



Republic of Namibia

Summarised
National Strategic Framework for
HIV and AIDS Response in Namibia
2010/11 - 2015/16
The Popular Version



2010
Windhoek

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TABLE OF CONTENTS

Acronyms	2
What is the NSF?	3
What is the Purpose of the NSF?	3
What are the priorities for the NSF?	3
What are the key results expected to be achieved by 2015/16?	4
Epidemiology of HIV and AIDS in Namibia	5
What achievements has Namibia made so far?	6
The NSF's Strategic Interventions	7
Preventing New HIV infections	7
Improving quality of life through treatment, care and support	8
Mitigating the socio-economic impacts of HIV and AIDS	9
Coordinating and managing the national response	9

ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante Natal Clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral medicine
CACOC	Constituency AIDS Coordinating Committee
CHBC	Community Home Based Care
FY	Financial Year
GDP	Gross Domestic Product
HCT	HIV Counselling and Testing
HIV	Human Immuno-Virus
M&E	Monitoring and Evaluation
MARPS	Most At Risk Populations
MCP	Multiple Concurrent Partners
MOHSS	Ministry of Health and Social Services
MTP	Medium Term Plan
NABCOA	Namibia Business Coalition on AIDS
NAC	National AIDS Council
NAEC	National AIDS Executive Committee
NaCCATuM	Namibia Coordinating Committee for HIV and AIDS, TB and Malaria
NANASO	Namibia Network of AIDS Service Organisations
NDHS	Namibia Demographic and Health Survey
NDP3	Third National Development Plan
NGO	Non Governmental Organisation
NPC	National Planning Commission
NSF	National Strategic Framework
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
RACOC	Regional AIDS Coordinating Committee
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UN	United Nations
WBCG	Walvis Bay Corridor Group
WHO	World Health Organisation

WHAT IS THE NSF?

The National Strategic Framework (NSF) for HIV and AIDS provides the strategic directions for the implementation of all HIV and AIDS programmes in Namibia. It is based on the understanding that HIV and AIDS remains the greatest human development challenge. The NSF marks a key shift towards using evidence and results based planning. It channels all our energies towards working together to achieve collectively agreed upon impacts, outcomes and output results. The NSF succeeds the Third Medium Term Plan (MTP-III) that came to an end in March 2010. It is a six year plan that spans from April 2010 to March 2016.

The NSF is based on the principles of ensuring equal access to services for all people, of being culturally sensitive and of promoting community involvement. It continues to support the mainstreaming of gender and human rights in all aspects of the national multisectoral HIV and AIDS response. It recognises that people living with HIV (PLHIV) are part of the solution not the problem and their participation is critical to our success. It puts into action the global call to strengthen the scale up of national AIDS responses by adopting the “Three Ones” principle - having one coordinating authority, one national strategic framework and one national M&E framework.

The NSF enables decentralised planning where each of the thirteen regions and fourteen sectors will have their own specific operational plans that are aligned to the National Operational Plan. The national, sector and regional operational plans will be used as vehicles for NSF implementation.

WHAT IS THE PURPOSE OF THE NSF?

The NSF defines how we as Namibians – in all sectors of society and at all levels – are going to respond to HIV and AIDS in the next six years. It helps us focus on national priorities and results. It identifies effective programmes and strategies for implementation. Stakeholders, knowing their mandates and comparative advantages, can use the NSF to define their strategic niche in the implementation. The priority settings also allow strategic resource allocation.

As HIV and AIDS is both a health and development issue, the NSF is aligned to other national socio-economic development frameworks such as Vision 2030, the Third National Development Plan, the Poverty Reduction Strategy and the Action Plan. This is necessary to address some of the epidemic drivers and to lessen the impact of the epidemic.

WHAT ARE THE PRIORITIES FOR THE NSF?

The overarching priority of the NSF is to maintain and improve the quality of life of Namibia’s people by preventing new infections from occurring and by providing comprehensive and quality treatment, care and support for those already infected or affected by HIV and AIDS.

Preventing new infections remains the key priority strategy. The NSF aims to reduce the annual number of new infections by 50% by 2015/16. Eventually the aim is to reduce the incidence rates to a threshold level where the epidemic cannot sustain itself. Available data indicates that 16 new infections occur daily. To reduce the incidence rate, targeted prevention interventions will focus on key drivers of the epidemic.

