

Republic of Namibia
Ministry of Health and Social Services



Southern African Development Community (SADC)
Secretariat

Namibia HIV and AIDS Epidemic Update Report

July 2010





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Preface

SADC is at the epicentre of the HIV and AIDS epidemic. According to the World Health Organization, the estimated HIV prevalence for Southern Africa in 1997-1998 was 20.3%, increasing to 23.5% in 1999-2000 and to 25.7% in 2001-2002. Namibia has shown political commitment to responding to the HIV epidemic in the SADC region by signing of various recent declarations across the region in support of the Millennium Declaration and Development Goals and the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) targets. These include the Abuja Declaration on HIV and AIDS, Tuberculosis and Other Related Infectious Diseases (2001), the Maseru Declaration on HIV and AIDS (2003), the Maputo Declaration accelerating HIV prevention (2005), and the 2006 Brazzaville Commitment on Scaling up towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa by 2010. The 2003 SADC Heads of State and Government also adopted and signed the Maseru Declaration on the Fight against HIV/AIDS in the SADC Region, which reaffirms the Heads of State and Government's commitment to the combating of HIV/AIDS pandemic in all its manifestations, as a matter of urgency through multi-sectoral strategic interventions.

Namibia developed and implemented a multi-sectoral national strategic plan for HIV AIDS for 2004 to 2009 (MTPIII) and has recently developed a National Strategic Framework for HIV and AIDS 2010 to 2016 (NSF). The Namibia SADC report reports on the status of the epidemic following the implementation of the multi-sectoral national strategic plans.

In Namibia, the HIV prevalence among pregnant women aged 15 to 49 years attending ANC was 17.8% in 2008. Although, this represented a slight decline from 19.9% in 2006, it may be too soon to conclude that the adult population prevalence has begun to reduce. However, the HIV prevalence among the pregnant women aged 15 to 24 years did significantly reduce from 14.2% in 2006 to 10.6% in 2008 suggesting that there may be a reduction in the annual number of new infections. With regard to HAART services, Namibia has indeed registered a remarkable scale up in the coverage.

SADC countries have committed to reducing new HIV infections by 50% by 2015 and Namibia has aligned its efforts to this goal by developing an NSF with this as the key prevention impact result. Given the high HIV prevalence, Namibia cannot afford to be complacent and joins the other SADC countries in committing to achieve this HIV prevention goal. There are some indications that the HIV prevalence may be beginning to plateau or reduce and the challenges are to further reduce the occurrence of new infections among adults and children while mitigating the impact of the HIV epidemic on the individual, the community and the countries development.

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Table of contents

Preface	3
Table of contents	4
List of Abbreviations and Acronyms.....	5
1. Background and Introduction	6
2. Progress in implementation of Regional, Continental and Global Commitments in Namibia.....	10
2.1 HIV Prevention and Social Mobilization.....	10
2.2 Treatment, Care and Support.....	14
2.3. HIV Impact Mitigation	15
2.4. Enabling Policy and Legal Environment.....	16
3. Update on integrating regional priorities	16
4. Implementation Challenges and Emerging Issues.....	17
5. Conclusion and Way Forward.....	18
5.1 Recommendations	18
APPENDIX 1 : COUNTRY DATA.....	20

List of Abbreviations and Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
ART	Anti Retroviral Therapy
CBS	Central Bureau Statistics
CDC	Centre for Disease Control (and Prevention)
CDR	Crude Death Rate
CHBC	Community Home Based Care
CMS	Central Medical Stores
CSO	Civil Society Based Organizations
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GRN	Government of the Republic of Namibia
HAART	Highly Active Anti-Retroviral Treatment
HCT	HIV Counselling and Testing
HIV	Human Immuno-Virus
IDU	Injecting Drug Users
M&E	Monitoring and Evaluation
MARPS	Most At Risk Populations
MC	Medical Circumcision
MCP	Multiple and Concurrent Partnerships
MGECW	Ministry of Gender Equality and Child Welfare
MOE	Ministry of Education
MOF	Ministry of Finance
MOHSS	Ministry of Health and Social Services
MSM	Men who have Sex with Men
MTP	Medium Term Plan
NDHS	Namibia Demographic and Health Survey
NIP	Namibian Institute of Pathology
NSF	National Strategic Framework
OI	Opportunistic Infection
OPM	Office of Prime Minister
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan For AIDS Relief
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
RM&E	Response Monitoring and Evaluation
SADC	South African Development Community
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

1. Background and Introduction

The SADC region has the highest levels of HIV infection globally. The magnitude of the HIV/AIDS pandemic and its impact on the social fabric of societies in the SADC region, as well as on the economies of the SADC member states has had a devastating effect.

