0	
1.98 Prevention activities not disaggregated by intervention	6,298,280	0			6,298,280	5,837,775	274,883	175,248	10,374		0	
1.99 Prevention activities not elsewhere classified	50,162	0			50,162			50,162			0	
2. Care and Treatment (sub-total)	**60,704,441**	**30,770,350**	**22,915,913**	**7,854,437**	**28,024,013**	**24,677,903**	**0**	**0**	**3,346,110**	**0**	**1,910,078**	**1,910,078**
2.01 Outpatient care	59,927,629	29,993,538	**22,915,913**	**7,077,625**	28,024,013	**24,677,903**	**0**	**0**	**3,346,110**	**0**	1,910,078	**1,910,078**
2.01.01 Provider- initiated testing and counselling	1,328,764	0			1,328,764	1,328,764					0	
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	0	0			0						0	
2.01.03 Antiretroviral therapy	44,980,614	24,944,508	17,866,883	7,077,625	18,126,028	18,126,028					1,910,078	1,910,078
2.01.04 Nutritional support associated to ARV therapy	6,981,344	2,926,960	2,926,960		4,054,384	795,707			3,258,677		0	
2.01.05 Specific HIV-related laboratory monitoring	231,363	0			231,363	143,930			87,433		0	
2.01.07 Psychological treatment and support services	3,375,142	0			3,375,142	3,375,142					0	
2.01.09 Home-based care	734,069	0			734,069	734,069					0	
2.01.98 Outpatient care services not disaggregated by intervention	2,296,333	2,122,070	2,122,070		174,263	174,263					0	
2.02 In-patient care	86,312	86,312	**0**	**86,312**	0	**0**	**0**	**0**	**0**	**0**	0	**0**
2.02.01 Inpatient treatment of opportunistic infections (OI)		86,312		86,312	0						0	
2.98 Care and treatment services not disaggregated by intervention	690,500	690,500		**690,500**	0						0	

3. Orphans and Vulnerable Children (sub-total)	**39,821,075**	**35,474,061**	**35,474,061**	**0**	**4,347,014**	**3,932,506**	**0**	**27,568**	**38,550**	**348,390**	**0**	**0**
3.01 OVC Education	3,702,668	2,170,000	2,170,000		1,532,668	1,184,278				348,390	0	
3.02 OVC Basic health care	3,547,406	3,547,406	3,547,406		0						0	
3.03 OVC Family/home support	31,127,477	28,379,249	28,379,249		2,748,228	2,748,228					0	
3.04 OVC Community support	38,550	0			38,550				38,550		0	
3.98 OVC services not disaggregated by intervention	1,377,406	1,377,406	1,377,406		0						0	
3.99 OVC services not-elsewhere classified	27,568	0			27,568			27,568			0	
4. Systems Strengthening & Programme Coordination (sub-total) [*renamed from "Program Management and Administration Strengthening"*]	**25,244,727**	**3,213,103**	**3,213,103**	**0**	**21,572,004**	**15,044,478**	**181,574**	**854,652**	**5,491,300**	**0**	**459,620**	**459,620**
4.01 National planning, coordination and programme management	9,006,297	659,096	659,096		8,347,201	6,790,570		141,209	1,415,422		0	
4.02 Administration and transaction costs associated with managing and disbursing funds	7,107,367	0			7,107,367	3,819,695			3,287,672		0	
4.03 Monitoring and evaluation	2,453,851	79,910	79,910		2,373,941	1,943,863	8,702	206,428	214,948		0	
4.04 Operations research	863,939	0			863,939	863,939					0	
4.05 Serological-surveillance (Serosurveillance)	2,348,465	2,021,274	2,021,274		327,191	327,191					0	
4.06 HIV drug-resistance surveillance	47,574	0			47,574	36,355		11,219			0	
4.07 Drug supply systems	532,215	0			532,215	532,215					0	
4.08 Information technology	821,657	0			821,657	539,402		123,035	159,220		0	
4.09 Patient tracking	0	0			0						0	
4.10 Upgrading and construction of infrastructure	409,461	133,183	133,183		276,278	191,248			85,030		0	
4.11 Mandatory HIV Testing (Not VCT)	0	0			0						0	
4.98 Program Management and Administration Strengthening not disaggregated by type	759,616	319,640	319,640		439,976		172,872	236,542	30,562		0	
4.99 Program Management and Administration Strengthening not-elsewhere classified	434,665	0			434,665			136,219	298,446		0	
5. Incentives for Human resources (sub-total)	**40,436,276**	**34,218,261**	**34,218,261**	**0**	**6,218,015**	**4,504,136**	**746,589**	**79,170**	**888,120**	**0**	**0**	**0**
5.01 Monetary incentives for human resources	33,263,257	32,516,668	32,516,668		746,589		746,589				0	
5.02 Formative education to build-up an HIV workforce	393,201	0			393,201	393,201					0	
5.03 Training	3,645,933	51,048	51,048		3,594,885	2,627,595		79,170	888,120		0	
5.98 Incentives for Human Resources not specified by kind	3,133,885	1,650,545	1,650,545		1,483,340	1,483,340					0	