The second priority for the NSF is to ensure PLHIV live longer. This calls for comprehensive treatment, care and support programmes. The NSF will scale up HIV counselling and testing so more people

can know their HIV status and access a range of services which will help to maintain good health for longer. People will be eligible to start antiretroviral treatment (ART) earlier.

Finally, the NSF prioritises reducing the socio-economic impacts of HIV especially among vulnerable households. It aims to empower vulnerable households and people through skills development, support to make their livelihoods sustainable and other strategies that promote self-reliance.

WHAT ARE THE KEY RESULTS EXPECTED TO BE ACHIEVED BY 2015/16?

The key results expected by 2015/16, when the term of this NSF comes to an end, are three fold. The quality of life will have improved significantly as new HIV infections will have reduced by more than 50%. People living with HIV and AIDS will be living longer as they will receive quality and comprehensive treatment, care and support. Those most affected, such as PLHIV, orphans and vulnerable children and other members of vulnerable households, will be better able to cope.

The table below presents the impact level results anticipated at national and thematic levels. The Human Development Index will only improve if the overall quality of life has changed. The combined results in prevention, treatment care and support, and impact mitigation are the key contributors to improving the Human Development Index¹.

Level	Anticipated Impact Results
National	Namibian Human Development Index is improved from 0.542 in 2008 to 0.55 by 2015/16
Prevention	Annual number of new infections has reduced by 50% between 2010/11 and 2015/16
	% of pregnant women attending ANC aged 15-24 who are HIV infected is reduced from 11% in 2008 to 5% by 2015/16
Treatment, Care and Support	% of infected infants born to HIV positive mothers is reduced from 12% in 2007 to 4% by 2015/16
	Life expectancy has increased from 51.6 years in 2008 to 55 years in 2015/16
Impact Mitigation	% of people reported dying from AIDS has decreased from 23% in 2008/09 to 18% in 2015/16
	% poor households has decreased from 28% in 2008 to 20% in 2015/16
Response management	% of households with vulnerable individuals that are able to cope with the impact of HIV has increased to 50% by 2015/16
	Effective and efficient management of the response and service delivery for those infected and affected by HIV and AIDS. (NDP3 Goal 14 Programme 1 outcome)
	% of NSF service coverage targets (output level results) that have been met in the areas of HIV prevention, treatment care and support and impact mitigation has increased from 0% in 2009 to 60% by 2013 and to 75% by 2015/16
	% of stakeholders that have expressed satisfaction with the level and type of services provided by MOHSS has increased from 60% in 2009 to 80% in 2015/16

¹ HDI is measured using three basic dimensions of human development. Firstly by health - "a long and healthy life" as measured in life expectancy at birth, secondly by "knowledge" as measured in adult literacy and education, and finally by a "decent standard of living" measured by GDP per capita (PPP US\$).

Linking HIV and AIDS programmes to development outcomes helps to place the response in the overall national development programme. This is why collectively all the NSF interventions should contribute to improving our quality of life.

EPIDEMIOLOGY OF HIV AND AIDS IN NAMIBIA

Namibia has a generalised epidemic that has spread throughout society. In 2008/09, HIV prevalence in the general population among people aged 15 to 49 years was estimated at 13.3%². Approximately 16 new infections were occurring every day - 25% amongst infants aged less than one year, 31% amongst youth aged 15-24 and 37% in persons aged 25 or older (MOHSS 2009). In that year alone, approximately 5,830 people became newly infected with HIV. The 2008 National HIV Sentinel Survey³ estimated that over 54% of the new infections were women and 32% children were under 15 years.

This steady stream of new infections over a time has resulted in an estimated 174,000 adults and children living with HIV and AIDS in Namibia by the end of the financial year 2008/09. By then, approximately 250,000 children below 18 years were orphans or vulnerable children, of whom around 28% (69,000) had been orphaned by AIDS (MOHSS 2009, NDHS 2007⁴ and NPC 2006⁵).

The 2008 HIV Sentinel Survey shows an overall decrease in prevalence among 15 -24 age group, which corresponds to a reduction in new infections amongst the youth from 39% of all new infections in 2002 to 31% of new infections in 2008 (MOHSS 2009). It is anticipated that new infections in adults aged 15-years and above are projected to decline to 3,025 during fiscal year 2010/11 and to 2,877 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.

The main mode of HIV transmission is heterosexual. The epidemic has sustained itself through specific sexual practices, community norms and practices, alcohol abuse that affects decisions on sexual behaviour and low levels of HIV risk perceptions. Recent studies have highlighted the drivers that fuel new infections are of a biological, behavioural, social and structural nature⁶. The main epidemic drivers which have been identified are listed in the box insert.