Nearly two thirds of the people in the region are directly or indirectly affected by the pandemic. Although HIV/AIDS is a global problem, the southern African region is the worst hit, with approximately one half of all infections in Africa and approximately one third of the global total, thus making the SADC region the worst affected in the world. It is a known fact that HIV/AIDS is the number one development hurdle for SADC countries. There is, therefore, a very urgent need to confront the pandemic and deal with its impact on the people and the long term development of the economies of the region. The impact of AIDS is taking a heavy toll on economies across the region, a toll which will mount steadily over the coming years if efforts are not intensified to contain the epidemic.

HIV/AIDS is now reversing the major socio-economic gains of the past three to four decades in such areas as health, agriculture and education. Health care systems are overwhelmed with HIV/AIDS patients and health care costs are escalating as acute conditions are crowded out. Conditions such as tuberculosis (TB) which were almost brought under control in the 1970's have re-emerged as a result of the pandemic. Therefore, there is need to regularly track the progress of HIV National responses in the region

Namibia is classified as an upper middle income country with a gross national income per capita of US\$4,200 for 2008¹. The country is divided into 13 administrative regions. The population of Namibia was estimated at 1,830,330 in the 2001 Census. The population is estimated to increase to 2,180,000 by 2011 (Central Bureau of Statistics (CBS) of population projections). Forty three percent (43%) of the population is under the age of 15 years and with less than 4% of the population over the age of 65.² Namibia experienced a high population growth rate of over 3%. However, due to a number of factors including the negative impacts of HIV and AIDS on health and longevity of the people, the population growth rate was reduced to 2.6% per annum between 1991 and 2001³.

Namibia adopted a multi-sectoral approach for the implementation of the national HIV and AIDS response during the Medium Term Plans II and III. The country is

¹ World Bank website: www.web.worldbank.org/wbsite/external/datastatistics

² 2001 Population and Housing Census

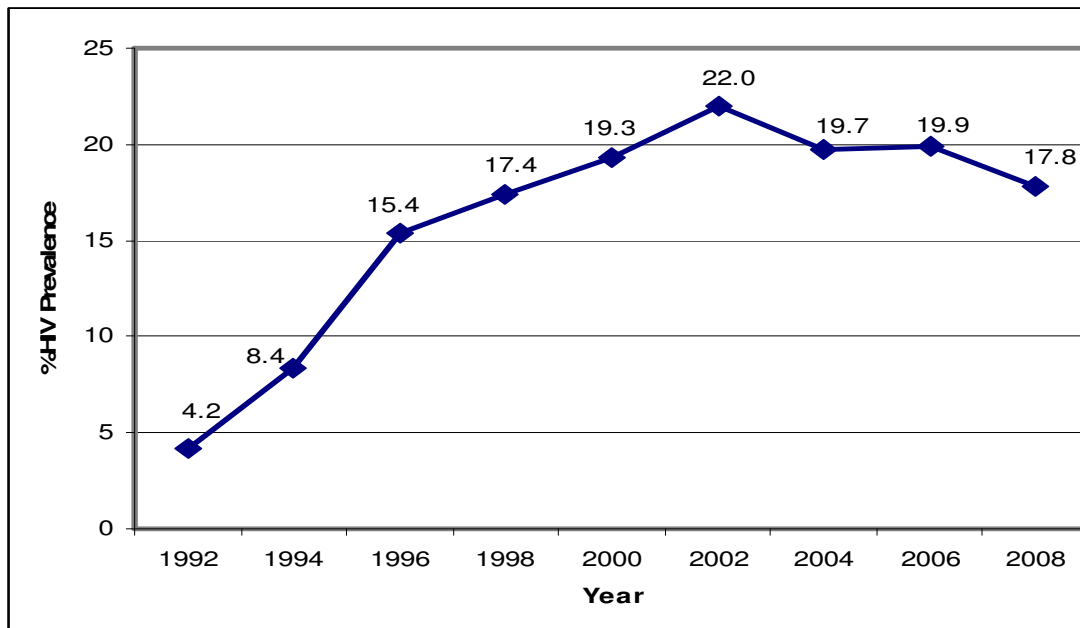
³ Vision 2030

in the final stage of finalising the National Strategic Framework (NSF) for HIV and AIDS 2010/11-2015/16 which succeeds the MTP III that came to an end in March 2010. The framework provides strategic policy, planning and implementation guidance and leadership for the national HIV and AIDS multi-sectoral response. The development of the NSF has been guided by strategic principles including the need to use evidence in the identification of priorities and selection of interventions. It focuses on results rather than service delivery only and on the operationalisation of the Three-Ones principles at all levels of the response. The framework marks a paradigm shift to evidence and results based management approaches.