6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	**1,656,656**	**652,240**	**652,240**	**0**	**1,004,416**	**894,074**	**0**	**0**	**110,342**	**0**	**0**	**0**
6.01 Social protection through monetary benefits	111,951	111,951	111,951		0						0	
6.02 Social protection through in-kind benefits	22,865	0			22,865	22,865					0	
6.03 Social protection through provision of social services	540,289	540,289	540,289		0						0	
6.04 HIV-specific income generation projects	871,209	0			871,209	871,209					0	
6.98 Social protection services and social services not disaggregated by type	110,342	0			110,342				110,342		0	
7. Enabling Environment (sub-total)	**5,381,350**	**0**	**0**	**0**	**5,381,350**	**4,831,834**	**204,002**	**319,760**	**25,754**	**0**	**0**	**0**
7.01 Advocacy	89,643	0			89,643		89,643				0	
7.02 Human rights programmes	69,399	0			69,399			69,399			0	
7.03 AIDS-specific institutional development	3,966,164	0			3,966,164	3,662,605	114,359	189,200			0	
7.04 AIDS-specific programmes focused on women	7,848	0			7,848			7,848			0	
7.98 Enabling Environment and Community Development not disaggregated by type	1,237,140	0			1,237,140	1,169,229		50,000	17,911		0	
7.99 Enabling Environment and Community Development not elsewhere classified	11,156	0			11,156			3,313	7,843		0	
8. Research (sub-total)	**1,831,042**	**319,149**	**0**	**0**	**1,511,893**	**1,511,893**	**0**	**0**	**0**	**0**	**0**	**0**
8.08 Social Science Research	319,149	319,149	319,149									
8.98 Research not disaggregated by type	1,511,893	0			1,511,893	1,511,893					0	

Country:		**NAMIBIA**	
Reporting cycle:		**FISCAL YEAR**	
Data Measurement Tool		**National AIDS Spending Assessment (NASA)**	
Amounts reported in:		**US DOLLARS**	
Please indicate month and year (M/YYYY		**Month**	**Year**
	From:	**April**	**2013**
	To:	**March**	**2014**

FUNDING MATRIX - 2013 - 2014

Financing Source

)												
Name of Local Currency	NAMIBIAN DOLLAR											
Currency expressed in:	Millions (x 1,000,000)											
Average Exchange Rate for the year (local currency to USD)	10.724		Public Sources			International Sources						Private Sources (optional for UNGASS reporting)	
2013 - 2014	TOTAL					Bilaterals		Multilaterals					
AIDS Spending Categories	US DOLLARS	Public Sub-Total	Central / National	All Other Public	International Sub-Total	PEPFAR	Other Bilaterals	UN Agencies	Global Fund	All Other International	Private Sub-Total	All Other Private
TOTAL US DOLLARS	213,346,629	136,620,606	128,793,293	6,874,932	74,283,368	57,658,447	1,675,726	2,448,193	11,978,348	522,654	2,442,655	2,442,655
1. Prevention (sub-total)	34,061,204	19,594,181	19,070,390	523,791	14,277,404	10,393,909	464,321	1,338,505	1,558,015	522,654	189,619	189,619
1.01 Communication for social and behavioural change (BCC)	909,481	575,342	575,342		334,139			334,139			0	
1.02 Community/social mobilization	228,012	0			228,012		91,805	136,207			0	
1.03 Voluntary counselling and testing (VCT)	18,383,974	15,264,847	14,767,103	497,744	3,119,127	2,319,629			302,834	496,664	0	
1.04 Risk-reduction and prevention activites for vulnerable and accessible populations	32,387	0			32,387		32,387				0	
1.05. Prevention - Youth in school	739,890	623,629	623,629		116,261		28,864	24,801	62,596		0	
1.06 Prevention - Youth out-of-school	356,615	313,320	313,320		43,295		43,295				0	
1.07 Prevention of HIV transmission aimed at people living with HIV	582,360	0			582,360	582,360					0	
1.08 Prevention programmes for sex workers and their clients	1,026,718	0			1,026,718	1,026,718					0	
1.09 Programmes for men who have sex with men	319,143	0			319,143	319,143					0	
1.10 Harm-reduction programmes for injecting drug users	14,778	0			14,778			14,778			0	
1.11 Prevention programmes in the workplace	175,566	0			175,566		95,683	79,883			0	
1.12 Condom social marketing	2,906,556	2,274,592	2,274,592		631,964				631,964		0	
1.13 Public and commercial sector male condom provision	0	0			0						0	
1.14 Public and commercial sector female condom provision	170,500	0			170,500			170,500			0	