The drivers of the epidemic in Namibia

1. Multiple and concurrent partnerships
2. Inter-generational sex
3. Transactional sex
4. low and inconsistent condom use,
5. low perceptions of risk of HIV infection
6. Low levels of male circumcision
7. Alcohol abuse
8. Peoples mobility and migration in and outside the country
9. Gender inequality
10. Income inequality
11. Early sexual debut

² MOHSS 2009, *Estimates and Projections of the Impact of HIV and AIDS in Namibia, 2008/9*

³ MOHSS 2008, *Report on the 2008 National HIV Sentinel Survey*

⁴ MOHSS 2008, *Namibia Demographic and Health Survey 2006-07*

⁵ NPC 2006, *Population projections 2001-2031, Namibia: National and regional figures*

⁶ De la Torre C, et al 2009, *HIV and AIDS in Namibia: Behavioural and Contextual Factors Driving the Epidemic*. MOHSS

WHAT ACHIEVEMENTS HAS NAMIBIA MADE SO FAR?

The table below highlights some of the achievements Namibia has made in prevention, treatment, care and support, impact mitigation and in response management. These achievements have accrued over time until the end of the MTP-III period.

- Knowledge about HIV and AIDS has steadily increased. The NDHS 2006/7 found the level of comprehensive knowledge of HIV and AIDS in Namibia was estimated at 63% for men and 67% for women.
- By March 2007, approximately 407 teachers have been trained on life skills education and over 189,327 students had benefited from life skills education.
- In 2007 the number of people who had tested and knew their HIV status had increased significantly to 51% women and 32% men compared to 24% women and 25% men in 2002.
- HIV Counselling and Testing has remained a strategic entry point for treatment. By March 2009, 64,637 PLHIV had been enrolled on ART in public health and mission facilities. Of these 57% were adult females, 31% were adult males and 12% were children (0 – 14 years)⁷. This represents 84% of people estimated to be in need of ART. By the end of 2009, the retention of patients enrolled in the last 12 months was estimated at 85%⁸.
- Regarding PMTCT, by 2008, 58% pregnant women had received a HIV test during ANC visits. By 2007, 70% of HIV-positive pregnant women had received ARVs to reduce the risk of transmission from mother-to-child.
- Namibia has attained 100% voluntary non-remunerated blood donation and 100% screening of blood products for transfusions transmissible infections.
- In 2006, sexually transmitted infections (STI) prevalence was estimated at 2.9%.
- During the FY2007, 28 million male and female condoms were distributed countrywide – more than a 120% increase from what was provided in 2003. Condom usage, especially during higher risk sex, also increased and condom use by the clients of sex workers is high.
- The number of TB patients tested for HIV increased from 16% in 2005 to 66.9% in 2008. Of those tested 59% tested HIV positive⁹. The treatment success rate for new smear positive TB cases was 75% by 2007. The defaulter rate has decreased from 13% to 10%.
- As of 2006, Community Home Based Care (CHBC) providers had reached 39,330 PLHIV in all 13 regions of the country. As a result of ART rollout, CHBC is moving towards preventive and adherence support as well as broader issues of primary health care.
- By 2007, 16.5%¹⁰ of OVC were receiving at least one type of external basic support e.g. medical, emotional, social/material and educational related support. In 2009, cash transfers were made to support 104,438 OVC¹¹. 94.6% of OVC were attending primary schools¹².
- Several policies and technical guidelines have been developed, adopted and disseminated to implementing partners. Funding for HIV and AIDS has increased significantly and more strategic partnerships have developed especially with the Global Fund and PEPFAR. Government has allowed the allocation of 2% of sector budgets for HIV and AIDS.