Namibia has a generalised epidemic with HIV primarily transmitted through heterosexual means. It is estimated that the HIV prevalence of the general population aged 15 to 49 years in Namibia was 13.3% in 2008/09 (Namibia HIV Estimates, 2009), resulting in around 6,130 AIDS-related deaths in 2008/09 (Namibia HIV Estimates 2009) which amounts to approximately 23% of all deaths in Namibia (Crude Death Rate (CDR) from Population projections for 2008/09). In the financial year 2008/09, approximately 5, 830 people were infected with HIV, with around 16 new infections occurring each day (Namibia HIV Estimates 2009). This steady stream of new infections over a long period of time has resulted in an estimated 174,000 adults and children living with HIV and AIDS (PLHIV) in Namibia by the end of the financial year 2008/09. Approximately 250,000 children 18 or younger are orphans or vulnerable children (OVC): around 28% of these OVC (69,000) had been orphaned by AIDS by end of the financial year 2008/09 (Spectrum 2009 estimates, Namibia Demographic and Health Survey (NDHS) 2006/7, and Namibia population projections 2001 to 2031).

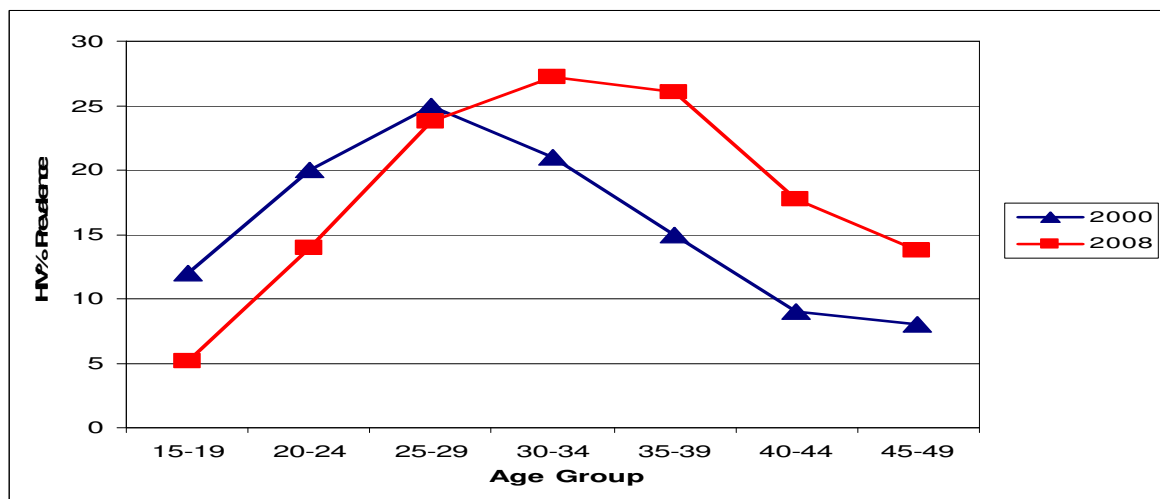
Available data from the National HIV Sentinel Surveys indicate that HIV prevalence among pregnant women attending ANC rapidly increased from 4.% in 1992 to 18% in 2008 (Figure 1). HIV prevalence among pregnant women reached a peak of 22.3% in 2002, before it started showing some signs of stabilization and a statistically significant decline.

Figure 1: ANC HIV Prevalence trends between 1992 and 2008



The 2008 Sentinel Surveillance Report found that HIV prevalence was the same in rural and urban areas. The prevalence in older adults is the highest (27% among women aged 30-34 years) while the prevalence amongst younger women declined from 12% (2000) to 5% (2008) among 15-19 year old women, and from 20% (2000) to 14% (2008) amongst women aged 20-24 years (Figure 2). This is indicative of a maturing epidemic and fewer new infections. It is anticipated that new infections will decline in the future. According to Spectrum 2009, new infections in adults aged 15-years and above are projected to decline to 3025 during fiscal year 2010/11 and to 2877 by 2012/13. The prevalence rates for the same age group will decline from 11.1% in 2010/11 to 10.0% by 2012/13.

Figure 2: Shift in age-specific HIV prevalence among pregnant women between 2000 and 2008



The main mode of HIV transmission is heterosexual. Other sources of new infections are from mother to child transmission (around 25% of new infections). Namibia has attained 100% voluntary non-remunerated blood donation and 100% screening of transfusions transmissible infections.

Recent studies have identified the following factors as the factors that fuel new infections. These drivers are⁴:

Multiple and concurrent partnerships (MCPs): Multiple and concurrent partnerships are legitimized through deep rooted traditions of a polygamous society. In 2006, 16% of sexually active men and 3% of women reported more than one partner over the previous 12 months (NDHS 2007). In the 2000 NDHS, 17% of women and 19% of married men reported one or more additional partner in the last 12 months.

Inter-generational sex: Among women aged 15-24 years, 7% of single women and 26% of married women reported having a partner 10 years older than them (NDHS 2006/7).

Transactional sex: Quantitative data is not easily obtainable, as transactional sex is much broader than sex with a sex worker (which is very low (1.4%) and measured by the NDHS). Transactional sex is commonly associated with poverty and income inequalities.

Condom use is not universal and not consistent: In the last NDHS (2007), rates of condom use by people with 2 or more partners and amongst people with non-regular partners is relatively high (66% women and 74% men with 2 or more partners used a condom at last sex, and 62% women and 78% men used a condom at last sex with non-regular partner). However, rates of consistent condom use was much lower – only 48% women and 58% of men with 2 or more partners reported consistently using a condom with their last partner.