1.17 Prevention of mother-to-child transmission	951,012	0			951,012	308,111		58,393	558,518	25,990	0	
1.18 Male Circumsicion	642,409	26,047	0	26,047	426,743	424,640			2,103		189,619	189,619
1.19 Blood safety	340,754	0			340,754	340,754					0	
1.22 Post-exposure prophylaxis	38,734	0			38,734	38,734					0	
1.23 Pre-exposure prophylaxis *(new category for GARPR 2014)*	319,292	0			319,292	319,292					0	
1.98 Prevention activities not disaggregated by intervention	5,901,736	516,404	516,404		5,385,332	4,714,528	172,287	498,517			0	
1.99 Prevention activities not elsewhere classified	21,287	0			21,287			21,287			0	
2. Care and Treatment (sub-total)	**38,291,448**	**21,050,125**	**14,698,984**	**6,351,141**	**15,325,827**	**9,885,375**	**0**	**57,756**	**5,382,696**	**0**	**1,915,496**	**1,915,496**
2.01 Outpatient care	35,623,095	20,327,784	**14,698,984**	**5,628,800**	15,295,311	**9,885,375**	**0**	**27,240**	**5,382,696**	**0**		**1,915,496**
2.01.01 Provider- initiated testing and counselling	857,134	0	0		857,134	857,134					0	
2.01.03 Antiretroviral therapy	29,247,514	18,410,525	12,781,725	5,628,800	8,921,493	4,391,161			4,530,332		1,915,496	1,915,496
2.01.04 Nutritional support associated to ARV therapy	2,339,624	1,917,259	1,917,259		422,365				422,365		0	
2.01.05 Specific HIV-related laboratory monitoring	181,112	0			181,112	181,112					0	
2.01.07 Psychological treatment and support services	719,384	0			719,384	692,144		27,240			0	
2.01.09 Home-based care	3,502,622	0			3,502,622	3,072,623			429,999		0	
2.01.98 Outpatient care services not disaggregated by intervention	691,201	0			691,201	691,201					0	
2.02 In-patient care	43,204	12,688	**0**	**12,688**	30,516	**0**	**0**	**30,516**	**0**	**0**	0	**0**
2.02.01 Inpatient treatment of opportunistic infections (OI)	12,688	12,688		12,688	0						0	
2.02.99 In-patient services not elsewhere classified	30,516	0			30,516			30,516			0	
2.98 Care and treatment services not disaggregated by intervention	709,653	709,653	**0**	**709,653**	0						0	
3. Orphans and Vulnerable Children (sub-total)	**34,689,499**	**32,457,913**	**32,457,913**	**0**	**2,231,586**	**1,998,537**	**0**	**130,776**	**102,273**	**0**	**0**	**0**
3.01 OVC Education	1,088,711	645,000	645,000		443,711	443,711					0	
3.02 OVC Basic health care	1,656,591	1,627,724	1,627,724		28,867	28,867					0	
3.03 OVC Family/home support	27,183,370	25,657,411	25,657,411		1,525,959	1,525,959					0	
3.05 OVC Social services and Administrative costs	130,776	0			130,776			130,776			0	
3.98 OVC services not disaggregated by intervention	4,630,051	4,527,778	4,527,778		102,273				102,273		0	