⁷ MOHSS RM&E March 2009 resultsE

⁸ MOHSS 2006, Report of the 2006 Namibia HIV Drug Sensitivity Survey

⁹ MOHSS 2009, National TB and Leprosy Control Programme 2008/9 Annual Report

¹⁰ MOHSS 2008, Namibia Demographic and Health Survey 2006-07

¹¹ MGECW Datawarehouse 2009

¹² MOHSS 2008, Namibia Demographic and Health Survey 2006-07

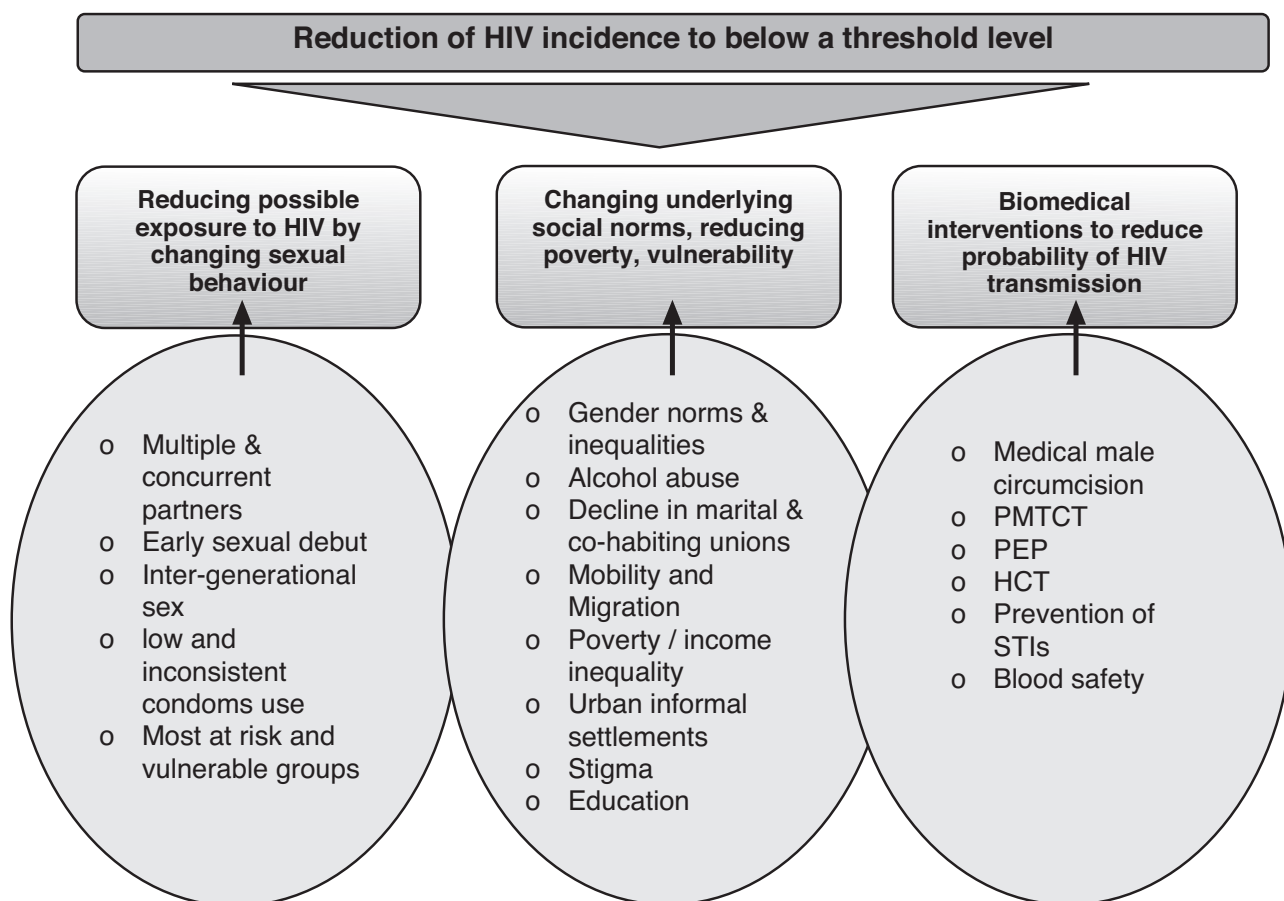
THE NSF'S STRATEGIC INTERVENTIONS

Preventing New HIV infections

Namibia has prioritised prevention as the key strategy in addressing HIV and AIDS. The aim is to reduce the number of new HIV infections to such a low level that the epidemic cannot sustain itself. The three pillars of the prevention strategy are changing people's sexual behaviour, reducing the risk of infection through biomedical interventions and changing aspects of our culture and society that make people vulnerable to HIV (such as alcohol abuse, poverty and gender inequalities).

Priority will be given to targeting the drivers of the epidemic which keep HIV spreading, such as having more than one partner at the same time (multiple and concurrent partnerships - MCP). HIV is also known to spread further when people have sex in other age groups (trans-generational sex) and when sex is driven by material gain such as gifts (transactional sex). More drivers are listed in the figure below.