Varying levels of medical male circumcision: Rates and methods of circumcision vary dramatically in Namibia: whilst 21% of men reported overall to be circumcised, only 11% of them were circumcised by a health practitioner. More educated men were more likely to be circumcised (35% of men with more than secondary education, compared to 15% of men with incomplete primary education), as well as men living in Kunene region (52%), in Omaheke region (57%) and in Otjozondjupa region (42%⁵).

Alcohol use and abuse is common: When under the influence of alcohol, many people are often unable to make informed choices and decisions about

⁴ HIV/AIDS in Namibia: Behavioural and Contextual Factors Driving the Epidemic, 2008, MOHSS

⁵ Namibia Demographic Health Survey: 2006/07, MOHSS

their sexuality. Alcohol abuse often leads to higher risk sexual encounters, included unprotected sex, or sex with a casual partner.

Oscillatory mobility and migration is a lifestyle for many Namibians: A large proportion of people in Namibia, are mobile and spend considerable periods of time away from home for work related reasons. The oscillatory migration by mobile partners is considered a major factor that influences people having MCPs and HIV infection is passed on rapidly through a chain of inter-connected sexual networks.

Most at Risk Populations (MARPS): Data and information on MARPS (sex workers, Men who have sex with men (MSM), Intravenous Drug Users (IDUs) and prisoners) in Namibia is limited. Survey of sex workers in Katutura in Windhoek indicates high prevalence of HIV (70%)⁶ among this population however the sample was not population based and therefore cannot be extrapolated. A study was conducted among MSM as part of multi-country study that evaluated the HIV prevalence, risks and human rights of MSM. Using a sample size of 200 MSM from Namibia, the HIV prevalence was 12.4% 95% CI (8.7%-17.5%)⁷. This prevalence may be under-estimated as the sampling technique used was non-random and with a small sample. The size of the sex worker and MSM populations have not been determined. However, World Bank estimates suggest that there are approximately 11,000 sex workers and 2600 MSM in Namibia. The exact sizes of these populations and HIV prevalence will be determined during the NSF and will guide the revision of services for MARPS planned during the NSF.

2. Progress in implementation of Regional, Continental and Global Commitments in Namibia

2.1 HIV Prevention and Social Mobilization

HIV prevention remains the cornerstone in any HIV response strategy. We have to stop or dramatically reduce new infections. Given the decline in HIV prevalence and estimated incidence, Namibia's HIV prevention efforts have been partially successful at starting to reverse and stabilise the epidemic. Continued effort is now needed to contract the epidemic to below the threshold level.

⁶ C Hjorth – 2005. Prostitution, HIV/AIDS and human rights: A case study of sex workers in the township of Katutura, Namibia. Centre for the Study of Human Rights (CSHR).

⁷ Baral, S. Trapance, G. Motimedi, F et al. HIV prevalence, risks for HIV infection, and human rights among men who have sex with men in Malawi, Botswana and Namibia. 2009.PLoS One. Vol 4, no3 e4997

Condom distribution and Marketing

Condom distribution and social marketing is an integral part of prevention efforts as this directly reduces the risk of infection. The government provides condoms for free distribution at the workplace, community and in the health facilities. Namibia also has established a condom social marketing program that has contributed to the scale up of condoms. Furthermore condoms are manufactured in the country. Latest data shows that 22.8 million male and female condoms were distributed during FY2009/10. Namibia has seen an increase in condom use particularly during high risk sex. In 2006/07, 78% of men and 62% women aged 15-49 used a condom last time they had sex with a casual partner within the last 12 months.

Prevention strategies Among Young people

Namibia is experiencing a decline in prevalence rates among young aged 15-24 years. It is acknowledged that young people are the window of hope and have the potential to halt the spread of HIV and consequently move towards an AIDS free generation. A decrease in HIV prevalence among young people is used as a proxy to show that the incidence is decreasing and also inform on the advances of the epidemic. Using data from women aged 15-24 attending antenatal care the HIV prevalence was 14.2% in 2006 and this decreased significantly to 10.6% in 2008. The drop in HIV prevalence among youth may be due to the prevention strategies linked to youth.

Schools are an important avenue for reaching young people. Life skills based HIV prevention education is taught in public primary and secondary schools in Namibia. The program has been expanding over the years. At the end of 2009 life skills based HIV education was taught in 75% of primary schools and 86% secondary schools.

Misconceptions may result in Young people engaging in risky sexual behavior and increasing their chances of HIV. Social behaviour change among young people has improved. In Namibia, more young people reject major misconceptions about HIV/AIDS and correctly identify ways of preventing infection. In 2006/07, 64.9% of women and 61.9% of men aged 15-24 correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission.