4. Systems Strengthening & Programme Coordination	**28,533,647**	**3,059,169**	**3,059,169**	**0**	**25,136,938**	**19,658,483**	**193,581**	**537,919**	**4,746,955**	**0**	**337,540**	**337,540**
4.01 National planning, coordination and programme management	4,616,030	1,087,321	1,087,321		3,528,709	2,919,230		118,480	490,999		0	
4.02 Administration and transaction costs associated with managing and disbursing funds	4,332,432	0			4,332,432	2,694,674			1,637,758		0	
4.03 Monitoring and evaluation	1,893,513	0			1,893,513	1,251,945	10,808	4,365	626,395		0	
4.04 Operations research	556,420	0			556,420	556,420					0	
4.05 Serological-surveillance (Serosurveillance)	619,889	380,952	380,952		238,937	238,937					0	
4.06 HIV drug-resistance surveillance	51,256	0			51,256	26,547		24,709			0	
4.07 Drug supply systems	417,175	0			417,175	417,175					0	
4.08 Information technology	11,804,973	126,296	126,296		11,678,677	11,163,716		4,388	510,573		0	
4.09 Patient tracking	0	0			0						0	
4.10 Upgrading and construction of infrastructure	426,181	0			426,181	389,839	9,325		27,017		0	
4.11 Mandatory HIV testing (not VCT)	0	0			0						0	
4.98 Program Management and Administration Strengthening not disaggregated by type	3,224,457	1,464,600	1,464,600		1,759,857		86,724	235,977	1,437,156		0	
4.99 Program Management and Administration Strengthening not-elsewhere classified	591,321	0			253781		86,724	150,000	17,057		337540	337,540
5. Incentives for Human resources (sub-total)	**60,804,671**	**57,775,234**	**57,775,234**	**0**	**3,029,437**	**2,150,810**	**687,147**	**19,703**	**171,777**	**0**	**0**	**0**
5.01 Monetary incentives for human resources	42,237,518	41,615,647	41,615,647		621,871		621,871				0	
5.02 Formative education to build-up an HIV workforce	379,331	0			379,331	379,331					0	
5.03 Training	1,876,258	310,685	310,685		1,565,573	1,374,093		19,703	171,777		0	
5.98 Incentives for Human Resources not specified by kind	14,269,266	13,871,880	13,871,880		397,386	397,386					0	
5.99 Incentives for Human Resources not elsewhere classified	2,042,298	1,977,022	1,977,022		65,276		65,276				0	
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	**3,303,525**	**1,977,022**	**1,977,022**	**0**	**1,326,503**	**1,326,503**	**0**	**0**	**0**	**0**	**0**	**0**
6.02 Social protection through in-kind benefits	240,617	0			240,617	240,617					0	
6.04 HIV-specific income generation projects	1,085,886	0			1,085,886	1,085,886					0	
6.98 Social protection services and social services not disaggregated by type	1,977,022	1,977,022	1,977,022		0						0	

7. Enabling Environment (sub-total)	**12,117,471**	**135,533**	**135,533**	**0**	**11,981,938**	**11,271,095**	**330,677**	**363,534**	**16,632**	**0**	**0**	**0**
7.01 Advocacy	123,257	0			123,257		123,257				0	
7.02 Human rights programmes	44,940	0			44,940			44,940			0	
7.03 AIDS-specific institutional development	8,118,267	0			8,118,267	7,816,445	207,420	94,402			0	
7.04 AIDS-specific programmes focused on women	55,795	0			55,795			55,795			0	
7.98 Enabling Environment and Community Development not disaggregated by type	3,597,668	135,533	135,533		3,462,135	3,454,650			7,485		0	
7.99 Enabling Environment and Community Development n.e.c	177,544	0			177,544			168,397	9,147		0	
8. Research (sub-total)	**1,545,164**	**571,429**	**0**	**0**	**973,735**	**973,735**	**0**	**0**	**0**	**0**	**0**	**0**
8.04 Social science research	571,429	571,429	571,429		0						0	
8.98 Research not disaggregated by type	973,735	0			973,735	973,735					0	

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