A key strategy will be to target people who are more at risk to HIV than others so then can access and use prevention services. Examples of most at risk populations (MARPS) are partners who often live apart due to work, sex workers, men who have sex with men, prisoners and people awaiting trial, people with disabilities, women and children. Many children have reported having had forced sexual intercourse¹³ and gender violence continues.



¹³ UNICEF 2006, *HIV and AIDS Knowledge, Attitudes, Practices and Behaviour (KAPB) study in Namibia*.

The NSF will support biomedical interventions that reduce HIV transmission including medical male circumcision, prevention of mother to child transmission (PMTCT), HIV counselling and testing and control of sexually transmitted infections (STIs). Although Namibia has achieved 100% blood safety, as a universal precaution the NSF will continue support for blood screening.

Namibia joins the global target to eliminate mother to child transmission of HIV. The NSF strategy is to prevent unintended pregnancies, to promote behaviour change to prevent HIV transmission during sex, to prevent mother to child transmission at birth and during breastfeeding and to provide treatment to mother and child according to the PMTCT guidelines.

Evidence shows that male circumcision can reduce the probability of HIV transmission from HIV positive women to HIV negative men by 60% . The NSF therefore details plans to roll out medical male circumcision throughout the country. Evidence shows that most people who have been counselled and tested for HIV change their behaviour and have less unprotected sex. The NSF plans to improve counselling and testing and expand its coverage in communities and workplaces.

We have learned that only focusing on individuals does not change people's sexual practices. We also need to focus on changing social norms – acceptable and unacceptable behaviour. The NSF supports interventions that expand and increase coverage to couples, families, social networks, communities and community leaders. Interventions will be scaled up in workplaces, prisons, military, police, schools and civil society organisations and will be adapted for urban and rural settings. The NSF will promote prevention programmes for PLHIV and integrate prevention into other health and non-health sector programmes.

The aim is to improve coordination of prevention efforts, particularly at implementation level, as combining strategies has a bigger impact. A National HIV Prevention Strategy for Namibia will be developed to guide and inform strategic interventions.

Improving quality of life through treatment, care and support

The priority of the Government of Namibia is to improve the quality of life of PLHIV and have them live longer, by implementing the proposed treatment, care and support interventions.

Pre-ART services will be scaled up so PLHIV can maintain good health for longer, before they need to start ART. Such services will include screening for opportunistic infections, providing prophylaxis, nutritional support, monitoring of viral loads, counselling and psychosocial support to avoid re-infection and treatment literacy when preparing to go onto ART.

TB remains the single most important cause of death among PLHIV so the NSF focuses efforts to prevent and treat TB in PLHIV. The NSF will adopt the WHO “Three I’s” strategy that entails Intensified case finding, Isoniazid Therapy and TB Infection control. The capacity to monitoring TB drug resistance will also be strengthened.

Provision of ART remains a key strategy in improving the quality of life of PLHIV. More people will be enrolled on ART at an earlier stage as Government has raised the eligibility criteria from CD4 200 to CD4 350 which will raise treatment success rates. All TB patients with HIV will be treated with ARVs and people with Hepatitis B and HIV will also be eligible for ART, following WHO guidelines.

To reach the target of providing ART to 95% of people who are eligible by 2015/16, the government will roll out ART services to more health facilities. Nurses will be trained to take on more responsibilities such as screening, diagnosis and prescribing medications to clients. Experienced doctors in HIV will be made available to provide clinical mentoring and long-distance support. Improved drug monitoring

will ensure that no stock outs are experienced. The NSF will also explore innovative and sustainable strategies for providing nutrition for malnourished adults and children during pre-ART and on ART.

The increasing demand for ART services will place more pressure on the available human and infrastructure resources in the public sector and greater involvement of the private sector will be crucial. As ART coverage levels increase, the need for continued care outside the health setting will also increase. The NSF recognises that home based care and support is best provided by civil society. The provision of Community and Home Based Care (CHBC) is an integral part of the treatment package. CHBC can support adherence to treatment schedules, track treatment defaulters, provide psycho-social support and ease pain and suffering through palliative care. During the period of the NSF, CHBC will be strengthened and expanded; service providers will be trained in appropriate skills and monitoring of quality of services will be intensified.

Therefore, this NSF rolls out and scales up the ART programme. It places greater emphasis on offering a more comprehensive, quality-oriented service provision with strategic partnerships between Government, civil society and the private sector.