HIV Counseling and Testing

HIV testing and counselling services are a gateway to HIV prevention, care and treatment. These services have significantly been scaled up. Currently HIV testing and counseling is being provided in 98% of health care facilities country wide. Despite the scale up to these services, utilization has been reported to be low. In 2006/07 the NDHS reported that only 28.6% of the women, and 17.6% of men surveyed reported to have taken an HIV test and received their results back. Reasons for low VCT uptake are many however; fear stigma and discrimination are among the many for low utilization. Efforts therefore need to be geared at targeting stigma.

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

Preventing mother-to child-transmission of HIV remains a priority in Namibia. PMTCT has been rolled out to over 85% of all health facilities in Namibia. Identifying HIV positive women through VCT is the first step to enter into the PMTCT program. In 2008/9, 58% of pregnant HIV infected women received ART prophylaxis for the prevention of MTCT. At that time transmission rates were reported to be at 12.7% (2008/09). PMTCT regimens have been revised from simple based sdNVP to regimens that been proved to be efficacious. In 2008 HIV-infected pregnant women who did not meet criteria for initiating HAART received AZT at 28 weeks gestation or any time thereafter, sdNVP and AZT/3TC at the onset of labour, followed by a 7 day "tail" of AZT and 3TC. In 2010, Namibia again planned for the adoption for the CD4 350 criteria guideline recommended by WHO, It has been decided to adopt option A of WHO whereby AZT is initiated from 14 weeks or later and or sd NVP AZT/3TC at the onset of labour (the intrapartum dose and the tail can be omitted if a women has been on AZT for greater than 4 weeks) followed by a 7 day tail of AZT/3TC. For the non breastfeeding infant, NVP daily from birth up to 6 weeks and for the breast feeding infant NVP daily from birth until 4 weeks after breastfeeding stops. Monitoring and evaluation needs to be undertaken to determine the rate of transmission after the introduction of this regimen.

PCR testing using Dried Blood Samples (DBS) was introduced by the MoHSS and the Namibia Institute of Pathology (NIP). The HIV status of infants born to HIV-infected mothers is detected from as early as 6 weeks of birth. Since 2006/07 the percentage of infants born to HIV-infected mothers who have undergone PCR testing has increased from 15% in FY 2006/07 to 23% in FY2008/09, almost achieving the 2010 target of 25%.

Prevention of HIV among the Most at Risk Populations (MARPS) and Vulnerable Groups (CSW, IDU, MSM, Prisoners)

Most at risk populations (MARPS) are groups that are often considered to be at an elevated risk for HIV infection due to their behaviours, and have inadequate

access to prevention, treatment care and support services. Limited data is available for MARPS.

As in many parts of the world sex workers in Namibia are most vulnerable and most affected by HIV. Although sex work remains an illegal practice in Namibia, evidence suggests this is well established and the HIV prevalence is high (70% among sex workers in Katutura). Because this practice is considered illegal, sex workers are hard to reach and thus information on the extent of sex work, knowledge of HIV and AIDS among sex workers and their behavioural practices is limited to a few studies and reports from organizations that have conducted limited interventions. For example, in Katutura (Windhoek), one study found that out of 1250 known sex workers only 180 regularly seek counseling and treatment for STI⁸. The NDHS (2006/07) noted that 1.4% of men had paid for sex. Therefore efforts need to be put in place to target sex workers and implement interventions geared at lowering the transmission of HIV. However these efforts are best targeted by first gathering evidence on the size, prevalence and behavioural characteristics of sex workers. Namibia is planning surveys to gather this strategic information

MSM

Limited data on MSM is available in Namibia. A study was conducted among MSM which was part of multi-country study which evaluated the HIV prevalence, risks and human rights of MSM. Using a sample size of 200 MSM from Namibia, the HIV prevalence was 12.4% 95% CI (8.7%-17.5%)⁹. This prevalence may be under-estimated as the sampling technique used was non-random and with a small sample. Therefore, to gain more insight and to assist in planning and decision making plans are underway to conduct a nation-wide size estimation and bio-behavioural surveillance of MARPS to address measurement of this result.

Male Circumcision

Male circumcision has been shown to decrease the risk of transmission. According to the NDHS (2006/07) approximately 21% of men aged 15-49 were circumcised by 2007. A total of 11% of the circumcisions were performed by a health worker at a health facility, while 4% were conducted by traditional health practitioners. The NDHS was unable to identify where the remaining 6% of the circumcisions were performed. 84% of the men were circumcised before the age of 13 years.

⁸ C Hjorth – 2005. Prostitution, HIV/AIDS and human rights: A case study of sex workers in the township of Katutura, Namibia. Centre for the Study of Human Rights (CSHR).

⁹ Baral, S. Trapance, G. Motimedi, F et al. HIV prevalence, risks for HIV infection, and human rights among men who have sex with men in Malawi, Botswana and Namibia. 2009.PLoS One. Vol 4, no3 e4997

As part of the MC program, MC has been piloted at public Health facilities (Windhoek Central, Oshakati and Onandjokwe hospitals). Between August 2009 and July 2010, a total of 728 males received safe male circumcision voluntarily and have had free access to HIV counseling and testing. 90% of these men have been tested before the procedure.

Namibia has an active male circumcision task force that has developed a MC Communication Strategy, and educational and awareness materials. A male circumcision policy has been finalised. In addition, Namibia has begun circumcision activities at five pilot sites and is now rolling out male circumcision activities country wide.

2.2 Treatment, Care and Support

Anti-Retroviral Therapy (ART)

Namibia has made significant progress in the provision of ART services since its introduction in 2003 where coverage was only 3%. To date Namibia offers ART services in 141 health facilities and outreach clinics. All districts or local administration units have at least one health facility providing antiretroviral therapy. By March 2010, 75681 people (coverage 90% at CD4 200) were receiving ART of which 7 971 (100% coverage at CD4 200) are children. Survival rates after initiating ART at 6, 12 and 24 months were 89%, 79% and 75% respectively. Progress made to the scale-up of ART services has largely been attributable to the mobilisation of resources from international partners such as the Global Fund and PEPFAR. The Government of Namibia has also increased its budgetary allocations for HIV/AIDS and the ART programme in particular. In order to provide ART services to all Namibians who are in need, Namibia has introduced approaches such as Integrated Management of Adult Illness (IMAI) and ART outreach services in order to bring services closer to the people. A number of health facilities have been renovated to accommodate ART services throughout the country. The national laboratory has been strengthened to be able to do bio-clinical monitoring of patients. Since 2006, Namibia has been able to diagnose infants early at six weeks using DNA- PCR test. However, the adoption of CD4 350 criteria from CD4 200 will see the number of people in need of ART inevitably increase. A major challenge however remain human resources, as scale-up will result in health workers being over-burdened and may compromise their ability to deliver quality ART services. However the Ministry of Health has implemented the HIV Quality improvement model (HIVQUAL) for assessing and improving the quality of HIV care provided in public health facilities. In addition a number of students are supported with bursaries for studies in different health related fields such as Medicine, nursing, pharmacy as a way of building capacity for health care workers in order to alleviate staff shortage in future.

TB/HIV Co-Infection

TB is the most life threatening opportunistic disease among people living with HIV, even in those receiving ARVs. The joint management of TB and HIV is therefore considered an important component of the Treatment, Care and Support strategy. The integration of TB services with HIV has led to an increase in the number of people diagnosed with TB being tested for HIV. By March 2010, 74% of TB patients were tested for HIV. A TB/HIV collaborative body has been established at national level to oversee the implementation of the collaborative activities in order to reduce the burden of TB among HIV patients as well as to reduce HIV burden among TB patients. Poor compliance to TB medication among PLWHIV can result in treatment failure and increase the chances of developing drug resistant TB. Therefore the monitoring of treatment success rate is essential. In 2008, 83% of PLWHIV who were co infected with TB were successfully treated for TB.

2.3. HIV Impact Mitigation

A key component of Community Based Health Care is the provision of Home Based Care (CHBC) which is offered as part of a continuum of care for chronically and terminally ill clients and their families, and includes people infected and affected by HIV and AIDS. The provision of care and support is in alignment with the National HIV Policy which requires all patients to be provided adequate and effective palliative care, at all times. CHBC entails the provision of care and support, in collaboration with CHBC providers, at the client's home and includes the family's involvement as a component of care. The CHBC package encompasses clinical care, nursing care, counseling and psycho-spiritual care and social support.

Care and Support for OVC

As a result of the scale-up in treatment, many PLWHIV survive for longer and fewer children are left orphaned. In 2006 18% of children aged less than 18 years were orphans (single, double orphans). Many of these children are cared for by extended family or grand-parents who are already struggling to support themselves. Consequently these children are at a higher risk of missing the opportunity to attend school, of poor nutrition, no shelter and other items important for normal growth and development. The government has therefore scaled up efforts for the care of orphans and vulnerable children to leave a sustainable life. By 2009/10, 113,995 children were receiving welfare grants. Also the ratio on OVC to non OVC aged 10 to 14 years school attendance is 1.

2.4. Enabling Policy and Legal Environment

Namibia has established strong foundations for an enabling environment. 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.

Respect for the rights of people living with HIV and AIDS is an essential and central component of an effective response. Discrimination against people living with HIV and AIDS violates their rights and is counterproductive to an effective response to HIV and AIDS in that it constitutes a significant disincentive for voluntary counseling and testing threatens voluntary disclosure of HIV status and increases vulnerability to HIV infection, thereby undermining efforts in response to the epidemic.

On 1 July 2010, the Government of Namibia lifted a long-standing regulation restricting the entry, stay and residence of people living with HIV and AIDS and other infectious diseases. This amendment has aligned Namibia's legislation with international health guidelines and even though there is no example of the enforcement of the regulation in Namibia, the Minister of Home Affairs and Immigration acknowledged that its existence created the wrong impression of Namibia as a democracy and its national and international commitments to a human rights-based approach to responding to HIV and AIDS.