Mitigating the socio-economic impacts of HIV and AIDS

The priority of the impact mitigation response is to reduce the number of vulnerable households and where vulnerability exists to strengthen and improve their coping mechanisms. The main causes of vulnerability are poverty, lack of food and nutrition, low levels of education and the presence of OVCs, PLHIV and other chronically ill patients.

The primary focus will be on vulnerable households that have vulnerable people especially PLHIV, OVC and the elderly; women-headed households and the urban poor are also vulnerable. Care of OVC and PLHIV remains the greatest challenge for vulnerable households as they struggle to meet basic needs including food, shelter, education, clothing, social-protection, access to health care, and sanitation. Such households often have to deal with psychological and mental trauma such as loss of loved ones, gender based violence, and physical, emotional, and sexual abuse.

The key shift in the NSF strategy is to move beyond the welfare approach to developing sustainable livelihoods, improving care and support for OVC and PLHIV and improving food security and nutrition. The aim is to reduce the vulnerability and risks faced by poor people and disadvantaged social groups who are unable to earn their own livelihoods. Interventions can include income transfers, school feeding programmes, vocational skills training, livelihoods training, early childhood development and micro credit to name a few. These strategies are potentially overlapping, and allow for interaction.

The NSF has aligned its impact mitigation strategies and results to key policy frameworks including NDP3, Poverty Reduction Strategy and Action Plan, National Plan of Action for Orphans and Vulnerable Children and the National Gender Plan of Action.

Coordinating and managing the national response

The NSF strategy is to strengthen the capacity of the coordinating and management structures to improve effectiveness and increase efficiency. A National Coordination Framework has been developed that clarifies the mandate, roles and responsibilities, membership and the terms of reference for all the coordinating structures.

The principal coordinating structures are NAC, NAEC, RACOCs, CACOCs and Sector Steering Committees. The NSF has restructured the sectors into fourteen thematic clusters, each coordinated through its Sector Steering Committee. NAEC has also established six thematic Technical Advisory

Committees. NAEC will work with other committees such as the NaCCATuM, the PEPFAR Steering Committee, the Permanent Task Force for OVC and the UN Theme Group. Umbrella organisations such as NABCOA and NANASO will continue to play a strategic role in sector coordination and implementation of sector operational plans.

People living with HIV must be key stakeholders rather than merely beneficiaries of services. Living with HIV is an experience that enables PLHIV to add value to every aspect of the HIV response ranging from awareness-raising to voluntary testing and counselling, through to the provision of ART and other services. The challenge is to address stigma that prevents more skilled and professional people living with HIV from being open, which would make the “body positive” more representative, not just in terms of image but also involvement in the response. The NSF will strengthen and expand the enabling environment to ensure that Namibia has effective policies and legislation in place to protect human rights associated with the HIV and AIDS and that address stigma, discrimination and gender inequalities.

Effective leadership is not simply an obligation of politicians, but of all leaders in the sectors, religious organisations and communities. The NSF plans to mobilise, engage and strengthen the capacity and participation of all leaders in the implementation of the response. Communities and workplaces are both beneficiaries and implementers of HIV and AIDS programmes and they play a critical role for sustainability and service uptake.

A key strategy for the NSF is strengthening community systems to support the implementation of community based HIV and AIDS activities. Support will be provided to CACOCs to establish a coordinating office with staff, human and financial resources. Communities will be trained and mobilized to address drivers of the epidemic and provide care and support to OVC and PLHIV.

During the period of the NSF, special attention will be paid to develop capacity of these key stakeholders in critical areas including human resources, leadership and governance, monitoring and evaluation, planning and programming using evidence, results based approaches, resource mobilisation and resource tracking. Innovative strategies for resources mobilisation in-country will be explored and Government will be encouraged to increase its funding for HIV and AIDS, strengthen public private partnerships and reduce dependence on international resources.

In expanding the scope of the response, sectors will be encouraged to establish or strengthen HIV and AIDS workplace programmes and mainstream HIV and AIDS interventions in their development programmes. Inter-sectoral coordination and collaboration will be strengthened.

The National Monitoring and Evaluation (M&E) framework will be strengthened and consolidated. All sectors, regions and development partners will be encouraged and supported to harmonize and align their M&E systems with the national M&E framework. Some of the key areas for harmonization and alignment are the indicators identified to measure performance, and the results or programme targets. The national M&E framework has articulated the indicators for NSF in addition to the impact, outcome and output results.