Resource Mobilization

In an effort to curb the epidemic, spending on HIV activities has increased. During FY2008/09 US\$ 194 million was spent on HIV/AIDS activities nationally. Government's contribution to HIV/AIDS spending has been approximately 50%. External funding is mostly from development partners i.e. GFATM and PEPFAR, GTZ, United Nations Agencies and private donors. The private sector tends to mobilize their own resources to support private sector workplace HIV and AIDS programmes. Dependence on a few funding agencies poses a serious risk in the event that one of the partners had to stop or reduce its funding significantly. This calls for a comprehensive sustainability strategy.

3. Update on integrating regional priorities

A Joint meeting of stakeholders from Zambia, Zimbabwe, South Africa, Botswana, Angola, Swaziland, Mozambique and Namibia was held during the 19th to the 23rd of April 2010 in Windhoek. Namibia will plan for surveys for size estimation of MARPS and reviewing the methods used in these countries. This workshop was organized by UNAIDS and the USG. The purpose of this

workshop was to train personnel from countries in the region on methods for size estimation of Most at Risk Populations in the community that are often hidden because of discrimination. The outcome of the meeting was specific implementation plans for MARPs size estimation for each country. Namibia in particular produced plans for SWs and MSMs.

4. Implementation Challenges and Emerging Issues

- Although prevention funding has increased over the years, the overall investment in prevention activities is not yet commensurate to the need given that prevention is a national priority in the fight against HIV and AIDS.
- Lack of focus and targeting on key epidemic drivers and most at risk population groups such as sex workers, Men who have Sex with other Men (MSM) and prisoners. Focus has been on where funding is readily available and not necessarily on what drives the epidemic.
- Health Systems: A review of the health systems indicate that current levels of human and infrastructure resources are insufficient to support the increased coverage of PLHIV, both who are on Pre-ART and ART. This shortfall of resources would become even more significant if additional emphasis is to be placed on quality of service delivery to PLHIV. Opportunities for more efficient service delivery could be provided through stronger linkages with the private health sector. However the lack of an established coordination system for the two sectors has resulted in both sectors operating separately and independently of each other.
- Approximately 59% of OVC do not possess all three basic needs (pair of shoes, set of clothes, and blanket)¹⁰
- There are major gaps in basic human rights, equal legal and social protection, and access to services for vulnerable groups
- Strategic information on HIV in Namibia is limited due to the absence of bio-behavioural population based surveys of the general and most at risk populations.
- Sustainability of the National HIV response after withdrawal of donor funding will be a challenge without a sustainability strategy.

¹⁰ NDHS 2006-2007

5. Conclusion and Way Forward

Although there is a demonstrated improvement in most areas especially in prevention, care and treatment, there are still a lot of challenges as a result of human resource and infrastructural capacity to further scale-up the national response. HIV prevalence is still very high. The monitoring of the non-health and private sector response also needs to be strengthened. Activities addressing most at risk and vulnerable populations need to be further enhanced as well as those addressing social cultural issues such as alcohol and gender. There is also a need to generate more evidence through bio-behavioural surveys to guide programming.

5.1 Recommendations

- Intensify implementation of quality social and behaviour change prevention interventions targeted to high risk populations that contribute to a reduction in HIV transmission through a reduction in multiple and concurrent partnerships, reduction in the practice of trans-generational sex, reduction in the practice of transactional sex, reduction in risky sex related to alcohol use, increase in those seeking biomedical interventions (MC, HCT, condoms)
- Strengthen the provision of life skills HIV based education in primary and secondary schools by establishing life skills HIV based education as stand-alone examinable subject in schools, incorporating the subject in the core curriculum in schools and training teachers on life skills HIV and AIDS based education
- Expand the opportunity for HCT so that people get tested, receive and know their HIV status results.
- Strengthen the human resources for HCT to enable the programme to meet demand by other programmes (ART, PMTCT, male and sector for HCT)
- Increase the availability of male and female condoms and the number of prevention programs promoting condom use so that HIV transmission may be reduced through improved and consistent use of condoms, particularly among those whose use is currently low
- Conduct a nation-wide size estimation and bio-behavioural surveillance of MARPS as well as of the general population to inform future planning, service delivery and policy considerations.
- Develop policy guidelines on the involvement of PLHIV in promoting and implementing universal access to HIV services
- Intensify community mobilisation targeting uncircumcised men, parents of newborns, potential parents and communities in general to generate demand from among the circumcised newborns and adult men through education and awareness information using inter-personal communications and community conversations.

- Scale up provision of comprehensive PMTCT services to all designated health facilities based on National PMTCT guidelines and aligned to international standards
- Improve ART coverage as well as the service provision environment including human resource and infrastructure capacities
- Review, develop and implement a successor for the National Plan of Action for OVC to run up to 2015/16
- Develop a sustainability strategy for the national response that includes financial and human resource elements.

APPENDIX 1 : COUNTRY DATA

NATIONAL DATA ON KEY SADC INDICATORS FOR HIV AND AIDS IN NAMIBIA: 2009/10

1. HIV Prevention and Social Mobilization				
Indicator	Description	National data	Year	Source
1.1 Youth_HIV_08	Percentage of young people aged 15-24 who are HIV-infected	10.6%	2008	Sentinel survey (MOHSS)
1.2 T_sex_08	Percentage of men and women aged 15-49 who had sex with more than one partner in the last 12 months	Women: 2.5% Men: 16%	2006/07	NDHS
1.3 Youth_Inf_08	Proportion of young people aged 10-24 who cite a member of the family as a source of HIV and AIDS related information	N/A	2006/07	NDHS
1.4 S_teac_08	Percentage of schools that provided life-skills-based HIV education in the last academic year	Primary Schools: 75% Secondary Schools: 86%	2009	MOE
1.5 Know_T_08	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	Woman (15-24) 65% Men (15-24) 62%	2006/07	NDHS
1.6 PMTCT_08	% of HIV-positive pregnant women who received anti-retrovirals to reduce risk of MTCT	58%	2008/09	MoHSS
1.7 Blood_08	Percentage of donated blood units screened for HIV in a quality assured manner	100%	2008	MoHSS/ NAMBTS
1.8 Cond_08	Number of female and male condoms distributed	22.8 million	2009/10	MoHSS / CMS
1.9 P_cond_08	Percentage of men and women aged 15-49 who used a condom last time they had sex with a casual partner within the last 12 months	Women: 62% Men: 78%	2006/07	DHS
1.10 Inf_08	Percentage of infants born to HIV infected mothers who are infected	12.7%	2008	MoHSS
1.11	Percentage of MARPs (IDU, MSM,SW) who are HIV infected	N/A		
1.12	Percentage of MARPs (IDU, MSM,CSW) who received an HIV test in the last 12	N/A		

	months who know the result			
1.13	Percentage of males circumcised	21% (15-49yrs)	2006/7	NDHS
1.14	Number of males circumcised	728	August 2009 to July 2010	MoHSS
1.11 NCPI_08	National Composite Policy Index	Conducted	2010	MoHSS

2. Improving Treatment, Care Access to Counseling and Testing Services and Support

Indicator	Description	National data	Year	Source
2.1 hcf1_08	Percentage of health care facilities providing ART	36% (n=141)	2009/10	MoHSS
2.2 hfc2_08	Percentage of health care facilities with referrals for HIV and AIDS care support services	75%	2008	MoHSS
2.3 OVC1_08	Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	16.5%	2006/7	NDHS / Min of Gender Equality & Child Welfare (MGECW)
2.4 School_08	Current school attendance among orphans and non-orphans aged 10-14	1.0	2006/7	NDHS
2.5 OVC2_08	Percentage of children aged less than 18 years who are orphans (single, double orphans)	15%	2006/7	NDHS / Min of Gender Equality & Child Welfare
2.6 WPP_08	Percentage of large enterprises / companies which have HIV and AIDS workplace policies and programmes	1%	2008	OPM
2.7 HBC1_08	Percentage of chronically ill people that are receiving Home Based Care from trained care providers	16%	2008	MoHSS
2.8 HBC2_08	Number of providers trained in Home Based Care	1,279	2008	MoHSS
2.9 TEST1_08	Percentage who undertook an HIV test in the last 12 months and who know the result	Women: 28.6% Men: 17.6%	2006/7	NDHS
2.10 TEST2_08	Percentage of facilities providing HIV testing services	98%	2009/10	MoHSS
2.11 POP_08	Percentage of population expressing accepting attitudes towards PLHIV	Women: 39.2% Men: 36.1%	2006/7	NDHS
2.12 ARV	Percentage still alive after initiating ART at 6, 12, 24 months	85% (6 months) 79% (12	2009/10	MoHSS

		months) 75% (24 months)		
2.13 ARV1_08	Percentage of people with advanced HIV infections receiving antiretroviral therapy	Total 75 681 (90%) A 88% C100% (CD4 200) (currently used) A 73% C82% (CD4 350) (to be used with the revised guideline)	2009/10	MoHSS
2.14 ARV2_08	Percentage of districts or local administration units with at least one health facility providing antiretroviral therapy	100%	2010	MoHSS
2.15 ARV2/TB	Percentage of HIV positive people who are screened for TB on their first visit to an HIV clinic	N/A		MoHSS
2.16 ARV/TB	Percentage of HIV positive TB patients who are on ART	35% (n=1995)	2009	MoHSS
2.17 ARV/TB	Percentage of HIV positive people who are TB positive (Co infection rate)	N/A		
3. Resource Mobilization				
Indicator	Description	National data	Year	Source
3.1 NB_08	Percentage of the national budget committed to the health sector	11.1%	2010	MOF National Budget
3.2 FR_08	Amounts of public funds for research and development of a preventative HIV vaccine and microbicide	N/A	-	-